2024/2025

# Community Health Needs Assessment

MultiCare

Covington Medical Center

# Introduction

King County
Community Health
Needs Assessment
2024/2025

## South King County

The 2024–2025 King County Community Health Needs Assessment (CHNA) provides a comprehensive view of health and social conditions across the county. While the data and findings span the entire region, Covington Medical Center's focus is directed toward South King County based on the primary community served.

South King County faces some of the greatest health inequities in King County, with residents experiencing higher rates of chronic disease, violence, and maternal and infant health challenges, alongside persistent barriers tied to income, housing, education, food access, and transportation. These realities make South King a priority area for Covington Medical Center's community health strategies.

By centering efforts in South King County, Covington Medical Center acknowledges that improving health in this region is both a moral and strategic imperative. The area's large and diverse population means that progress here can meaningfully influence overall county health outcomes, while also addressing urgent local needs. Through partnerships, targeted investments, and equity-driven programming, Covington Medical Center aims to strengthen community resilience and reduce disparities for the patients and families it serves.

## Health & Social Conditions

South King County faces some of the deepest health disparities in King County. Residents experience lower life expectancy, higher rates of chronic disease, violence, and poor maternal and infant outcomes compared to county averages. These inequities are tied to systemic socioeconomic barriers: income disparities, lower educational attainment, unaffordable housing, food insecurity, and transportation challenges.

The COVID-19 pandemic further strained community health, with rising drug-related deaths, firearm violence, unintentional injuries, and domestic violence. At the same time, certain positives—such as high adult vegetable consumption and a decline in fall hospitalizations—show resilience and opportunities to build upon.

The data underscores the need for a sustained, equity-focused strategy that moves beyond traditional clinical care to address root causes, prioritize vulnerable groups, and strengthen long-term resilience.

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## Regional & Demographic Profile

South King County is home to roughly 663,000 residents spread across 12 diverse cities, including Kent, Renton, Federal Way, Auburn, SeaTac, Tukwila, Burien, Covington, and White Center. As one of the fastest-growing areas of King County, the region plays a pivotal role in shaping countywide health outcomes. Even modest improvements in population health here have the potential to generate meaningful gains across the entire county.

The region's demographic composition reflects a rich and complex diversity. South King has higher proportions of Black (18.8%) and Hispanic (20.3%) residents than the county average, alongside a sizable Asian community and one of the highest shares of foreign-born residents in the county—more than one in three. Nearly 40% of residents speak a language other than English at home, and about 15% report limited English proficiency.

This linguistic and cultural diversity is a source of strength, but it also highlights critical access challenges. For many families, navigating healthcare, education, and social services is complicated by language barriers, which can lead to social isolation, reduced access to preventive care, and added economic vulnerability.

Together, these dynamics make South King County a uniquely important region for addressing health equity and advancing inclusive, community-centered solutions.

## Key Economic & Environmental Profile

South King County faces a combination of economic and social pressures that directly shape community health. Median household incomes across the region consistently trail county averages, and poverty rates are noticeably higher. In Federal Way, for example, the poverty rate is 12.7%, compared to 8.8% countywide. These financial challenges are reinforced by lower educational attainment—while more than half of adults in King County hold a bachelor's degree or higher, only about 27–32% of adults in Auburn and Burien have reached that level. The gap in education translates into reduced earning potential, reinforcing cycles of disadvantage.

Housing affordability is another pressing issue. More than 83% of low-income households spend at least half of their income on rent, leaving little room for other essentials like food, transportation, or healthcare.

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Food insecurity is particularly acute, with South King registering the highest rate in the county at 14.9%. In certain communities such as SeaTac and White Center, food insecurity rises to 22–26%, levels that highlight just how difficult it is for many families to maintain consistent access to nutritious meals. Obesity is a significant health concern in South King County, where 29.3% of adults are classified as obese. Some communities experience even higher rates, including Kent (41%), Greater Maple Valley (37%), and Tukwila (36.2%).

Transportation barriers further compound these struggles. Over a quarter of parents in South King County report challenges in getting their children to healthcare visits. Families with children who found it difficult to afford transportation were at 27.3%. These transportation issues also limit access to grocery stores and other vital services, reinforcing the interconnected nature of the region's socioeconomic challenges.

These conditions create a cycle of stress and instability that not only undermines daily life but also fuels persistent health disparities across the region.



## Health Outcomes & Access

The health challenges facing South King County are both widespread and deeply interconnected. Chronic disease remains a central concern, with hypertension affecting 28.3% of adults compared to 25% countywide, and diabetes prevalence nearly three percentage points higher than the county average. Childhood asthma is especially problematic in Federal Way, where rates outpace all other areas of the county. Preventive care gaps add to this burden—nearly one in three adults in the region has not completed recommended colorectal cancer screening, leaving serious conditions undetected until later stages.

Mental health and substance use concerns are equally pressing. Nearly 38% of youth in the South Region report symptoms of depression, with Hispanic and Multiracial students experiencing even higher rates. Drug-induced deaths have climbed sharply in recent years, disproportionately impacting American Indian/Alaska Native residents. Suicide remains another area of concern, with rates highest among White residents, reflecting the widespread toll of untreated mental health needs across different populations.

# Introduction

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Maternal and child health indicators point to inequities that begin at birth. Infant mortality is higher in South King County than the county average (5.1 vs. 4.0 per 1,000 births), and early prenatal care is less common here than anywhere else in the county. Vaccination coverage is also alarmingly low, with nearly half of children under age three lacking complete immunizations—leaving many families vulnerable to preventable illnesses.

Barriers to healthcare access and affordability compound these challenges. Uninsurance rates are double the county average in cities such as Federal Way and Auburn, and even among insured residents, cost prevents many from seeking needed care. Overall, nearly 12% of adults in South King report unmet medical needs due to cost, with some neighborhoods reporting rates exceeding 25%.

Finally, violence and injury add yet another layer of risk to community health. Emergency department visits for domestic violence are 76% higher than the county average, firearm-related deaths are 47% higher, and child abuse and neglect-related visits are 38% higher. These figures reflect not only the prevalence of violence but also its disproportionate impact on already vulnerable populations—particularly Black residents, who are more likely to be affected by firearm-related deaths.

The patterns show how health disparities in South King County are reinforced by overlapping crises in chronic disease, behavioral health, maternal and child outcomes, and community safety, all compounded by barriers to access and affordability.

## Year-Over-Year Trends

The year-over-year data reveals a troubling picture of worsening health and safety in South King County. Drug-related deaths have climbed sharply, firearm violence has increased, and both unintentional injuries and domestic violence rates have risen significantly. These issues are not occurring in isolation but are compounded by a broader decline in life expectancy, with the steepest drops seen among Black and Hispanic residents. Maternal health is also a growing concern, as the maternal mortality ratio in King County has doubled over the past decade, signaling a deepening crisis that particularly affects South King families.



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Amid these concerning trends, a few areas show stability or modest improvement. Vegetable consumption among adults in the South Region has remained consistently high, suggesting an encouraging foundation for nutrition-related health promotion. Countywide, fall hospitalizations have declined over time, offering another small but positive shift. Chronic disease prevalence, while still elevated, has remained relatively stable in recent years. However, stability at high levels of disease burden means progress remains limited, especially in a region facing multiple, overlapping health challenges.

## Conclusion

The health landscape of South King County is shaped by entrenched inequities that extend beyond individual behavior and into the social, economic, and environmental conditions of daily life. Lower educational attainment and limited income opportunities fuel a cycle of disadvantage, which manifests in higher rates of chronic disease, violence, and poor maternal and child health outcomes. The COVID-19 pandemic has intensified these disparities, amplifying drug-related deaths, violence, and declining life expectancy.

Reversing these trends requires upstream, community-centered strategies that move beyond short-term fixes and address the structural causes of poor health. By prioritizing equity, investing in social supports, building a healthcare system that reflects and serves the community, and focusing on vulnerable populations, South King County has the opportunity to reshape its health trajectory. Given the region's size, diversity, and strategic role within King County, progress here has the power to drive meaningful improvements across the county as a whole.

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## Impact Report

MultiCare Covington 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 Covington Medical Center supported, either through financial or in-kind support, and that addressed the health needs identified in the CHNA.

From 2022 through 2025, Covington Medical Center focused on the following priority health needs:

1. Access to Care
2. Behavioral Health
3. Chronic Disease

The tables below present strategies and program activities the medical center 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.

| Health Need: Access to Care | |
|---|---|
| **Strategy or Program** | **Summary Description** |
| Increase Capacity | • Supported Project Access Northwest<br>• Continued to build capacity within the hospital and service area to serve more patients.<br>  • Off Campus Emergency Department, adding access in North King County as well as Federal Way.<br>  • Indigo Clinics<br>  • Clinic expansion in Kent-Kangley area of So. King County<br>  • Virtual Care, increased the number of telehealth visits provided<br>  • Dispatch Health<br>  • Community Health Partnership Grants |

| Health Need: Access to Care (cont.) | |
|---|---|
| Strategy or Program | Summary Description |
| Established or Expanded Partnerships | • School nurse education<br>• Medical Teams International dental team<br>• Quilted Health - prenatal care |
| Patient Support | • Enrolled qualified patients into Medicaid and other support programs.<br>• Partnered with SeaMar on community-based resource days for insurance enrollment<br>• Continued to make access to charity care easy and accessible for all who qualify.<br>• Screened for health-related social needs and provided patients with support for barriers to care including transportation, housing, food, equipment, etc. |
| Sponsor and Support Community Based Interventions | • MultiCare provided financial support, via Community Partnership Grants and sponsorships, to community-based organizations that increase access to care. |
| **Impact** | Since the last CHNA, published in 2022, the rate of uninsured adults has remained relatively stable at around 6.6% to 6.7% during the period. Unmet needs due to cost have decreased from 13% in 2019 to 9.5%, the most recent data point available. |
| **Planned Collaborators** | MultiCare plans to strengthen collaboration with HealthierHere, the King County Accountable Community of Health (ACH) and establish a referral pathway for patients to receive resource navigation to address transportation barriers and other basic needs support. |

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| Health Need: Behavioral Health | |
|---|---|
| **Strategy or Program** | **Summary Description** |
| Increase Timely Access to Services | • Decreased number of days from Mental Health/ SUD assessment to first appointment in MHS behavioral health network<br>• MultiCare continues to partner with Virginia Mason Franciscan Health to operate Wellfound Behavioral Health Hospital in Pierce County.<br>• MultiCare operates Navos Behavioral Health Hospital in King County who has contracted for long-term treatment beds, established warm hand-offs to substance use treatment programs and other measures to increase capacity for care. |
| Promote Integration of Physical and Behavioral Health Care | • Increased number of integrated behavioral health visits provided through collaborative care.<br>• Continued integration of behavioral health services into several MHS medical clinics.<br>• Screened patients for depression at annual well visits in outpatient primary care.<br>• Screened patients for intimate partner violence and health related social needs/ stressors inpatient. |
| Sponsor and Support Community Based Interventions | • MultiCare provided financial support, via Community Partnership Grants and sponsorships, to community-based organizations to provide behavioral health services and resources. |
| **Impact** | Frequent mental distress is defined as having 14 or more days with poor mental health in the last 30 days. Since the last CHNA, published in 2022, rates of adults with frequent distress averaged 12.9% for the most recent reporting period. |
| **Planned Collaborators** | Covington Medical Center collaborates with Navos Behavioral Health Hospital in King County, Wellfound Behavioral Health Hospital in Pierce County, various behavioral health agencies, and community partners to achieve these goals. Additionally, MultiCare Auburn Medical Center offers inpatient behavioral health services. |

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| Health Need: Chronic Disease | |
|---|---|
| Strategy or Program | Summary Description |
| Collaboration and Resources | • Identified community resources to support families with infants who face food insecurity.<br>• Continued outreach, promotion, and training related to hypertension and heart disease.<br>• Continued diabetes education, promotion, and risk assessments in underserved, BIPOC, and disparate communities.<br>• Participated in coalitions related to food security and chronic disease in King County.<br>• Supported access to healthy food through community partnership funds and sponsorships of food banks and farmer's markets. |
| Impact | Since the last CHNA, published in 2022, rates of hypertension have remained relatively steady at 25%. Additionally, heart disease mortality has remained relatively steady in King County but has decrease for Hispanics from 153.0 per 100k to 145.8 per 100k (2019 vs. 2022 – both are 3-year averages). Source: National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention |
| Planned Collaborators | Continue to partner with community-based organizations that focus on health promotion, wellness, food access and management of chronic disease. |

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The CHIP will be formally presented for approval and adoption by the Board of Directors no later than May 15th, 2026, in compliance with federal CMS and IRS requirements.

## New CHNA Implementation Plan

As part of the Community Health Needs Assessment (CHNA) process, each hospital will develop a Community Health Implementation Plan (CHIP) to ensure that identified priorities translate into actionable strategies. These strategies will include clear objectives, measurable outcomes, and cross-sector partnerships that address the most pressing community health concerns. The CHIP serves as a framework for aligning resources, guiding program development, and reinforcing MultiCare's long-standing commitment to improving the health and well-being of children, families, and communities.

While the prior CHNA and CHIP were prepared and released simultaneously, this cycle reflects a deliberate shift in process. By utilizing additional time between the completion of the CHNA and the finalization of the CHIP, we are strengthening opportunities for collaboration, dialogue, and alignment. This enables deeper engagement with community stakeholders, hospital leaders, and system-level decision makers, resulting in a stronger connection between community health priorities and the strategic direction of MultiCare hospitals. In this way, the CHIP is not simply an operational document, but a strategic blueprint that ties community health priorities to long-term organizational goals.

An essential component is the development of a robust data visualization and reporting strategy. This approach translates complex community health data into accessible, dynamic tools that enable internal monitoring of progress in real time. By integrating quantitative indicators with qualitative community insights, these tools allow hospitals and the broader MultiCare system to track performance against stated goals, identify emerging trends, and make timely, data-informed adjustments to implementation strategies.

Importantly, this work will extend across the entire MultiCare system. The intent is not only to strengthen the link between CHNA priorities and hospital-level planning, but also to create a unified framework that connects community health improvement efforts with system-wide strategic initiatives. This alignment ensures that the lessons learned in one community can inform action in others, while promoting consistency in measurement, accountability, and reporting across the system.

The CHNA, CHIP, and data visualization strategy create a continuous cycle of assessment, planning, action, and evaluation. This cycle enables MultiCare hospitals to remain responsive to evolving needs while also advancing long-term system goals. By building a process that is collaborative, transparent, and data-driven, MultiCare is positioning itself to more effectively demonstrate measurable impact for communities.



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## Board Approval & Adoption

Covington Medical Center has undertaken this Community Health Needs Assessment (CHNA) to better understand the most significant health challenges and opportunities facing individuals and families in our region. This assessment represents an important continuation of our commitment to improving community health, advancing health equity, and ensuring that every person has the opportunity to flourish.

The CHNA process reflects the integration of local and national data sources, health indicators, and social determinants of health with the lived experiences of community members, providers, and local leaders. Through focus groups, key informant interviews, surveys, and collaborative analysis, the CHNA provides a comprehensive picture of the current state of health in our service area. By engaging directly with the voices of those most impacted, Covington Medical Center ensures that this assessment is both evidence-based and community-driven.

This CHNA fulfills federal requirements under the Affordable Care Act and Washington State standards, while also serving as a roadmap for future strategy within MultiCare. The findings and priorities identified here will inform how Covington Medical Center aligns resources, develops innovative partnerships, and strengthens programs that meet the unique needs of our population.

The Board of Directors of MultiCare Covington Medical Center, together with leadership across MultiCare Health System, has formally reviewed and acknowledges this Community Health Needs Assessment as the official CHNA for the hospital. In doing so, the Board affirms its responsibility to ensure that identified community health needs guide organizational planning, program design, and investment decisions over the next three years.

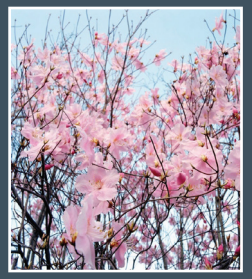
This acknowledgement reflects more than compliance with state and federal requirements. It affirms a shared vision: to create healthier communities through a commitment to health, equity, and well-being. The Board recognizes that meaningful progress requires sustained collaboration across public health, education, social services, and health care delivery partners.

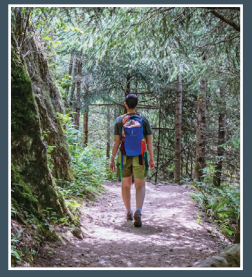
By endorsing this CHNA, the Covington Medical Center Board and MultiCare leadership signal their dedication to turning assessment into action. This document will serve as a framework for measurable improvement in the identified priority areas (Healthcare Access and Delivery (emphasizing Mental and Behavioral Health), Equity and Social Determinants of Health, Food Insecurity and Access, Support for Children and Youth), transparent reporting, and continued accountability to the communities we serve.

**Approved Date:** December 15th, 2025

# King County Community Health Needs Assessment

## 2024/2025





King County Hospitals for a Healthier Community

Updated: March 29, 2024

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*Entre Hermanos*
*Supportive Community for All*
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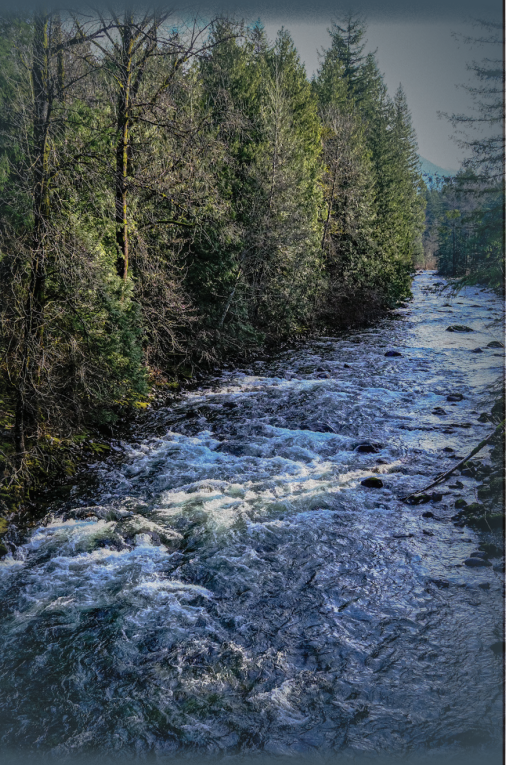
# Executive Summary



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## Overall rates of food insecurity and uninsurance remained stable after the COVID-19 pandemic-related federal and state assistance ended, though disparities by race, place and identity persist.

King County Hospitals for a Healthier Community (HHC) is a collaborative of 10 hospitals/health systems in King County, in partnership with Public Health – Seattle & King County. HHC jointly produces a Community Health Needs Assessment (CHNA) to learn about community inequities as well as strengths to fulfill Section 9007 of the Affordable Care Act. In accordance with the 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 chronic illness throughout King County. This report also provides a first look at the potential health impacts of climate change events. The data presented in this report provide information about the health and social landscape in King County toward the end of the COVID-19 pandemic and during its transition to an epidemic. COVID-19 health issues and the end of state and federal COVID-19 assistance are likely impacting people's ability to meet basic needs, especially among communities of color and in South King County.[1,2] Acknowledging that racism is a public health crisis and noting the importance of understanding and responding to inequities, this report presents key findings by race/ethnicity to highlight disparities, opportunities, and strengths among racial/ethnic groups.

## COMMUNITY INPUT

Local community needs assessments, strategic plans, and reports from 2021 to 2023 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. This review showed that many of the priorities elevated in previous CHNA reports persist.

- Equity and social determinants of health
- Supports for children and youth
- Housing access and quality

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- Food insecurity and access to healthy, high-quality, and culturally appropriate foods
- Healthcare access and delivery

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

Key findings from nine listening sessions conducted for this report with communities of color disproportionately impacted by barriers in access to food and mental/behavioral health services provided a more in-depth understanding of local community experiences. Participating community members identified that rising food costs, proximity of food sources and transportation availability were barriers to accessing healthy food. They also identified cost as a barrier to accessing mental and behavioral health services, in addition to cultural alignment and timeliness of appointments. Across all groups, the top priority after cost was having a mental health provider that shares a similar cultural background or identity (race/ethnicity, gender, age, etc.).

## ACROSS KING COUNTY OVERALL, WHAT'S GETTING BETTER?

A review of recent King County data identifies key successes.

- Rates of daily **vegetable consumption** increased among some groups. Vegetable consumption among South Region adults has remained consistently high compared to other King County regions. Vegetable consumption among adults with annual household income less than $20,000 (30.2%) and between $20,000 and $34,999 (23.8%) was significantly higher than the King County average (17.9%). Compared to white adults (15.3%), Black (31.8%) and Hispanic (30.7%) adults were more than twice as likely to consume vegetables one or more times per day. Adults ages 18-24 (27.7%) were most likely to consume vegetables one or more times per day compared to all other age groups.
- The rate of **attempted suicide** hospitalization in King County has declined from 31.3 per 100,000 (2012-2016) to 25.6 (2017-2021). The rate of attempted suicide hospitalization among adults ages 18–24 was highest, and more than two times the King County average.
- The prevalence of **adult smoking** continues to decrease. The rate of cigarette smoking among lesbian, gay, and bisexual (LGB) adults has also declined in recent years, from 20.1% (2016-2018) to 8.9% (2019-2021).
- The rate of **e-cig usage** among King County youth has declined by more than half from 16.8% in 2018 to 7.6% in 2021.

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- The rate of **substance use** among King County youth has declined significantly from 24.5% in 2018 to 14.2% in 2021. The rate of marijuana use among King County youth has also declined, from 15.2% in 2018 to 8.4% in 2021.
- **Fall hospitalizations** have declined county-wide, between the most current 5-year period (2017-2021), compared to the previous 5-year period (2012-2016), including among several sub-groups. Most notably, at 412.3 per 100,000, the rate of fall hospitalizations for Native Hawaiian/Pacific Islander residents is currently 47% lower than previously (779.0 per 100,000).

The 2021/22 CHNA report highlighted increases in pregnant people receiving adequate prenatal care as well as declining rates of cigarette smoking, homelessness, and youth consumption of sugar-sweetened beverages. Among those previous successes, the rates for adult cigarette smoking continue to decline for the county's population overall, and the previous improvement in decreasing rates of youth substance use was sustained.

**Several indicators remained stable since the previous report.** The percentage of uninsurance among King County adults remains stable around 6.6%. Rates of adult hypertension and diabetes were similar in recent years, as was the rate of adults experiencing food insecurity. Continued monitoring of these indicators may reveal ongoing and late-manifesting health and social impacts of the COVID-19 pandemic, beyond the most current timeframe of these data.

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

The following indicators showed downward trends or what has worsened compared to the last CHNA reporting period and therefore are areas of concern.

- The **life expectancy** of King County residents decreased; the 2019-2021 life expectancy of 81.4 years is significantly lower than the 2016-2018 life expectancy of 81.9, and the lowest it has been in the previous nine years. Life expectancy at birth has declined by two years among Black (from 76.8 to 74.8 years) and Hispanic (from 88.8 to 86.3 years) residents compared to estimates from 2016-2018. Average life expectancy at birth is lowest among Native Hawaiian/Pacific Islander (68.5 years) and American Indian/Alaska Native (69.1 years) residents compared to other racial/ethnic groups, and more than 10 years lower than the King County average.
- The rate of **drug-induced deaths** among King County residents has increased from 14.8 per 100,000 (2016-2018) to 22.0 per 100,000 (2019-2021). During this period, the rate of drug-induced deaths

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significantly increased among Black residents, white residents, residents in Seattle, South Region, North Region, and residents living in very high-, high-, and medium-poverty areas. Compared to other age groups, the rate of drug-induced deaths was highest among adults ages 45-64 years.

- **Firearm-related violence** increased. EMS response to incidents of assault involving a firearm injury has continued to increase since 2019. At 21.7 per 100,000, the firearm death rate among Black residents was higher than the King County average and more than eight times the rate among Asian residents (2.5 per 100,000). By region, firearm-related deaths were highest in the South Region, at 12.2 per 100,000.

- The death rate for **unintentional injuries** among King County residents (39.8 per 100,000) has increased over the last 10 years. Unintentional injury death rates have risen in Seattle and South Region in 2019-2021 compared to the prior 2016-2018 time period.

- Since 2020, **domestic violence** emergency department (ED) visit rates increased by 48%, from 64 visits per 100,000 in 2020 to 95 visits per 100,000 in 2022.

- Though the overall rate of attempted suicide hospitalization declined, concerns for youth mental health persist. The prevalence of **depression** among King County students increased between 2018 (32.9%) and 2021 (36.4%). In 2021, the rate of **suicide ideation** ED visits among Black youth increased nearly 2-fold compared to 2020 (from 596 visits to 1,064 visits, per 100,000 population). Among King County residents aged one to 17, **mood disorders** (185.6 per 100,000) were the leading cause of hospitalization.

- King County's Maternal Mortality Ratio (MMR), the number of **maternal or birthing person deaths** per 100,000 live births, more than doubled over the past ten years. The average was 19.1 birthing people deaths per 100,000 live births in 2017-2021 compared to 8.8 deaths per 100,000 live births in 2011-2015. Though these differences are not statistically significant, the pattern mirrors national patterns and warrants further monitoring.

- The percentage of King County students who meet **physical activity** recommendations has declined with each survey year since 2014. Similarly, the percentage of youth in the top 5% for BMI by age and gender has increased in King County over time from 8.8% in 2014 to 12.3% in 2021. The percentage of Native Hawaiian/ Pacific Islander (37.2%), Hispanic (20.7%), and Black (15.9%) youth in this BMI category was significantly higher than the King County average (11.4%). Students in the South Region were most likely to be in the top 5% for BMI compared to all other regions of the county.

- The **food insecurity** rate for the overall county remained similar to that of recent years, though disparities in food insecurity rates increased. Food insecurity is highest among Black adults (29.8%) and

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Hispanic adults (28.4%) and is nearly three times the county average. Food insecurity among LGB residents (15.0%) is significantly higher than the county average (10.3%). Transgender adults (38.5%) were nearly four times as likely as cisgender adults (9.9%) to report food insecurity.

- The rate of **incomplete vaccination** coverage for King County children ages 19-35 months was 39.5% in 2022, an increase from 35.9%[i] in 2020.[3]

The previous 2021/22 CHNA report highlighted indicators that were worsening at that time, including youth obesity, deaths from unintentional injuries, and disparities in insurance coverage, life expectancy and disparities in food insecurity between white and Black food-insecure households. Insufficient physical activity for youth and youth mental health continue to worsen and are areas of concern in King County. Increased disparities in life expectancy were also observed.

## CLIMATE CHANGE EFFECT ON HEALTH

Climate change impacts including rising temperatures, extreme weather events, rising sea levels, and increasing CO2 and particulate matter are a major threat to human health. Health impacts of climate change include heat-related illness, exacerbation of respiratory, cardiovascular, and certain allergic diseases, as well as increased injuries and mental health concerns. King County and Washington state are already experiencing higher temperatures and increased wildfire smoke.

- King County experienced a notable heat dome event in 2021; that year, the rate of emergency department visits involving heat-related illness among King County residents was nine times the rate in 2020 and twice the rate in 2022. Rates of emergency department visits for heat-related illnesses are highest among Black residents and residents over 75 years of age.
- Extreme weather and wildfire events can trigger or exacerbate asthma symptoms. The rate of asthma-related ED visits among adults aged 75 and older increased significantly from 1,733.7 per 100,000 in 2019 to 1,940.8 per 100,000 in 2022.

*[i]Rate differs from the 2021/22 CHNA report due to a methodological change implemented by WA DOH. The rate currently referenced for 2019 is from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/immunization-data/county-public-health-measures-dashboard*

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## AREAS TO MONITOR FOLLOWING THE END OF COVID-19-RELATED ASSISTANCE

A number of COVID-19-related types of assistance ended in 2023, including the pause on student loan payments, suspension of work requirements for food assistance, emergency assistance for childcare centers, and the automatic continuation of Medicaid coverage. These changes in assistance will affect some residents more than others, underscoring the need for continued monitoring of key determinants of health impacted by the pandemic by race, place and identity. Health outcomes and the ability to meet basic needs continue to differ by race/ethnicity, sexual orientation, gender identity, household income, and geography. Disparities by these characteristics also exist for many determinants of health, including access to health and preventive care, prenatal and birth care, child health, behavioral and mental health, and physical activity, nutrition, and weight.

- **Access to healthcare:** In 2022, 6.6% of King County adults were uninsured. Hispanic (19.3%) and American Indian/Alaska Native (19.1%) adults had the highest rate of uninsurance which is three times the King County average. Rates of uninsurance and incomplete vaccination among children 19-35 months of age were highest for those below the federal poverty line or living in very high-poverty areas.
- **Food insecurity:** Among households with children, food insecurity peaked in 2020 (16.3%) and has declined to 10.6% as of August 2023. The prevalence of food insecurity is highest in lower-income households and the county's South Region.
- **Mental and behavioral health:** Frequent mental distress, attempted suicide hospitalizations, death by suicide, and drug-induced deaths are more likely among lower-income households than higher-income households. LGB and transgender youth are more likely to report substance use compared to their counterparts. Youth in the South Region were more likely than youth in other regions to report depressive feelings.

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## HOSPITALS FOR A HEALTHIER COMMUNITY (HHC) PRIORITIES

Among the priorities elevated by King County communities, HHC members identified a core set of shared priorities to address jointly, as well as individually, and to direct community benefit activities in the coming years:

- Healthcare Access and Delivery (emphasizing Mental and Behavioral Health for youth and adults)
- Equity and Social Determinants of Health
- Food Insecurity and Access
- Support for Children and Youth

While each of the priorities include addressing social determinants of health, calling out Equity and Social Determinants emphasizes the impacts of poverty and economic insecurity, unemployment and underemployment, language barriers, systemic racism, and discrimination on community health. Systemic racism and the COVID-19 response were identified as underlying contributors to negative community health outcomes in the 2021-2022 Community Health Needs Assessment report. The COVID-19 pandemic further exposed the intersection of structural racism and health and continues to be an area of focus across HHC members as the county has moved into a phase of pandemic recovery.

Mental and behavioral health needs stand out among all local hospitals and health systems, specifically related to access to services. This includes identifying ways to improve awareness of and access to mental health services for adults, children, and youth. Hospitals also recognize the impact of the opioid crisis and its intersection with each of the other priorities. HHC members are committed to supporting improved access in all disciplines, through direct services and through partnerships with local community-based organizations that share similar priorities.

An ongoing national shortage of healthcare workers has been worsened by the COVID-19 pandemic. HHC members identified the significant effect the staffing crisis has on accessing healthcare including mental and behavioral health. Many healthcare workers face the same barriers as the general population including access to affordable housing, transportation, childcare, and other services. Addressing staffing shortages is critical to all priorities, as it impacts the ability of each hospital and health system to meet community needs.

As part of this prioritization, HHC members seek opportunities to align efforts across organizations, learn about best practices, 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,

# Executive Summary

## Continued

and community organizations will continue to be an essential component of the development of effective community health improvement plans to address these areas.

# Introduction

**This community health needs assessment is produced by the King County Hospitals for a Healthier Community (HHC) collaborative and Public Health – Seattle & King County to describe emerging and ongoing needs of King County families and communities.** The report 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 fourth CHNA conducted by HHC in collaboration with Public Health – Seattle & King County.

The previous 2021/2022 CHNA report described conditions leading into the COVID-19 pandemic – many of which set the stage for disproportionate community impacts of the pandemic – and outlined some early observations of changes in key economic, social, and other health indicators resulting from strategies to slow the spread of COVID-19. The uneven impact of COVID-19 heightened many existing inequities, including poverty and unemployment for communities of color. The current report includes updated data for most indicators, including some that were flagged in the previous report as areas to watch carefully. A new set of climate change indicators for King County has been added. This report also includes findings from listening sessions with community members of color about food security and access to mental health services, and highlights community assets and resilience factors that help protect and improve health and well-being. Data and narrative from this report and the accompanying dashboards can be used to inform programs, strategies, policies, and community interventions.

## KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY

Formed in 2012, the goal of the King County Hospitals for a Healthier Community (HHC) collaborative is to provide healthcare partners with a forum to share best practices and strategies, identify opportunities, and coordinate efforts to improve the health and well-being of local communities (see Appendix C for a full list of the 10 member hospitals/health systems). Members of the HHC collaborative work together to identify community needs, assets, resources, and strategies toward ensuring better health and health equity for King County residents. With fiscal administrative support from the Washington State Hospital Association, the HHC and Public Health – Seattle & King County partner to jointly produce the King County CHNA.

Through the HHC, King County hospitals/health systems have worked jointly on several health initiatives, including work toward increasing access to healthy food choices in their facilities, supporting food security for local communities, distributing safety

items such as firearm lock boxes, and creating tools to address the healthcare barriers and opportunities of LGBTQ+ youth and young adults. Recognizing the increasing importance of monitoring and addressing climate change related health impacts on local populations, in 2022 the HHC made a joint investment in learning more about combating climate change. This included supporting a Fuse Fellow to develop a suite of local healthcare sector climate change adaptation resources as well as integrating a climate change section with relevant indicators within this report.

## COMMITMENT TO HEALTH EQUITY & RACISM AS A PUBLIC HEALTH CRISIS

In June 2020, Public Health – Seattle & King County declared racism a public health crisis, collectively acknowledging the historical and present-day impacts of systemic oppression and racism on the well-being of children, youth, adults, and families in King County.[4] Racism and systemic oppression influence health inequities by affecting social conditions and impacting access to high-quality healthcare, education, housing, employment, nutrition, joy, and wellness. Throughout this report, we primarily focus on differences by race/ethnicity while also recognizing the importance of analyzing health data by other factors such as geography, socioeconomic status, and additional demographic characteristics to illustrate the health of our county. This report helps us understand the conditions and disproportionate impacts coming out of the pandemic as well as monitor community impacts of increasingly more frequent severe climate events.

## 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, timeliness of the information, and health equity impact. 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.

# Introduction

## Continued

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:

- Access to healthcare and use of preventive services
- Behavioral health and substance use
- Prenatal, birthing, and child health
- Physical activity, nutrition, and weight
- Violence and injury prevention
- Climate change

The HHC has also invested in a series of community listening sessions to gather input from families of color in King County to provide context and further understand findings from existing community reports that describe food security and access to mental health services for these communities. Themes from these additional listening sessions are included in the ***Community Identified Priorities*** section of this report. These findings will help inform the HHC collaborative's Community Benefit strategies, programs, services, and partnerships.

Additional data for each indicator included in this report, as well as indicators for more health topics, are available online at http://www.kingcounty.gov/chi/. Detailed data are reported, when available, for King County geographies (e.g., neighborhoods, cities, ZIP codes, and regions), and by race/ethnicity, age, income/poverty, gender, sexual orientation, 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 30 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 specific data limitations.

### TIMING OF DATA

Many of the health indicator data included in this report reflect data collected in 2020 and 2021, with more recent data included where available. In some cases, the community assessment/engagement reports that were reviewed to summarize community identified priories include more recent data collected

in 2022. Community listening session conducted in Spring/Summer 2023 provide additional context to complement population-level data on food insecurity and mental/behavioral healthcare access.

### RACE/ETHNICITY CATEGORIES

Throughout the report and the online Community Health Indicators, racial and ethnic comparisons are made using broad race categories based on a narrow range of options for self-identification in population-based surveys. We recognize the importance of reviewing 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. Where available, indicators include further disaggregated racial/ethnic data (such as with the Healthy Youth Survey, Best Starts for Kids Health Survey, and birth vital statistics).

### LANGUAGE LIMITATIONS

In many cases, the evolution of language and terminology to describe health conditions, risk factors, and impacts is not yet reflected in the data sources that we pull from. While PHSKC and HHC are committed to using language that is inclusive, non-stigmatizing, and people-first in all communications, descriptive terms for health indicators are presented as they were listed in the original data source (indicator names have not been changed).

## WORKING TOGETHER TO SUPPORT HEALTHIER COMMUNITIES

As with prior reports, the HHC continues to use the community identified priorities and key findings described in the CHNA to develop a set of joint priority areas to address for the coming years. In the previous 2021/2022 CHNA, HHC members identified systemic racism and the COVID-19 response as both short- and long-term priorities in addition to the following priority areas:

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

# Introduction

## Continued

Examples of how HHC members have been addressing these priorities are included throughout the Community Identified Priorities report section. In addition, Appendix D lists many of the community-based organizations that HHC members have partnered with to address these joint priority areas. Based on the updated data, as well as community priorities highlighted in this 2024/2025 CHNA report, HHC members have identified new or ongoing priorities as described in the Executive Summary section of this report.

## COMMUNITY ASSETS AND RESOURCES

King County is home to countless community-based organizations (CBOs) that provide valuable services, programs, and resources for local communities. HHC members have developed several partnerships with CBOs that serve King County populations through a variety of mechanisms including but not limited to programmatic support, sponsorships, grants, and/or in-kind investments. Through these relationships, CBOs and hospital/health systems can work together to address community priorities and invest in local communities. While not exhaustive, Appendix D includes a list of many CBOs that HHC members partner with to address the priority areas that were identified in the previous 2021/2022 CHNA report.

# Community Identified Priorities

**Hospitals and health systems in King County play a crucial role in promoting and improving community health through the provision of high-quality healthcare services.** Many of our local hospitals work in collaboration with community members and community-based organizations (CBOs) to address the root causes of health outcomes and inequities. To be accountable to the communities they serve, hospitals and health systems need a deep understanding of local conditions and community experiences, which requires engaging with and listen to the emerging priorities voiced by residents.

Across King County a diverse network of community-based, government, and healthcare organizations are serving the needs of residents in a variety of ways. It is a priority of every CHNA to identify existing community priorities and recommendations through a review of recent needs assessments, community listening sessions, and strategic plans conducted by different sectors and stakeholder groups. This review spans all topic areas to enhance our understanding of King County residents' priorities. For this CHNA, we reviewed over 30 community reports produced between 2021 and 2023 (see Appendix A for a full list).

We conducted a thorough search for publicly available reports representing specific populations and neighborhoods in different regions of King County. Each resource had a community engagement component from which we summarized themes shared across the reports. Emerging themes identified through this review illustrate our local communities' experiences during the various stages of the COVID-19 pandemic through 2023, describing the health and social needs and priorities of each community during this unprecedented time.

Communities continue to describe challenges accessing basic needs like food and housing, and in many cases describe how the COVID-19 pandemic worsened the social conditions that were already challenging peoples' ability to thrive in King County.

In addition to our review of existing reports, we conducted listening sessions with communities of color throughout King County that are disproportionately impacted by barriers in access to food and mental/behavioral health services. Key

# Community Identified Priorities

Continued

findings from these listening sessions provide a more in-depth understanding of local community experiences related to food and mental/behavioral health services. Key findings from listening sessions are highlighted after our discussion of community identified priorities from our review of reports.

## COMMUNITY IDENTIFIED PRIORITIES

The following five themes emerged from review of community reports.

- Equity and social determinants of health
- Support for children and youth
- Housing access and quality
- Food insecurity and access
- Healthcare access and delivery

Through our review, we determined that many of the priorities elevated in previous CHNA reports persist. Some previously identified needs were compounded by the COVID-19 pandemic. Communities continue to describe challenges accessing basic needs like food and housing, and in many cases describe how the pandemic impacted the social conditions that were already challenging peoples' ability to thrive in King County. Community-based organizations and institutions shifted their focus over the past few years to focus resources on pandemic response and addressing emerging community needs during that time. As the federal COVID-19 public health emergency declaration ended in May 2023, community-based organizations across King County are working hard each day to address ongoing community priorities. Government services as well as hospital and health systems should develop relationships with community-based organizations serving local communities to collaboratively identify opportunities that will support and foster healthy community conditions. King County hospitals and health systems continue to nurture existing community partnerships and work to build new relationships with the goal of working collaboratively to address local community needs and support community strengths.

A few examples highlighting how HHC members and community organizations work collaboratively to meet the needs of King County residents are shared at the end of this section. Though not exhaustive or comprehensive, the examples provided include collaborative programs and initiatives between HHC members, community-based organizations, Public Health – Seattle & King County, and other governmental organizations.

We acknowledge and appreciate the countless community members who contributed their voices, perspectives, and personal experiences to these reports, and the community-based organizations

# Community Identified Priorities

Continued

that gathered this data to elevate those voices and experiences. We encourage readers to refer to the original reports linked in Appendix A for more information about the concerns and needs outlined by specific King County communities and organizations.

## EQUITY AND SOCIAL DETERMINANTS OF HEALTH

Across several community reports, King County communities highlighted inequitable access to services and resources, as well as the impacts of racism, bias, and discrimination on diverse communities. Several reports specifically highlighted challenges attaining economic security, gaining employment, and accessing culturally appropriate and respectful health and social services.

### Poverty and economic insecurity

Community reports describe how many King County residents have experienced the impacts of pandemic-related job loss, reduced work hours, and workplace closures. Job loss heightened the challenges that many residents were already facing and has particularly impacted low-income residents and people living with disabilities. Many people with jobs are financially strained or needing to make adjustments in their lives as the rate of earnings is not keeping up with inflation. The rising cost of living makes it difficult, even for people that were not previously experiencing financial hardship. Many families are struggling to pay bills and accumulating debt. With rising costs of living, people are not able to save for emergency situations and are therefore unable to handle unexpected expenses without significant hardship or sacrificing other bills, causing significant financial stress.

Rising costs of living influence the types of jobs people are willing and able to do, leaving gaps in some crucial yet low-wage social service professions. Inflation also impacts small non-profit organizations that were once providing essential community services – many of which are now closed or challenged to remain open. Free public service programs are often short-term or underfunded to meet the need. Emergency financial assistance programs during COVID-19 were helpful but temporary and are now drying up, leaving many to struggle to pay their bills. In addition, people who consistently work in low paying occupations experience more food insecurity and are likely to have less comprehensive health insurance coverage.

### Access to employment

Job stability is a main source of stress and communities describe the need for well-paying jobs as a key priority. Many jobs do not pay a living wage and people are not earning enough to cover basic needs. Community reports also describe the impact of job loss and

# Community Identified Priorities

Continued

financial strain on mental health. In addition, people need help searching for jobs, writing resumes, etc. and express the need for more access to trade schools, training programs, on the job training, and services to help people overcome skills gaps to access higher paying jobs. Access to childcare is a key component of this to support caregivers' ability to work. When faced with job loss and financial insecurity, people rely on social services, which are often limited or drying up.

## Language access

Language access impacts people's ability to access resources and services. Several community reports describe the lack of language supports for immigrants in King County, and the challenges many of them face accessing employment, transportation, housing, and healthcare. Given the cultural and linguistic diversity of King County, language accessible and culturally relevant outreach and informational materials are essential for people to take advantage of community resources and public services. In the absence of these inclusive processes, residents who speak languages other than English struggle to navigate recreational activities like parks and sports, educational and employment opportunities, healthcare systems, and public transportation. This contributes to social isolation and economic instability.

## Discrimination

Community reports describe the impacts of discrimination in different populations and settings on the well-being of King County residents. Discrimination is a community issue that is a source of chronic stress and affects mental health. Many describe the impacts of bias and stigma related to race, nationality, gender identity, and sexuality. Specific experiences of discrimination that were highlighted throughout community reports include:

- Immigrant and refugee communities
  - » Incidents of racial and ethnic discrimination, bias incidents, and hate crimes against immigrants and refugees are on the rise and impact peoples' feelings of safety. As a result, many refugees and immigrants are refusing services and disengaging from public or private systems.
  - » Fears about immigration status contribute to stressful conditions for children and their families. Some believe that accessing resources is not safe due to their citizenship status.
- Communities of color
  - » Communities of color describe experiences of racial or ethnic discrimination in the form of racially motivated incidents like threatening words or unfair treatment in public spaces like buses and parks.
  - » Discrimination and racism faced by kids in schools contributes to their feelings of isolation.

# Community Identified Priorities

Continued

» Communities of color report power imbalances and lack of diverse representation in decision-making bodies like school boards and county commissions, which are often not reflective of communities they serve.

» Racism and discrimination based on class, gender, and sexuality in healthcare settings are experienced as bias, stereotypes, and assumptions that negatively impact the patient experience and health outcomes.

■ LGBTQ+ communities

» Lack of support for transgender and gender diverse residents, especially youth, challenges their feelings of safety and belonging. Reports specifically call out the need for LGBTQ+ representation in senior programming and support for LGBTQ+ youth to feel connected in schools.

## CHILDREN AND YOUTH

Support for children and youth includes supporting families to provide healthy conditions for them to thrive. The stress of many of the other factors identified as priorities in this section challenge parents' ability to provide the best opportunities for their children. The impacts of closures of schools, childcare, and recreational facilities, learning disruptions, and economic hardship experienced by many families during the pandemic will have long-term effects on children's learning and development.

In community reports, King County residents highlight the need for more services in their neighborhoods and schools to support social and emotional well-being of children and families. While this is a recurring theme from past years, the focus seems to be shifting beyond discussions of the need for more sports, recreational and job training activities to emphasize mental and behavioral health supports for youth, further described in the 'healthcare access & delivery' community identified priority section.

### School system support

Several reports describe the challenges that families encountered with remote schooling during the early days of the COVID-19 pandemic, and the resulting impacts on their school-aged children. For example, online school created a hardship for students with disabilities and for many who had trouble with internet access or distractions at home. However, some parents said their child or family preferred online school due to their learning style, or as a result of being removed from racist or unsafe school environments. In addition to the need for more mental health services in schools, King County residents describe other challenges and needed changes in school systems.

■ There is a need to expand access to culturally relevant and empowering **food and nutrition education** for youth, adults, and older adults.

# Community Identified Priorities

Continued

- Many families rely on **school meal programs** to ensure children are not hungry, which were impacted by COVID-19-related school closures. Not all children were reached by food programs when schools switched to remote learning.
- Providing free **meals for all students** in schools, increasing access to summer school meals, and eliminating lunch debt were offered as solutions that would reduce access barriers for many.
- **LGBTQ+ youth** want more support and connection in schools, more inclusive curriculum, and adults that openly advocate for them to feel safe in schools.
- Increase access to local parks and schools for **physical activity programming.**

### Childcare and early learning

Many King County families struggle to find accessible and affordable childcare. Community stakeholders emphasized the importance of access to high quality and affordable childcare options in the community. More early learning opportunities are needed to set families up for success. Community reports offer the following key considerations:

- **Lack of affordable childcare** impacts employment opportunities for parents and negatively impacts their emotional health.
- **Closures related to COVID-19** reduced options for childcare, and many childcare centers have experienced challenges with economic recovery because of closures, limited hours, and capacity constraints. Childcare needs changed with COVID-19, as did financial resources to pay for care. Many families pulled their children out of childcare due to COVID-19 concerns. Childcare demands prevented many parents from working or attending to other needs.
- **Sustained funding for early learning programs** is sorely needed. Tenuous funding for government programs and free public services impacts their sustainability such that communities cannot trust that they'll continue to be able to access those services.

## HOUSING ACCESS AND QUALITY

Access to affordable and safe housing continues to be a priority identified in the majority of reports. The COVID-19 pandemic has affected housing for many King County residents who have lost income, faced evictions, or experienced disruptions in their family structure.

### Housing affordability

With steadily rising housing costs, affordable housing is one of the most pressing needs across the region. The high cost of housing is especially challenging for families with mixed documentation

# Community Identified Priorities

Continued

status or underemployed individuals. Rising housing costs and evictions have caused many residents to relocate, often living with family members. For some families, moving means children must change schools, introducing an additional hardship for them. Community reports describe the lack of affordable housing as a serious health issue and offer the following considerations.

- Community members need more access to **rent and utility assistance** and support navigating local resources.
- The lack of information on how to successfully complete **public housing assistance** application is a barrier.
- Many describe challenges finding **affordable and safe housing** in Seattle. People want the ability to rent and purchase in economically diverse neighborhoods.

### Homelessness

Homelessness has been included as a top priority in every CHNA report since 2015/2016. Once concentrated in our urban centers, communities in rural areas are describing this growing concern in their communities. Communities describe high costs of housing, rising costs of living, and gentrification as factors that contribute to homelessness and impact health. The intersection of mental health and homelessness is described an many reports, where homelessness is described as both a result and a cause of mental and behavioral health challenges.

- More **low-income housing options** are needed, as well as shelter beds. Children in families that cycle in and out of homelessness experience repeated trauma of moving schools and entering shelters.
- Addressing **chronic health conditions** and ensuring access to care is challenging when people are experiencing homelessness or unstably housed and do not have their basic needs met.
- Communities report alarming rates of **evictions** and limited access to housing stipends to keep them where they are. Those who are tied into digital access and know how to navigate the system are more likely to access resources, while residents who are older, live in rural areas, or English is not their first language are more likely to be evicted.

## FOOD INSECURITY AND FOOD ACCESS

Food insecurity, or the lack of access to sufficient food for every household member, is an economic and social indicator of community health. Every family should have access to a convenient and affordable means of purchasing healthy food. When access is limited, people are more likely to rely on less nutritious options. Several factors can affect food

# Community Identified Priorities

Continued

access and security, including poverty, low income, and unemployment, among others. King County communities describe challenges, as well as racial/ethnic and economic disparities in access to food.

### Access to healthy, high-quality, and cultural foods

Community reports describe that growing numbers of community members do not have enough resources to meet their basic needs. Food access has been reported as a needed service since the start of the COVID-19 pandemic, which worsened conditions for many. Cost is a key barrier, along with access to supportive services and resources.

- Many residents report eating less than what they needed due to financial constraints. Communities need increased access to **financial resources** through food programs like SNAP, Fresh Bucks, grocery vouchers, and cash assistance (preferred because there are no restrictions).
- Many reports described the need to improve the quality of **food served in schools** to meet children's nutritional needs during the school day by offering meals that are fresh, culturally specific, and locally and equitably sourced.
- There is a need for more **low-cost or free meal delivery options** for low-income or home-bound seniors, especially during extreme weather events.
- Communities want more **support for urban agriculture and gardening** including access to land to grow food, connect with neighbors, build wealth, and provide food and agriculture education. This finding was also emphasized in community listening sessions, described later in this report section.

Many families rely on **food banks and meal programs** to meet their nutritional needs. There was unprecedented demand for food banks during the COVID-19 pandemic. King County families face a number of challenges accessing food through these programs.

- **Costs of transportatio**n to food banks requires planning for basic needs.
- A lot of food services and meal **programs are centered in Seattle**, making it difficult for residents of surrounding areas to find resources within reach.
- Many families are **fearful of government systems** or do not qualify due to income thresholds. Fear of retaliation from government because of immigration status deters some individuals from accessing resources like SNAP or food banks.
- Community members describe **'red tape' associated with accessing food banks** as a challenge and sometimes a deterrent (family size, ZIP code, etc.).

# Community Identified Priorities

Continued

Several reports also describe some of the challenges faced by food service providers, which make it difficult for them to meet community needs. Many programs did not have adequate infrastructure (staff, refrigeration, etc.) to meet the demand associated with the COVID-19 pandemic. Some struggled to keep a consistent location, staff their programs, and to get enough food donations to support local families with high quality, healthy and culturally appropriate foods. Small nonprofit organizations, often serving communities of color, have less access to grants to support their work.

Ultimately, community reports emphasize the importance of addressing the root causes of food insecurity. There is a need to increase funding for services that prevent people from having to rely on food banks, such as rental assistance and living wage jobs. Through community listening sessions (described below), local communities of color shared similar experiences and concerns, and offered additional examples of supportive services that would improve their access to healthy, high-quality, and cultural foods.

## HEALTHCARE ACCESS AND DELIVERY

Community members describe general access barriers, such as long wait times, limited availability of providers and appointments, lack of childcare, time constraints, lack of culturally competent providers, lack of language access in healthcare materials/resources, costs of services, access to transportation, and challenges navigating insurance plans and paperwork – especially for seniors and immigrants.

### Access to mental & behavioral health services for adults and youth

One of the top services community members perceived as needed was mental health counseling – a growing need since the beginning of the COVID-19 pandemic. Youth and adults both identify this as a priority. Financial stress delayed routine medical care, and school and childcare closures have had lasting impacts on the physical and emotional health and well-being of families. Communities note increased anxiety, depression, and social isolation, especially among older adults and youth.

- **Availability of mental health providers** is limited with many not accepting new patients.
- Low-income communities are most likely to experience poor mental health yet have limited access to supportive resources. As a result of **low Medicaid reimbursement rates**, few providers can afford to accept Medicaid, and in some cases, communities rely on counselors that are trained but not yet fully licensed practicing under supervision. Not all useful services are covered by Medicaid and can be especially difficult for the lowest income community members to access.

# Community Identified Priorities

Continued

- Youth are facing feelings of depression and hopelessness. **School counselors** are often providing mental health needs for youth in schools, but there are not enough staff or resources to connect families to services outside of schools.
- Families need support to address changes in **children's social-emotional development** and mental health. Some children regressed in areas during school and childcare closures, due to unmet socioemotional and mental health needs associated with kids missing friends, teachers, and enrichment activities like sports and clubs.
- **Substance use among youth** is a big concern, especially vaping. Youth describe peer substance use as a barrier to emotional safety in schools, along with lack of diversity, unsafe teachers, bullying from peers, and a lack of physical safety.
- More **detox services**, inpatient treatment and wraparound services are needed for community members with substance use disorders.

Community listening session participants shared additional concerns regarding access to mental and behavioral health services and offered additional examples of supportive services (described below).

## COMMUNITY COLLABORATIONS

Local hospitals and health systems play a central role in supporting community health. Members of the HHC work across multiple priorities to address needs in their respective communities. While not an exhaustive list, the following are examples of how HHC members are addressing community needs related to healthcare access and health promotion in collaboration with community-based organizations.

### Equity and Social Determinants of Health

HHC members have community benefit activities focused on equity and social determinants of health; several focus specifically on increasing language access for patients who speak a language other than English. Some health systems fund community-based organizations to address poverty, access to employment, language access, and needed support for LGBTQ+ populations. Other HHC members engage in efforts to hire more healthcare providers who reflect the demographic characteristics of the patient populations they serve (e.g., LGBTQ+ providers, providers that live in the same communities as their patients, similar race/ethnicity/religion/cultural beliefs, or those who speak languages other than English). Initiatives are underway to offer more diversity, equity, and inclusion trainings to providers. Many health systems are also supporting workforce development and financial assistance programs to address the

# Community Identified Priorities

Continued

employment and economic needs of their patient populations. Additionally, many health systems utilize patient screening tools for social determinants of health, enabling the development of new resources, and address issues related to housing, food, transportation, financial assistance, and interpersonal safety.

- **Spotlight on innovation:** UW Medicine's Community House Calls Program leverages bilingual and bicultural caseworker cultural mediators, or CCMs, to enhance care for immigrant and refugee communities. CCMs provide same language services and bring an understanding of both western medical concepts and culturally specific practices. They maintain strong community connections, and their deep knowledge of community is invaluable in helping to craft culturally relevant interventions for the individuals and families they support.

## Children and Youth

HHC members are engaged in community benefit activities in support of children and youth. Many provide funding and other supports to local schools and youth mental health programs to bolster behavioral health services. Other activities include funding local organizations to address other health and social needs (e.g., homelessness, nutrition, and access to care) and leveraging social workers to connect youth to these resources.

- **Spotlight on innovation:** Overlake Medical Center & Clinics offers free community classes that support children and youth. A Mental Health First Aid class helps adults recognize when a young person might be experiencing a mental health or substance use crisis, what to say, and how to direct youth to appropriate help. A Teen Resilience & Thriving workshop complements the adult class by teaching pre-teens and teens how to identify stress, learn coping skills, and build emotional resilience.

## Housing Access and Quality

Several HHC members are engaged in community benefit activities related to housing access and quality, including funding community-based organizations that provide housing and address homelessness. HHC member activities include providing medical respite programs to support individuals experiencing homelessness when they are discharged from the hospital, providing social workers and care navigators additional time to identify resources. Another example includes screening patients for housing instability and pairing them with navigators to assist with housing support.

- **Spotlight on innovation:** Through its RxHome Fund, Kaiser Permanente provides low-cost, long-term loans to affordable housing developers to create and preserve multi-family rental homes for low-income

# Community Identified Priorities

Continued

residents in communities across the country where Kaiser Permanente provides care and coverage.

### Food Insecurity and Access

The vast majority of HHC members have community benefit activities focused on food access, including funding and sponsoring community-based organizations that address food insecurity. Many health systems also provide nutritional education classes for the community.

- Spotlight on innovation: One objective of Virginia Mason Franciscan Health (VMFH)'s food systems initiative is to build cultural relevance within the local food system, including support for food agency partners. To achieve this, VMFH partners with Pacific Lutheran University students to develop and conduct surveys that assess participating food banks' physical environment, cultural food offerings, signage, and translated materials. Students analyze the survey data, which is shared with the food banks and highlights what each food bank is doing well and opportunities to better serve their client base. In addition, VMFH partners with the University of Washington-Tacoma and others – including those with lived experience – to build and activate a cultural foods program.

### Healthcare Access and Delivery

All HHC members are engaged in community benefit activities connected to healthcare access and delivery. Many are partnering with community-based organizations, providing community education, and connecting patients to needed services. Other examples include funding care coordination programs for individuals who are uninsured, expanding mobile mammogram service, reducing wait times for high acuity patients, and improving access to outpatient substance use disorder services.

- Spotlight on innovation: The Fred Hutch Cancer Center partners with Cancer Lifeline to support cancer patients/families, with a focus on communities of color and low-income communities. Through this partnership, patients are connected to Cancer Lifeline's services, which includes support groups, mental health counseling, and education. Fred Hutch also provides funding to Cancer Lifeline to expand their free mental health counseling program, which connects low-income and marginalized cancer patients and survivors with licensed mental health counselors at no cost.

# Community Identified Priorities

Continued

## LISTENING SESSIONS WITH KING COUNTY COMMUNITIES OF COLOR

A review of community health indicators related to food insecurity, depression, and other mental health indicators revealed racial and ethnic disparities in among King County residents (see the Physical Activity, Nutrition, and Weight and Behavioral Health & Substance Use sections of this report). We conducted a series of listening sessions with local communities of color to add community voice to help understand the experiences of local families related to food insecurity and access to mental and behavioral health services. The goals of these listening sessions were to hear directly from families of color in King County about their access to food and information about nutritious food, and common challenges and barriers they face when seeking mental/behavioral healthcare. Listening sessions also gathered insights about the impacts of climate change and extreme weather events on food security and mental/behavioral health.

We partnered with local community-based organizations to hold nine listening sessions with Black/African American, Hispanic/Latino, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Cambodian, and Filipino communities. Listening sessions were conducted in English, Spanish, Somali, Khmer, Marshallese, and Chuukese. A total of 72 community members participated to share their thoughts and experiences. Key themes related to food security, access to mental/behavior health services, and the impacts of climate change on each are described in this section. Findings from these listening sessions can help guide healthcare systems to support communities of color through investments in various partnerships, programs, and resources.

## ACCESS TO FOOD AND NUTRITION INFORMATION

Listening session participants were asked to describe nutrition topics that they would like to learn more about, their experiences accessing fresh, healthy, and cultural foods, and what types of community programs might support food access in their communities.

### Nutrition Knowledge

In general, community members want more opportunities to learn about how to eat well to protect their health. During discussions, participants described wanting to learn more about the following topics:

- ***How to identify healthy foods*** – how to interpret nutrition labels, where to find naturopathic or homeopathic foods and herbs that people can forage themselves.
- ***How to prepare healthy foods*** – healthy recipes, how to balance food groups, substitutes for

# Community Identified Priorities

Continued

ingredients that are not healthy in recipes (e.g., sugar, salt, fish sauce, unhealthy oils).

- ***Affordable healthy foods*** – low-cost nutritious food options, where to get affordable organic and cultural foods.
- ***How to maintain a healthy diet*** – meal planning, how to be disciplined to carry a food regimen.
- ***How food and supplements impact health*** – how foods impact physical and mental health, how foods can help with health conditions (e.g., diabetes and inflammation), the effects of taking vitamins and other supplements on physical and mental health.

Most participants said that their community has a good understanding of what foods support their health, with very few stating the opposite. Some people know what it means to eat healthy, but lifestyle factors like lack of time and money lead people to eat unhealthy foods. All agree that it's important to have information about healthy foods, and the information needs to be accessible. For example, it can be hard for people who speak English as a second language to understand nutrition labels. The issue of misinformation about nutrition on TV, social media, and through marketing strategies (e.g., by making people believe that a drink labeled as having 'zero calories' is healthy) also came up in more than one session.

Participants described how best to share information with their community about the topics identified above. Many mentioned that the best way to share out nutrition information is through community-based organizations, community events, and community groups (e.g., Native American clubs). A particular way suggested by participants was to have "ambassadors", or champions, that could work with community to help introduce people to a healthy lifestyle. Putting up flyers at schools and using school apps could also be effective in getting information to families. Participants mentioned that they reach out to friends to learn about nutritious foods, and that they would like to receive nutrition information through their health providers.

## Access to High-Quality, Fresh, and Cultural Foods

**Access to high-quality, fresh foods varies among local communities of color.** While some participants find high quality, healthy foods easy to obtain, others described why they are often not able to access high-quality and fresh food.

- **Cost is a barrier,** which especially impacts large families, older adults and people who have recently moved to the U.S. When healthy foods are not affordable, participants report eating unhealthy foods to feel satiated. Some mentioned that affordable ways to get healthy foods such as raising chickens are often not allowed by the city government.

# Community Identified Priorities

## Continued

- **Transportation is a challenge for many,** especially for those who do not have grocery stores or markets near their homes. Many report that some of the better and more affordable markets are far from home.
- It is **not always easy to find** high-quality, fresh foods. Participants argued that most foods found in grocery stores are not healthy. Immigrant participants mentioned that foods in the U.S. taste different and are thought to have more preservatives - and are therefore less fresh and healthy compared to what they have found in their home countries. In rural areas, grocery stores that are close to people's homes are often busy and expensive.
- **Food banks and other services may not be available** near peoples' homes and are often perceived to give out "junk food" or expired food.

*"If you're poor, you're never going to eat healthy. It's not easy to access healthy foods… They sell junk food to people of low-income because that is all they can afford. Everything is very processed."*

– Listening Session Participant

**Almost all participants expressed that having access to cultural foods is important** to their community for promoting health and keeping the culture alive. Cultural foods are readily available for some, while others face barriers such as affordability and availability. Cultural foods are often costly, especially when imported from small countries. Participants shared that prices for unique cultural foods have increased during COVID-19 and remain high.

Availability of cultural foods varies depending on the community. For instance, while Filipino participants reported their cultural food is easy to find, American Indian/Alaska Native folks shared that many of their cultural foods cannot be found in King County. Within the Hispanic/Latino community, cultural foods from Mexico are easy to find, but foods from other countries (e.g., Colombia) are not always available. Somali participants mentioned that Halal stores often overcharge for halal meat, leaving few options for healthy protein sources. People feel they do not have a choice but to purchase it. Some cultural foods are not easy to get and may only be available in special stores – many of which have closed because of COVID-19. Having to drive a long distance to cultural food vendors is a barrier for many.

Children are especially impacted by not being able to access cultural foods. Participants highlighted that when cultural foods are not available, children are at risk of losing touch with their culture - as they might not even learn that certain foods are part of their culture.

# Community Identified Priorities

Continued

*"…when we don't have access to our cultural foods, our children and grandchildren never acquire the taste for those cultural foods because they start becoming like exotic."*

– Listening Session Participant from American Indian/ Alaska Native community

**Various support services could increase families' access to high-quality, fresh, and cultural foods –** as identified by participants:

- **Transportation programs** that can take people to organic grocery stores would help people access fresh and healthy food.
- **Learning opportunities** around nutrition topics like how to balance food groups, how to read nutrition labels, and how to cook foods in a healthy way. This includes educating children in school about healthy foods. Participants mentioned that educational opportunities like nutrition and cooking classes should be community-based, accessible, culturally appropriate, and available in multiple languages.
- Healthy **food giveaways** at schools and senior centers would help address cost and transportation barriers.
- **Food banks** with healthy food options, cultural foods, and extended hours. Some people end up eating unhealthy foods provided by food banks because in their culture it feels wrong to waste food. Food bank hours should be longer, and it would be helpful to have delivery, including after business hours (so that people can be home to put away refrigerated items).
- **Food vouchers** to purchase healthy and/or cultural foods.
- More **community gardens** with training opportunities for communities to grow their own food.

## ACCESS TO MENTAL AND BEHAVIORAL HEALTH SERVICES

Listening session participants were asked to name some things they consider to be important when thinking about getting mental health services for themselves or a family member, and to share what barriers they have faced when doing so. Participants also described what types of services they would like to access to support their mental health.

### Important Factors

Key factors folks consider when thinking about getting mental health services for themselves or family members are cost, cultural alignment, and timeliness of appointments. Across all groups, the top priority after cost was having a mental health provider that shares a similar cultural background or identity (race/ ethnicity, gender, age, etc.).

# Community Identified Priorities

## Continued

- **Cost** can be an issue for some who do not have insurance. Many people don't know if they have coverage for mental health services, what services are available to them, or how to find a provider.
- Trust is an important factor when seeking mental/behavioral health services. Participants report they would need a provider who **understands their culture** and is kind in their approach in order to feel comfortable opening up. Participants who speak languages other than English shared that having a provider that offers professional interpretation is great, but inferior to having a native speaker who also understands the cultural context.
- Not being able to find an **appointment in a timely manner** makes people not want to seek help at all.

*"If counseling or consultation is communicated in our mother tongue, then we would be able to share everything from the bottom of our heart. If it cannot be communicated in our tongue, I think it is difficult to help and give recommendations."*

– Listening Session Participant from Cambodian/Khmer community

### Barriers to Access

Participants were asked whether they had any trouble accessing mental/behavioral health services if/when needed over the past year. The main barriers identified were cultural alignment, language access, awareness about what services and resources are available, cost, and scheduling. The issue of stigma was shared among most groups, which leads to people not wanting to acknowledge or discuss their mental health concerns or reach out for support.

- Lack of **available providers** who are skilled and culturally competent or share cultural background. Finding culturally competent providers specialized in serving children is especially difficult.
- **Language barriers** and having to use interpreters when there is a lack of trust and uncertainty about whether what is being said is correctly interpreted.
- Lack of **awareness** about the importance of mental health, when to seek services, and where to go for culturally appropriate services.
- **Stigma** and shame associated with discussing mental health, which causes people to avoid accessing mental health services. Seeking care is, at times, discouraged by family or friends.
- **Scheduling** challenges such as long wait times or providers who do not accept new patients. Not having walk-in or urgent services available makes it difficult to get needs met.
- Not being able to afford care, due to **lack of health insurance**, or health insurance not covering mental/behavioral health services.
- Being **undocumented** and unable to access care.

# Community Identified Priorities

Continued

*"What irritates me is, I can make a counseling mental health appointment and have my next appointment be two or three months out. That's a long wait. That's too long to wait for a mental health specialist or anything. At that point, it's already hard enough for me to even say that I need mental health help."*

– Listening Session Participant

## Impacts of not having services

When mental health services are not accessible, community members say that they either settle for a provider that will not meet all their needs, or they forego care altogether. Foregoing care leads to worsening mental health, which spills over to negatively impact family life, and/or people use unhealthy coping mechanisms like drugs and alcohol. When culturally competent care is not accessible, many community members 'leave themselves stressed' and mental health conditions worsen, affecting family members and work productivity.

## Desired Services

Participants offered suggestions to improve access to mental health services at the clinic, community, and personal levels. Clinics can expand hours, offer sliding scale, and provide access to other professionals like social workers and home health aides. Community-based organizations can play the important role of connecting community members to resources, which should include free/affordable classes to support wellness and mental health. Overarching is the need for more educational opportunities for individuals to increase awareness about mental health, reduce stigma, and help folks understand what services are available and how to access them.

Clinic Resources

- Sliding payment scale
- Access to other professionals e.g., social workers or counselors that can also provide guidance
- Providers that incorporate religious beliefs and practices
- Expanded open hours to include evenings and weekends, allow walk-in service, and 24/7 on-call access for emergencies
- Home care options (having providers come to the home to provide mental health counseling and support)

Community Resources

- Classes, sports, and cultural events to support mental health (free, affordable)
- Support community-based organizations to do outreach work and provide people with resources

# Community Identified Priorities

Continued

Education

- Increase awareness about mental health (it is not a topic people feel comfortable talking about in many cultures)
- Provide more information and community outreach about available services

Some communities offered specific things that would help them. Cambodian participants described that having Cambodian counselors who can give dharma or religious advice would be most helpful for them. American Indian/Alaska Native would benefit from more access to traditional healing practices (e.g., sweat lodges), and to information about such opportunities.

## CLIMATE CHANGE IMPACTS ON FOOD SECURITY AND MENTAL HEALTH

King County has experienced deadly extreme heat events in recent years. Wildfires are starting earlier in the year and happening with greater frequency. Western Washington is projected to experience more frequent wildfires in the future. Media reports of wildfires, heavy rains, catastrophic flooding, and other weather disasters in other parts of the world are becoming more common, making it difficult to ignore changes in our global environment.

Climate change disproportionately affects people of color and low-income communities, who are more likely to experience inequitable living conditions.[5] A historical legacy of discriminatory social policies and political decisions has created conditions for certain communities to be disproportionately vulnerable to the impacts of climate change, and these communities experience health impacts at lower levels of exposure.[6,7] Action on climate change and equity and social justice have been identified as priorities for King County government.[8]

We sought to hear from King County communities of color to explore the connection between food access and mental health, climate change, and whether existing challenges are compounded by climate change events. Listening session participants were asked if and how extreme weather events – such as intense rain and winds, heavy snow, very hot days, and smoke from wildfires – have affected their mental health and their ability to access food.

**Extreme weather events impact the emotional health and well-being of the whole family,** according to listening session participants. In some cases, physical health conditions like chronic pain and respiratory disorders are also aggravated, worsening the mental and emotional impacts. Family's emotional health can be impacted when people feel trapped indoors – particularly during intense heat with no

# Community Identified Priorities

## Continued

air conditioning. Caring for children under such circumstances can be stressful as they feel moody and upset about having to stay home, and many resort to technology because they cannot be outside. Parents then feel the need to keep children entertained, which in turn affects the parents' stress and mental health. Participants pointed out that indoor activities for children (e.g., play gyms) are a helpful option for days of extreme heat but are cost prohibitive for some families.

Communities shared concerns about the future, feelings of sadness and worry for those around the world who have been impacted by extreme weather events, and fear about increasing frequency and magnitude of extreme events in the future.

*"What is going on in Hawaii right now makes me really uncomfortable and it is affecting my mental health. It makes me feel sad. It's also preparing me to know what to do and get myself ready in case a situation like that arises. It makes me worried about the future."*

– Listening Session Participant

Some communities shared that it is not helpful to worry about things they cannot predict or control. Specifically, Somali participants explained that they are not worried about climate change because it is something "foretold by God".

**Extreme weather conditions impact peoples' ability to purchase food and impact the available food options.** Going out to get food can be hard under extreme weather, and there is concern about the impact of climate change on food prices, quality, and availability. Wildfire smoke makes it especially challenging for those who have asthma and other health conditions to go out to get food.

*"When we had that smoke—I think it's probably due to me having asthma too – with having intense smoke, I can't breathe. Not being able to breathe and then having to go out and get food makes it very difficult because then, you're putting your own health at risk."*

– Listening Session Participant

Another impact that participants identified is that food products go bad more easily in hot days, as most people do not have air conditioning. A participant from Snoqualmie Valley reported that during the June 2021 heat wave, the power went down in a major grocery store of their small town, and refrigerators stopped working. The store had to shut down and people had to drive long distances to get groceries. Others described not being able to cook at home during the heat wave.

Finally, participants pointed out that road conditions can worsen with some extreme weather events, and

# Community Identified Priorities

Continued

it may be unsafe to travel for food. The transport of foods can also be affected, and thus food availability and affordability – which brings a lot of concern for communities. There is also apprehension about how folks might have to eat food that contains more harmful chemicals if crops' productivity is impacted.

## COMMUNITY PROTECTIVE FACTORS

Through listening session discussions, participants shared some examples of how they keep themselves healthy and how they support one another by sharing information and resources.

Participants in the American Indian/Alaska Native listening session talked about how community members support each other by sharing information about events and resources.

*"I think, in our cultural community events, that's where I get most of my information, like our Native groups."*

– Listening Session Participant from American Indian/ Alaska Native community

The Marshallese community described how they feel supported by their culture and community, which helps mitigate stress and worry about food access, especially during extreme weather events.

*"In our culture, when we don't get our food that we need at home… in our culture we like to share. That's another way to get access to our cultural food. It's our culture. We like to share."*

– Listening Session Participant from Marshallese community

While multiple communities described transportation as a barrier to accessing mental and behavioral healthcare services, members of the Filipino community discussion described how they support themselves and one another to access services. Participants said they there are community members who volunteer to drive the seniors when they need to go to an appointment.

Participants in the Somali community discussion said that they avoid worrying about climate change or letting it impact their mental health.

*"These climate and weather changes were already foretold by God, and we don't have to worry about that. We are only afraid that we don't go astray, and we believe in God."*

– Listening Session Participant from Somali community

Findings from these community listening sessions underscore and provide additional context to those identified in community reports and through review of King County community health indicators. We acknowledge the contribution of the participating community members and host organizations for their

# Community Identified Priorities

## Continued

time and voices to help us understand the intersection of climate change, food access, and mental health for local communities of color, which is especially important as King County faces racial ethnic disparities in food insecurity, a growing mental health crisis, and increasingly frequent extreme weather events.

# Description of Community

A complex set of social, political, and economic policies and systems shape the conditions of daily life for King County residents. Residents are also experiencing the impacts of racism and discrimination, as well as climate change on their health and well-being. This section of the report provides an overview of how demographics and social outcomes are changing, and further informs the priorities and assets described in the ***Community Identified Priorities*** section of the report.

Rapid population growth, a housing and homelessness crisis, and lasting economic, social, and health impacts of COVID-19 and strategies to slow its spread are re-shaping the local environment. The data and key findings included throughout the report describe conditions during the COVID-19 pandemic, and in some cases (e.g., unemployment) include the period after certain COVID-19 programs ended, providing a glimpse into unequal community impacts.

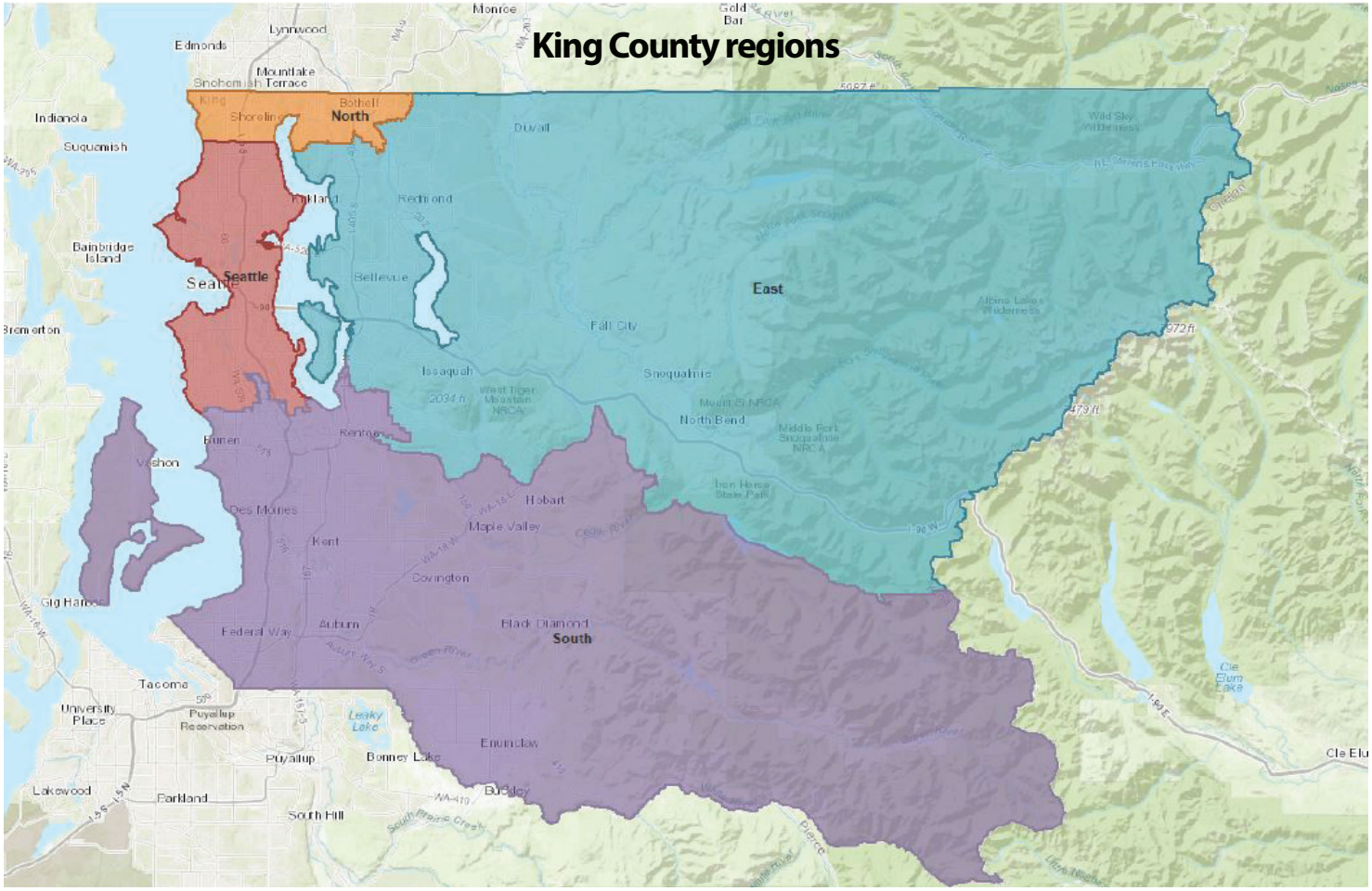
King County growth brings increasing cultural and linguistic diversity. Demographic changes are highlighted by increasing racial and ethnic diversity among children under age 18, which is now 62% people of color.

# Description of Community

Continued

## POPULATION TRENDS

**King County is the most populous county in Washington state, with continued population growth and increasing diversity.** King County ranks 11th in the state for total land area and first in the state for population density. About 90% of King County's population lives in the county's 39 cities and towns, while about 246,000 residents live in unincorporated areas.[9,10] The county is divided into four geographic regions: Seattle, North, South, and East. Across four regions there are 19 public school districts (as well as charter schools, private schools, and the



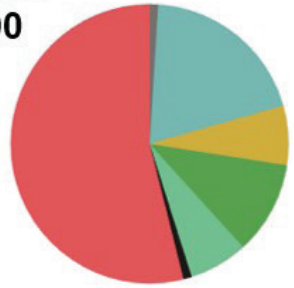
# Description of Community

## Continued

Muckleshoot Tribal School). According to the most recent census data, King County's annual growth rate is 1.3%, and the population has increased by more than 22% since 2010.[11]

In 2022, the King County population was 2,317,700. The Washington state population that year was 7,864,400.[12] There was a positive net migration trend in King County between 2020-2022 with a gain of about 31,000 people.[13] International migration remained a key component to the county's population growth between 2020-2022, in line with other major metro counties around the country. King County was 4th in the nation for international net migration during this period, according to the Census Bureau, and the 13th most populous county overall in 2022.[14]

**King County, 2020 Population 2,269,700**

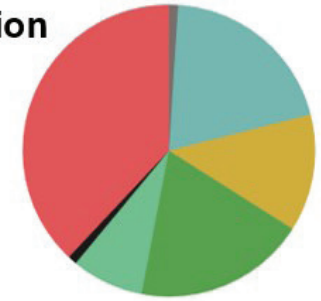


| | |
|---|---|
| White/non-Hispanic | 55% |
| Asian/non-Hispanic | 20% |
| Hispanic/Latino | 11% |
| Black/African American/non-Hispanic | 7% |
| Multiple race/non-Hispanic | 7% |
| American Indian/Alaska Native/non-Hispanic | 1% |
| Native Hawaiian/Pacific Islander/non-Hispanic | 1% |

**King County, 2022 Population 2,317,700**

| | |
|---|---|
| White/non-Hispanic | 53% |
| Asian/non-Hispanic | 21% |
| Hispanic/Latino | 11% |
| Black/African American/non-Hispanic | 7% |
| Multiple race/non-Hispanic | 7% |
| American Indian/Alaska Native/non-Hispanic | 1% |
| Native Hawaiian/Pacific Islander/non-Hispanic | 1% |

**Population under 18, King County, 2022 Population 460,300**



| | |
|---|---|
| White/non-Hispanic | 38% |
| Asian/non-Hispanic | 20% |
| Hispanic/Latino | 19% |
| Black/African American/non-Hispanic | 13% |
| Multiple race/non-Hispanic | 8% |
| American Indian/Alaska Native/non-Hispanic | 1% |
| Native Hawaiian/Pacific Islander/non-Hispanic | 1% |

Data source: WA Office of Financial Management 2020 & 2022
Percentages may not add up to 100% due to rounding

# Description of Community

Continued

The population of people of color in King County continues to rise. King County is now 53% white, compared to 57% in 2018. While the percentage of Native Hawaiian/Pacific Islander, American Indian/Alaska Native, Black, and Hispanic residents has remained relatively stable, the Asian population experienced continued growth in King County from 18% of the total population in 2018 to 21% in 2022.[15] Just over 10% of the Washington state population is Asian – much of which is concentrated in the Puget Sound region.[16,17]

## DEMOGRAPHIC DIVERSITY

**King County growth brings increasing cultural and linguistic diversity.** Demographic changes are highlighted by increasing racial and ethnic diversity among the King County population of children under age 18, which is now 62% people of color.

### Top 10 languages by region
**King County (2022)**

| 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 | Amharic, Somali or other Afro-Asian languages | Vietnamese | Tagalog |
| 4 | Hindi | Russian | Korean | Amharic, Somali or other Afro-Asian languages | Chinese |
| 5 | Russian | Telugu | Vietnamese | Hindi | Amharic, Somali or other Afro-Asian languages |
| 6 | Tagalog (incl. Filipino) | Korean | Persian (incl. Farsi, Dari) | Tagalog (incl. Filipino) | Russian |
| 7 | Amharic, Somali or other Afro-Asian languages | Japanese | Japanese | German | Ilocano, Samoan, Hawaiian or other Austronesian languages |
| 8 | Korean | Tamil | Russian | Korean | Ukranian or other Slavic languages |
| 9 | Telugu | Vietnamese | Bengali | Japanese | Other languages of Asia |
| 10 | Japanese | Portuguese | Tagalog | French | Punjabi |

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

# Description of Community

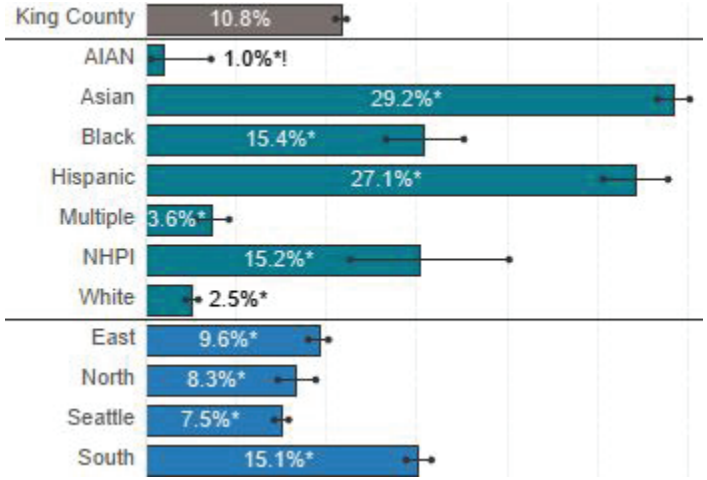
Continued

As of 2022, nearly 32% of King County residents live in a household where a **language other than English** is spoken. Spanish was the most spoken language outside of English that year, followed by Chinese. Spanish was the most common language outside of English in the South and North Regions of King County, whereas Chinese was the most common language in Seattle and the East Region of King County. Among the next most common languages across King County regions are Vietnamese, Hindi, Russian, Tagalog, Amharic, Somali, or other Afro-Asiatic languages, and Korean.

Averaging data from 2017-2021, 10.8% of King County residents over the age of five reported that they **spoke English less than 'very well.'** The percentage is higher in the South Region (15.1%) – the percentages in SeaTac (24.0%), Tukwila (24.7%), Kent–West (26.9%), Federal Way–North Corridor (25.8%), and South Beacon Hill/Georgetown/South Park (29.3%) are 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 less than 7% of people with an income of $150,000 or more. Language barriers limit access to education, employment, and healthcare, presenting challenges

**Limited English proficiency (age 5+)**
**King County (average: 2017-2021)**




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
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

for immigrant families to meet their basic needs. The percentage of people with disabilities who report speaking English less than 'very well' is higher than the King County average.

# Description of Community

Continued

## HEALTH AND WEALTH

**King County is ranked among the healthiest counties in Washington and continues to rank among the top counties in the U.S. on measures of health and wealth.**[18] While King County life expectancy has declined in recent years, it exceeded the national average by 4.7 years at 80.8 in 2021.[19] That same year, 6.9% of King County adults were uninsured, compared to 8.3 percent nationally.[20] Household income has nearly doubled over the past 10 years, at least partially attributable to the increase in both the number of jobs in the high-paying information and technology sector, as well as the rapidly increasing wages paid within the sector.[21] For the most recent single year (2021), median household income in King County was $110, 586 – much higher than the Washington state median income estimate of $84,247 and national **median household income** of $69,717.[22,23] Ranked 8th in the U.S. for income from assets, King County's asset income is more than double the national average.[24]

**However, disparities in health and wealth persist in King County.** Unequal access to opportunities and resources based on class, gender, sexual orientation, age, or race influence the health and wealth of county residents. 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 five to 12 years shorter than the life expectancy of white adults.

Communities of color continue to be disproportionately uninsured. In 2022, the percentage of uninsurance among Hispanic adults was three times the county average, and American Indian/Alaska Native adults were more than four times as likely to be uninsured as white adults.

Income inequality has rippling effects on a range of social and economic outcomes, such as housing, educational opportunities, employment, access to healthcare, and access to opportunities to thrive. While Washington state has seen an increase in household income in recent years, there is still significant income inequality and earnings disparities by race and ethnicity.[25-27] The same is true locally. In King County, the median income for Black households is $57,027, which is less than half the median income of Asian households ($127,469) and significantly less than white households ($110,701).

There is a growing divide between people who have assets that generate income and those who do not. Income generating assets like stocks, bonds, real estate, and other investments can generate a large amount of supplemental income for the most

affluent people.[24] Racial disparities in household income, net worth, home ownership, and other economic indicators displace communities of color from the economic prosperity that King County is known for.[28] For residents who do not have access to wealth generating income or even disposable income after accounting for daily living expenses, sudden disruptions in work or health can easily impacts that family's risk of financial instability.

## EDUCATION AND EMPLOYMENT

**Adults without college degrees are often excluded from jobs, have less political power, and may have shorter life expectancy.[29] People of color in King County are disproportionately impacted**. Educational attainment is an important determinant of health, as it is associated with income, employment, housing, and access to services. Overall, educational attainment in King County is high, with the percentages of residents who have completed high school and at least some college exceeding the Washington state average.[18] However, averaging data from 2017-2021, close to half (46%) of King County adults have less than a **bachelor's degree**. There are disparities in educational attainment by race/ethnicity – compared to white (42.9%) adults, Native Hawaiian/Pacific Islander (86.4%), American Indian/Alaska Native (79.4%), Hispanic (70.7%), and Black (70.7%) adults are at least 1.6 times as likely to be without a bachelor's degree.

Just over 6% of King County residents aged 25 or older have less than a high school education. Among Hispanic residents 25.8% have **less than a high school education**, compared to only 2.6% of white residents. Among South Region residents, 10.8% have less than a high school diploma – more than double the percentage in Seattle (4.5%) and the North Region (4.6%), and more than three times the percentage in the East Region (3.1%).

**As with other indicators of economic health, disparities in unemployment rate persist by race and place.** In 2021, the King County unemployment rate was 5.7% - compared to 3.5% in 2019, preceding the COVID-19 pandemic. Averaging data from 2017-2021, the King County unemployment rate among residents aged 16 and older is 4.6%. Unemployment among American Indian/Alaska Native residents (10.0%) is two times the county average. The unemployment rate is highest in the South Region (5.7%) and reaches up to 11% in Kent–West. Unemployment is lowest in the East Region (3.7%) compared to other county regions.

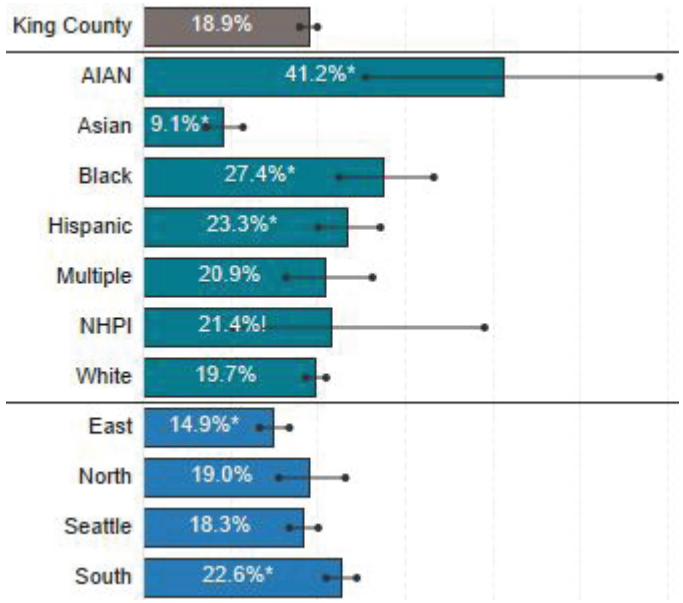
In March 2020, after the onset of the COVID-19 pandemic, mass unemployment waves hit King County resulting from community mitigation

measures such as business closures and limits on large gatherings. Unemployment during the pandemic had a significant impact on King County residents of color. Between March 15, 2020, and January 1, 2022, 59.1% of Native Hawaiian/Pacific Islander workers, 45.6% of Black workers, and 42.2 % of American Indian/Alaska Native workers filed new unemployment claims.[30] Pandemic unemployment benefits ended in September 2021. Between March 2020 and October 2021, Black workers were most likely to file multiple non-overlapping unemployment claims and to have the longest average number of unemployment payment weeks.[31] In addition, claimants of color were more likely than white claimants to be essential workers.

## DISABILITY

Averaging data from 2017-2021, the most recent years for which we have data, 18.9% of King County adults report having a disability: (1) deaf or having serious difficulty hearing, (2) blind or having serious difficulty seeing, (3) having serious difficulty concentrating, remembering, or making decisions, (4) having serious difficulty walking or climbing stairs, (5) having difficulty dressing or bathing, and (6) having difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental or emotional condition. By this definition, more than

**Disability (adults)**
**King County (average: 2017-2021)**




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

41% of American Indian/Alaska Native residents have a disability. At 27.0%, LGB adults are significantly more likely than heterosexual adults to report having a disability. Thirty-five percent of Vashon residents reported a disability – the highest of all King County neighborhoods, followed by Kent-West (30.2%).

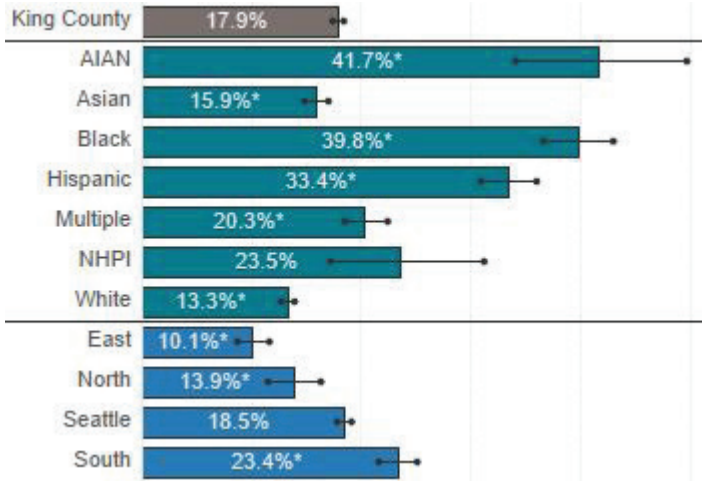
# Description of Community

Continued

## ECONOMIC INEQUITIES

**King County continues to experience economic disparities by race, place, and disability status.** King County poverty rates are down from a 10-year peak of 25.4% in 2012. Averaging data from 2017-2021, 17.9% of King County residents live in poverty or near poverty, with a household income less than 200% of the federal poverty level (FPL)[i]. At 19.7%, female residents are significantly more likely to live in poverty than male (16.6%) residents. More than 33% of young adults (18-24) and approximately 40% of Black and American Indian/Alaska Native residents lived below 200% of the federal poverty level. Black adults are three times as likely to be living in poverty or near poverty compared to white adults. The poverty rate among persons with disabilities is 1.9 times the county average. The South Region is disproportionately impacted, with two of the highest-poverty neighborhoods – North Highline and White Center (38.4%) and Kent-West (37.5%).

**Income <200% of Federal Poverty Level**
**King County (average: 2017-2021)**




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
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[i] *In 2019, twice the national poverty threshold* for a family of four including two related children was an annual income of less than $51,853. *Data source: Poverty Thresholds for 2019 by Size of Family and N of Related Children Under 18 Years: https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html*

# Description of Community

Continued

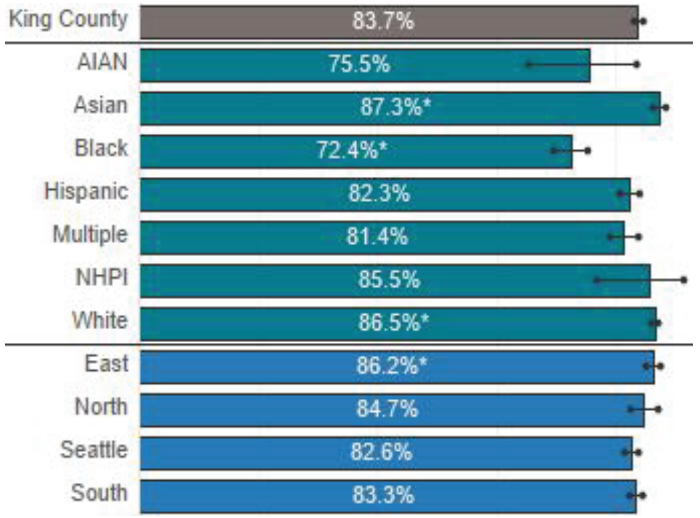
## HOUSING

**Rapidly rising housing costs threaten housing stability for many King County residents.** King County is experiencing a housing crisis of affordability and availability. Home prices far exceed national averages. The national median home price in 2021 was $346,900.[32] In March of 2021, the median King County home sold for $824,997.[33] Rental prices have also increased in several cities, further threatening housing stability.[34,35] These issues especially impact low-income residents' ability to sustain safe housing and continue to meet their other financial responsibilities.

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 2017-2021, 83.7% 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 less likely to experience severe housing cost burden. There are continued gender disparities in housing cost burden. Female residents (renters, owners with mortgages, and owners without mortgages) are significantly more likely than males to be severely burdened by 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: 2017-2021)**




Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average
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**King County is facing a homelessness crisis, intersecting with crises of mental health and substance use disorders.** The 2022 Point-In-Time count identified 13,368 individuals experiencing homelessness in King County as of March 1, 2022. Fifty-seven percent of the homeless population was unsheltered – an increase from 47% of the population in 2020. Among the individuals counted, 51%

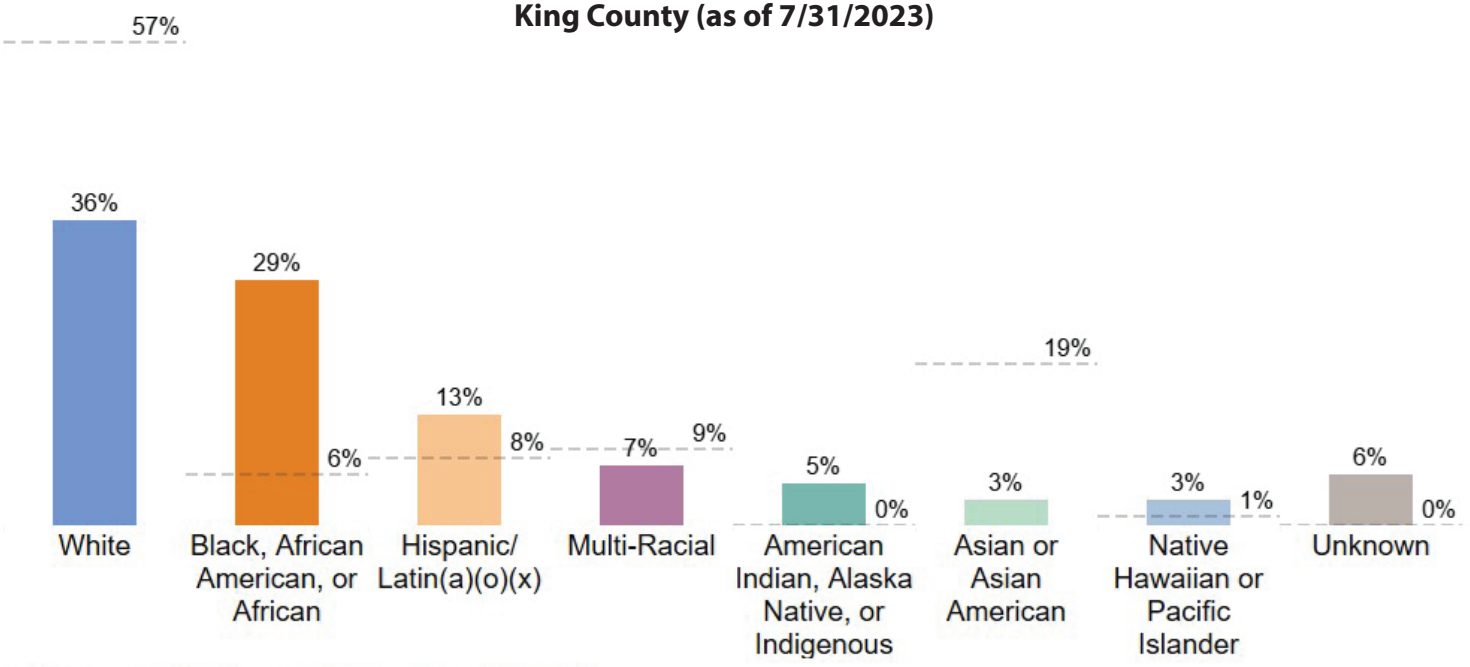
# Description of Community

Continued

identified as having a disability, 31% identified as having a mental health disorder, and 37% identified as having a substance use disorder.

**Homelessness continues to have a disproportionate impact on communities of color.** Reporting data from July 31, 2023, 10,817 King County households experienced homelessness and received services in the King County homeless response system, which includes a diverse set of programs and organizations that provide shelter, housing, and services to people experiencing homelessness.[36] Most heads of these households identified as people of color. While approximately 6% of individuals in King County are Black, 28% of households in the homeless response system identified as Black, African American, or African. American Indian/Alaska Native individuals make up less than 1% of the King County population, but they make up 5% of the homeless response system.[i]

**King County's Homeless Response System (10,817 individuals)**
**King County (as of 7/31/2023)**




Data Source: King County Regional Homelessness Authority, 2023
(1) Data includes households experiencing homelessness and accessing services as captured in Homeless Management Information System (HMIS) on 9/1/2023
(2) Demographic data reflect characteristics of the head of household.
(3) Dotted lines represent the King County population according to the 2015 American Community Survey.

[i]HMIS estimates may slightly differ from King County estimates presented elsewhere in this report due to our use of Washington State Population Interim Estimates (PIE) to generate denominators..

## TRANSPORTATION

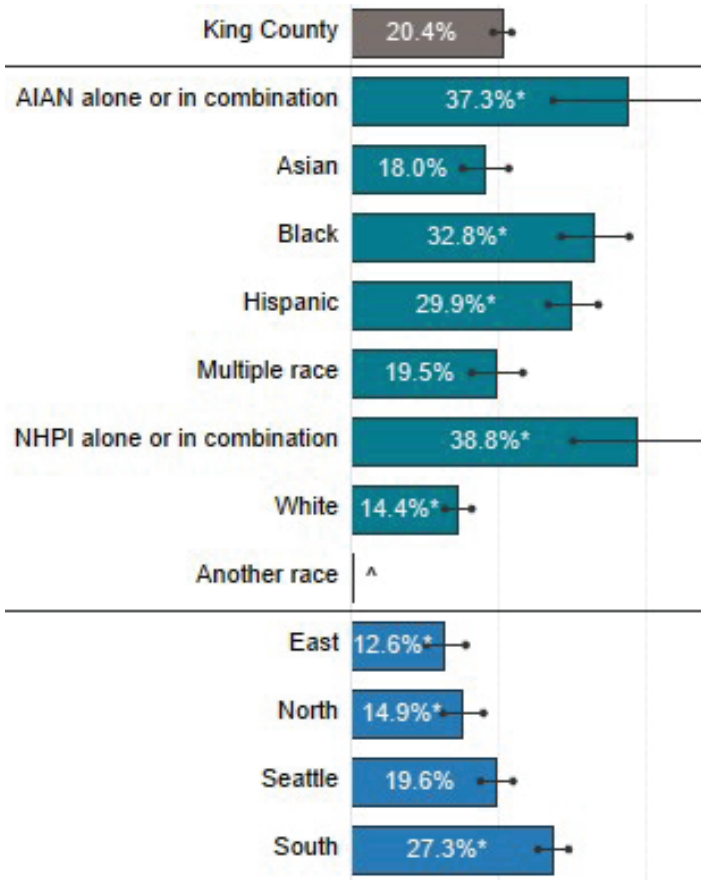
**Access to affordable and reliable transportation is a challenge for many King County families.** Averaging data from 2019 & 2021, in King County, 20.4% of children lived in families that had found it difficult to afford transportation at least some of the time since the child was born. Looking at broad race classifications, with the exception of Asian residents, residents of color are more likely to report that they struggle to afford transportation compared to King County overall residents. More than 50% of Samoan children lived in families that struggled to afford transportation. As people move further away from the city centers in search of affordable housing, affordable and reliable transportation resources are even more important.

## CLIMATE CHANGE

**Climate change is already impacting the health of residents in Washington state and King County.** Long-term changes in temperatures and weather patterns impact communities and landscapes globally and locally. Effects of climate change include rising temperatures, more extreme weather events, rising sea levels and increasing carbon dioxide levels in the atmosphere. Some human health effects of climate change include heat-related illness, exacerbation of

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

**King County (average: 2019 & 2021)**




Source: Best Starts for Kids Health Survey
* 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

respiratory and cardiovascular diseases, injuries, and mental health impacts.

Two key climate-related health hazards include extreme heat and wildfire smoke. Wildfires are starting earlier in the year and occurring with greater frequency. Western Washington is projected for increased wildfires in the future. Wildfire smoke contains many substances that are hazardous to human health, such as benzene, nitrogen oxide and particulate matter, which can irritate eyes, nose, throat, and exacerbate existing respiratory and heart diseases.[37] King County has experienced deadly extreme heat events in recent years. During a record-breaking heat wave in June 2021, the highest temperature ever measured at Sea-Tac Airport was recorded at 108 degrees.[38] This heat wave resulted in over 30 deaths in the county and more than 150 across Washington state.[39]

**The impacts of climate change affect all King County residents, but not all residents experience the impacts in the same way.** Some individuals and communities are at increased risk for the health impacts of climate change compared to others and may experience health impacts at lower levels of exposure. These include older adults, people with chronic health conditions, pregnant people, communities of color, low-income households, those experiencing homelessness and those working outdoors. People can also be at increased risk due to health status, life stage, lack of access to resources or healthcare, or historical and current environmental injustices that most seriously harm people of color.

Studies of heat, extreme cold, hurricanes, flooding, and wildfires find evidence that people of color, including Black, Hispanic, Native American/Pacific Islander, and Asian communities are at increased risk of climate-related health impacts. Many of these population groups are more likely to live in neighborhoods with limited greenspace and poor air quality, occupy rental housing, and to be low-income.[40-42] Urban areas have an abundance of hard surfaces that absorb heat, such as parking lots, rooftops, and roads. Neighborhoods with limited trees and green spaces to mitigate the effects are especially at risk of what is known as the urban heat island effect.[43,44] A study measuring temperatures at different locations at the same time/same summer day found temperatures were up to 20 degrees warmer and stayed elevated in South King County neighborhoods with limited greenspace, high density, and most racial/ethnic diversity relative to other areas of the county.[44] These temperatures remained much higher throughout the evening, while other neighborhoods were cooling. The most impacted individuals lack the resources or access to protective equipment like air conditioners and heat pumps for extreme heat, or air filters for wildfire smoke. In addition, some larger

# Description of Community

Continued

infrastructure and solutions are needed to protect the entire community, such as cooling centers, trees, and flood protection.

## RECURRING THEMES: PERSISTENT INEQUITIES THREATEN COMMUNITY RESILIENCE

In many ways, King County is an example of economic prosperity. Unfortunately, that prosperity is not experienced equally. Inequities by income, race, and place continue to shape the distribution of poor health and social outcomes in King County.

We continue to see health disparities across King County, especially when looking at indicators by race/ethnicity, sexual orientation, gender identity, and geography. Several factors affect the health and well-being of King County residents, including economic inequities, a growing homelessness crisis, the COVID-19 pandemic, and climate change, among others, which disproportionately impact people of color, LGBTQ+ residents, and South Region residents.

Systemic racism is a determinant of health, shaping the conditions of daily life for King County residents. Previous CHNA reports outlined the cumulative effects of racism and social inequities on communities of color, which have, in many cases been compounded by the COVID-19 crisis. Persistent disparities in health, social, and economic outcomes have challenged the ability of many individuals and communities to withstand the widespread social and economic impacts of the pandemic. In many ways, the pandemic worsened structural and systemic inequities, causing people of color to be more vulnerable to its impacts, many of whom were already struggling. We observe similar patterns in experiences with climate change.

The inequities we experience locally are driven in part by unjust systems, policies and practices. Increasing diversity and the pressures of continued population growth are opportunities to build more equitable systems to serve our region. Ongoing investments in the communities that are most impacted are needed to ensure that everyone has equal opportunity to thrive in our region, and that all residents are better situated for the inevitability of future public health emergencies.

# Access to Healthcare & Use of Preventive Services

Healthy People 2030 focuses on improving health by helping people access comprehensive, timely, high-quality health services.[45] Use of preventive services like annual check-ups, screenings for chronic diseases, and immunizations are important to prevent disease and protect quality of life. Clinical preventive strategies include intervening before disease occurs (primary prevention), detecting and treating disease at an early stage (secondary prevention), and managing disease to slow or stop its progression (tertiary prevention).[46] Prevention and behaviors to promote a healthy lifestyle can substantially reduce the incidence of chronic disease. In addition, 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.

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.

Twenty-five percent of transgender adults reported unmet healthcare needs due to cost – more than 2.5 times the percentage of cisgender adults and twice the King County average.

# Access to Healthcare & Use of Preventive Services

Continued

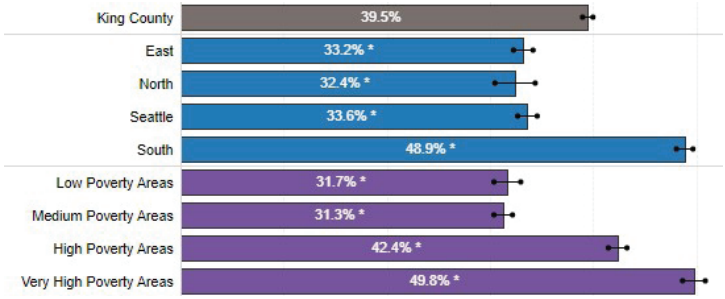
## INCOMPLETE VACCINATION COVERAGE (AGE 19-35 MONTHS)

On-time vaccination during childhood is vital to protect kids from potentially life-threatening diseases and complications.[47] 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, 2022, the rate of incomplete vaccination coverage for King County children ages 19-35 months was 39.5%.

- Comparing by neighborhood poverty level, the percentage of incomplete vaccination was highest for children aged 19-35 months living in very high-poverty areas (49.8%) defined as census tracts where 25% or more of the population earned below 200% of federal poverty level.
- Incomplete vaccination rates in the South Region (48.9%) were higher than the King County average (39.5%). The two ZIP codes with the highest rates were 98032 (58.9%) and 98001 (56.5%), which includes Kent as well as the Federal Way/Auburn 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, mumps and rubella (MMR) 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 (2022)**




Source: WA State Immunization Information System (Child Profile Health Promotion & Immunization Registry 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

# Access to Healthcare & Use of Preventive Services

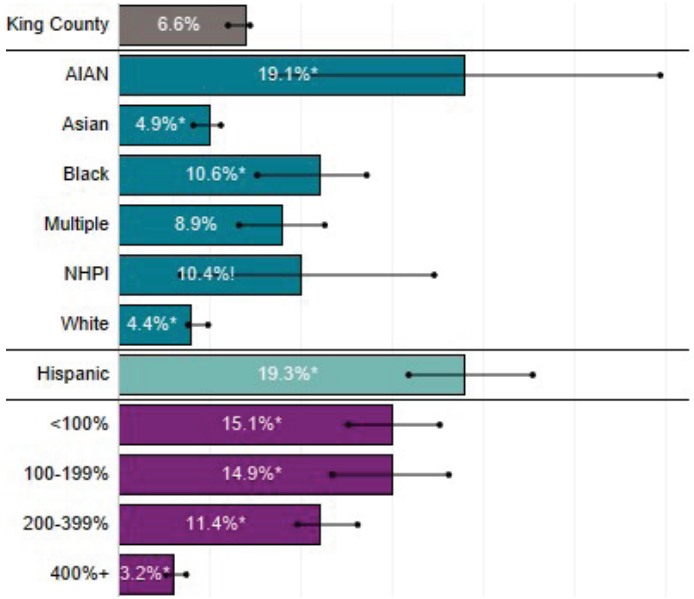
Continued

## UNINSURED ADULTS

This indicator describes the percent of the King County population without health insurance coverage. In 2022, 6.6% of King County adults were uninsured, which represents approximately 97,373 people.

- In 2022, the percentage of uninsurance among adults of Hispanic ethnicity (any race) was 3 times the county average at 19.3%
- American Indian/Alaska Native adults (19.1%) were more than four times as likely to be uninsured compared to white adults (4.4%), who had the lowest rate of uninsurance compared to other racial groups.
- Among households with income below 100% of the federal poverty level, the proportion of uninsured adults was 4.7 times as high (15.1%) as the proportion of uninsured adults in the highest-income households (3.2%).
- Among those unemployed, the proportion of uninsured adults was 11.3% – higher than the King County average. This represents a 42% decline in uninsured adults among the unemployed compared to 2021 (19.6%). This decline is likely due in part to the continuous enrollment provision that was in effect during the COVID-19 pandemic, which has since expired as of March 2023.[48]

**Uninsured adults**
**King County (2022)**




Source: American Community Survey
* Significantly different from King County average
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- Residents of Federal Way (13.4% uninsured) were nearly three times as likely, and those in Auburn (11.6% uninsured) were 2.4 times as likely as residents of Redmond (4.8%) to be uninsured.

# Access to Healthcare & Use of Preventive Services

Continued

## COLORECTAL CANCER SCREENING

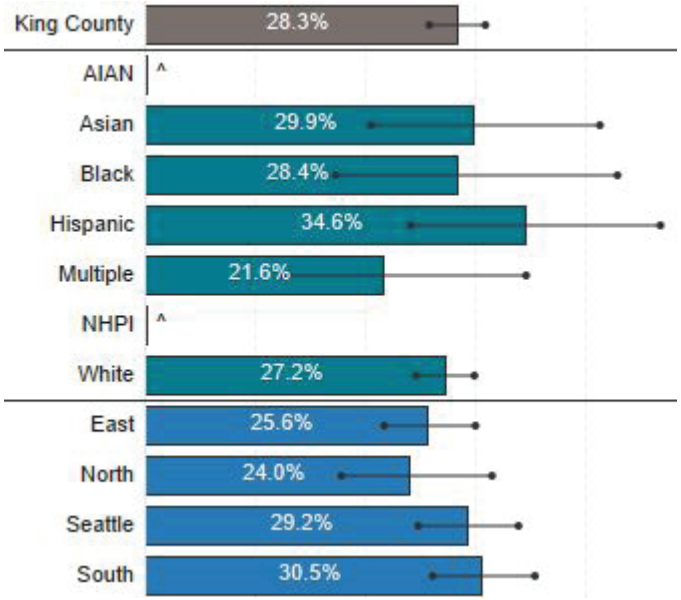
The United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in all adults aged 45 to 75 years.[49] It is recommended that most people should begin screening for colorectal cancer soon after turning 45, then continue getting screened at regular intervals. However, colorectal cancer screening is underused in the U.S. and can be a challenge for many, especially individuals without insurance or without a regular care provider.[50,51] Additional barriers include financial burden, fear that the test will be painful, lack of understanding, and inaccurate perception of colon cancer risk.[52,53]

This indicator describes the percentage of adults aged 50-75 who have not received the following screening: Fecal occult blood test (FOBT) within one year, sigmoidoscopy within five years + FOBT within three years, or colonoscopy within 10 years. Averaging data from 2016, 2018, & 2020 for King County, 28.3% of adults did not meet colorectal cancer screening guidelines.

- Adults aged 65-75 had the highest rate of adherence, with only 16.4% not meeting colorectal cancer screening guidelines compared to 33.4% of adults aged 50-64.

**Colorectal cancer screening recommendation not met (adults)**

**King County (average: 2016, 2018, & 2020)**




Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
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- Among adults with a household income less than $20,000, 43.5% did not meet screening guidelines – higher than the King County average.

# Access to Healthcare & Use of Preventive Services

Continued

## MAMMOGRAPHY RECOMMENDATIONS

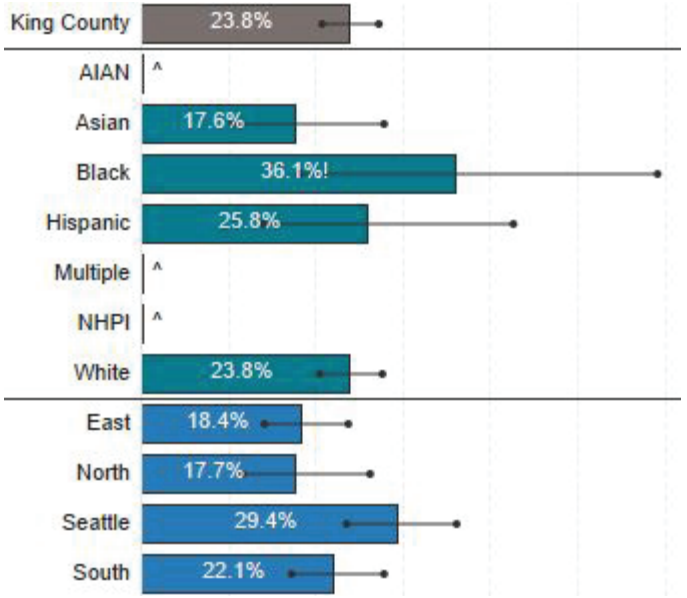
Regular mammograms are key to early detection and treatment of breast cancer. The American Cancer Society recommends that females aged 45 to 54 get mammograms every year, and at ages 55 and older at least every other year.[54]

Averaging data from 2016, 2018, & 2020 for King County, 23.8% of females aged 50-74 did not have a mammogram within the past two years.

- Mammography screening varies with household income. Among adults with household income less than $20,000, 38.9% have not had a mammogram within the past two years, compared to 17.1% of adults with household income of $100,000+ who have not had a mammogram within the past two years.

**Mammography recommendation not met (adults)**

**King County (average: 2016, 2018, & 2020)**




Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
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# Access to Healthcare & Use of Preventive Services

Continued

## ACCESS TO NEEDED MENTAL & BEHAVIORAL HEALTH SERVICES (AGE 6 MONTHS – 5TH GRADERS)

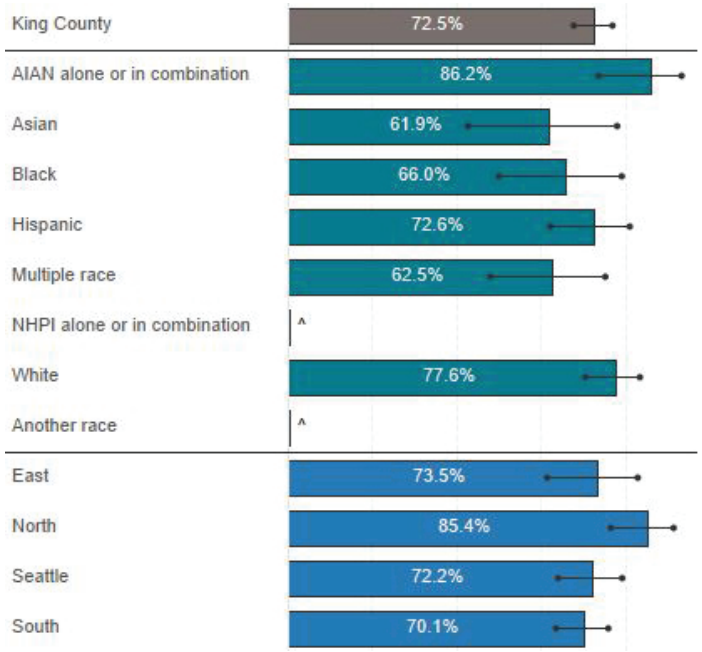
The Best Starts for Kids Health Survey of King County families assesses the health and well-being of children 5th grade and younger. This indicator describes access to mental health professionals for children aged six months through 5th grade.

Averaging data from 2019 & 2021 for King County, 72.5% of children who needed to see a mental health professional during the previous 12 months were able to access services.

- While 90.1% of children in the Shoreline School District who needed mental and behavioral health services received it, the percentage for children in the Federal Way School District was 64.8%.

**Access to needed mental and behavioral health services (ages 6 months – 5th grade)**

**King County (average: 2019 & 2021)**




Source: Best Starts for Kids Health Survey
* Significantly different from King County average
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^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

# Access to Healthcare & Use of Preventive Services

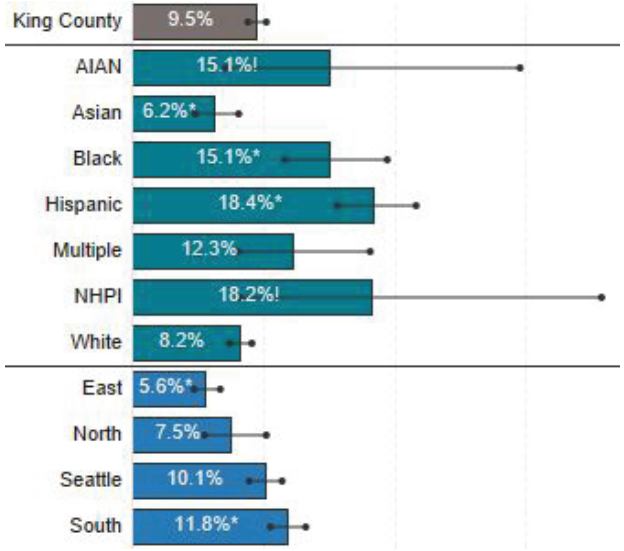
Continued

## UNMET HEALTHCARE NEEDS DUE TO COST, ADULTS

Cost can be a significant barrier to accessing healthcare, especially for people who are uninsured or underinsured. Delay or failure to receive needed medical care may result in poor health outcomes. Averaging data from 2017-2021 for King County, 9.5% of adults needed to see a doctor in the last 12 months but could not because of cost.

- The proportion of adults aged 65-75 and 75 and older who reported unmet healthcare needs due to cost was 3.2% and 3.5% respectively, lower than the King County average.
- Unmet healthcare needs due to cost for females aged 25-44 (12.4%) were higher than the King County average.
- Transgender adults (25.0%) were more than 2.5 times as likely to report unmet healthcare needs due to cost compared to cisgender adults (9.0%).
- Lesbian, gay, or bisexual adults (15.3%) were more than 1.5 times as likely to report unmet healthcare needs compared to heterosexual adults (8.2%).
- Asian (6.2%) adults were the least likely of any racial/ethnic group to report having unmet medical needs. Compared to Asian adults, Black adults (15.1%) were more than two times as likely and Hispanic adults (18.5%) were more than three times as likely to report unmet medical needs due to cost.

**Unmet medical needs due to cost (adults)**
**King County (average: 2017-2021)**




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

- Adults with household income between $20,000-34,999 (23.5%) were more than 6 times as likely as those earning more than $100,000 (3.7%) to report unmet medical needs due to cost.
- Adults living in Kent–West (27.2%) were most likely to report that they could not see a doctor due to cost compared to residents in other King County cities/ neighborhoods.

# Life Expectancy & Leading Causes of Death

Life expectancy and leading causes of death are key measures used to monitor progress in preventing disease and disability and identify emerging challenges. After decades of rising average life expectancy in the U.S., life expectancy began to fall in 2020, with COVID-19, drug overdoses, and accidental injury greatly contributing to the decline.[55,56] In King county, at the end of the pandemic's first year (2020), death rates were found to be 12% higher than during the preceding three years (2017-2019), with certain sub-groups experiencing death rates up to 38% higher.[57] Inequitable conditions and experiences with poverty, food insecurity, and lack of access to healthcare contribute to alarming racial/ethnic disparities in life expectancy and death rates nationally and locally. Worsening overall access to these social and environmental determinants of health nationwide has been highlighted in published descriptions of the 'mortality crisis', which describe substantially worse life expectancy and death rates in the U.S., compared to its peer industrialized nations.[58,59] Locally, monitoring changes in causes of death helps us understand trends in life expectancy and identify areas where investments in social determinants of health are needed.

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

U.S. death rates have risen, and life expectancy declined following the start of the COVID pandemic. In King County, life expectancy is currently the lowest it has been in several years. Unintentional injuries (including drowning, falls, fires, firearms, motor vehicle collision, poisoning, and suffocations) were the leading cause of death among King County residents under the age of 45.

# Life Expectancy & Leading Causes of Death

Continued

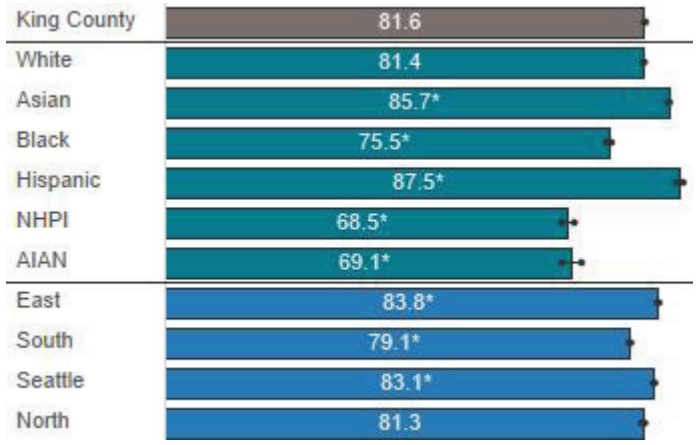
## LIFE EXPECTANCY

Life expectancy is the total number of years a newborn can expect to live. In 2021, King County life expectancy of 80.8 exceeded the national life expectancy of 76.1 years.[19] However, in a pattern mirrored across the nation, life expectancy in King County has declined in recent years. Additionally, we experience noteworthy differences in life expectancy by place and race/ethnicity in King County.

Averaging data from 2017-2021 for King County, the average life expectancy at birth is 81.6 years for newborns.

- Reviewing 3-year rolling averages, the 2019-2021 life expectancy of 81.4 years is significantly lower than the 2016-2018 life expectancy of 81.9, and the lowest it has been in the previous nine years.
- Compared to other racial/ethnic groups, average life expectancy at birth is lowest among Native Hawaiian/Pacific Islander (68.5 years) and American Indian/Alaska Native (69.1 years) King County residents – more than 10 years lower than the King County average.
- Compared to estimates from 2016-2018, life expectancy at birth has declined by two years among Black (from 76.8 to 74.8 years) and Hispanic (from 88.8 to 86.3 years) residents.

**Life expectancy**
**King County (average: 2017-2021)**




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
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

- Neighborhood poverty is associated with a lower life expectancy. Life expectancy among residents in high (80.9 years) and very high (78.6 years) poverty areas is lower than the King County average.
- Compared to other King County regions, life expectancy is lowest in South King County at 79.1 years. The neighborhood with the lowest life expectancy at birth is Auburn-South, at 74.8 years, which is 15 years shorter than Seattle-University District, the neighborhood with the highest life expectancy at 89.8 years.

# Life Expectancy & Leading Causes of Death

Continued

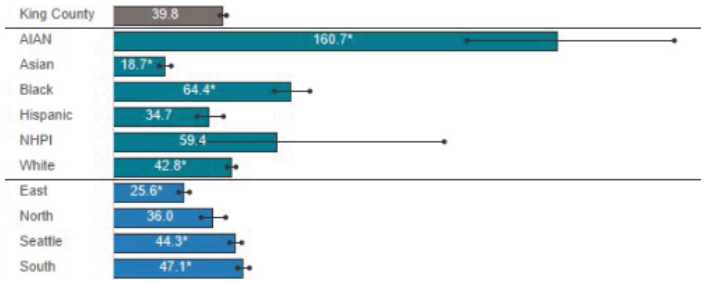
## UNINTENTIONAL INJURY DEATHS

Unintentional injury deaths include deaths from drowning, falls, fire, firearms, motor vehicle collision, poisoning, and suffocation. Unintentional injuries are in the top five leading causes of death for all racial/ethnic groups in King County. In 2021, the most recent year for which data are currently available, the unintentional injury death rate was 50.3 per 100,000, including 1,215 deaths.

Averaging data from 2017-2021, the death rate of King County residents is 39.8 per 100,000 for unintentional injuries. The death rate has been slowly increasing over the last 10 years.

- The death rate from unintentional injuries for people aged 75+ was 204.0 per 100,000, which translates to 1,179 deaths.
- Among American Indian/Alaska Native residents, the rate of unintentional injury deaths was 160.7 per 100,000, which translates to 99 deaths. This rate is almost nine times the death rate among Asian residents (18.7 per 100,000) and four times the county average. The racial/ethnic group with the next highest death rate was Black residents with a rate of 64.4 per 100,000, which translates to 452 deaths.
- The rate of unintentional injury death increases with level of neighborhood poverty, reaching 61.0 per 100,000 residents very high poverty areas.

**Unintentional injury deaths**
**King County (average: 2017-2021)**




Source: WA State Department of Health, Death Certificate Data
Note: The number shown is the 5-year average rate per 100,000 King County residents.
* 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

- Unintentional injury death rates have risen in Seattle and South Region in 2019-2021 compared to the prior 2016-2018 time period. The neighborhood with the highest unintentional injury death rate was Seattle-Downtown, Belltown, and First Hill at 165.9 per 100,000 – more than 4 times the King County average.

# Life Expectancy & Leading Causes of Death

Continued

## LEADING CAUSES OF DEATH

Leading causes of death among King County residents vary by race/ethnicity. Averaging data from 2017-2021 for King County, cancer and heart disease remain the top two leading causes of death in King County overall.

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

- While cancer is the leading cause of death among female residents (113.7 per 100,000), heart disease leads among male residents (161.7 per 100,000). After cancer and heart disease, the third leading cause of death was Alzheimer's disease among female residents (47.5 per 100,000) and unintentional injuries among male residents (56.1 per 100,000).
- Unintentional injuries were the leading cause of death among residents ages 1-44 years, with cancer leading among residents aged 45-64 and heart disease leading among those aged 65+.
- COVID-19 was the 8th leading cause of death among King County residents, replacing suicide as the 8th leading cause in 2014-2018.
- Among infants (under one year of age), the leading cause of death was congenital malformations (1.1 per 100,000, representing 27 deaths per year), followed by maternal complications (0.4 per 100,000, representing 11 deaths per year) and sudden infant death syndrome (0.4 per 100,000, representing 10 deaths per year).
- While suicide was the 9th leading cause of death for King County residents overall, it was the 6th leading cause among Native Hawaiian/Pacific Islander residents.
- Homicide was the 6th leading cause of death among Black King County residents.

# Life Expectancy & Leading Causes of Death

Continued

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

### King County (average: 2017 - 2021)


| Rank | Total | AIAN | Asian | Black | Hispanic | NHPI | White |
|---|---|---|---|---|---|---|---|
| 0 | All causes 617.1 (13,769) | All causes 970.6 (137) | All causes 444.1 (1,397) | All causes 881.8 (940) | All causes 469.6 (479) | All causes 1,548.3 (118) | All causes 639.7 (10,866) |
| 1 | Cancer 129.2 (2,924) | Heart disease 188.4 (22) | Cancer 101.5 (356) | Heart disease 183.8 (186) | Cancer 102.1 (95) | Heart disease 335.0 (25) | Cancer 134.0 (2,288) |
| 2 | Heart disease 122.2 (2,731) | Unintentional injuries 96.1 (21) | Heart disease 78.2 (237) | Cancer 168.1 (184) | Unintentional injuries 36.2 (65) | Cancer 191.6 (20) | Heart disease 127.0 (2,209) |
| 3 | Alzheimer's disease 43.5 (930) | Cancer 134.1 (19) | Stroke 34.1 (102) | Unintentional injuries 64.1 (92) | Heart disease 74.9 (63) | Diabetes Mellitus 118.4 (11) COVID-19 (U07.1) 124.4 (11) | Alzheimer's disease 47.3 (814) |
| 4 | Unintentional injuries 40.2 (926) | Chronic liver disease 55.9 (12) | Alzheimer's disease 29.1 (76) | Diabetes Mellitus 50.3 (54) | COVID-19 (U07.1) 33.8 (32) | Unintentional injuries 57.5 (7) | Unintentional injuries 44.2 (699) |
| 5 | Stroke 30.5 (666) | Stroke 69.7 (6) | Unintentional injuries 19.0 (69) | Stroke 45.9 (41) | Chronic liver disease 17.4 (21) | Stroke 76.9 (4) | Stroke 29.4 (502) |
| 6 | Chronic lower resp. disease 20.7 (455) | Diabetes Mellitus 39.1 (5) | Diabetes Mellitus 21.3 (65) | Homicide 20.4 (33) | Diabetes Mellitus 22.3 (20) | Suicide 12.7 (3) | Chronic lower resp. disease 22.8 (389) |
| 7 | Diabetes Mellitus 18.9 (424) | COVID-19 (U07.1) 37.6 (5) | COVID-19 (U07.1) 16.2 (52) | COVID-19 (U07.1) 26.9 (29) | Suicide 8.4 (19) | Influenza/pneu-monia 41.1 (3) Septicemia 26.8 (3) | Diabetes Mellitus 16.3 (276) |
| 8 | COVID-19 (U07.1) 15.2 (340) | Chronic lower resp. disease 27.8 (4) | Essential (primary) hypertension 11.0 (31) | Alzheimer's disease 41.1 (28) | Stroke 23.4 (19) | Homicide 9.2 (2) | COVID-19 (U07.1) 13.8 (237) |
| 9 | Suicide 12.5 (287) | Other diseases of respiratory system 22.2 (3) Homicide 9.1 (3) | Suicide 6.9 (30) | Chronic lower resp. disease 25.4 (27) | Homicide 6.5 (17) | -- | Suicide 14.04 (220) |
| 10 | Chronic liver disease 11.2 (271) | Alzheimer's disease 30.7 (2) | Chronic lower resp. disease 8.7 (25) | Essential (primary) hypertension 19.9 (19) | Alzheimer's disease 21.7 (15) | -- | Chronic liver disease 12.7 (218) |

Source: WA State Department of Health, Death Certificate Data

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

# Chronic Illnesses

According to the Centers for Disease Control and Prevention, six in ten Americans live with at least one chronic illness, defined as a condition that lasts one year or more and requires ongoing medical attention and/or limits activities of daily living.[60] Chronic illnesses are among the leading causes of death and disability nationally and contribute to significant healthcare costs. Key areas for focused chronic disease prevention include place-based strategies to promote good nutrition, regular physical activity, and avoiding tobacco and substance for communities to thrive. Chronic disease surveillance is an important practice to help understand the extent and impact of chronic diseases, guide prevention efforts, inform the work of health professionals, and support effective public health policies.

Additional indicators available online include asthma prevalence (adults), asthma hospitalizations, chronic respiratory disease (adults), and stroke prevalence (adults).

In King County, low-income adults are four times as likely as high-income adults to have diabetes.

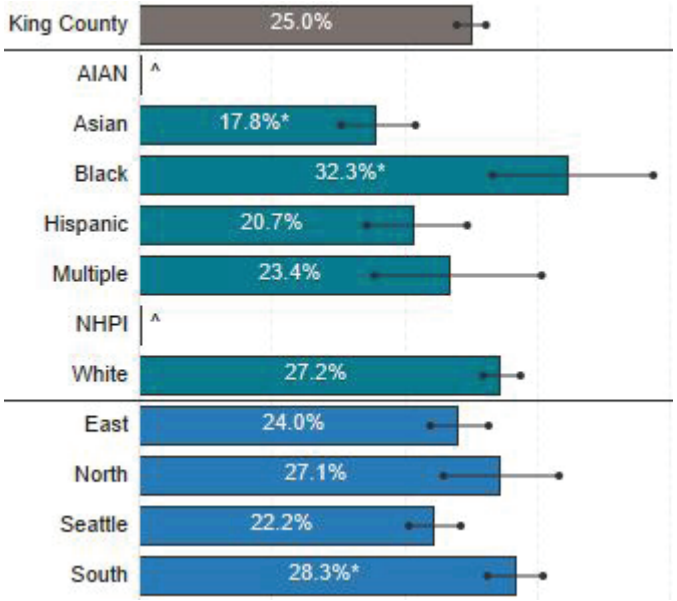
## ADULT HYPERTENSION

The term hypertension refers to blood pressure that is consistently higher than normal.[61] Hypertension increases the risk of heart disease and stroke, both leading causes of death nationally and locally.[62,63] Data on hypertension for King County residents is available every other year through the Behavioral Risk Factor Surveillance System (BRFSS). Averaging data from 2017, 2019, and 2021[i] for King County, 25.0% of adults were ever told by a doctor, nurse, or other health professional that they have high blood pressure. This rate has been relatively stable for the past 10 years.

- Compared to other age groups, hypertension was highest among older adults: 49.3% of adults ages 65-75 and 56.9% of adults aged 75 and older.
- At 32.3%, the rate of hypertension among Black residents was higher than the King County average. The rate among Black women was even higher at 39.1%. The rate of hypertension among Asian residents (17.8%) was lower than the King County average.
- The rate of hypertension among military veterans (38.3%) was more than 1.5 times the rate among non-veterans (23.9%).

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

**Hypertension (adults)**
**King County (average: 2017, 2019, & 2021)**




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

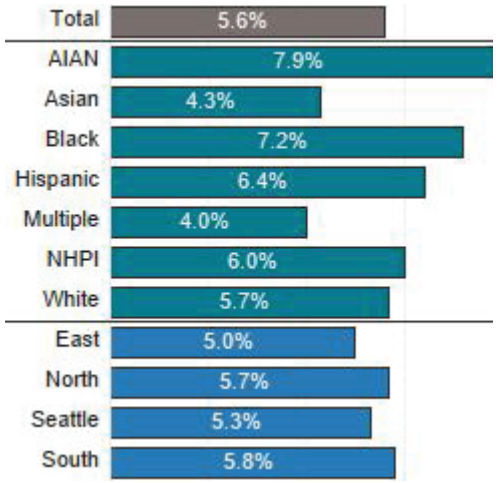
- The rate of high blood pressure among South Region adults was 28.3% – higher than the King County average. Among cities/neighborhoods, Auburn-South has one of the highest rates of adult hypertension at 37.8%. This is almost three times the rate of North Highline and White Center, which has one of the lowest rates at 10.8%.

## CHILDHOOD ASTHMA (MEDICAID)

In 2022, 5.6% of King County Medicaid members (age 0-17) had an asthma diagnosis, which represents 8,957 Medicaid members. The data presented are from Medicaid enrolled children (age 0-17) who had seven or more cumulative months of Medicaid coverage in 2022.

- The 2022 childhood asthma rate is slightly higher than the 2019 rate presented in the last CHNA report (4.2%).
- Asthma is slightly more common among male children (6.4%) than female children (4.7%).
- Compared to other racial/ethnic groups, asthma rates were highest among American Indian/Alaska Native (7.9%) and Black (7.2%) Medicaid-enrolled children.
- The neighborhood with the highest childhood asthma rate was Federal Way-Central (7.6%) – two times the rate of Mercer Island and Point Cities (3.5%), which has the lowest asthma rate among all King County cities/neighborhoods.

**Asthma diagnosis (Medicaid children)**
**King County (2022)**




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

# Chronic Illnesses

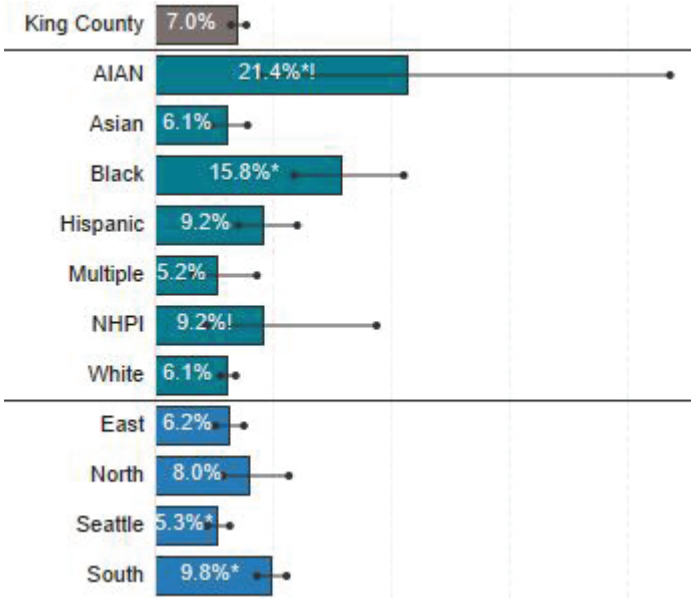
Continued

## ADULT DIABETES

Averaging data from 2017–2021, 7.0% of King County adults were ever told by a doctor, nurse, or other health professional that they have diabetes. This estimate does not include diabetes during pregnancy or pre-diabetes. The overall King County diabetes rate has been relatively stable for the past 10 years.

- Diabetes prevalence among adults aged 75 and older (19.2%) was more than 2.5 times the county average.
- The diabetes rate among Black adults (15.8%) was more than two times the county average.
- Adults with an annual income less than $20,000 (15.6%) have four times the diabetes rate of those with income greater than $100,000 (3.9%).
- The rate of diabetes among military veterans (12.2%) was almost twice the rate among nonveterans (6.6%).
- Among South Region adults, diabetes prevalence is higher than the King County average at 9.8%, and more than 1.5 times the rate among adults in Seattle (5.3%).

**Diabetes prevalence (adults)**
**King County (average: 2017-2021)**




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

# Chronic Illnesses

Continued

## LEADING CAUSES OF HOSPITALIZATIONS

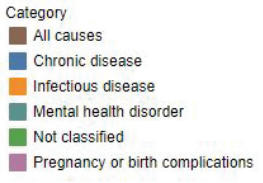
This section includes analyses of King County hospital discharge data and presents 5-year average rates per 100,000 county residents. Averaging data from 2017-2021 for King County, the three leading causes of hospitalization among King County residents were septicemia (except in labor) (427.3 per 100,000), unintentional injury (295.2 per 100,000), and pregnancy or birth complications (209.7 per 100,000).

- Older adults (age 65 and older) had the highest number of hospitalizations (17,793.4 per 100,000) compared to younger age groups, with septicemia (except in labor) (1,756.2 per 100,000), unintentional injury (1,249.8 per 100,000), and hypertension (1,082.2 per 100,000) leading in this group.
- Among King County residents aged one to 17, mood disorders (185.6 per 100,000) were the leading cause of hospitalization, followed by unintentional injury (60.4 per 100,000) and asthma (49.4 per 100,000).
- Pregnancy and birth complications account for five of the top 10 leading causes of death among female residents.
- Schizophrenia and other psychotic disorders were the leading cause of hospitalizations for males aged 18 to 24 (370.9 per 100,000) and 25-44 (313.8 per 100,000) whereas for females aged 18 to 24 (676.7 per 100,000) and 25 to 44 (1,268.9 per 100,000) the leading cause was related to pregnancy or birth complications.

## Leading causes of hospitalizations (ranked by number of hospitalizations)

### King County (average: 2017-2021)

| Rank | Total | Female | Male |
|---|---|---|---|
| 0 | All causes<br>7,126.2 (161,225) | All causes<br>7,841.7 (91,589) | All causes<br>6,535.0 (69,619) |
| 1 | Septicemia (except in labor)<br>427.3 (9,941) | Other complications of birth; puerperium affecting management of mother<br>433.4 (5,220) | Septicemia (except in labor)<br>486.3 (5,237) |
| 2 | Unintentional injury<br>295.2 (6,705) | Septicemia (except in labor)<br>379.8 (4,703) | Unintentional injury<br>313.7 (3,344) |
| 3 | Other complications of birth; puerperium affecting management of mother<br>209.7 (5,220) | Polyhydramnios and other problems of amniotic cavity<br>285.7 (3,482) | Complications of medical care<br>226.3 (2,449) |
| 4 | Hypertension<br>201.2 (4,583) | Unintentional injury<br>269.7 (3.360) | Hypertension<br>233.8 (2,394) |
| 5 | Mood disorders<br>206.0 (4,579) | Prolonged pregnancy<br>214.5 (2,655) | Schizophrenia and other psychotic disorders<br>187.8 (2,262) |
| 6 | Complications of medical care<br>194.0 (4,551) | Mood disorders<br>242.6 (2,619) | Mood disorders<br>170.3 (1,958) |
| 7 | Fractures<br>187.9 (4,252) | Previous C-section<br>208.6 (2,480) | Fractures<br>174.6 (1,832) |
| 8 | Osteoarthritis<br>167.8 (4,114) | Osteoarthritis<br>188.2 (2,436) | Alcohol-related disorders<br>136.8 (1,688) |
| 9 | Schizophrenia and other psychotic disorders<br>151.3 (3,573) | Fractures<br>191.5 (2,419) | Osteoarthritis<br>144.3 (1,678) |
| 10 | Polyhydramnios and other problems of amniotic cavity<br>138.1 (3,483) | Hypertension complicating pregnancy; childbirth, and the puerperium<br>191.0 (2,277) | Acute cerebrovascular disease<br>150.3 (1,578) |




Source: Comprehensive Hospital Abstract Reporting System (CHARS)
Note: Under each cause, the first number shown is the 5-year average rate per 100,000 and the number in parenthesis is the average annual count from that cause over the 5-year period. For the leading causes by age, the rates are age-specific. All other rates are age-adjusted rates .

## LEADING TYPES OF CANCER

This indicator ranks the ten most common types of cancer based on the total number of new invasive cases (excluding cancers at the in-situ stage) during a five-year period. Averaging data from 2016-2020, the three leading causes of cancer in King County were breast (female; 148.2 per 100,000), prostate (male; 116.5 per 100,000) and lung (45.4 per 100,000).

- The incidence of cancer diagnosis was highest among adults aged 65 and older (1,938.1 per 100,000).
- Breast cancer was the leading cancer type among all races except Black residents, where prostate cancer incidence (167.4 per 100,000) exceeded breast cancer incidence (118.5 per 100,000).
- Cancer rates are much lower among children aged 1-14 (17.8 per 100,000), with leukemia (5.0 per 100,000), brain cancer (4.2 per 100,000), and non-Hodgkin lymphoma (1.0 per 100.000) as the three leading cancer types among this age group.
- Skin melanoma was the third leading cause of cancer among residents in the East Region (35.7 per 100,000) and residents living in low poverty areas (38.8 per 100,000).

### Most common cancer types (new cases)
**King County (average: 2016-2020)**

| Rank | Total | Female | Male |
|---|---|---|---|
| 0 | All<br>448.3 (10,238) | All<br>438.1 (5,239) | All<br>471.7 (4,995) |
| 1 | Breast (Female)<br>148.2 (1,766) | Breast (Female)<br>148.2 (1,766) | Prostate (Male)<br>116.5 (1,294) |
| 2 | Prostate (Male)<br>116.5 (1,294) | Lung<br>43.2 (523) | Lung<br>48.4 (484) |
| 3 | Lung<br>45.4 (1,007) | Colorectal<br>31.0 (370) | Colorectal<br>39.5 (419) |
| 4 | Colorectal<br>35.0 (790) | Uterine (Female)<br>28.1 (349) | Skin Melanoma<br>36.0 (379) |
| 5 | Skin Melanoma<br>29.7 (679) | Skin Melanoma<br>25.2 (300) | Non-Hodgkin Lymphoma<br>25.2 (258) |
| 6 | Non-Hodgkin Lymphoma<br>20.8 (464) | Thyroid<br>19.2 (221) | Kidney<br>21.1 (225) |
| 7 | Uterine (Female)<br>28.1 (349) | Non-Hodgkin Lymphoma<br>17.2 (206) | Leukemia<br>19.9 (205) |
| 8 | Leukemia<br>15.1 (336) | Pancreas<br>12.1 (147) | Oral/Pharynx<br>17.8 (198) |
| 9 | Kidney<br>14.6 (335) | Leukemia<br>11.0 (130) | Liver<br>14.4 (163) |
| 10 | Thyroid<br>13.2 (304) | Ovary (Female)<br>9.2 (111) | Urinary Bladder<br>16.6 (160) |

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.

# Behavioral Health & Substance Use

Behavioral health is a broad term that generally refers to mental health and substance use disorders, life stressors or crises, and stress-related physical symptoms.[64] The United States is experiencing a national mental health crisis, compounded by stress related to the COVID-19 pandemic, political conflict, an economic downturn, a drug overdose epidemic, surging violent crime in many American cities, and impacts of racism and discrimination.[65-68]

Mental illness, such as depression, can increase the risk for many types of physical health problems and chronic conditions, including stroke, diabetes, and heart disease.[69] Common risk factors can contribute to both substance use disorders and other mental health disorders, including family history, stress, and trauma.[70] With a national rise in suicide-related injuries and overdose deaths and increasing rate of drug overdose deaths in Washington state,[71] public health officials and service providers continue to closely monitor local trends to inform policies and strategies aimed at overdose prevention.

Additional indicators available online include binge drinking (youth and adults), e-cigarette use (adults), adolescents with an adult they can talk with (youth), suicide attempt emergency department visits, driving or riding in a car while high (youth).

In 2022, the rate of emergency departments visits involving suicidal ideation among King County residents was 662.1 per 100,000 residents, which translates to 13,617 visits.

Please refer to the ***Community Identified Priorities*** section of this report for a summary of findings from listening sessions with King County families of color about their access to mental and behavioral health services.

# Behavioral Health & Substance Use

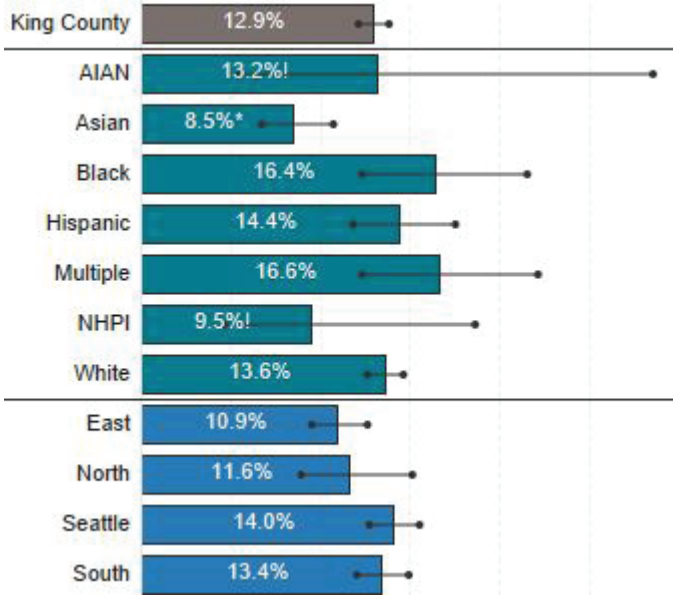
Continued

## ADULT FREQUENT MENTAL DISTRESS

Screening for mental health disorders is important to identify problems, initiate treatment, improve quality of life, and prevent future conditions and negative health and social outcomes. Frequent mental distress is defined as having 14 or more days with poor mental health in the past 30 days. Averaging data from 2017-2021 for King County, 12.9% of adults had frequent mental distress.

- Compared to other age groups, frequent mental distress was most often reported among adults aged 18-24 (23.2%). The percentage of adults reporting frequent mental distress decreased with age.
- Female residents (15.1%) were more likely than male residents (10.8%) to experience frequent mental distress.
- Transgender adults (39.7%) were more than three times as likely as cisgender adults (12.5%) to experience frequent mental distress.
- Lesbian, gay, or bisexual adults were more than 2.5 times as likely (29.6%) as heterosexual adults (11.2%) to experience frequent mental distress.
- Compared to other racial/ethnic groups, Asian adults (8.5%) were least likely to experience frequent mental distress. The highest rates were among Black (16.4%) and Multiple race (16.6%) adults.

**Frequent mental distress (adults)**
**King County (average: 2017-2021)**




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

- The likelihood of experiencing frequent mental distress generally decreased with higher household income. Adults with annual household income less than $20,000 (27.2%) were more than three times as likely as those with household income greater than $100,000 (8.6%) to experience frequent mental distress.

# Behavioral Health & Substance Use

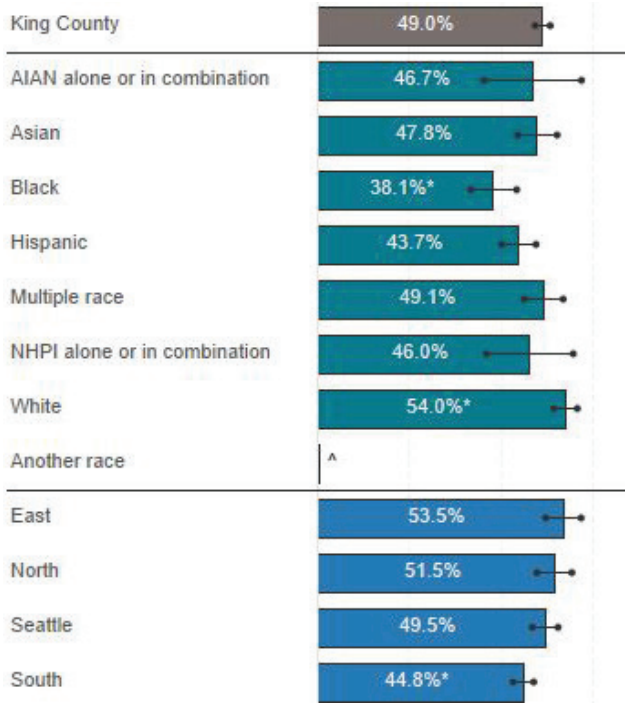
Continued

## FAMILIES WHO LIVE IN A SUPPORTIVE NEIGHBORHOOD

The Best Starts for Kids Health Survey of families and caregivers of children aged six months through 5th grade examined their perceptions of the neighborhoods in which they live. A supportive neighborhood is defined as a neighborhood where members help each other out, watch out for one another, and where there is somewhere they can turn for support. Averaging survey data from 2019 & 2021 for King County, 49.0% of children lived in a supportive neighborhood.

- Families of Black children (38.1%) were less likely than the King County average to report living in a supportive neighborhood. Families of white children (54.0%) were more likely than the King County average to report living in a supportive neighborhood.
- The likelihood of living in a supportive neighborhood generally increased with higher household income. Households with income less than $75,000 were less likely to live in a supportive neighborhood than households earning $100,000 or higher.
- Reviewing these data by school district, children living in the Riverview (75.1%), Enumclaw (72.4%), Mercer Island (69.8%), Tahoma (68.4%), and Snoqualmie Valley (64.6%) School Districts were most likely to live in a supportive neighborhood, with percentages higher than the King County average. Children living in the Renton (39.9%), Kent (40.4%), and Federal Way (40.8%) School Districts were least likely to report living in a supportive neighborhood with percentages lower than the King County average.

**Families who live in a supportive neighborhood (ages 6 months - 5th grade)**
**King County (average: 2019 & 2021)**




Source: Best Starts for Kids Health Survey
* 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

# Behavioral Health & Substance Use

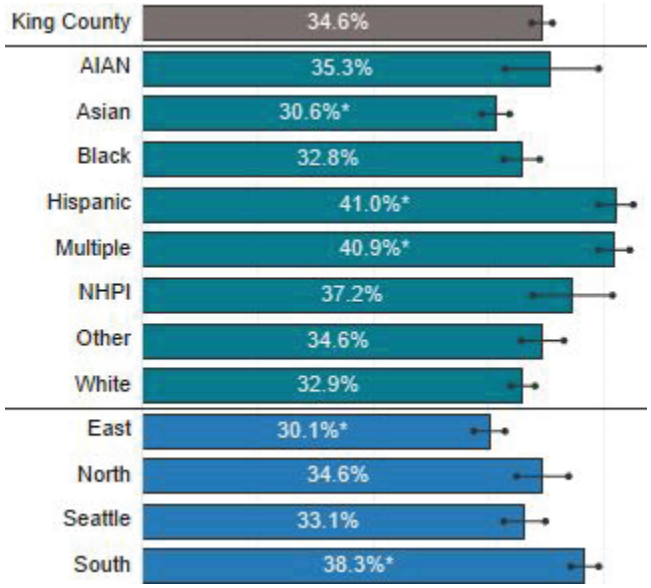
Continued

## YOUTH DEPRESSION

Using data from the Washington State Healthy Youth Survey, youth depression is defined as having felt so sad/hopeless for two weeks or more during the past 12 months that they stopped doing usual activities. Averaging data from 2018 & 2021 for King County, 34.6% of 8th, 10th, and 12th graders report depressive feelings.

- The prevalence of depression among King County students increased between 2018 (32.9%) and 2021 (36.4%).
- The percentage of youth reporting depressive feelings increased with each grade level from 28.7% of 8th grade students to 39.6% of 12th grade students reporting depressive feelings.
- Female students (42.0%) were more likely than male students (25.7%) to experience symptoms of depression. Compared to the King County average (34.6%), transgender students (67.3%), students who reported that 'something else fits better' (67.0%), and students who were questioning their gender (62.9%) were almost twice as likely to experience depressive feelings.
- LGB+ youth (60.0%) were more than twice as likely to report depressive feelings compared to heterosexual youth (28.3%).

**Depression prevalence (8th, 10th, 12th grades)**
**King County (average: 2018 & 2021)**




Source: Healthy Youth Survey
* 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

- Hispanic (41.0%) and Multiple Race (40.9%) students were more likely to experience depressive feelings than the King County average.
- Asian students (30.6%) were less likely less likely to experience depressive feelings compared to the King County average. However, there were differences

among Asian students by ethnic group: Filipino students (42.2%) were more likely to report depressive feelings, while Asian Indian (26.2%) and Chinese (28.9%) students were less likely to report feelings.

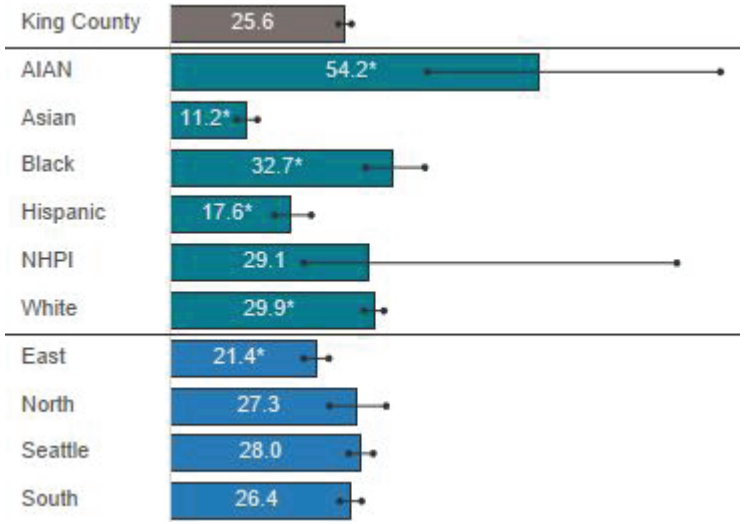
- Youth in the South Region (38.3%) were more likely than youth in other King County regions to report depressive feelings.

## ATTEMPTED SUICIDE HOSPITALIZATIONS

It is estimated that there is an average of 25 attempted suicides for every suicide death in the U.S.[72] People who attempt suicide and survive may experience serious injuries that can have long-term effects on their health.[73] Averaging data from 2017-2021, the average non-fatal hospital admission rate for suicides was 25.6 per 100,000 King County residents.

- The rate of attempted suicide hospitalization in King County has seen an 18% decline from 31.3 per 100,000 (2012-2016) to 25.6 (2017-2021).
- Compared to all other age groups, the rate of attempted suicide hospitalization was highest among adults ages 18–24 (57.4 per 100,000) and more than two times the King County average (25.6 per 100,000).
- Female residents (31.6 per 100,000) were more likely than male residents (19.9 per 100,000) to be hospitalized for attempted suicide.

**Attempted suicide hospitalizations**
**King County (average: 2017-2021)**




Source: Comprehensive Hospital Abstract Reporting System (CHARS)
Note: The number shown is the 5-year average rate per 100,000 King County residents
* 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.

- American Indian/Alaska Native residents (54.2 per 100,000) had the highest rate of attempted suicide hospitalization, followed by Black residents (32.7 per 100,000), and white residents (29.9 per 100,000).
- The hospitalization rate for attempted suicide was highest for people living in very high-poverty neighborhoods (30.3 per 100,000) compared to medium- and low-poverty neighborhoods.

# Behavioral Health & Substance Use

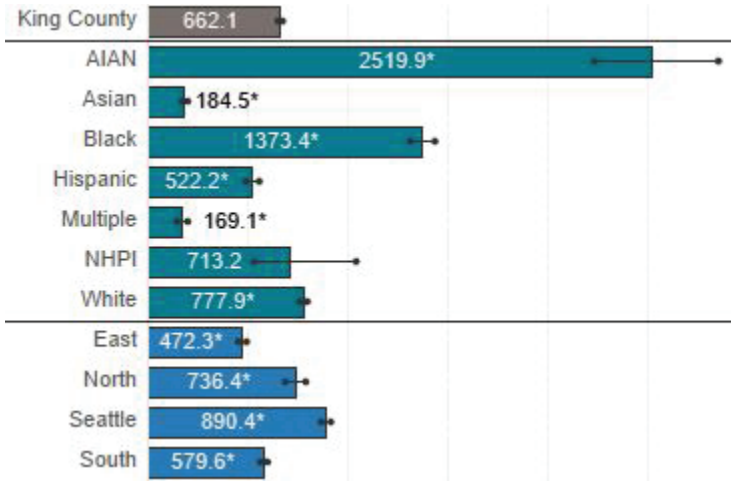
Continued

## SUICIDAL IDEATION (ED VISITS)

Suicidal ideation refers to having thoughts or plans of engaging in suicide-related behavior. This indicator includes data representing all visits to a non-federal emergency department (ED) by King County residents. In 2022, the rate of emergency department visits involving suicidal ideation among King County residents was 662.1 per 100,000 residents, which translates to 13,617 visits. 2,405 of these visits were among youth between the ages of 8 and 17.

- Compared to the King County average, the rate of emergency department visits involving suicidal ideation was higher among children aged 8-17 (1,132.0 per 100,000) and young adults aged 18–24 (1,114.8 per 100,000). The rate among youth between the ages of 8 and 17 dipped to 954.5 per 100,000 in 2020, only to approach previous rates in 2021 and 2022. Community mitigation of COVID-19 led to substantial decreases in use of healthcare in 2020, including use of the ED. Thus, this decline does not necessarily suggest that suicidal ideation decreased among youth in 2020, but rather that these youth did not seek care in the ED. In 2022, most visits in the youth category were among youth ages 13-17 with a rate of 1,508.7 per 100,000, which translates to 1,958 visits.
- Female residents (697.9 per 100,000) were more likely than male residents (621.5 per 100,000) to visit the ED for suicidal ideation. This disparity was particularly pronounced among children, where females have a rate (1,632 per 100,000) that is 2.5 times that rate for males (646 per 100,000). Studies have shown that transgender people are at increased risk for suicide ideation, attempts, and deaths compared to the general population.[74-76] Since this data source only includes male and female genders, we are unable to describe local data for transgender residents or people of other genders.

**Suicidal ideation (ED visits)**
**King County (2022)**




Source: WA State Department of Health, Rapid Health Information NetwOrk (RHINO)
Note: The number shown is the rate per 100,000 King County residents.
* Significantly different from King County average
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# Behavioral Health & Substance Use

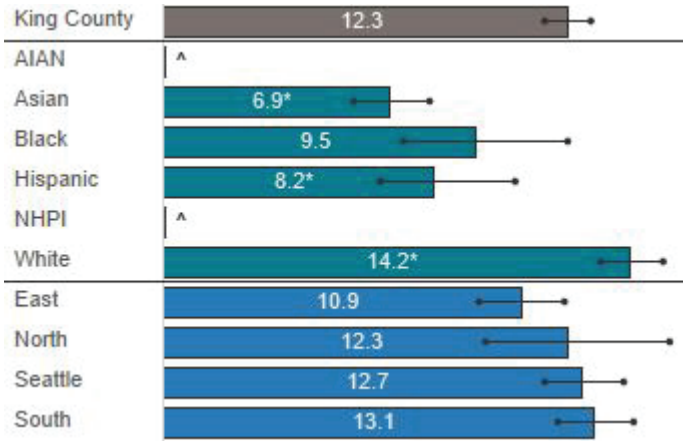
Continued

- The suicidal ideation ED visit rate among American Indian/Alaska Native residents was 2519.9 per 100,000 – the highest among all racial/ethnic groups. The rates for Black (1,373.4 per 100,000) and white (777.9 per 100,000) residents were higher than the King County average. In 2021, the rate of suicide ideation among Black youth saw a nearly 2-fold increase compared to 2020 (from 596 visits to 1,064 visits, per 100,000 population).
- Compared to the King County average, the rate of emergency department visits involving suicidal ideation was higher among residents living in Seattle (890.4 per 100,000) and the North Region (736.4 per 100,000).
- The rate of emergency department visits involving suicidal ideation was at least four times higher than the King County average for the 98101 (6,775.5 per 100,000), 98104 (4,749.7 per 100,000), and 98134 (2,799.7 per 100,000) ZIP codes, which includes areas of downtown Seattle and SoDo.

## SUICIDE DEATHS

Suicide is a leading cause of death in the United States with increasing prevalence.[77] CDC's provisional data for 2022 show a record high of 49,369 suicide deaths nationally, coming after modest declines in 2019 and 2020.[78] Suicide rates in Washington State rose from 2006-2017 but appear to be relatively consistent in recent years.[79]

**Suicidal deaths**
**King County (average: 2017-2021)**




Source: WA State Department of Health, Death Certificate Data
Note: The number shown is the 5-year average rate per 100,000 King County residents.
* Significantly different from King County average
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The Washington State Department of Health, Center for Health Statistics collects information on deaths in Washington state from death certificate data. Averaging data from 2017-2021, the suicide death rate for King County residents is 12.3 per 100,000. In 2021 – the most recent year for which data are available – the overall rate of 12 per 100,000 represents 292 deaths.

# Behavioral Health & Substance Use

Continued

This compares to 15.3 per 100,000 for the state of Washington (representing 1,229 deaths) in 2021.[80]

- The suicide death rate among children and adolescents (<18 years old) was 2.4 per 100,000, representing 54 deaths. Suicide rates for young adults ages 18-24 (18.1 per 100,000), adults 45-64 (18.3 per 100,000), and older adults 75+ (20.4 per 100,000) were higher than the King County average.
- The suicide death rate for male residents (19.1 per 100,000) was more than three times the rate among female residents (5.8 per 100,000). Since this data source only includes male and female genders, we are unable to describe local data for transgender residents, who are at increased risk for suicide deaths compared to the general population.[74-76]
- Suicide rates for Asian residents (6.9 per 100,000) and Hispanic residents (8.2 per 100,000) were lower than the King County average. The suicide rate among white residents was 14.2 per 100,000 – more than double the rate among Asian residents. While American Indian/Alaska Native and Native Hawaiian/Pacific Islander groups have the highest rates of suicide nationally, we are unable to compare locally since King County data for these groups are suppressed due to small sample sizes.[77, 14]
- People living in very high poverty areas had the highest suicide death rate (14.9 per 100,000) compared to those in lower poverty areas.
- The death rate from suicide for people in the Seattle–Downtown, Belltown, and First Hill neighborhood was 29.8 per 100,000. This rate is 2.4 times the King County average and the highest of all King County neighborhoods.

# Behavioral Health & Substance Use

Continued

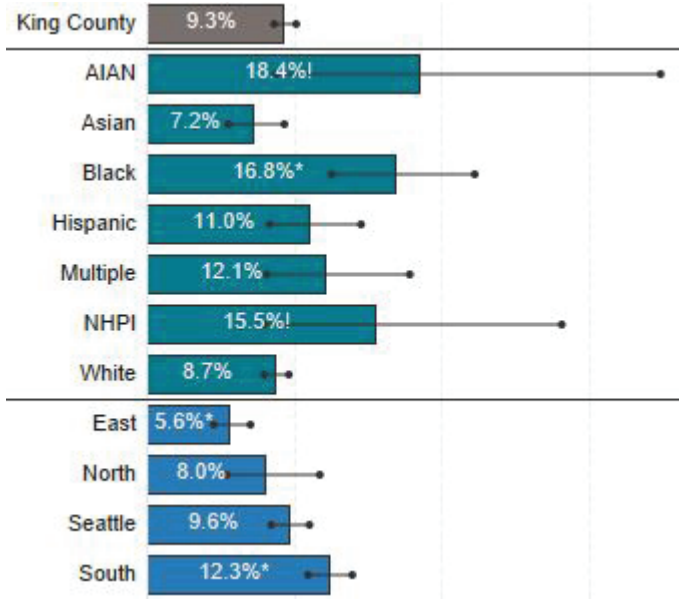
## ADULT CIGARETTE SMOKING

Cigarette smoking harms nearly every organ of the body and is the leading cause of preventable death in the United States.[81] Smokers are at increased risk of cardiovascular disease, respiratory illness, and cancer. Quitting smoking is one of the most important actions to improve health, prevent disease, and extend life expectancy. In 2021, 7.7 % of King County adults were cigarette smokers, compared to just over 11% among U.S. adults overall.[82]

Averaging data from 2017-2021 for King County, 9.3% of adults currently smoke cigarettes every day or some days. While this estimate is relatively low compared to the national adult smoking rate, there are some noteworthy disparities in cigarette smoking among King County residents.

- The rate of cigarette smoking among LGB adults has steeply declined in recent years by 56%, from 20.1% (2016-2018) to 8.9% (2019-2021). A similar pattern has been observed nationally, with a relative decrease in cigarette smoking among LGB adults observed in 2019 compared to 2014.[83]
- 5.8% of adults ages 18-24 and 4.4% of adults aged 75+ were current smokers – lower than the King County average.
- 16.8% of Black residents are cigarette smokers – almost two times the King County average.

**Cigarette smoking (adults)**
**King County (average: 2017-2021)**




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

- Smoking among residents making less than $20,000 (20.5%) was more than three times the rate among higher-income households making over $100,000 (6.1%).
- South Region adults (12.3%) are more likely to be current smokers than the average King County resident (9.3%), and more than twice as likely as adults in the East Region (5.6%). Maple Valley (22.3%) reported the highest rate of cigarette smoking

# Behavioral Health & Substance Use

Continued

among all King County neighborhoods, followed by Seattle–Downtown, Belltown, and First Hill (20.3%).

## Youth Substance Use

Adverse mental health frequently co-occurs with substance use.[70] Analyses of 2018 HYS data for King County 10th graders revealed that current substance use (cannabis, vapor or tobacco products use in the past 30 days) was two times higher among students who reported depressive feelings, suicidal thoughts, experiencing a high level of anxiety, or being bullied compared to peers who do not report these mental health factors.[84]

King County data for youth substance use come from the Healthy Youth Survey, which is usually administered every year, but was delayed from 2020 to 2021 due to disruptions related to the COVID-19 pandemic. The following youth substance use indicators – youth e-cig or vape pen use; alcohol, marijuana, painkiller, or any illicit drug use; and marijuana use – average data for 2018 & 2021. Some downward trends were observed through these analyses of recent data. National data on youth trends reflects a decrease in alcohol and substance use during the pandemic, which may be partially explained by pandemic-specific contextual factors, including decreased access to substances because of reduced contact with peers and increases in parental supervision.[85]

# Behavioral Health & Substance Use

Continued

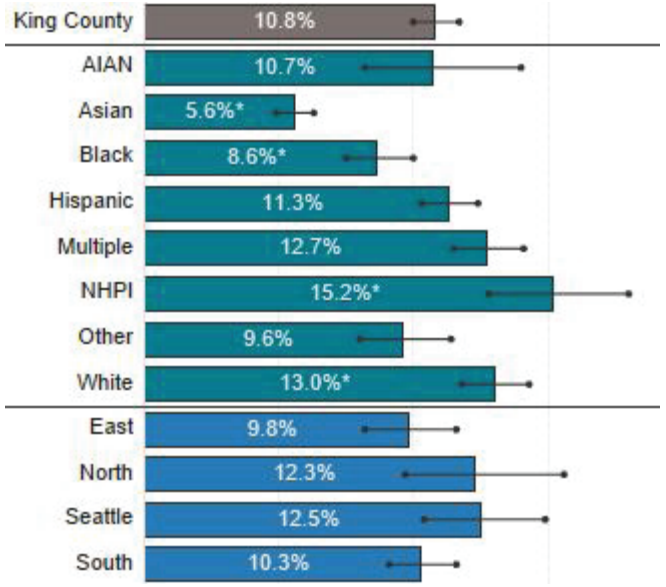
## YOUTH E-CIG OR VAPE PEN USE

Adolescent electronic cigarette use poses a serious public health risk. In 2022, more than 2.5 million United States youth reported e-cigarette use.[86]

Averaging data from 2018 & 2021 for King County, 10.8% of 8th, 10th, and 12th graders used an electronic cigarette, also called e-cigs or vape pens, on one or more of the past 30 days. The rate of e-cig usage among King County youth has declined by more than half from 16.8% in 2018 to 7.6% in 2021.

- Among 10th grade students, a key group for examining youth substance use in high school, 10% reported current e-cig usage. Among 12th-grade students (17.2%), almost one in five were current e-cig users – more than 3.5 times the rate for 8th grade students (4.6%).
- At 14.1%, LGB+ youth were more likely to be current e-cig users than heterosexual youth (10.0%).
- Compared to other racial/ethnic groups, E-cig usage was highest among Native Hawaiian/Pacific Islander youth (15.2%) followed by white youth (13.0%). Among Asian sub-groups, Filipino youth had the highest proportion of E-cig use (12.6%)

**Current e-cigarette or vape pen use (8th, 10th, 12th grades)**
**King County (average: 2018 & 2021)**




Source: Healthy Youth Survey
* 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

# Behavioral Health & Substance Use

Continued

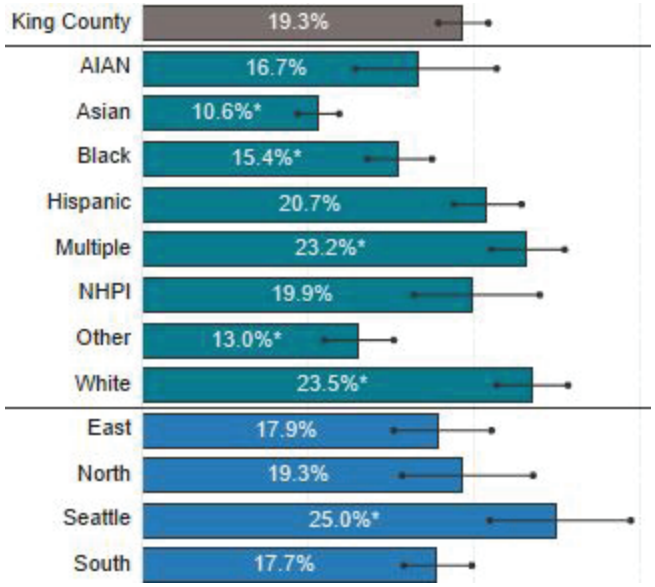
## YOUTH ALCOHOL, MARIJUANA, PAINKILLER, OR ANY ILLICIT DRUG USE

Averaging data from 2018 & 2021 for King County, 19.3% of 8th, 10th, and 12th graders used alcohol, marijuana, painkillers, or other illegal drugs during the past 30 days.

The rate of substance use among King County youth has steeply declined by 42%, from 24.5% in 2018 to 14.2% in 2021. Recent studies have shown a decline in adolescent substance use during the COVID-19 pandemic, including decreases in lifetime and past 30-day marijuana use.[85,87]

- The percentage of youth reporting substance use increased with each grade level, quadrupling between 8th grade (7.4%) and 12th grade (31.5%). Nearly one in three King County 12th graders have engaged in illicit drug use in the past 30 days.
- 27.5% of transgender youth report substance use – higher than the King County average (19.3%).
- LGB+ youth (24.1%) were more likely to engage in illicit drug use compared to heterosexual youth (18.7%).
- Substance use among white (23.5%) and Multiple Race (23.2%) youth was higher than the King County average, whereas the percentage of Asian (10.6%), Other Race (13.0%), and Black (15.4%) youth reporting substance use was lower than the King County average.
- Substance use among Seattle students (25.0%) was higher than the King County average.

**Alcohol, marijuana, painkiller, or any illegal drug use (8th, 10th, 12th grades)**
**King County (average: 2018 & 2021)**




Source: Healthy Youth Survey
* 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

# Behavioral Health & Substance Use

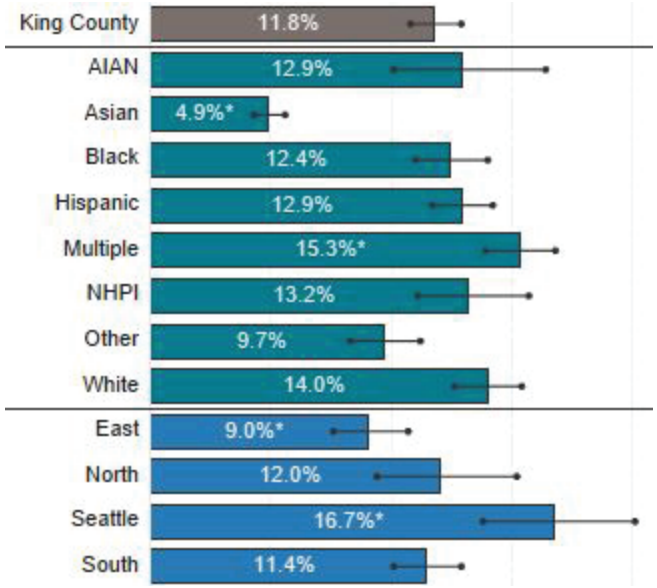
Continued

## YOUTH MARIJUANA USE

Averaging data from 2018 & 2021 for King County, 11.8% of 8th, 10th, and 12th graders used marijuana or hashish in the past 30 days. The rate of marijuana use among King County youth has declined significantly from 15.2% in 2018 to 8.4% in 2021.

- The percentage of youth reporting marijuana or hashish use increased with each grade level, jumping from 3.7% of 8th-graders, to 10.9% of 10th graders, and 20% of 12th graders.
- At 16.5%, marijuana use among transgender youth was higher than the King County average (11.8%).
- LGB+ youth (16.4%) were more likely than heterosexual youth (10.8%) to report use of marijuana.
- Compared to other racial/ethnic groups, marijuana use was lowest among Asian youth (4.9%).
- Marijuana use among Seattle students (16.7%) was higher than the King County average (11.8%), and almost two times as the percentage among students in the East Region (9.0%).

**Marijuana use (8th, 10th, 12th grades)**
**King County (average: 2018 & 2021)**




Source: Healthy Youth Survey
* Significantly different from King County average
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# Behavioral Health & Substance Use

Continued

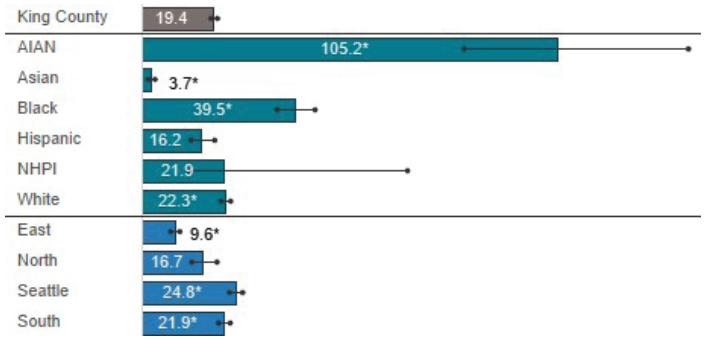
## DRUG-INDUCED DEATHS

### DEATHS DUE TO DRUG OVERDOSE OR OTHER DRUG-RELATED CAUSES

Drug-induced deaths include deaths with underlying cause of death ICD-10 codes signifying drug poisoning/overdose and other medical conditions caused by the use of legal or illegal drugs, excluding alcohol. Averaging data from 2017-2021, the drug-induced death rate of King County residents was 19.4 per 100,000.

- Comparing recent 3-year rolling averages, the rate of drug-induced deaths among King County residents has increased from 14.8 per 100,000 (2016-2018) to 22.0 per 100,000 (2019-2021). During this period, the rate of drug-induced deaths significantly increased among Black residents, white residents; residents in Seattle, South Region, North Region; residents living in very high-, high-, and medium-poverty areas.
- Compared to other age groups, the rate of drug-induced deaths was highest among adults ages 45-64 (35.2 per 100,000).
- Drug-induced deaths were rare among youth and adolescents <18 years of age (1.2 per 100,000). Drug-induced deaths among older adults aged 75+ (8.0 per 100,000) were also lower than the King County average.

**Drug-induced deaths**
**King County (average: 2017-2021)**




Source: WA State Department of Health, Death Certificate Data
Note: The number shown is the 5-year average rate per 100,000 King County residents.
* 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

- The rate of drug-induced deaths among male residents was more than twice the rate among female residents of King County (26.4 versus 12.1 per 100,000).
- The rate of drug-induced deaths among American Indian/Alaska Native residents was 105.2 per 100,000 – more than five times the King County average.
- The rate of drug-induced deaths was higher among Black residents (39.5 per 100,000) and white residents (22.3 per 100,000) compared to the King County average (19.4 per 100,000).

# Behavioral Health & Substance Use

Continued

- The likelihood of drug-induced death increased with neighborhood poverty level: residents living in very high-poverty areas (36.3 per 100,000) were 3.7 times as likely as residents living in low-poverty areas (9.8 per 100,000) to have a drug-induced death.
- Drug-induced deaths were higher among Seattle (24.8 per 100,000) and South Region (21.9 per 100,000) residents and lower among East Region (9.6 per 100,000) residents compared to the King County average.
- Compared to all other King County neighborhoods, the drug-induced death rate was highest for people in the Seattle–Downtown, Belltown, and First Hill neighborhood (130.1 per 100,000). This rate is 6.7 times the King County average.

## DEATHS DUE SPECIFICALLY TO DRUG OVERDOSE

Data from our King County Medical Examiner's Office (KCMEO) includes overdose deaths, defined by searching across 'cause of death' text fields for key words connoting acute drug intoxication or poisoning.

The number of drug overdose deaths approximately doubled between 2020 and 2022 in King County. The rapid increase in drug overdose deaths reflects a sudden pervasiveness of fentanyl in the local drug supply. While fentanyl was involved in <15% of overdose deaths prior to 2019, fentanyl was involved in over 70% of overdose deaths that occurred in 2022. Over half of the drug overdose deaths that occurred in 2022 involved both opioids (e.g., fentanyl, heroin, and/or prescription opioids) and stimulants (e.g., methamphetamine and/or cocaine), up from approximately 30% prior to 2018.[88]

Tremendous disparities in overdose incidence exist in King County, most notably for King County residents who are American Indian/Alaskan Native or Black or African American, experiencing homelessness or living at a facility managed by a social service agency, living in central Seattle or South King County, between the ages of 45-64, or Male.

More information can be found on the Overdose data dashboards - King County, Washington

# Prenatal, Birthing, & Child Health

The health and well-being of mothers and other birthing people, infants, and children are markers of overall community health. Any pregnancy-related death is a tragedy. Improving birth outcomes, such as preterm birth and infant mortality, is among the nation's most pressing public health priorities, one that is deserving of a renewed sense of urgency with national data showing that for the first time in 20 years, U.S. infant mortality rates rose by 3% in 2022, relative to the previous year. Maternal and child health surveillance through ongoing investigation and reporting of health events enables us to identify early warning signs where interventions may be needed.[89]

The language of 'pregnant people' and 'birthing people' in this section is inclusive of people who do not consider themselves mothers, such as transgender or non-binary people and women who may be carrying a baby for another person or couple.[90,91]

Additional indicators available online include adolescent birth rate, breastfeeding initiation, no condom used when last had sex (youth), smoking during pregnancy, and preterm birth rate.

Infant mortality among American Indian/Alaska Native birthing people is nearly five times the King County average. Nationally, for the first time in two decades, infant mortality rates have increased in 2022.

# Prenatal, Birthing, & Child Health

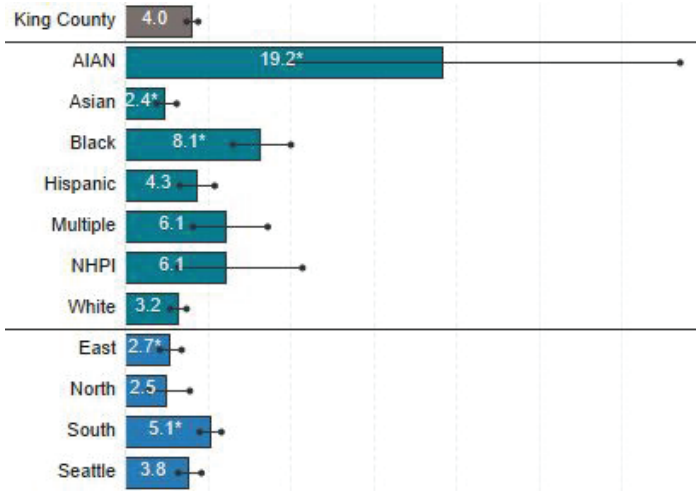
Continued

## INFANT MORTALITY

Infant mortality, or the death of an infant before their first birthday, is tracked using birth data from Washington State Vital Statistics. The infant mortality rate is expressed as the number of deaths per 1,000 live births. Averaging data from 2017–2021 on births to King County residents, 4.0 per 1,000 infants died within 365 days after birth. However, the overall population infant mortality rate can mask disparities by race, ethnicity, and place.

- Among racial/ethnic groups, mortality was lowest among infants born to Asian (2.4 per 1,000) and white (3.2 per 1,000) birthing people, although disaggregated race data for Asian groups demonstrate a more nuanced picture. Infants born to American Indian/Alaska Native birthing people (19.2 per 1,000) died at rates more than six times the rate among Asian or white birthing people.
- Infants born to Black birthing people (8.1 per 1,000) died at rates more than 2.5 times the rate of infants born to Asian or white birthing people.
- While infant mortality among Native Hawaiian/Pacific Islander birthing people (6.1 per 1,000) is not significantly different from the overall King County average, the rate among Samoan birthing people (11.3 per 1,000) was 2.8 times the King County average (4.0 per 1,000). Rates were also very high among Filipino (4.7 deaths per 1,000) and other Asian sub-groups (other than Indian, Chinese, Filipino, Japanese, Korean and Vietnamese) at 7.3 deaths per 1,000 live births.
- Infants born to birthing people living in the South Region (5.1 per 1,000) died at significantly higher rates than the King County average (4.0 per 1,000) and more than 1.5 times that of babies born in the East Region (2.7 per 1,000).

**Infant mortality**
**King County (average: 2017-2021)**




Source: WA State Department of Health, Birth Certificate Data
Note: The number shown is the 5-year average infant death rate per 1,000 live births.
* 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

# Prenatal, Birthing, & Child Health

## Continued

- Infant mortality among birthing persons aged 18 – 24 (5.8 per 1,000) is significantly higher than the King County average (4.0 per 1,000).

While King County data does not allow for assessing how infant mortality rates have changed over time, provisional data for 2022 U.S. births released by the National Center for Health Statistics has shown an alarming increase for the first time in two decades. In 2022, infant mortality rose by 3% to land at 5.6 infant deaths per 1,000 live births, representing 20,538 infant deaths across the nation. Rates rose among every ethnic group except Asian infants, and particularly pronounced infant mortality rates were seen among infants of Black (10.86 per 1,000 births) and American Indian/ Alaska Native (9.06 deaths per 1,000 births) birthing people.[92]

# Prenatal, Birthing, & Child Health

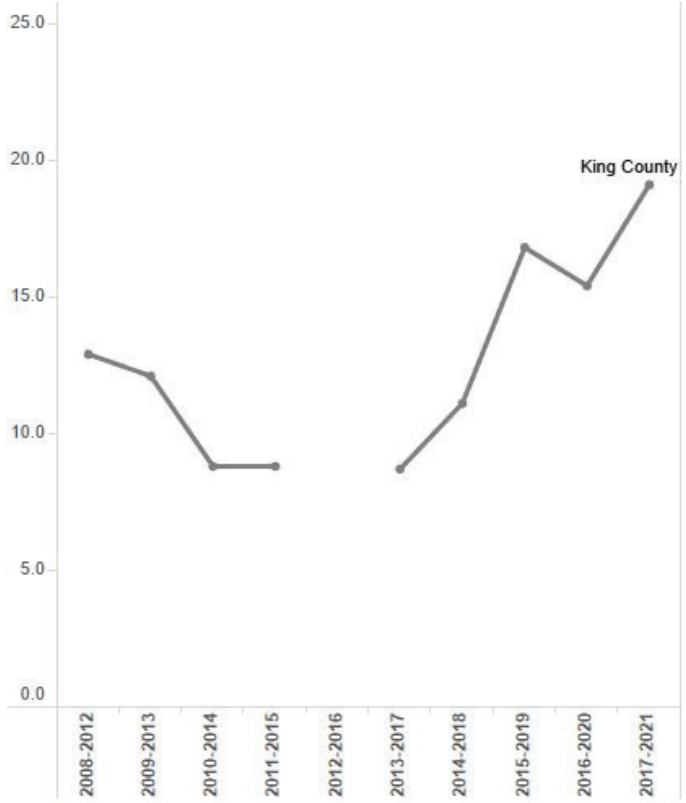
Continued

## BIRTHING PERSON MORTALITY

A maternal or birthing person death is defined as a death while pregnant or within 42 days of the end of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.[93] Maternal Mortality Ratio (MMR) is defined as the number of maternal (or birthing person) deaths, per 100,000 live births. Averaging data from 2017-2021 for King County residents, 19.1 birthing people per 100,000 live births died from pregnancy-related causes – representing 23 deaths.

- During this same time frame, there were 106 deaths across the state of WA.[79]
- Compared to the national average (23.5 maternal deaths per 100,000 live births from 2018-2021), maternal or birthing person mortality was lower in King County over a similar time period (19.1 per 100,000 live births from 2017-2021).
- MMR more than doubled in King County over the past ten years, reaching an average of 19.1 maternal/birthing person deaths per 100,000 live births in 2017-2021 compared to 8.8 deaths per 100,000 live births in 2011-2015. Though these differences are not statistically significant, the pattern mirrors national patterns and warrants further monitoring.[94]

**Birthing person mortality**
**King County (rolling averages: 2008-2021)**




Source: WA State Department of Health, Birth and Death Certificate data
Note: Each point shown is the 5-year average birthing person death rate per 100,000 live births.
Break in the line indicates suppression of data, in accordance with APDE data suppression and confidentiality criteria.

Maternal Mortality Review Committees are multidisciplinary committees that convene at the state or local level to comprehensively review deaths

# Prenatal, Birthing, & Child Health

Continued

that occur during or within a year of pregnancy (pregnancy-associated deaths), thus employing a broader definition of maternal mortality compared to traditional surveillance measures like maternal maternity ratio. Findings from MMRCs nationwide, as well as Washington state's own MMRC, highlight the urgent importance of managing care for chronic conditions, including mental health.

- Averaging national data from 2017-2019, the most common underlying causes of pregnancy-related deaths were mental health conditions, hemorrhage, cardiac conditions, and infection.[95]
- Similarly in Washington state (2014-2020), the most common underlying causes of pregnancy-related deaths were behavioral health conditions (i.e., mental health conditions and substance use, excluding instances of substance overdose), hemorrhage, and infection.[96]
- The U.S. maternal mortality rate rose sharply in 2021, reaching a high of 32.9 deaths per 100,000 live births. Racial disparities in maternal/birthing person deaths persisted: Black birthing people experienced death rates (69.9 deaths per 100,000 live births) more than 2.6 times the rate for white birthing people (26.6 deaths per 100,000 live births) – in the race with the lowest death rate in 2021.[94]
- More than half (52%) of pregnancy-related deaths occur after delivery, emphasizing the need for clinical and policy interventions to embrace a life course perspective by supporting birthing people before, during, and after birth.[97]
- Efforts to reduce pregnancy-related morbidity and mortality include a push to extend Medicaid coverage during the postpartum period from 60 days, as is currently required by federal law, to 12 months after giving birth. The 2024 federal budget includes $471 million to support the ongoing implementation of the White House Blueprint for Addressing the Maternal Health Crisis and would require all states to provide continuous Medicaid coverage for 12 months postpartum.[98-100]

# Prenatal, Birthing, & Child Health

Continued

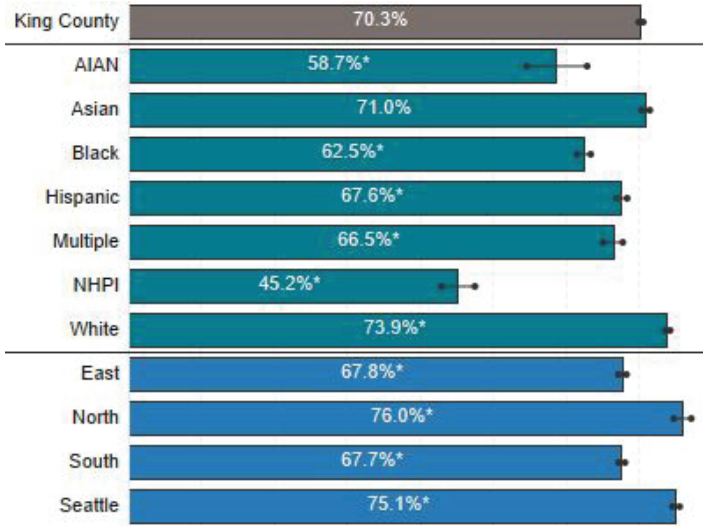
## EARLY AND ADEQUATE PRENATAL CARE

Prenatal care is important to prevent complications and inform promote a healthy pregnancy.[101] Babies of pregnant people who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to those who do get care.[102] Individuals are encouraged to establish care with a healthcare provider as soon as they know they are pregnant.

This indicator describes the percent of births to pregnant people who received prenatal care before the end of the 4th month and at least 80% of the recommended number of prenatal visits. Among births to King County residents, 70.3% of babies were born to individuals who received prenatal care before the end of the 4th month and at least 80% of the recommended number of prenatal visits.

- Among Native Hawaiian/Pacific Islanders, 45.2% of babies were born to birthing people who had early and adequate prenatal care.
- The likelihood of receiving early and adequate prenatal care increased with age of birthing person.
- Babies born to youth 10-17 years of age experienced the lowest rate of prenatal care access by the birthing person (46.7%)

**Early and adequate prenatal care**
**King County (average: 2017-2021)**




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
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

- Babies born to birthing people aged 35-44 (74.5%) and 45 years or older (80.3%) experienced significantly higher rates of early and adequate prenatal care access by the birthing person, compared to the King County average (70.3%).
- Babies born to residents living in very high poverty areas (66.3%) had low rates of early and adequate prenatal care access by the birthing person, compared to the King County average (70.3%).

# Prenatal, Birthing, & Child Health

## Continued

- Babies born to residents of the North Region (76.0%) and Seattle (75.1%) experienced the highest rates of early and adequate prenatal care access by the birthing person, compared to the King County average (70.3%).
- Babies born to residents of the East Region (67.8%) and South Region (67.7%) experienced the lowest rate of early and adequate prenatal care access by the birthing person, compared to the King County average (70.3%).

# Prenatal, Birthing, & Child Health

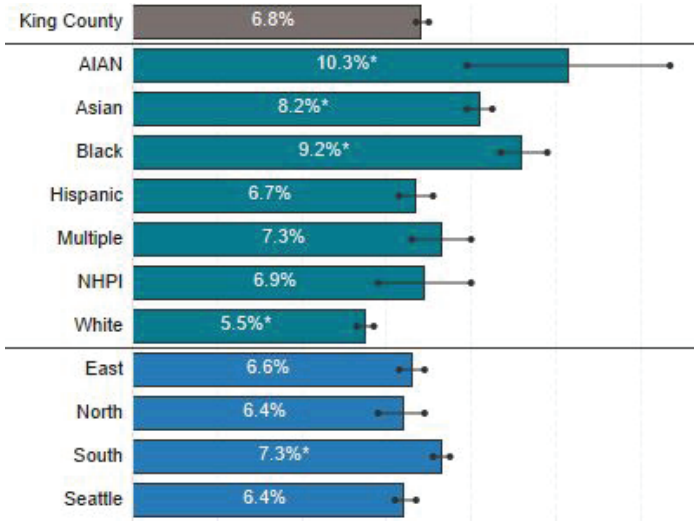
Continued

## LOW BIRTHWEIGHT

Birthweight is an indicator of the health of the newborn. In the United States, the average birthweight is seven to 7.5 pounds, or 3400 grams.[103] Low birthweight is defined as birthweight less than five pounds 8 ounces, or 2500 grams. Averaging data from 2017-2021, among births to King County residents, 6.8% of babies had a low birthweight.

- Over ten percent of babies born to American Indian/Alaska Native birthing people had low birthweight, nearly twice the rate of the group with the lowest rate, white birthing people (5.5 %). This rate was followed by babies born to Black (9.2%) and Asian (8.2%) birthing people.
- Babies born to white birthing people (5.5%) were less likely to be low birthweight compared to the King County average (6.8%).
- Babies born to birthing people aged 10-17 (11.9%) and 45 years or older (13.4%) were more likely to be low birthweight compared to all other age groups.
- Babies born to birthing people living in low-poverty neighborhoods (6.2%) and medium-poverty neighborhoods (6.4%) were less likely to be low-birthweight compared to the King County average (6.8%).

**Low birthweight (all births)**
**King County (average: 2017-2021)**




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
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

- Babies born to birthing people living in the South Region (7.3%) were more likely to be low-birthweight babies compared to all other King County regions.

# Physical Activity, Nutrition, & Weight

Eating a healthy diet and getting regular physical activity are key behaviors for maintaining a healthy weight and reducing the risk of chronic conditions. The benefits of healthy eating and physical activity include lower risk of all-cause mortality, cardiovascular disease, type 2 diabetes, some cancers, anxiety, depression, and Alzheimer's disease and other dementias.[104-105] Regular physical activity also provides additional benefits related to stress management, sleep quality, and mental health among youth and adults. Several factors influence a person's ability to engage in these types of health promoting behaviors, such as their access to high-quality and nutritious foods, amount of leisure time, and safety of their environment. In King County, we observe disparities in several indicators of physical activity, nutrition, and weight by race/ethnicity, economic status, and geographic location, mirroring national trends.

While body weight is often emphasized as a key risk factor for chronic disease and disability, it is not the only factor to consider. Social determinants, race/ethnicity, and age may modify the risk associated with a given Body Mass Index (BMI).[i] In addition, diet and physical activity are not the only influences on body weight. Weight bias and stigmatization directed at people with obesity are serious problems, which fail

## Nearly 30% of Black adults and Hispanic adults in King County experience food insecurity.

to consider varied cultural conceptions of beauty and weight, affect self-esteem and willingness to engage in healthcare, and contribute to poor health. To avoid the negative impacts of stigma associated with terms like "obese" and "obesity," it is important for healthcare providers to establish trusted relationships with their patients and engage in a holistic and empathetic dialogue around weight when needed.

Additional indicators available online include no breakfast today (youth), children who drink soda or sugar-sweetened beverages daily (youth), excessive screen time (youth), and physical activity (adults).

[i] *Strategies to Overcome and Prevent (STOP) Obesity Alliance. The George Washington University.*

# Physical Activity, Nutrition, & Weight

Continued

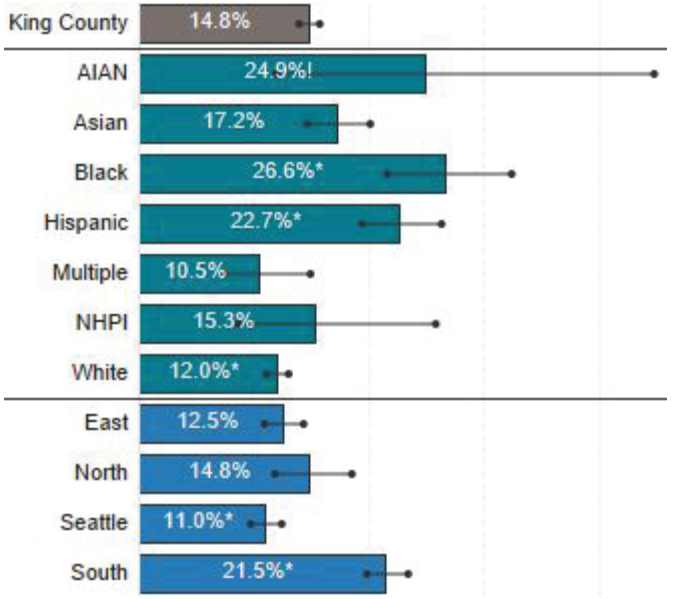
## ADULT LEISURE TIME PHYSICAL ACTIVITY

Regular physical activity is important to protect health by helping to manage weight, reduce risk of disease, promote brain health, strengthen bones and muscles, and improve coordination.[106] The U.S. Department of Health and Human Services recommends that adults do the equivalent of at least 150 minutes (2.5 hours) of moderate-intensity aerobic activity each week, and muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week.[104] National data from 2020 show that just over 46% of U.S. adults did not meet the guidelines for either type of activity.[107]

This indicator describes the percentage of King County adults who did not participate in any physical activity within the last month, other than their regular job. Averaging data from 2017-2021 for King County, 14.8% of adults reported that they did not participate in any exercise within the last month.

- The likelihood of physical inactivity increased with each decreasing income category. Adults with annual income lower than $20,000 (27.0%) were more than 3.6 times as likely as those with household income greater than $100,000 (7.4%) to report physical inactivity. Low-income adults are more likely to report no physical activity at all in their leisure time.

**No leisure time physical activity (adults)**
**King County (average: 2017-2021)**




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

- South Region adults (21.5%) are significantly more likely to report no physical activity at all in their leisure time compared to the average King County resident (14.8%).
- The Federal Way-North Corridor neighborhood had the highest rate of adults reporting no physical activity at all in their free time (36.3%).
- 26.6% of Black adults and 22.7% of Hispanic adults did not participate in any exercise within the last month – higher than the King County average.

# Physical Activity, Nutrition, & Weight

Continued

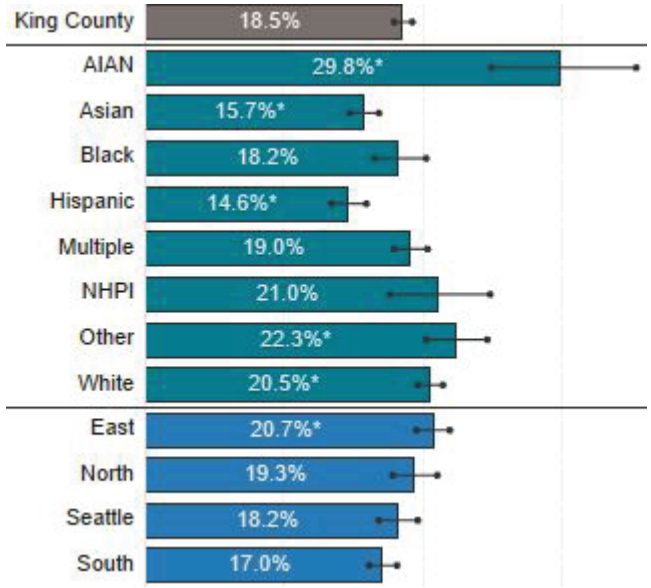
## YOUTH PHYSICAL ACTIVITY

The statewide Healthy Youth Survey (HYS) is conducted every two years, with the 2020 administration delayed until 2021 due to COVID-19-related school disruptions. This indicator defines physical activity as having participated in physical activity for 60+ minutes each day for the past seven days, which aligns with guidelines issued by the U.S. Department of Health and Human Services recommending that children and adolescents ages six through 17 years do 60 minutes (1 hour) or more of moderate-to-vigorous physical activity daily.[104]

Averaging data from 2018 & 2021, 18.5% of King County 8th, 10th, and 12th graders participated in physical activity for 60+ minutes each day for the past seven days.

- American Indian/Alaska Native (29.8%) and white (20.5%) students were significantly more likely to meet physical activity recommendations than the average King County student (18.5%).
- Hispanic (14.6%) and Asian (15.7%) students were significantly less likely to meet physical activity recommendations than the average King County student (18.5%).
- Male students (23.5%) were most likely to meet physical activity recommendations compared to all other gender identities.

**Physical activity (8th, 10th, 12th grades)**
**King County (average: 2018 & 2021)**




Source: Healthy Youth Survey
* 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

- As grade level increases, student participation in physical activity declines. By 12th grade, only 15.1% of students met recommendations compared to 22.8% of 8th graders.
- The percentage of King County students who meet physical activity recommendations in 2021 (17.7%) has declined 17% compared to 2016 (21.3%).

# Physical Activity, Nutrition, & Weight

Continued

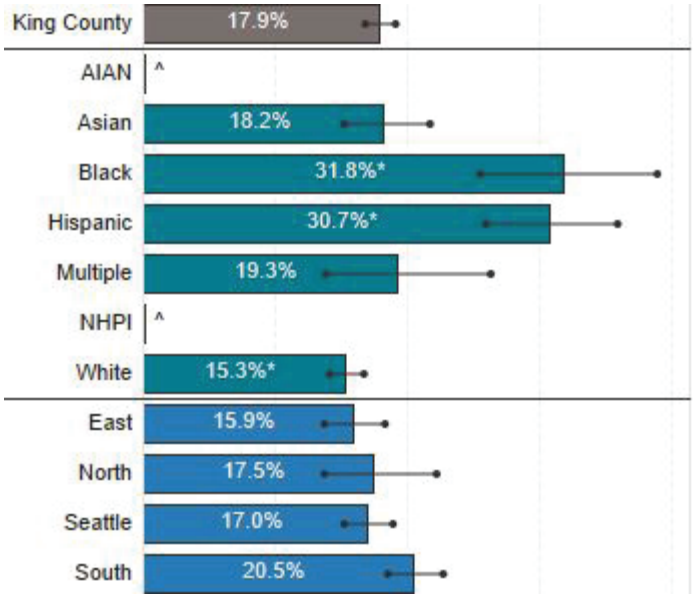
## ADULT VEGETABLE CONSUMPTION

Healthy diet is important to promote health and prevent disease. The 2020–2025 Dietary Guidelines for Americans recommends that adults should consume 1.5–2 cup-equivalents of fruits and 2–3 cup-equivalents of vegetables daily.[108] The percentage of U.S. adults meeting fruit and vegetable intake recommendations is generally low.[109]

Using data from the Washington Behavioral Risk Factor Surveillance System (BRFSS), this indicator describes the percentage of adults that consume vegetables one or more times per day. Averaging data from 2017, 2019, & 2021 for King County, 17.9% of adults reported that they consume vegetables 1+ times per day. While we see disparities in several health indicators where people of color, low-income, and South Region residents are disproportionately burdened, some of the highest rates of daily vegetable consumption are observed among Black and Hispanic racial/ethnic groups, lower income households, and South King County residents.

- Adults ages 18-24 (27.7%) were most likely to consume vegetables one or more times per day compared to all other age groups.
- Compared to white adults (15.3%), Black (31.8%) and Hispanic (30.7%) adults were more than twice as likely to consume vegetables one or more times per day.

**Consumed vegetables 1+ times per day (adults)**
**King County (average: 2017, 2019, & 2021)**




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

- Vegetable consumption among adults with annual household income less than $20,000 (30.2%) and between $20,000 and $34,999 (23.8%) was significantly higher than the King County average.
- Vegetable consumption among South Region adults has remained consistently high compared to other King County regions. Adults living in Federal Way–North Corridor (34.9%) reported the highest rate

of vegetable consumption among all King County neighborhoods.

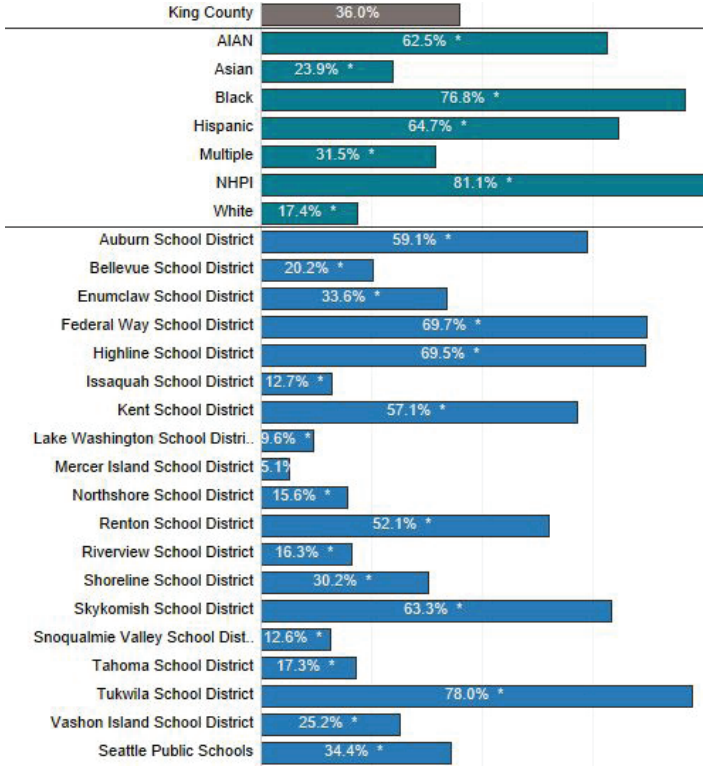
- Vegetable consumption has increased by nearly 60% among East Region adults when comparing the 2015 & 2017 average (11.3%) to the 2019 & 2021 average (18.0%).

## FREE/REDUCED PRICE LUNCH

The free or reduced-price lunch indicator includes any student who was eligible for free/reduced price meals at any point during the school year and is a proxy measure of the percent of students who live in low-income households.[i] Research shows that school lunch participation reduces food insecurity, improves dietary intake, positively impacts mental and physical health including weight-related outcomes, and meets children's nutritional needs, which leads to a better learning environment.[110] In the 2021 – 2022 school year, 36.0% of King County students were classified as eligible for free and reduced-price lunch.[ii]

- Compared to white students (17.4%), Native Hawaiian/Pacific Islander students (81.1%) and Black students (76.8%) were more than four times, and Hispanic students (64.7%) and American Indian/Alaska Native students (62.5%) were more than 3.5 times as likely to be eligible for free and reduced-price school lunch.
- At 78.0%, the Tukwila School District had the highest rate of students eligible for free and reduced-price lunch.

**Free and reduced price lunch**
**King County (2021-2022)**




Source: The Office of Superintendent of Public Instruction
* 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

*[i] Free and Reduced-Price Meal eligibility is based on financial circumstances for each family unless a district offers free meals school-wide. See Meal Application and Verification Information | OSPI*

*[ii] Data for Fife School District is not included, as the majority of this school district area sits outside of King County.*

# Physical Activity, Nutrition, & Weight

Continued

- With the exception of the Skykomish School District (63.3%), all school districts with 50% or more students eligible for the Free or Reduced-Price Meal programs were in the South Region: Tukwila School District (78.0%), Federal Way School District (69.7%), Highline School District (69.5%), Auburn School District (59.1%), Kent School District (57.1%), and Renton School District (52.1%).

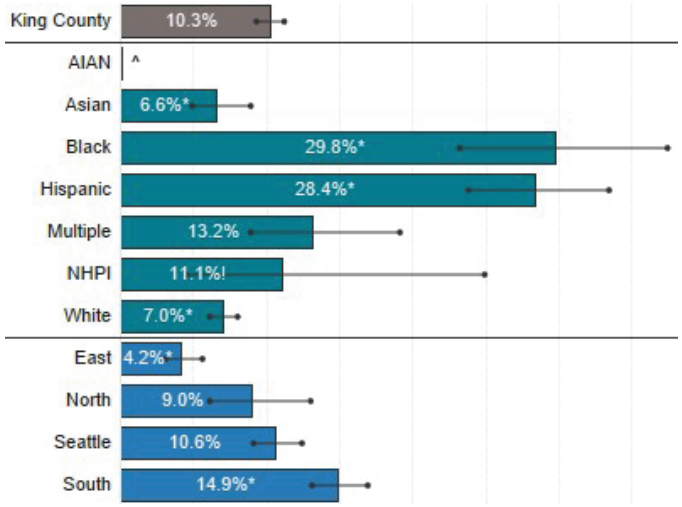
## FOOD INSECURITY

During the pandemic, analyses based on U.S. Census Bureau's Household Pulse Survey found that food insecurity nearly doubled after COVID-19 mitigation strategies were implemented.[111,112] Among households with children, food insecurity peaked in 2020 at 16.7% of households, at 13.5% in 2021 and 14.4% in 2022. Most current data show 10.6% of households with children face food insecurity as of August 2023.[113]

This WA BRFSS indicator describes the percentage of adults who reported that, during the last 12 months, they bought food that sometimes or often didn't last, and they didn't have money to get more. Averaging data from 2018-2021 for King County, 10.3% of adults experienced food insecurity.

- Transgender adults (38.5%) were nearly four times as likely as cisgender adults (9.9%) to report food insecurity.

**Food insecurity (adults)**
**King County (average: 2018-2021)**




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

- Food insecurity among LGB adults (15.0%) is significantly higher than the county average.
- Food insecurity is highest among Black adults (29.8%) and Hispanic adults (28.4%) and is nearly three times the county average.
- Comparing by household income, food insecurity was highest among households in the lowest income categories: 38.2% of households making less than $20,000 and 29.5% of households making between $20,000 and $34,999 were food insecure.

# Physical Activity, Nutrition, & Weight

Continued

- South Region adults were significantly more likely (14.9%) to experience food insecurity than East Region adults (4.2%) or the average King County resident (10.3%).
- The Seattle neighborhoods of South Beacon Hill, Georgetown, and South Park reported the highest food insecurity (26.7%) among all King County neighborhoods.

Refer to the ***Community Identified Priorities*** section of this report for a summary of findings from listening sessions with King County families of color about their access to healthy, high-quality, and cultural foods and nutrition information needs.

Additional local data on food insecurity are available online, including food insecurity among households with children, information about households receiving basic food SNAP benefits, and Crisis Connections 211 calls regarding food/meal-related social service needs.

# Physical Activity, Nutrition, & Weight

Continued

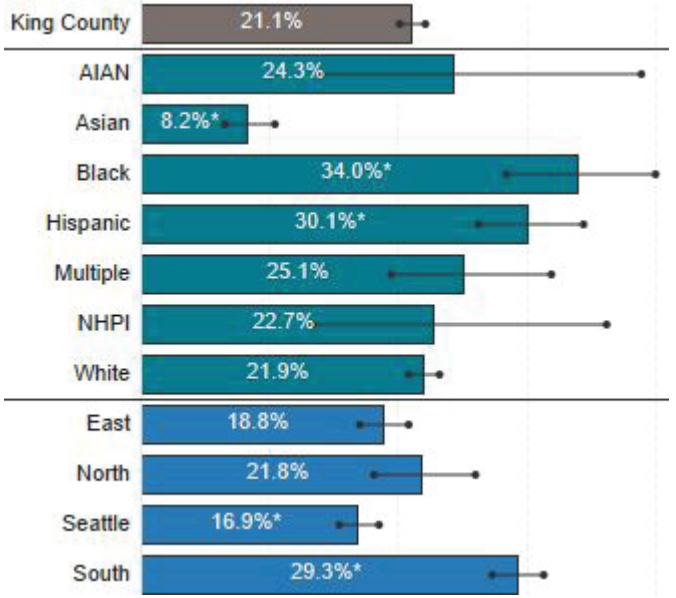
## ADULT OBESITY

Body mass index (BMI) is a calculation of height and weight that can be used to screen for categories that might be at higher risk for health problems. Adults with BMI ≥30 are categorized as having obesity, which is associated with greater risk for many diseases and health conditions.[114] It is important to note that BMI is a screening tool that measures body mass index, which does not serve as a direct measure of body fat and should not be used as a single predictor of health.[115]

Averaging data from 2017-2021 for King County, 21.1% of adults have a body mass index greater than or equal to 30. This proportion has stayed relatively stable over the past decade.

- The percentage of Black adults (34.0%) with BMI ≥ 30 was significantly higher than the King County average (21.1%) and more than 4 times the percentage among Asian (8.2%) adults. The percentage of BMI ≥ 30 among Hispanic (30.1%) adults was also significantly higher than the King County average and more than 3.6 times the percentage among Asian adults.
- Compared to other King County regions, South Region adults (29.3%) were more likely to have a BMI ≥ 30.
- The King County neighborhoods with the highest percentage were Central Kent (41.0%), East Highlands, Hobart, and Greater Maple Valley (37.0%), and Tukwila (36.2%).
- Comparing by household income, adults with household income less than $20,000 (29.3%) were most likely to have BMI ≥ 30, and adults with annual household income greater than $100,000 (18.4%) were least likely.

**Obese (adults)**
**King County (average: 2017-2021)**




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

## YOUTH OBESITY

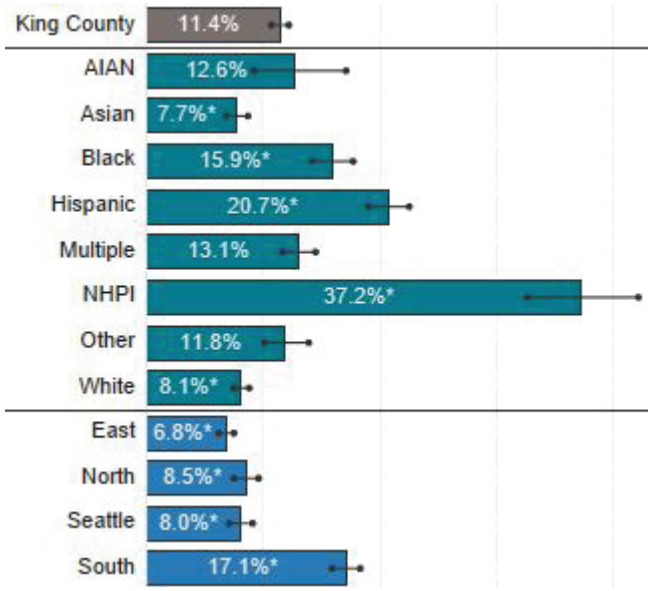
Achieving and maintaining a healthy weight can reduce risk for many serious diseases and health conditions. For children and teens, obesity is defined as a BMI at or above the 95th percentile for their age and sex.[116] Children and adolescents that meet this definition may be at greater risk for poor health. The Healthy Youth Survey asks students to report their height and weight and computes BMI from those two responses.

Averaging data from 2018 & 2021, 11.4% of King County 8th, 10th, and 12th graders report body weight that puts them in the top 5% for BMI by age and gender. Note that a single self-reported BMI-for-age calculation is not enough to evaluate long-term weight status, especially among youth who may still be growing.[116]

- Among Native Hawaiian/Pacific Islander students, 37.2% had BMI in the top 5% – more than three times the King County average (11.4%).
- Compared to other racial/ethnic groups, Hispanic youth experienced the largest increase in percentage of students in the top 5% for BMI, from 17.1% in 2018 to 24.6% in 2021.
- The percentage of Native Hawaiian/Pacific Islander (37.2%), Hispanic (20.7%), and Black (15.9%) youth in this BMI category was significantly higher than the King County average (11.4%).

**Obese (8th, 10th, 12th grades)**

**King County (average: 2018 & 2021)**




Source: Healthy Youth Survey
* 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

- The percentage of King County youth in the top 5% for BMI has increased from 8.8% in 2014 to 12.3% in 2021, a 40% increase within a span of seven years.
- Students in the South Region (17.1%) were most likely to be in the top 5% for BMI compared to all other regions. When compared to East Region students (6.8%), South Region students were more than 2.5 times as likely to be in the top 5% for BMI by age and gender.

# Violence & Injury Prevention




This section reports on health indicators related to child abuse and neglect, domestic violence, firearm-related incidents and deaths, homicides, and fall hospitalizations. Unintentional injuries are a leading cause of death nationally and in King County.[117] Firearm violence and injury are growing public health problems, with firearm misuse contributing significantly to domestic violence, homicides, and suicides in the United States.[118,119] Firearm injuries disproportionately affect youth and young adults in the United States. In 2020, firearm-related injuries became the leading cause of death among children and adolescents (ages 1-19), surpassing motor vehicle crashes.[120] Between 2019 and 2020, the firearm homicide rate in the United States increased about 35%, reaching its highest level since 1994.[118] In 2022, more than half of firearm-related deaths were suicides and more than four out of every 10 were firearm homicides.[121]

The 2021-2022 CHNA reported early observations from 2020 on COVID-19 impacts to violence and injury prevention (VIP) indicators. Domestic violence homicide cases were up, many of which involved firearms. In this section we report updated data through 2021, and in some cases through 2022, describing the conditions in King County following the initial period of the COVID-19 pandemic.

Since the start of the pandemic in 2020, there has been a steep and significant rise in the rate of domestic violence emergency department visits in King County.

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

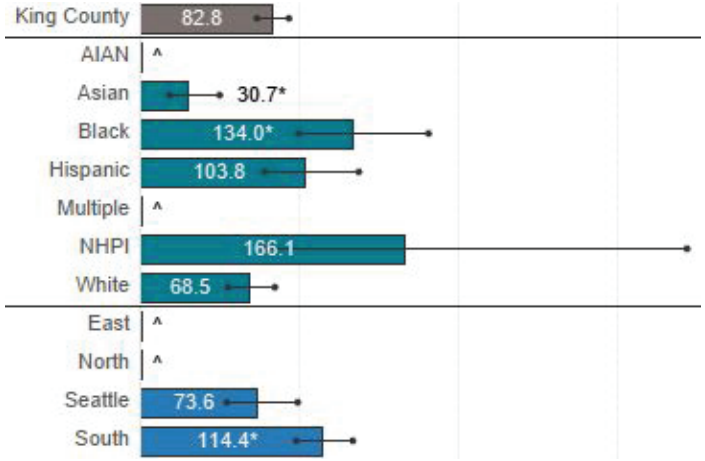
## CHILD ABUSE & NEGLECT (ED VISITS)

Child abuse and neglect have lasting harmful impacts on the physical and emotional health and well-being of victims throughout their lives. Children who are abused and neglected may experience psychological problems like anxiety or posttraumatic stress, and are at increased risk for future violence, substance use, sexually transmitted infections, and delayed brain development.[122] Some may receive physical injuries that require immediate medical attention. This indicator includes data representing all visits to a non-federal emergency department (ED) by King County residents, using the chief complaint and discharge diagnosis fields to identify visits related to suspected or confirmed physical, sexual, or emotional abuse; or physical or emotional neglect as perpetrated by a parent or other caregiver.[123]

In 2022, the rate of emergency department visits involving suspected child abuse and neglect among King County residents was 82.8 per 100,000 residents ages 0-17.

- For children aged 0-17 years, the rate among females (120.7 per 100,000) was more than 2.5 times the rate among males (46.2 per 100,000).
- Among the 0-4 years age group, the rate of ED visits involving suspected child abuse and neglect was 112.0 per 100,000 – higher than the county average.

**Child abuse & neglect (ED visits)**
**King County (2022)**




Source: WA State Department of Health, Rapid Health Information NetwOrk (RHINO)
Note: The number shown is the rate per 100,000 King County residents.
* 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

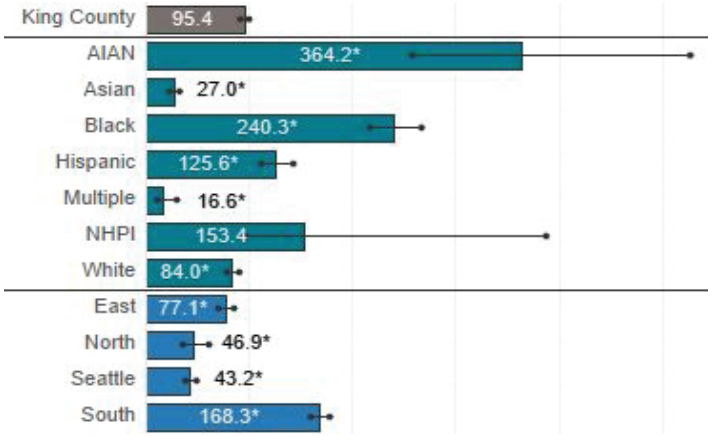
- At 30.7 per 100,000, the rate among Asian children was significantly lower than the King County average. The rate among Black children (134.0 per 100,000) was 4 times the rate among Asian children.
- The rate of ED visits involving child abuse and neglect among residents in the South Region was 114.4 per 100,000 – higher than the King County average. The ZIP code with the highest rate was 98032 (359.2 per 100,000), which includes the Kent area.

## DOMESTIC VIOLENCE (ED VISITS)

Domestic violence, or intimate partner violence, refers to abuse or aggression that occurs in a family or romantic relationship. Domestic violence may include physical violence, sexual violence, stalking, or psychological aggression and affects millions of people in the United States each year.[124] King County ED visits involving domestic violence were selected by applying a definition developed by Washington Department of Health Rapid Health Information NetwOrk (RHINO) team that searches triage notes and clinical impression fields in addition to chief compliant (reason for visit) and discharge diagnosis fields.[125] In 2022, the rate of emergency departments visits involving domestic violence among King County residents was 95.4 per 100,000 residents.

- Since 2020, there has been a steep and significant rise in domestic violence ED visit rates by 48%; there was a 20% increase from 2020 to 2021 (from 64.3 visits per 100,000 to 76.6 per 100,000), and an even steeper 25% increase the subsequent year, to 95.4 visits per 100,000 in 2022.
- Compared to other age groups, the rate of ED visits involving domestic violence was highest among residents ages 18-24 (200.0 per 100,000).
- Females (128.3 per 100,000) were twice as likely as males (64.4 per 100,000) to visit the emergency department due to domestic violence.

**Domestic violence (ED visits)**
**King County (2022)**




Source: WA State Department of Health, Rapid Health Information NetwOrk (RHINO)
Note: The number shown is the rate per 100,000 King County residents.
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- Compared to other racial/ethnic groups, multiple-race residents (16.6 per 100,000) had the lowest rate of domestic violence ED visits. With a rate of 364.2 per 100,000, American Indian/Alaska Native residents were 22 times as likely, and Black residents (240.3 per 100,000) were 14 times as likely as multiple-race residents to visit the emergency department due to domestic violence.
- Geographically, emergency visits involving domestic violence were highest in the South Region (168.3 per 100,000). The two ZIP codes with the highest rates were 98002 (344.8 per 100,000) and 98047 (250.3 per 100,000), which includes the Auburn and Pacific areas, respectively.

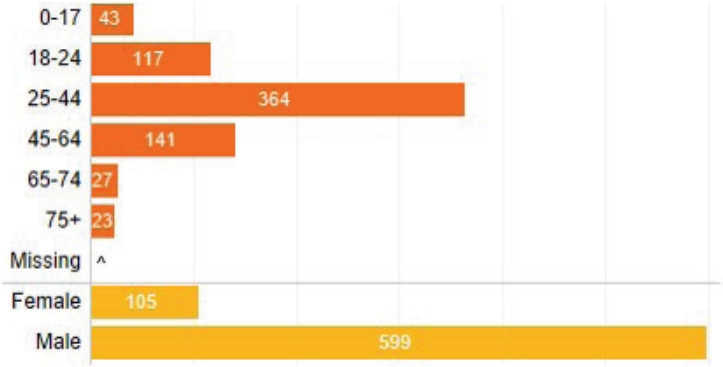
## EMS RESPONSES TO FIREARM-INCIDENTS

This image summarizes firearm incidents in King County treated by Emergency Medical Services (EMS) personnel. EMS firearm incident data provides critical information on firearm injuries including characteristics of those injured and location of the incidents to inform prevention and response activities. Age and gender data may be based on responders' observation rather than patients' self-report. Race/ethnicity is not presented because it is frequently missing in EMS records.

- EMS response to incidents of assault involving a firearm injury has continued to increase since 2019.
- In 2022, there were more firearm incidents involving residents ages 0-17 (43 incidents), 25-44 (364 incidents), and 45-64 (141 incidents) than the year before. While the 18-24 age group has seen increasing counts in previous years, the counts in 2022 decreased from 2021.
- Compared to 2020, the number of incidents involving a firearm injury among people aged 25-44 increased by 68% in 2022.
- Males are more than five times as likely as females to have an incident involving a firearm injury.

**EMS responses to firearm-incidents (number of incidents)**

**King County (2022)**




Source: King County Emergency Medical Services

- The rate of firearm-related injuries in 2022 was highest in North Highline and White Center (112.8 per 100,000), followed by Seattle-Downtown, Belltown, and First Hill (104.9 per 100,000) and Tukwila (100.4 per 100,000).

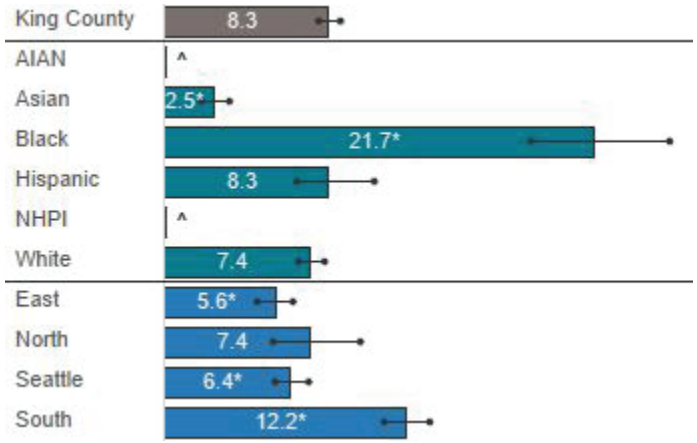
## FIREARM-RELATED DEATHS

This indicator includes unintentional death, suicide, and homicide by firearm. In 2021, the most recent year for which data are currently available, the rate was 9.4 per 100,000, including 224 deaths.

Averaging data from 2017-2021, the death rate of King County residents was 8.3 per 100,000 for firearms-related deaths.

- Firearm-related deaths were highest among younger and older adults, compared to other age groups: 18.7 per 100,000 adults ages 18-24, and 14.7 per 100,000 adults aged 75 and older. When looking at firearm deaths separated by intent, among suicide firearm deaths, the 65+ group has the highest rate, whereas, for homicide firearm deaths, 18–24-year-olds have the highest rate.[126] Further, national data shows that suicide rates rapidly rose among young people (10-24) from 6.9 deaths per 100,000 individuals in 2001 to 11 per 100,000 in 2021, including a larger than 60% increase since 2007.[127]
- Firearm-related death rate was seven times as high among male residents (14.8 per 100,000) compared to female residents (2.1 per 100,000).
- At 21.7 per 100,000, the rate among Black residents was higher than the King County average and more than eight times the rate among Asian residents (2.5 per 100,000).

**Firearm-related deaths**
**King County (average: 2017-2021)**




Source: WA State Department of Health, Death Certificate Data
Note: The number shown is the 5-year average rate per 100,000 King County residents.
* Significantly different from King County average
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- Of all King County regions, firearms-related deaths were highest in the South Region, at 12.2 per 100,000.
- The neighborhoods with the highest firearm-related death rates were Kent-West (21.1 per 100,000) and East Highlands, Hobart, and Greater Maple Valley (21.0 per 100,000) – almost five times the rate of Seattle-Queen Anne (4.6 per 100,000), which has the lowest firearms-related deaths among all the King County cities/neighborhoods.

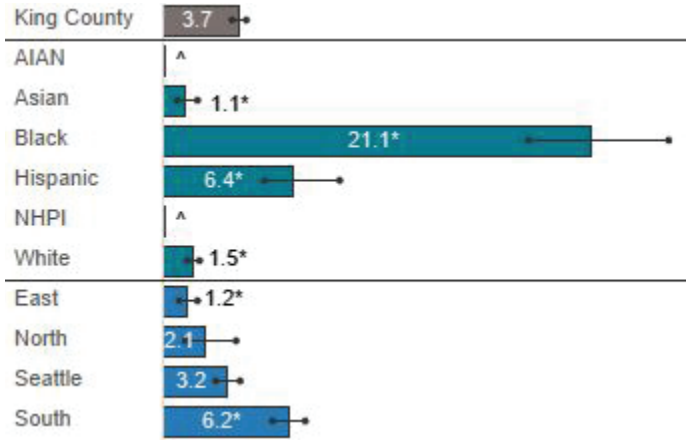
## HOMICIDE DEATHS

The Washington State Department of Health, Center for Health Statistics collects information on deaths in Washington from death certificate data. This indicator includes all homicides by any mechanism. In 2021, the most recent year for which data are currently available, the homicide death rate was 4.4 per 100,000, including 102 deaths.

Averaging data from 2017-2021, the death rate of King County residents is 3.7 per 100,000 for homicide.

- The rate of death by homicide among young adults aged 18-24 (10.9 per 100,000) was higher than the King County average. The rate among male residents in this age group was even higher at 19.1 per 100,000, which is consistent with national data.[128]
- Compared to Asian residents (1.1 per 100,000), Black residents (21.1 per 100,000) were more than 19 times as likely and Hispanic residents (6.4 per 100,000) were almost 6 times as likely to die by homicide.
- Residents living in high poverty areas (7.4 per 100,000) were more than six times as likely to die by homicide as residents living in low poverty areas (1.2 per 100,000)
- The neighborhood with the highest rate of death by homicide was Kent-Central, at 12.5 per 100,000, which represents 20 deaths between 2017-2021.

**Homicide deaths**
**King County (average: 2017-2021)**




Source: WA State Department of Health, Death Certificate Data
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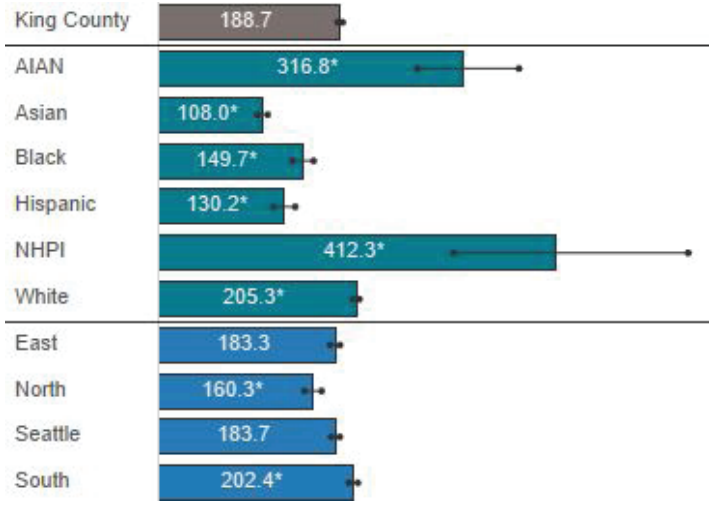
## FALL HOSPITALIZATIONS

Using data on inpatient (admitted overnight) and observation (short time) stays for people admitted to hospitals in Washington state, this indicator includes non-fatal fall-related hospital admission among King County residents. From 2017-2021, the average non-fatal hospital admission rate for falls was 188.7 per 100,000 King County residents.

- Fall hospitalizations continue to rarely occur among children and young adults. Hospitalization rates from falls were highest among older adults aged 65-74 (448.3 per 100,000) and aged 75 and older (1,964.9 per 100,000).
- The hospitalization rate from falls for females (193.7 per 100,000) was higher than the rate for males (177.4 per 100,000).
- Native Hawaiian/Pacific Islander (412.3 per 100,000), American Indian/Alaska Native (316.8 per 100,000) and white (205.3 per 100,000) residents were at least 1.5 times as likely to be hospitalized from falls compared to Asian (108.0 per 100,000) residents.
- The hospitalization rate from falls for residents living in very high poverty areas was 197.6 per 100,000 – higher than the King County average.
- Fall hospitalizations among South Region residents was 202.4 per 100,000 – higher than the King County average.

**Fall hospitalizations**
**King County (average: 2017-2021)**




Source: Comprehensive Hospital Abstract Reporting System (CHARS)
Note: The number shown is the 5-year average rate per 100,000 King County residents.
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- Notably, rates of fall hospitalizations have seen several declines in the most current time period (2017-2021), compared to the prior (2012-2016), including a 9% decline for King County overall (207.5 per 100,000 to 188.7 per 100,000). While Native Hawaiian/Pacific Islander residents have the highest rate of fall hospitalizations across all racial/ethnic groups, the decline was particularly pronounced for this population; rates fell by 47% (779 falls per 100,000 to 412 falls per 100,000) between the two time periods.

# Violence & Injury Prevention

## Continued

Similarly, several other areas/sub-populations saw substantial declines: 20% and 13% decline among North Region (200.2 per 100,000 to 160.3 per 100,000) and Seattle residents respectively (211 per 100,000 to 183.7 per 100,000), a 12% decline among Female residents (219.1 per 100,000 to 193.7 per 100,000), and a 12% decline among residents in very high poverty areas (223.8 per 100,000 to 197.6 per 100,000).

# Climate Change

Climate change is the single biggest health threat facing humanity according to the World Health Organization, with an estimated 250,000 additional deaths per year between 2030 and 2050.[129] The effects of climate change include rising temperatures, extreme weather events, rising sea levels, and increasing CO2 levels. The diverse associated health impacts of climate change include heat-related illness, exacerbation of respiratory, cardiovascular, and certain allergic diseases, as well as injuries and mental health impacts. Climate change is already impacting the health of residents in Washington state and King County, with health hazards associated with extreme heat and wildfire smoke.

Throughout this section we describe climate change impacts with health indicators using emergency department (ED) data, which are reported to the Washington State Department of Health's Rapid Health Information NetwOrk (RHINO). These data represent all visits to a non-federal emergency department by King County residents.

Additional indicators available online include allergic disease ED visits.

In 2021, the rate of emergency department visits involving heat-related illness among King County residents was nine times the rate in 2020 and twice the rate in 2022.

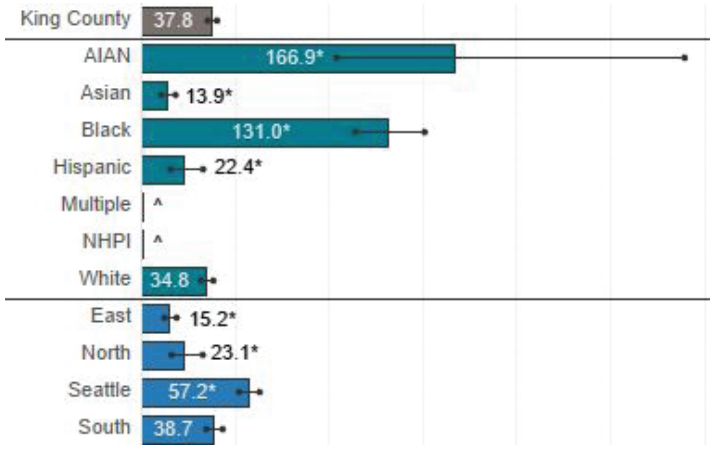
## COLD-RELATED ILLNESS (ED VISITS)

Cold-related illnesses include hypothermia, frostbite, and other injuries due to direct cold exposure.[130] In 2022, the rate of emergency department visits involving cold-related illness among King County residents was 37.8 per 100,000 population.

- In 2022, males (53.4 per 100,000) were 2.5 times as likely to visit the emergency department due to cold-related illness as females (21.7 per 100,000).
- For adults aged 75 and older, the rate of emergency department visits involving cold-related illness (73.5 per 100,000) was double the county rate.
- Compared to Asian residents (13.9 per 100,000), American Indian/Alaska Native residents (166.9 per 100,000) were 12 times as likely and Black residents (131.0 per 100,000) were nine times as likely to visit the emergency department due to cold-related illnesses.
- Emergency visits involving cold-related illness were highest in the Seattle Region (57.2 per 100,000). The two ZIP codes with the highest rates, 98104 (563.4 per 100,000) and 98101 (530.1 per 100,000), are located within Downtown Seattle.

The lack of stable housing is known to be a risk factor for cold-related illness and death. Deaths caused by hypothermia were thirteen-fold more frequently recorded among people experiencing homelessness than for the general population.[131] Analyses using

**Cold-related illness (ED visits)**
**King County (2022)**




Source: WA State Department of Health, Rapid Health Information NetwOrk (RHINO)
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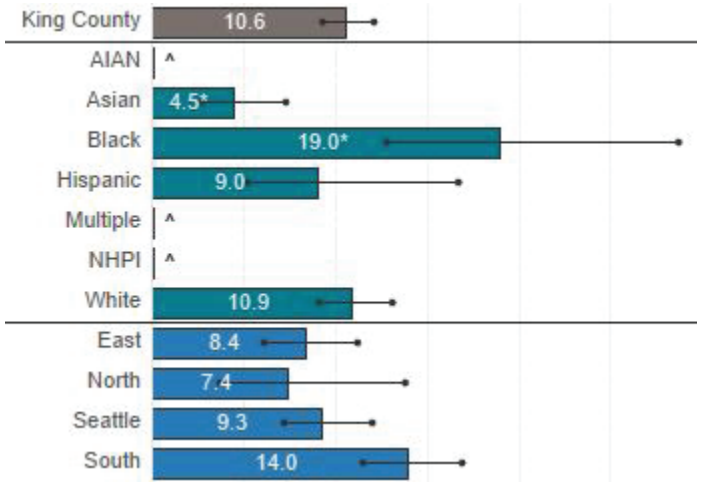
10 years of hospitalization, death, and medical examiner's office data in New York City found that people experiencing homelessness were among those at highest risk of cold-related illness or death, along with people who use substances and become incapacitated outdoors, and older adults with medical and psychiatric conditions without home heat.[132] While the data presented here for King County do not allow us to stratify by housing status, this existing evidence suggest that the demographic disparities presented in our region, may have substantial overlap with residents who are unhoused/unstably housed.

## HEAT-RELATED ILLNESS (ED VISITS)

Heat-related illnesses include things like heat rash, heat cramps, heat exhaustion, and heat stroke, which can range from mild to severe and potentially deadly.[133] In 2022, the rate of emergency department visits involving heat-related illness among King County residents was 10.6 per 100,000 population. This was less than half the rate from 2021 (29.8 per 100,000) when an unprecedented heat wave impacted the Pacific Northwest, resulting in at least 100 heat-related deaths.[134]

- Older adults are particularly vulnerable during extreme heat events. In 2022, the rate of emergency department visits involving heat-related illness for older adults aged 75 and older was 34.3 per 100,000 – significantly higher than the King County rate.
- At 19.0 per 100,000, the rate among Black residents was higher than the King County average and four times the rate among Asian residents (4.5 per 100,000).

**Heat-related illness (ED visits)**
**King County (2022)**




Source: WA State Department of Health, Rapid Health Information NetwOrk (RHINO)
Note: The number shown is the rate per 100,000 King County residents
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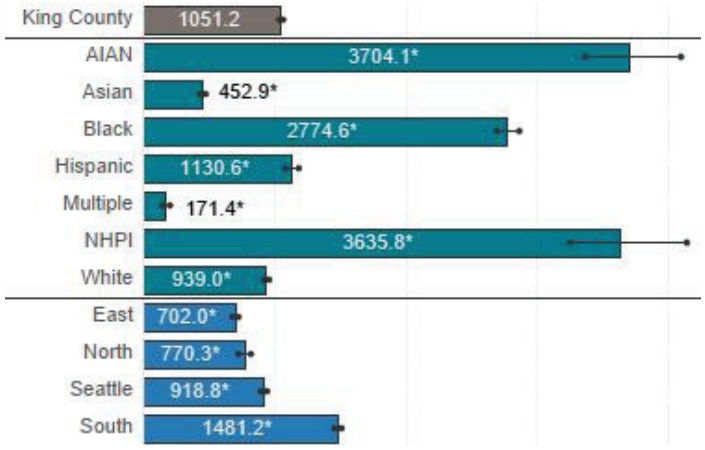
## ASTHMA (ED VISITS)

Asthma prevalence in King County has been generally stable for the past ten years, hovering around 9.0% for adults.[135] Extreme weather and wildfire events can trigger or exacerbate symptoms for individuals with asthma or other respiratory conditions. In 2022, the rate of emergency department visits involving asthma among King County residents was 1,051.2 per 100,000 King County residents.

- Compared to other age groups, the rate of asthma-related ED visits was highest among older adults: The rate among adults aged 75 and older has significantly increased from 1,733.7 per 100,000 in 2019 to 1,940.8 per 100,000 in 2022.
- In 2022, the rate of asthma-related ED visits among American Indian/Alaska Native residents was 3,704.1 per 100,000 – more than eight times the rate among Asian residents (452.9 per 100,000).
- Of all King County regions, ED visits involving asthma were highest in the South Region (1,481.2 per 100,000). The two ZIP codes with the highest rates were 98002 (2,589.4 per 100,000), which includes the Auburn area, and 98022 (2,487.1 per 100,000), which includes the Enumclaw area.

**Asthma (ED visits)**
**King County (2022)**




Source: WA State Department of Health, Rapid Health Information NetwOrk (RHINO)
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# Determinants of Equity




## RELATIONSHIPS BETWEEN RACE/ ETHNICITY AND HEALTH

Racial and ethnic disparities in health and social outcomes persist throughout the county. Like patterns shared in previous CHNA reports, white and Asian populations in King County fare better than other racial/ethnic groups across several health and social indicators. Since the aggregate "Asian" category masks disparities within, findings among detailed Asian ethnicities are presented when available. Detailed race/ethnicity for some Native Hawaiian/Pacific Islander groups are available in some cases as well. With the exception of data for very young children (collected via the BSK Health Survey), current data do not permit us to disaggregate multigenerational African American communities from Somali, Ethiopian, and other 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 2022, of the rate of uninsurance for adults with Hispanic ethnicity was three times the King County average. American Indian/Alaska Native adults were more than four times as likely to be **uninsured** compared to white adults, who had the lowest rate of uninsurance compared to other races.
- Compared to Asian adults (the racial/ethnic groups with the lowest rate of unmet healthcare needs due to cost), Black adults were more than two times as likely and Hispanic adults were more than three times as likely to report **unmet healthcare needs** due to cost.

### Prenatal, birthing, and child health

- Native Hawaiian/Pacific Islanders were least likely to receive **early and adequate prenatal care** compared to other racial/ethnic groups.
- Babies born to American Indian/Alaska Native birthing people were most likely to be **low birthweight**, followed by babies born to Black and Asian birthing people.
- **Infant mortality** among Samoan birthing people was 2.8 times the King County average, and for Asian sub-groups (other than Indian, Chinese, Filipino, Japanese, Korean and Vietnamese) it was 1.8 times the King County average.

### Behavioral health and substance use

- Compared to other racial/ethnic groups, Asian adults were least likely to experience **frequent mental distress**. The highest rates were among Black and Multiple race adults.

# Determinants of Equity

Continued

- Families of Black children were less likely than the King County average to report living in a **supportive neighborhood**.
- While Asian students were less likely to report **depressive feelings** compared to the King County average, there were differences among Asian students by ethnic groups. Filipino students were more likely to report depressive feelings than the King County average.
- **Attempted suicide hospitalizations** among American Indian/Alaska Native and Black residents were higher than the King County average.
- The **suicide death** rates for Asian and Hispanic residents were lower than the King County average. The suicide rate among white residents was 14.2 per 100,000 – more than double the rate among Asian residents.
- The rate of **suicidal ideation emergency department visits** among American Indian/Alaska Native residents was the highest among all racial/ethnic groups. The rates for Black and white residents were higher than the King County average.
- Cigarette **smoking** among Black adults was nearly two times the county average.
- Compared to other racial/ethnic groups, **E-cig or vape pen use** was highest among Native Hawaiian/Pacific Islander youth followed by white youth.
- White 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 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

- Black adults and Hispanic adults were most likely to have not participated in any **physical activity/exercise** within the last month – higher than the King County average. Among youth, American Indian/Alaska Native and white students were significantly more likely to meet physical activity guidelines than the average King County student.
- Compared to white adults, Black and Hispanic adults were more than twice as likely to **consume vegetables** one or more times per day.
- Compared to white students, Native Hawaiian/Pacific Islander students and Black students were more

than four times, and Hispanic students and American Indian/Alaska Native students were more than 3.5 times as likely to be eligible for **free and reduced-price school lunch**.

- **Food insecurity** among Black adults and Hispanic adults and was nearly three times the county average.
- The prevalence of **Body Mass Index (BMI) ≥ 30** among Black and Hispanic adults was significantly higher than the King County average and more than 3.5 times the rate among Asian residents. Native Hawaiian/Pacific Islander students were most likely to report height and weight in the **top 5% for BMI** by age and gender compared to other racial/ethnic groups, and nearly three times the King County average.

## 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.
- The rate of **diabetes** among Black adults was more than two times the King County average.

### Life expectancy and causes of death

- **Life expectancy** is highest among Hispanic (87.5 years) and Asian (85.7 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 (75.5 years) is nearly 6 years shorter than life expectancy for white residents (81.4 years). While estimates may be imprecise due to small population numbers, Native Hawaiian/Pacific Islander (68.5 years) and American Indian/Alaska Native (69.1 years) residents have the lowest life expectancy of all racial groups in King County.
- The death rate from **unintentional injury** among American Indian/Alaska Native King County residents is almost nine times the death rate among Asian residents and four times the county average. The racial/ethnic group with the next highest death rate was Black residents.

## RELATIONSHIPS BETWEEN INCOME AND HEALTH

Our review of health and social indicators reveals consistent income/poverty gradients in social determinants and health outcomes. Neighborhood poverty level is based on the proportion of households in a census tract in which annual household income falls below 200% of the federal poverty threshold. Very high poverty neighborhoods are defined as

# Determinants of Equity

Continued

those where 25% or more of the population is below 200% of the federal poverty level, high poverty neighborhoods are defined as those where 15-24% or more households are below 200% of the poverty threshold, medium poverty as 10% to 14% of households below 200% of the poverty threshold, and low poverty as less than 10% of households below 200% poverty threshold.

## DETERMINANTS OF HEALTH BY INCOME AND POVERTY LEVEL

### Access to care and use of preventive services

- Incomplete **vaccination rates** for children (19-35 months) are highest for children living in very high poverty areas – defined as census tracts where 25% or more of the population earned below 200% of federal poverty level.
- Adults with a household income below 100% of the federal poverty level[i] were more than four times as likely as those with a household income at 400% or more of the federal poverty level to be **uninsured.**
- Adults with household income between $20,000-34,999 (23.5%) were more than six times as likely as those earning more than $100,000 (3.7%) to report **unmet medical needs due to cost**.
- Adherence to **colorectal cancer screening** guidelines generally increases with household income. Among adults with a household income less than $20,000, 43.5% did not meet screening guidelines – higher than the King County average.
- Among adults with household income less than $20,000, 38.9% have not met **mammography screening guidelines**, compared to 17.1% of adults with household income of $100,000+.

### Prenatal, birthing, and child health

- Disparities in **early and adequate prenatal care** exist by neighborhood poverty. Birthing people in very high-poverty areas had low rates of early and adequate prenatal care access compared to the King County average.
- Birthing people living in high- and very high-poverty neighborhoods were more likely than those living in low- and medium-poverty neighborhoods to have **low birthweight** babies.

[i] *The national poverty threshold for a family of four with two related children under 18 in 2022 was $29,678. https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html*

# Determinants of Equity

Continued

### Behavioral health and substance use

- The rate of **frequent mental distress** among the lowest income adults (household income <$20,000) was more than three times the rate for the highest-income group (household income $100,000+).
- The likelihood of **living in a supportive neighborhood** generally increased with higher household income.
- The rate of **attempted suicide hospitalizations** was highest for people living in very high-poverty neighborhoods compared to medium- and low-poverty neighborhoods.
- People living in very high-poverty areas had the highest **suicide death** rate compared to other neighborhood poverty groups.
- **Smoking** among adults with household income <$20,000 was almost three times the rate among adults with household income $100,000+.
- The likelihood of **drug-induced death** increased with neighborhood poverty level: residents living in very high-poverty areas more than three times as likely as residents living in low-poverty areas to have died from drugs.

### Physical activity, nutrition, and weight

- Among adults, lack of adherence to **physical activity** guidelines decreases with higher income. Adults with household income less than $20,000 were more than three times as likely as those with household income of $100,000+ to have not met physical activity recommendations.
- **Vegetable consumption** among adults with annual household income less than $34,999 was significantly higher than the King County average.
- **Food insecurity** was highest among households making less than $34,999.
- **BMI ≥ 30** was most prevalent among adults with household income <$20,000, and least prevalent among those with household income $100,000+.

## HEALTH OUTCOMES BY INCOME

### Chronic illness

- Adults with household income lower than $20,000 were more than four times as likely as adults with household income $100,000+ to have **diabetes**.
- The rate of **hypertension** among the highest income adults was significantly lower than the King County average and all other household income categories below $75,000.

### Life expectancy and causes of death

- Neighborhood poverty is associated with a lower **life expectancy**. Life expectancy among residents in high- and very high-poverty areas is lower than the King County average.

- Adults living in high-poverty areas were more likely than those living in medium- or low-poverty areas to die from **unintentional injuries**.

## RELATIONSHIPS BETWEEN PLACE AND HEALTH

Analyses of King County health indicators continue to reveal disparities by geographic location, or place. Geographic variability of community resources, such as access to healthcare systems, community centers, healthy and affordable food, public transportation, and safe places to play contribute in part to some of these differences across cities/neighborhoods and regions.

### DETERMINANTS OF HEALTH BY LOCATION

#### Access to care and use of preventive services

- The percentage of children (age 19–35 months) 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 Federal Way and Auburn are higher than the county average.
- Adults living in Kent–West were most likely to report **unmet healthcare needs** due to cost compared to residents in other King County cities/neighborhoods.

#### Prenatal, birthing, and child health

- **Infant mortality** in the South Region is higher than the King County average and 1.5 times the rate in East Region.
- Babies born to residents of the East Region and South Region are less likely to receive **early and adequate prenatal care** access by their birthing person compared to the King County average.
- Babies born to birthing people living in the South Region were more likely to be **low-birthweight** compared to all other King County regions.

#### Behavioral health and substance use

- Youth in the South Region were more likely than residents in other regions to report **depressive feelings**.
- The death rate from **suicide** for people in the Seattle-Downtown, Belltown, and First Hill neighborhood was more than double the King County average and the highest of all King County neighborhoods.
- South Region adults are significantly more likely to be current **smokers** than the average King County resident, and more than twice as likely as adults in the East Region.

- **Substance use** among Seattle 8th, 10th, and 12th grade students in Seattle (25.0%) was higher than the King County average.
- **Drug-induced deaths** were higher among Seattle and South Region residents compared to the King County average.

### Physical activity, nutrition, and weight

- South Region adults are significantly less likely to meet **physical activity** guidelines compared to other King County regions.
- South Region adults were significantly more likely to experience **food insecurity** than East Region adults or the average King County resident.
- Youth and adults in the South Region – compared to other county regions – are most likely to be **in the top 5% for BMI** for their age and gender. Compared to East Region students, South Region students were more than 2.5 times as likely to be in the top 5% for BMI by age and gender.

## 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 almost three times the rate of North Highline and White Center, which has among the lowest rate of adult hypertension. South Region adults are also more likely to have **diabetes** compared to the King County average.
- Federal Way–Central has the highest **childhood asthma** rate for Medicaid-enrolled children of all King County neighborhoods – two times the rate of Mercer Island and Point Cities, where asthma rates were the lowest.

### Life expectancy and causes of death

- The South Region has significantly lower **life expectancy** compared to the King County average. East Region residents are expected to live approximately five years longer than residents of the South Region.
- Among King County neighborhoods, Seattle–Downtown, Belltown, and First Hill had the highest rate of **unintentional injury death**, more than four times the King County average.

## RELATIONSHIPS BETWEEN SEXUAL ORIENTATION AND HEALTH

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 response option 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 a standard to which others should be compared. While information about sexual orientation is not available for many indicators, analyses of recent data show noteworthy disparities in some areas.

- Lesbian, gay, or bisexual (LGB) adults were more than twice as likely as heterosexual adults to report **frequent mental distress**. While the percent of heterosexual adults reporting frequent mental distress has remained stable over the past decade, LGB adults have seen an increase, from 21% in 2014–2016 to 32% in 2019–2021. LGB+ youth were also more than twice as likely to report **depressive feelings** compared to heterosexual youth.
- LGB adults are significantly more likely than heterosexual adults to report having a **disability**.
- LGB adults were more likely to report **unmet medical needs** due to cost and were more likely to be current **smokers** compared to heterosexual adults.
- LGB+ youth were more likely to report current **substance, marijuana**, and **e-cigarette use** compared to heterosexual youth.
- **Food insecurity** among LGB adults was significantly higher than the county average.

## RELATIONSHIPS BETWEEN GENDER IDENTITY AND HEALTH

The collection of more detailed and inclusive gender identity data is a relatively recent addition to state and national surveys. In this report, adult indicators from the Behavioral Risk Factor Surveillance System present transgender identity data starting in 2016, and include "Transgender male to female," "Transgender female to male," and "Gender non-conforming" response options. The Healthy Youth Survey started collecting information about gender identity in 2018. Youth indicators present gender identity including "Transgender," "Questioning," "Something else fits better," "Male," and "Female" response options. Respondents could select multiple groups and are included in all categories they selected. As with other comparisons between groups described throughout the report, comparison here are meant to highlight inequities by gender identity where they exist, and not to imply that cisgender is a standard to which others should be compared. Analyses of recent data show noteworthy disparities in some areas.

- Transgender adults were nearly four times as likely as cisgender adults to report **food insecurity**.

# Determinants of Equity

## Continued

- Transgender adults were more than three times as likely as cisgender adults to experience **frequent mental distress**.
- Female students were 1.6 times as likely as male students to experience symptoms of depression. Compared to the King County average, students who identified as transgender, something else that fits better, and who were questioning their gender were almost twice as likely to experience **depressive feelings**.
- The percentage of transgender youth who report **substance use** is higher than the King County average.
- **Marijuana use** among transgender youth was higher than the King County average.
- Transgender adults were more than 2.5 times as likely to report **unmet healthcare needs** due to cost compared to cisgender adults.

# End Notes


1. Public Health - Seattle and King County. Economic, Social, and Overall Health Impacts Dashboard. COVID-19 data. Updated May 10, 2023. Accessed November 2, 2023. https://kingcounty.gov/Sites/depts/health/covid-19/data/impacts.aspx

2. Public Health - Seattle and King County. Reports Related to COVID-19. COVID-19 data. Published 2021. Accessed November 2, 2023. https://kingcounty.gov/en/legacy/depts/health/covid-19/data/reports

3. Washington State Department of Health. Public Health Immunization Measures by County. Immunization Measures by County Dashboard. Published 2022. Accessed November 2, 2023. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/immunization-data/county-public-health-measures-dashboard

4. Constantine D, Hayes P. Racism is a Public Health Crisis: The Transformation Starts Here. It Starts with Us. *Public Health Insider Blog*. Published June 11, 2020. Accessed November 2, 2023. https://publichealthinsider.com/2020/06/11/racism-is-a-public-health-crisis

5. U.S. Environmental Protection Agency. *Climate Change and Social Vulnerability in the United States: A Focus on Six Impacts*. EPA. 2021.

6. Berberian AG, Gonzalez DJX, Cushing LJ. Racial Disparities in Climate Change-Related Health Effects in the United States. *Curr Environ Health Rep*. 2022;9(3):451-464. doi:10.1007/s40572-022-00360-w

7. Morello-Frosch R, Obasogie OK. The Climate Gap and the Color Line – Racial Health Inequities and Climate Change. *N Engl J Med*. 2023;388(10):943-949. doi:10.1056/NEJMsb2213250

8. King County Climate Action Team (eds). *2020 Strategic Climate Action Plan (SCAP).*; 2020. Accessed November 2, 2023. https://kingcounty.gov/en/legacy/services/environment/climate/actions-strategies/strategic-climate-action-plan

9. King County. *Statistical Profile on King County.*; 2022.

10. Vance-Sherman A. *King County Profile.*; 2022. Accessed October 15, 2023. https://media.esd.wa.gov/esdwa/Default/ESDWAGOV/labor-market-info/Libraries/Regional-reports/County-Profiles/King%20County%20Profile%202022.pdf#:~:text=King%20County%20and%20Seattle%2C%20the%20county%20seat%2C%20are,and%20first%20in%20the%20state%20for%20population%20density

11. Office of Financial Management, Washington State. April 1 official population estimates. Updated September 12, 2023. Accessed November 2, 2023. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/april-1-official-population-estimates

12. Office of Financial Management, Washington State. Total population and percent change, 1990-2022. Washington Data & Research. Updated January 10, 2023. Accessed October 30, 2023. https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/total-population-and-percent-change

13. Office of Financial Management, Washington State. Components of population change, 1960-present. Washington Data & Research. Updated June 29,

# End Notes

## Continued


2023. Accessed October 31, 2023. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/components-population-change

14. US Census Bureau. County population totals and components of change: 2020-2022. Updated June 13, 2023. Accessed November 1, 2023. https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html

15. Public Health - Seattle & King County. Washington State Population Interim Estimates (PIE), March 2022. Accessed October 18, 2023. https://phskc-apde.shinyapps.io/PopPIE/

16. U.S. Census Bureau. QuickFacts - Washington. Accessed October 15, 2023. https://www.census.gov/quickfacts/fact/table/WA/PST045222

17. Saldanha A. How WA's Asian demographics have changed dramatically. *The Seattle Times.* Published October 3, 2023. Accessed October 15, 2023. https://www.seattletimes.com/seattle-news/the-2010s-radically-changed-washingtons-asian-demographics-new-data-shows/

18. County Health Rankings & Roadmaps - King, WA 2022. Accessed October 15, 2023. https://www.countyhealthrankings.org/explore-health-rankings/washington/king?year=2022

19. Arias E, Tejada-Vera B, Kochanek KD, Ahmad FB. *Vital Statistics Rapid Release Provisional Life Expectancy Estimates for 2021*. National Center for Health Statistics.; 2021. Report No.23.

20. Keisler-Starkey K, Bunch L. Health Insurance Coverage in the United States: 2021. In: *U.S. Census Bureau, Current Population Reports*. Vol P60-278. U.S. Government Publishing Office; 2022.

21. King County Office of Economic and Financial Analysis. Household income in King County. King County economic indicators. Accessed October 15, 2023. https://kingcounty.gov/en/legacy/independent/forecasting/king-county-economy-status/king-county-economic-indicators/household-income.

22. United States Census Bureau. S1903 Median Income in the Past 12 Months (In 2021 Inflation-Adjusted Dollars) - United States. Accessed October 29, 2023. https://data.census.gov/table/ACSST1Y2021.S1903?q=median+income.

23. United States Census Bureau. S1903 Median Income in the Past 12 Months (In 2021 Inflation-Adjusted Dollars) - Washington. Accessed October 29, 2023. https://data.census.gov/table/ACSST1Y2021.S1903?q=median+income&g=040XX00US53.

24. Balk G. Wealth without working: King County ranks 8th in the U.S. for income from assets. The Columbian. Published August 21, 2021. Accessed October 27, 2023. https://www.columbian.com/news/2021/aug/30/wealth-without-working-king-county-ranks-8th-in-u-s-for-income-from-assets/

25. Kent AH. Examining U.S. economic racial inequality by state. Published August 17, 2020. Accessed October 15, 2023. https://www.stlouisfed.org/publications/bridges/volume-3-2020/examining-us-economic-racial-inequality-by-state

# End Notes

## Continued


26. U.S. Department of Labor, Office of Federal Contract Compliance Programs. Earnings disparities by race and ethnicity. Published July 2020. Accessed October 27, 2023. https://www.dol.gov/agencies/ofccp/about/data/earnings/race-and-ethnicity.

27. Prosperity Now. 2023 State Summaries. Prosperity Now Scorecard. Published October 2023. Accessed October 27, 2023. https://scorecard.prosperitynow.org/state-summaries

28. Prosperity Now. *Racial Wealth Divide in Seattle*.; 2021. Accessed November 2, 2023. https://prosperitynow.org/sites/default/files/Racial%20Wealth%20Divide_%20Profile_Seattle_FINAL_3.2.21.pdf

29. Case A, Deaton A. Without a college degree, life in America is staggeringly shorter. *The New York Times*. Published October 3, 2023. Accessed October 27, 2023. https://www.nytimes.com/2023/10/03/opinion/life-expectancy-college-degree.htm

30. Public Health - Seattle and King County. Unemployment claims among King County Residents. Economic, Social, and Overall Health Impacts. Accessed October 27, 2023. https://kingcounty.gov/en/legacy/depts/health/covid-19/data/impacts/unemployment.asp

31. Dawadi S, Sekar A, Johnson K, et al. Unemployment trends in King County, WA: March 2020-October 2021. Published November 2022. Accessed October 27, 2023. https://kingcounty.gov/en/legacy/depts/health/covid-19/data/impacts/-/media/depts/health/communicable-diseases/documents/C19/report-unemployment-trends-Nov2022.ashx

32. Bahney A. Home prices in 2021 rose 16.9%, the highest on record. *CNN Business*. Published January 20, 2022. Accessed October 27, 2023. https://edition.cnn.com/2022/01/20/homes/us-nar-home-sales-december-and-2021/index.html

33. Groover H. Seattle-area housing market is "on steroids": see what's happening near you. *The Seattle Times*. Published April 7, 2021. Accessed October 27, 2023. https://www.seattletimes.com/business/real-estate/seattle-area-housing-market-is-on-steroids-see-whats-happening-in-your-community/

34. Miller M. Skyrocketing Seattle-area rents leave tenants with no easy choices. *The Seattle Times*. Published August 14, 2022. Accessed October 27, 2023. https://www.seattletimes.com/business/real-estate/skyrocketing-seattle-area-rents-leave-tenants-with-no-easy-choices/

35. Regimbal A. Report: Rent prices in the Seattle metro area grew exponentially over the past year. *Seattle PI*. Published April 1, 2022. Accessed October 27, 2023. https://www.seattlepi.com/local/seattlenews/article/Rent-prices-Seattle-over-the-last-year-17049848.php

36. King County Regional Homelessness Authority. King County's Homeless Response System. Data Overview. 2022. Accessed October 27, 2023. https://kcrha.org/data-overview/

37. Doubleday A, Schulte J, Sheppard L, et al. Mortality associated with wildfire smoke exposure in Washington state, 2006–2017: a case-crossover study. *Environmental Health*. 2020;19(1):4. doi:10.1186/s12940-020-0559-2

# End Notes

## Continued


38. Isaksen TB, Yost MG, Hom EK, Ren Y, Lyons H, Fenske RA. Increased hospital admissions associated with extreme-heat exposure in King County, Washington, 1990–2010. *Rev Environ Health*. 2015;0(0). doi:10.1515/reveh-2014-0050

39. Downs J, Painter I, Hutchinson K, Coffinger S. *Excess Deaths During the COVID-19 Pandemic and 2021 Heat Dome - Washington State 2020 & 2021*. Washington State Department of Health; 2023. Publication Number 422-243.

40. King County. Poverty Rate. ArcGIS StoryMaps. Jobs and Jobs Training. Published September 14, 2023. Accessed July 18, 2023. https://storymaps.arcgis.com/collections/368e59d3a46c4017b202da2d8d4c8e3f?item=2

41. King County. Tree Canopy. ArcGIS StoryMaps. Healthy Built and Natural Environment. Published September 14, 2023. Accessed July 18, 2023. https://storymaps.arcgis.com/collections/da252bcaa3bc467b83fbf8deb8fc16b0?item=2

42. King County. Home Ownership Rates. ArcGIS StoryMaps. Community Economic Development. Published September 12, 2023. Accessed July 18, 2023. https://storymaps.arcgis.com/collections/fedfb76c910e4583a8992496438c9563?item=3

43. United States Environmental Protection Agency. Learn About Heat Islands. Heat Island. Updated August 28, 2023. Accessed October 27, 2023. https://www.epa.gov/heatislands/learn-about-heat-islands.

44. King County. Results of heat mapping project show inequitable impact of hotter summers, will inform actions by King County and City of Seattle. Executive News. Published June 23, 2021. Accessed November 1, 2023. https://kingcounty.gov/en/legacy/elected/executive/constantine/news/release/2021/june/23-heat-mapping-results.

45. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Health Care Access and Quality – Healthy People 2030. Accessed October 27, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality#cit1.

46. Levine S, Malone E, Lekiachvili A, Briss P. Health care industry insights: why the use of preventive services is still low. *Prev Chronic Dis*. 2019; 16:180625. doi:10.5888/pcd16.180625

47. Centers for Disease Control and Prevention (CDC). Reasons to Follow CDC's Recommended Immunization Schedule. Vaccine Schedule. Reviewed August 5, 2019. Accessed October 30, 2023. https://www.cdc.gov/vaccines/parents/schedules/index.html.

48. Tolbert J, Ammula M. 10 things to know about the unwinding of the Medicaid continuous enrollment provision. KFF. June 9, 2023. Accessed October 27, 2023. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/

49. U.S. Preventive Services Task Force. Colorectal Cancer: Screening. Published May 18, 2021. Accessed October 27, 2023. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.

# End Notes

## Continued


50. Zhu X, Weiser E, Jacobson DJ, Griffin JM, Limburg PJ, Finney Rutten LJ. Factors associated with clinician recommendations for colorectal cancer screening among average-risk patients: data from a national survey. *Prev Chronic Dis*. 2022; 19:210315. doi:10.5888/pcd19.210315

51. Centers for Disease Control and Prevention (CDC). Vital signs: colorectal cancer screening test use--United States, 2012. *MMWR Morb Mortal Wkly Rep*. 2013;62(44):881-888. Accessed October 27, 2023. https://pubmed.ncbi.nlm.nih.gov/24196665/

52. Butterly LF. Proven strategies for increasing adherence to colorectal cancer screening. *Gastrointest Endosc Clin N Am*. 2020;30(3):377-392. doi:10.1016/j.giec.2020.02.003

53. Johnson Shen M, Elston Lafata J, D'Agostino TA, Bylund CL. Lower adherence: a description of colorectal cancer screening barrier talk. *J Health Commun*. 2020;25(1):43-53. doi:10.1080/10810730.2019.1697909

54. American Cancer Society. American Cancer Society recommendations for the early detection of breast cancer. Updated January 14, 2022. Accessed October 27, 2023. https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html#:~:text=American%20Cancer%20Society%20screening%20recommendations%20for%20women%20at,choose%20to%20continue%20yearly%20mammograms.%20...%20More%20items

55. Shmerling RH. Why life expectancy in the U.S. is falling - COVID-19 and drug overdoses are the biggest contributors. H*arvard Health Publishing*. Published October 20, 2022. Accessed October 29, 2023. https://www.health.harvard.edu/blog/why-life-expectancy-in-the-us-is-falling-202210202835

56. Bastian B, Tejada B, Arias E, et al. Mortality trends in the United States, 1900-2018. National Center for Health Statistics. Published August 25, 2020. Accessed October 29, 2023. https://www.cdc.gov/nchs/data-visualization/mortality-trends/index.htm

57. Colombara D, Schachter A, Wong E, Laurent A. Changes in death rates during the COVID-19 pandemic in King County, WA: January 1 - December 31, 2020.; 2021. Accessed November 1, 2023. https://kingcounty.gov/en/-/media/depts/health/communicable-diseases/documents/C19/changes-in-death-rates-report.ashx?la=en&hash=77124F86B5BA0D78C33CA37F7C2105CD

58. Achenbach J, Keating D, McGinley L, Johnson A, Chikwendiu J. An epidemic of chronic illness is killing us too soon. *The Washington Post*. Published October 3, 2023. Accessed November 1, 2023. https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/

59. Wallace-Wells D. Why are so many Americans dying? *The New York Times*. Published October 18, 2023. Accessed November 1, 202. https://www.nytimes.com/2023/10/18/opinion/beyond-deaths-of-despair

60. Centers for Disease Control and Prevention (CDC). About Chronic Diseases. Reviewed July 21, 2022. Published 2022. https://www.cdc.gov/chronicdisease/about/index.htm

# End Notes

## Continued


61. Centers for Disease Control and Prevention (CDC). Facts About Hypertension. Reviewed July 6, 2023. Published July 6, 2023. Accessed October 29, 2023. https://www.cdc.gov/bloodpressure/facts.htm

62. Public Health-Seattle & King County. Top 10 leading causes of death, King County (average: 2017-2021). Community Health Indicator. https://tableaupub.kingcounty.gov/t/Public/views/LeadingcausesofdeathKingCounty/Table?%3Aembed=y&%3AisGuestRedirectFromVizportal=y

63. Xu J, Murphy, Sherry L. Kochanek, Kenneth D. Arias E. *Mortality in the United States, 2021*.; 2022. doi:https://dx.doi.org/10.15620/ cdc:122516.

64. American Medical Association. What is behavioral health? Reviewed August 16, 2022. Accessed October 4, 2023. https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health

65. American Psychological Association. *Stress in America 2020: A National Mental Health Crisis*. 2020. Accessed October 24, 2023. https://www.apa.org/news/press/releases/stress/2020/sia-mental-health-crisis.pdf

66. Abt T, Bocanegra E, Tingirides E. Violent crime in the U.S, is surging. But we know what to do about it. Time. Published online January 12, 2022. Accessed October 24, 2023. https://time.com/6138650/violent-crime-us-surging-what-to-do/

67. American Psychological Association. *Stress in America: Money, Inflation, War Pile on to Nation Stuck in COVID-19 Survival Mode*. 2022. Accessed October 24, 2023. https://www.apa.org/news/press/releases/stress/2022/march-2022-survival-mode

68. Centers for Disease Control and Prevention (CDC). America's Drug Overdose Epidemic: Putting Data to Action. Injury Prevention & Control. Reviewed March 8, 2021. Accessed November 1, 2023. https://www.cdc.gov/injury/features/prescription-drug-overdose/index.html

69. Centers for Disease Control and Prevention (CDC). About Mental Health. Mental Health. Reviewed April 25, 2023. Accessed October 5, 2023. https://www.cdc.gov/mentalhealth/learn/index.htm

70. National Institute of Mental Health (NIMH). Substance use and co-occurring mental disorders. Mental Health Information. Reviewed March 2023. Accessed November 1, 2023. https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health

71. Centers for Disease Control and Prevention (CDC). Provisional Data Shows U.S. Drug Overdose Deaths Top 100,000 in 2022. *NCHS: A Blog of the National Center for Health Statistics*. Published May 18, 2023. Accessed November 1, 2023. https://blogs.cdc.gov/nchs/2023/05/18/7365/

72. Oladunjoye AO, Oladunjoye OO, Ayeni OA, et al. Seasonal trends in hospitalization of attempted suicide and self-inflicted injury in United States adults. *Cureus*. Published online October 6, 2020. doi:https://doi.org/10.7759/cureus.10830

73. Centers for Disease Control and Prevention (CDC). Facts about Suicide. Suicide Prevention. Reviewed May 8, 2023. Accessed October 4, 2023. https://www.cdc.gov/suicide/facts/index.html

# End Notes

## Continued


74. Paley A. 2022 National Survey on LGBTQ Youth Mental Health. The Trevor Project. Published 2022. https://www.thetrevorproject.org/survey-2022/

75. Dickey L., Budge SL. Suicide and the transgender experience: a public health crisis. *Am Psychol.* 2020;75(3):380-390. doi:10.1037/amp0000619

76. Wolford-Clevenger C, Frantell K, Smith PN, Flores LY, Stuart GL. Correlates of suicide ideation and behaviors among transgender people: a systematic review guided by ideation-to-action theory. *Clin Psychol Rev.* 2018;63:93-105. doi:10.1016/j.cpr.2018.06.009

77. Centers for Disease Control and Prevention (CDC). Suicide Data and Statistics. Suicide Prevention. Reviewed August 10, 2023. Accessed October 21, 2023. https://www.cdc.gov/suicide/suicide-data-statistics.html

78. Saunders H, Aug 04 NPP, 2023. A look at the latest suicide data and change over the last decade. KFF. Published August 4, 2023. Accessed October 25, 2023. https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-suicide-data-and-change-over-the-last-decade/

79. Washington State Department of Health, Center for Health Statistics. Death Certificate Data, 1990-2021. Community Health Assessment Tool (CHAT). October 2022.

80. Centers for Disease Control and Prevention (CDC). Suicide Mortality by State. CDC Wonder. Reviewed February 15, 2023. Accessed October 24, 2023. https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

81. Centers for Disease Control and Prevention (CDC). Health Effects of Cigarette Smoking. Fast Facts and Fact Sheets. Reviewed October 29, 2021. Accessed October 4, 2023. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

82. Centers for Disease Control and Prevention (CDC). Current Cigarette Smoking Among Adults in the United States. Smoking & Tobacco Use. Reviewed May 4, 2023. Accessed October 23, 2023. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm#states

83. King JL, Shan L, Azagba S. Trends in sexual orientation disparities in cigarette smoking: intersections between race/ethnicity and sex. *Prev Med (Baltim).* 2021;153:106760. doi:10.1016/j.ypmed.2021.106760

84. Public Health - Seattle & King County. Internal analysis, Assessment, Policy Development & Evaluation Unit. 2021.

85. Hoots B, Li J, Hertz M, et al. Alcohol and other substance use before and during the COVID-19 pandemic among high school students — Youth Risk Behavior Survey, United States, 2021. *MMWR Suppl.* 2023;72(Suppl-1):84-92. doi:http://dx.doi.org/10.15585/mmwr.su7201a10

86. Cooper M, Park-Lee E, Cornelius M, Jamal A, Cullen K. Notes from the Field: E-cigarette use among middle and high school students — United States, 2022. *MMWR Morb Mortal Wkly Rep.* 2022;71:1283-1285. doi:http://dx.doi.org/10.15585/mmwr.mm7140a3

# End Notes

## Continued


87. Johnston LD, Miech RA, O'Malley PM, Bachman JG, Schulenberg JE, Patrick ME. *Monitoring the Future National Survey Results on Drug Use, 1975–2021. Overview, Key Findings on Drug Use.*; 2022.

88. King County. Overdose data dashboards. Published 2022. Accessed November 1, 2023. https://kingcounty.gov/overdose/data

89. Centers for Disease Control and Prevention (CDC). Monitoring and evaluating maternal and child health programs. Reviewed July 29, 2021. Accessed October 19, 2023. https://www.cdc.gov/reproductivehealth/global/programs/monitoring-evaluating-maternal-child-health-programs/index.htm#print

90. Brooks H. Exploring a Nonbinary Approach to Health: Holding space for inclusive and expansive language in maternal and child health. NICHQ Insights. Published June 29, 2021. Accessed October 19, 2023. https://nichq.org/insight/exploring-nonbinary-approach-health.

91. National Institutes of Health (NIH). Inclusive and Gender-Neutral Language. NIH Style Guide. Published August 11, 2022. Accessed October 28, 2023. https://www.nih.gov/nih-style-guide/inclusive-gender-neutral-language.

92. Ely DM, Driscoll AK. *Infant Mortality in United States: Provisional Data From the 2022 Period Linked Birth/Infant Death File.*; 2023. doi:10.15620/cdc:133699

93. Hoyert DL. *Maternal Mortality Rates in the United States,* 2020. NCHS Health E-Stats. 2022. doi:https://dx.doi.org/10.15620/cdc:113967

94. Hoyert DL. *Maternal Mortality Rates in the United States, 2021.*; NCHS Health E-Stats. 2023. doi:10.15620/cdc:124678

95. Trost S, Beauregard J, Chandra G, et al. *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019*. Centers for Disease Control and Prevention, US Department of Health and Human Services. 2022.

96. Stein BS, Sedano C, Gardner D, Silverman E, Mentzer K, Christensen TT. *Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2020.*; 2023.

97. Declercq E, Zephyrin L. Maternal Mortality in the United States: A Primer.; 2020. https://doi.org/10.26099/ta1q-mw24.

98. *White House Blueprint for Addressing the Maternal Health Crisis*. The White House. 2022. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf

99. U.S. Department of Health and Human Services. Biden-Harris Administration Announces More than Half of All States Have Expanded Access to 12 Months of Medicaid and CHIP Postpartum Coverage. HHS.gov. October 27, 2022. https://www.hhs.gov/about/news/2022/10/27/biden-harris-administration-announces-more-half-all-states-have-expanded-access-to-12-months-of-medicaid-and-chip-postpartum-coverage.html

100. Kaiser Family Foundation. Medicaid postpartum coverage extension tracker. KFF. Published August 26, 2021. Accessed October 5, 2023. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/

# End Notes

## Continued


101. National Institutes of Health (NIH). What is prenatal care and why is it important? Pregnancy. Reviewed January 31, 2017. Accessed September 26, 2023. https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care

102. Office on Women's Health, U.S. Department of Health & Human Services. Prenatal Care. Updated Febuary 22, 2021. Accessed September 26, 2023. https://www.womenshealth.gov/a-z-topics/prenatal-care.

103. Iannelli V. Baby Birth Weight Statistics: The definition of average, normal, small, and large babies. Growth & Development. Updated December 11, 2022. Accessed September 26, 2023. https://www.verywellfamily.com/baby-birth-weight-statistics-2633630.

104. U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd Edition.; 2018. Accessed October 29, 2023. https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf

105. Centers for Disease Control and Prevention (CDC). About Nutrition. Nutrition. Published February 15, 2023. Accessed October 29, 2023. https://www.cdc.gov/nutrition/

106. Centers for Disease Control and Prevention (CDC). Benefits of Physical Activity. Physical Activity. Reviewed August 1, 2023. Accessed October 29, 2023. https://www.cdc.gov/physicalactivity/basics/pa-health/index.htm

107. Elgaddal N, Kramarow EA, Reuben C. *Physical Activity Among Adults Aged 18 and Over: United States, 2020.*; 2022. doi:10.15620/cdc:120213.

108. U.S. Department of Agriculture, U.S. Department of Health and Human Services. Dietary guidelines for Americans, 2020-2025. 9th Edition.; 2020. Accessed October 29, 2023. www.DietaryGuidelines.gov

109. Lee SH, Moore L V., Park S, Harris DM, Blanck HM. Adults meeting fruit and vegetable intake recommendations — United States, 2019. *MMWR Morb Mortal Wkly Rep*. 2022;71(1):1-9. doi:10.15585/mmwr.mm7101a1

110. Food Research & Action Center (FRAC). *School Meals Are Essential for Student Health & Learning*.; 2021.

111. United States Census Bureau. Household pulse survey: measuring social and economic impacts during the coronavirus pandemic. Household Pulse Survey (COVID-19). Reviewed September 29, 2023. Accessed October 29, 2023. https://www.census.gov/programs-surveys/household-pulse-survey.html

112. Public Health - Seattle & King County. Web Infographic: Food Insecurity. Economic, social, and overall health impacts. Accessed October 29, 2023. https://kingcounty.gov/en/legacy/depts/health/covid-19/data/impacts/food.aspx

113. Public Health - Seattle & King County. Food assistance in King County. Economic, social, and overall health impacts. Accessed October 29, 2023. https://kingcounty.gov/en/legacy/depts/health/covid-19/data/impacts/food.aspx

114. Centers for Disease Control and Prevention (CDC). About adult BMI. Healthy weight, nutrition, and physical activity. Reviewed June 3, 2022. Accessed October 29, 2023. https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

# End Notes

## Continued


115. Centers for Disease Control and Prevention (CDC). *Body Mass Index: Considerations for Practitioners*. 2011. Accessed October 29, 2023. https://www.cdc.gov/obesity/downloads/BMIforPactitioners.pdf

116. Centers for Disease Control and Prevention (CDC). About child & teen BMI. Healthy weight, nutrition, and physical activity. Reviewed September 24, 2022. Accessed October 29, 2023. https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html#how-is-BMI-used

117. Centers for Disease Control and Prevention (CDC). Leading causes of death. FastStats. Reviewed January 18, 2023. Accessed October 23, 2023. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

118. Kegler SR, Simon TR, Zwald ML, et al. Vital Signs: Changes in firearm homicide and suicide rates — United States, 2019–2020. *MMWR Morb Mortal Wkly Rep*. 2022;71(19). doi:10.15585/mmwr.mm7119e1

119. The Educational Fund to Stop Gun Violence. Domestic Violence and Firearms. Updated July 2020. Accessed October 23, 2023. https://efsgv.org/learn/type-of-gun-violence/domestic-violence-and-firearms/

120. Goldstick JE, Cunningham RM, Carter PM. Current causes of death in children and adolescents in the United States. *N Engl J Med*. 2022;386(20):1955-1956. doi:10.1056/NEJMc2201761

121. Centers for Disease Control and Prevention (CDC) Fast Facts: Firearm Violence and Injury Prevention. Firearm Violence Prevention. Reviewed September 19, 2023. Accessed October 23, 2023. https://www.cdc.gov/violenceprevention/firearms/fastfact.html

122. Centers for Disease Control and Prevention (CDC). Fast Facts: Preventing Child Abuse & Neglect. Child Abuse & Neglect. Reviewed April 6, 2022. Accessed October 4, 2023. https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html

123. Swedo E. CDC Suspected child abuse and neglect v1. National Syndromic Surveillance Program Community of Practice Knowledge Repository. Published 2020. Accessed October 4, 2023. https://knowledgerepository.syndromicsurveillance.org/cdc-suspected-child-abuse-and-neglect-v1

124. Centers for Disease Control and Prevention (CDC). Fast Facts: Preventing Intimate Partner Violence. Intimate Partner Violence. Reviewed October 11, 2022. Accessed October 4, 2023. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

125. Washington State Department of Health. Syndromic Surveillance (RHINO). https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/data-exchange/syndromic-surveillance-rhino

126. Public Health - Seattle & King County. Data Dashboard: The impact of firearms in King County. Accessed November 1, 2023. https://kingcounty.gov/en/legacy/depts/health/data/firearms/dashboard

127. Curtin SC, Garnett MF. Suicide and homicide death rates among youth and young adults aged 10-24: United States, 2001-2021. NCHS Data Brief, no 471. 2023. https://dx.doi.org/10.15620/cdc:128423.

# End Notes

## Continued


128. Ahmad F, Cisewski J. *Quarterly Provisional Estimates for Selected Indicators of Mortality, 2022-Quarter 1, 2023.*; 2023. Accessed November 1, 2023. https://www.cdc.gov/nchs/nvss/vsrr/mortality-dashboard.htm#

129. World Health Organization: Climate change. Published October 12, 2023. Accessed October 25, 2023. https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health

130. Council of State and Territorial Epidemiologists (CSTE). *Cold-Related Illness Query: Guidance for Implementing Cold-Related Illness Syndromic Surveillance in Public Health Practice.* 2022. https://knowledgerepository.syndromicsurveillance.org/sites/default/files/2022-10/CRI Syndrome Definition Guidance Document.pdf

131. Romaszko J, Cymes I, Dragańska E, Kuchta R, Glińska-Lewczuk K. Mortality among the homeless: causes and meteorological relationships. *PLoS One*. 2017;12(12):e0189938. doi:10.1371/journal.pone.0189938

132. Lane K, Ito K, Johnson S, Gibson E, Tang A, Matte T. Burden and Risk Factors for Cold-Related Illness and Death in New York City. *Int J Environ Res Public Health*. 2018;15(4):632. doi:10.3390/ijerph15040632

133. Cleveland Clinic. Heat illness. Reviewed April 1, 2021. Accessed October 31, 2023. https://my.clevelandclinic.org/health/diseases/16425-heat-illness.

134. Washington State Department of Health. Heat Wave 2021. Published 2021. Accessed October 31, 2023. https://doh.wa.gov/emergencies/be-prepared-be-safe/severe-weather-and-natural-disasters/hot-weather-safety/heat-wave-2021.

135. Public Health – Seattle & King County. Asthma Prevalence (adults), King County (average: 2017-2021). Community Health Indicators. Published May 2023. Accessed November 2, 2023. https://kingcounty.gov/en/legacy/depts/health/data/community-health-indicators/behavioral-risk-factor-surveillance-system.aspx?shortname=Asthma%20prevalence

136. Professional Transcription and Translation Services. Accessed August 9, 2023. https://thelai.com/

137. Hamilton A. Qualitative methods in rapid turn-around health services research.; 2013. Accessed May 12, 2020. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=780

138. Skillman M, Cross-Barnet C, Friedman Singer R, Rotondo C, Ruiz S, Moiduddin A. A framework for rigorous qualitative research as a component of mixed method rapid-cycle evaluation. *Qual Health Res*. 2019; 29(2):279-289. doi:10.1177/1049732318795675

# Appendix A: Methods

## IDENTIFICATION OF HEALTH NEEDS AND SELECTION OF INDICATORS

For the 2024/2025 King County Community Health Needs Assessment (CHNA), a CHNA Advisory Committee (composed of four 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 and presenting key findings. The CHNA Advisory Committee and PHSKC presented a plan for the 2024/2025 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 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 2024/2025 CHNA report continues to build upon the population-based community health framework. To identify community concerns and assets, this report included a review of a variety of existing community engagement reports from 2021-2023 to inform community identified priorities and overall themes. In addition to the required section of the report, HHC identified additional priorities, including access to care and use of preventive services; behavioral health and substance use; prenatal, birthing, and child health; physical activity, nutrition, and weight; and violence and injury prevention. Furthermore, a new section on climate change was added along with a deeper analysis in the ***Description of the Community*** section to describe the overall health and social impacts of climate change. 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 population.

Recognizing that the CHNA is not intended to provide comprehensive data for each specialized topic,

# Appendix A: Methods

Continued

indicators continue to be selected according to 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 and should include demographic and geographic disaggregation.

2. Ability to make valid **comparisons** to a baseline or benchmark, such as HealthyPeople 2030.

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.

For this 2024/2025 CHNA Report, eight indicators were removed for which timely and/or actionable data were not available in King County. Thirteen new indicators were added to the CHNA to reflect emerging or more widely accepted community health needs, such as mammography recommendations, birthing person mortality, homicide deaths, domestic violence, and climate-change related indicators. 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, Washington State Health Care Authority, and King County.

## COMMUNITY ENGAGEMENT: LISTENING SESSIONS

This community health needs assessment includes direct engagement with communities representing the following racial and ethnic groups to learn more about their experiences with access to mental health and healthy eating: Black, Native Hawaiian/Pacific Islander (specifically Marshallese and Chuukese), American Indian/Alaska Native, Asian (specifically

# Appendix A: Methods

Continued

Cambodian/Khmer and Filipino), and Hispanic. These topic areas and focus populations were selected based on a review of existing quantitative data and where the greatest disparities and data suppression often exist. In addition to mental health and healthy eating, listening sessions also examined the crosscutting impact of racial equity, climate change, and COVID-19 on these topics with participants.

## METHODS

***Overview.*** Listening sessions were designed, not for research purposes, but to gather community input to provide context to specific topics from ethnic and cultural groups that are experiencing disparities and/or are underrepresented in the data. The goals of this community engagement were to:

- Hear directly from King County families from the identified language and cultural groups in King County about their **access to food**
- Find out what common challenges these families of color in King County are facing and what they want when seeking **mental/behavioral healthcare**
- Get some insights about the **impacts of climate change** and extreme weather events on food security and mental health
- Inform King County hospitals about the **health needs** of the families and communities they serve.

Recruitment efforts prioritized established partners of either PHSKC or HHC, serving the focus populations within King County. Discussion guides were designed to elaborate on findings from community reports including topics of specific interest to HHC partners.

***Listening Sessions.*** Listening sessions were hosted by community-based organization (CBO) partners or community leaders who regularly led support or community groups at each host site. Local families were invited to join. Parents were invited to attend with up to two children ages 13 and over. Public Health staff were invited to join the regular community meetings and co-facilitated the listening session along with the CBO hosts. All hosts were responsible for gathering and informing participants of the upcoming listening session, either leading or co-facilitating the listening session with Public Health staff and following up with individual community members who requested additional support after the session. A brief training on the project's purpose and objectives, expectations, consent process, and facilitation techniques was provided to all listening session hosts prior to the session. Listening session hosts received a $250 honorarium for their time planning and hosting the session.

A total of nine listening sessions were conducted with CBO partners, which included 72 adult participants. No youth joined the sessions. Based on the preferences of

# Appendix A: Methods

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CBO partners, listening sessions were either conducted remotely using an online meeting platform or in person at community locations identified by the host organization. Four sessions were conducted in English where all participants were English speakers, and five were conducted in other languages requested by the host when English was not the primary language of participants. PHSKC staff worked with the King County Public Health Language Access Team and NWI Global for document translation. In most cases, the Public Health Language Access Team provided language interpretation. When CBOs had a preferred interpreter, PHSKC partnered with them to either facilitate, co-facilitate, or offer simultaneous interpretation during the sessions.

Participants were informed that their participation was completely voluntary, all responses would be collected confidentially, and that conversations would be summarized for a county-wide report using de-identified quotes from sessions. Participants were informed that their privacy would be protected, and they did not need to share personal stories or answer questions they did not want to answer. Each participant received a $75 grocery card for their time.

***Discussion Topics.*** Discussion began after all participants acknowledged the objectives, confidentiality procedures, ground rules, and verbally agreed to participate. They were asked to reflect on their experiences accessing food and mental health services and comment on barriers and facilitators associated with accessing the care they need. Sessions lasted between 45-90 minutes, depending on the number of participants and availability of the host organization. The following topics were discussed during listening sessions:

- Nutrition knowledge / education about nutrition
- Access to healthy, fresh, and cultural foods
- Food supports needed
- Access to mental and behavioral health services
- Perceived effects of climate change (extreme weather events) on access to food and mental health

***Analysis.*** Listening sessions were audio-recorded for notetaking purposes. Audio files were deleted once analyses were completed. When available, a note taker was also present during the listening sessions. Audio transcription and language translation was provided by Landmark Transcription Services Inc.[136] Transcripts were analyzed for themes by PHSKC using rapid cycle analyses methods.[137,138] Coding and summaries were reviewed by two staff, who conducted all sessions, and consensus was reached to determine themes. Key themes were shared with listening session hosts during an open comment period.

# Appendix A: Methods

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## COMMUNITY ENGAGEMENT: COMMUNITY ASSESSMENTS AND REPORTS

Recent reports with community engagement that were conducted between 2021-2023 were reviewed including community needs assessments, strategic plans, or reports on specific health needs. These were reviewed to identify themes and further inform the broad interests of the communities served by HHC hospitals and health systems as well as to highlight relevant assets, resources, and opportunities. The following reports were reviewed:

| # | Report Name | Organization(s) |
|---|---|---|
| 1 | 2021 Community Health Needs Assessment | Overlake Medical Center |
| 2 | 2022 Community Health Needs Assessment | Kaiser Permanente |
| 3 | 2022 Community Needs Assessment | Solid Ground |
| 4 | 2023 Community Health Needs Assessment Valley Medical Center | UW Medicine |
| 5 | King County Middle School Youth Share Their Experiences and Perspectives on Emotional Safety and Well-Being at School | Public Health - Seattle & King County, Empowering Youth & Families Outreach, Communities In Schools - Federal Way-Highline, Cardea |
| 6 | Blueprint for Addressing Climate Change and Health | Public Health - Seattle & King County |
| 7 | City of Bellevue Human Services Needs Update 2021-2022 | City of Bellevue |
| 8 | City of Burien 2022 Community Assessment Survey | City of Burien (Draft report) |
| 9 | City of Kent Senior Services Needs Assessment | City of Kent |
| 10 | City of Kirkland 2002 Biennial Residents Survey | City of Kirkland |
| 11 | City of Mercer Island Community Survey Findings Report | City of Mercer Island |
| 12 | Resilient Together: An Assessment of Human Service Needs in Redmond | City of Redmond |
| 13 | City of Seattle Food Action Plan Update - Community Engagement Report | City of Seattle Office of Sustainability & Environment |
| 14 | City of Seattle Food Action Plan Update - Community Leader Engagements | City of Seattle Office of Sustainability & Environment |
| 15 | Community Advocates and Food Justice Expert Interviews: Final Report | Public Health - Seattle & King County |
| 16 | Community Health Needs Assessment Swedish | Swedish |

# Appendix A: Methods

Continued

| # | Report Name | Organization(s) |
|---|---|---|
| 17 | El Centro de la Raza Community Needs Assessment | El Centro de la Raza |
| 18 | Food Insecurity in King County | Public Health - Seattle & King County |
| 19 | Impacts of the COVID pandemic on parents and young children in 2021, King County, WA | Public Health - Seattle & King County |
| 20 | King County Equitable Access to Parks - Community Needs Assessment | The Wilderness Society, King County Parks, ECOSS |
| 21 | King County Public Hospital District #4 Community Health Needs Assessment 2023-2025 | Snoqualmie Valley Hospital |
| 22 | King County Traffic Safety Strategic Plan | Public Health - Seattle & King County |
| 23 | King County Transportation Needs Assessment | Hopelink |
| 24 | Public Health - Seattle & King County Healthy Eating Active Living Program (HEAL) Evaluation Results | Public Health - Seattle & King County |
| 25 | Social, Economic and Overall Health Impacts of COVID-19 on People Living with Disabilities in King County, WA | Public Health - Seattle & King County |
| 26 | The Community Navigator Program | Collective Liberation of Practice |
| 27 | Vashon-Maury Island Behavioral Health Needs Assessment | Vashon Youth & Family Services |
| 28 | White Center Community Development Association Community Engagement Report | White Center Community Development Association |
| 29 | Community Needs Assessment | Hopelink |
| 30 | North King County Mobility Coalition | Hopelink/North King County Mobility Coalition |
| 31 | Snoqualmie Indian Tribe Title VI Survey, Meal Category, Tribal Elder Respondents | Snoqualmie Indian Tribe |
| 32 | Our Words Build Power | Surge Reproductive Justice |
| 33 | Black Perinatal Health Community Campaign Report | Surge Reproductive Justice |

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

**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

# Appendix B: Report Definitions & Structure

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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 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), maternal mortality ratio (for birthing parent 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 surveys (e.g., Healthy Youth Survey, Behavioral Risk Factor Surveillance System) are weighted to the population.
- Prevalence rates from the Behavioral Risk Factor Surveillance System (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. HYS is asked only of students in grades 6 (abbreviated version), 8, 10, and 12 every other year.

**Population:** Population data (e.g., denominators) comes from Population Interim Estimates (PIE) developed by Public Health – Seattle & King County in consultation with Washington State Department of Health and the Washington State Office of Financial Management (OFM). PIE incorporates Census 2020 results and replaces prior population estimates that were based on Census 2010. It combines several population data sources produced by the U.S.

# Appendix B: Report Definitions & Structure

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Census Bureau and OFM into an internally consistent spatiotemporal set of population estimates.

**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, 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 our CHI geographical definitions page.

**Cities/Neighborhoods (also known as Health Reporting Areas or HRAs):** Health Reporting Areas are sub-county geographies based on Census 2020 results for reporting health statistics.

The 61 Health Reporting Areas (HRAs) are aggregates of Census 2020 blocks created to facilitate the analysis and presentation of sub-county health statistics. Where possible, HRAs are defined as neighborhoods within large cities, smaller cities, unincorporated areas in King County, or a combination of these geographies, with a Census 2020 population over 30,000. While in the 2012/2022 CHNA, King County was divided into 48 HRAs based on 2010 Census geographies, in comparison, there are 13 more HRAs in the current CHNA, including some with different geographical boundaries.

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 $29,678 in 2022.

**Neighborhood poverty levels** are based on the proportion of people in a census tract in with an annual household income (as reported in the U.S. Census Bureau's American Community Survey) that falls below 200% of the federal poverty level.

- Low poverty: less than 10% of the population is below 200% of the federal poverty level. Using this criterion, 22.9% of the King County population lives in low-poverty neighborhoods.
- Medium poverty: 10% to 14% of the population is below 200% of the federal poverty level. Using this criterion, 28.0% of the King County population lives in medium-poverty neighborhoods.
- High poverty: 15% to 24% of the population is below 200% of the federal poverty level. Using this criterion, 26.1% of the King County population lives in high-poverty neighborhoods.
- Very high poverty: 25% or more of the population is below 200% of the federal poverty level. Using this criterion, 22.9 % of the King County population lives in very high-poverty neighborhoods.

# Appendix B: Report Definitions & Structure

Continued

This neighborhood-level characteristic is used where individual measures of income or poverty level are not available.

For area-based measures of poverty, a census tract is considered a neighborhood. Data sources where census tract information is not available use ZIP Code Tabulation Areas (ZCTAs) 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).

**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. The 2020 Census follows standards on race and ethnicity set by the U.S. Office of Management and Budget (OMB) in 1997. These standards identify a minimum of five categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. The Census also creates a sixth category, Some Other Race, for people who do not identify for the five standard categories. 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.

# Appendix B: Report Definitions & Structure

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

- 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 3-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 for health indicators 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 pairwise differences, as well as difference across two time points 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

# Appendix B: Report Definitions & Structure

Continued

permission. Please use the following citation(s) when reproducing:

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# 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) 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 four CHNA reports: the 2015/2016, 2018/2019, and 2021/2022 reports (available online at www.kingcounty.gov/chna), and this most recent 2024/2025 report.

This joint 2024/2025 CHNA report will be available to the public in 2024. Individual hospital/health system members will use this report to meet their own reporting requirements and may use the findings presented in this report as a foundation to inform and build upon their own community health needs assessments and in the development of their community health improvement strategies.

## PARTICIPATING HOSPITALS AND HEALTH SYSTEMS

**Evergreen Health**

**Fred Hutchinson Cancer Center**

**Kaiser Permanente**

**MultiCare Health System**

Auburn Medical Center
Covington Medical Center

**Navos**

**Overlake Medical Center & Clinics**

**Seattle Children's**

**Providence Swedish**

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: Community Assets & Resources

King County is home to countless community-based organizations (CBOs) that provide valuable services, programs, and resources for local communities. HHC members have developed several partnerships with CBOs that serve King County populations through a variety of mechanisms including but not limited to programmatic support, sponsorships, grants, and/or in-kind investments. Through these relationships, CBOs and hospital/health systems can work together to address community priorities and invest in local communities. While not exhaustive, this is a list of many CBOs and service organizations that HHC members partner with to address the priority areas that were identified in the previous 2021/2022 CHNA report.

Space and resource limitations prevent us from mentioning all 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/.

| | 2021/2022 CHNA: HHC Joint Priority | | | |
|---|---|---|---|---|
| **Organization Name** | **Access to health-care** | **Chronic disease management** | **Food insecurity** | **Mental health & sub-stance use disorders** |
| African Americans Reach & Teach Health Ministry | X | X | | |
| American Heart Association Puget Sound | | X | | |
| American Parkinson's Disease Association Northwest Chapter Mag-ic of Hope | X | X | | |
| API Chaya | X | | | |
| Asian Counseling and Referral Service | X | | X | X |
| Bellevue College | | | X | |
| Bellevue Schools Foundation | | | | X |
| Byrd Barr Place | | | X | |
| Cancer Lifeline | X | X | X | X |
| Chinese Information and Service Center | X | | | X |
| Cierra Sisters | X | | | |
| City of Kirkland Senior Council/Senior Steppers | | X | | |

# Appendix D: Community Assets & Resources

Continued

| Organization Name | 2021/2022 CHNA: HHC Joint Priority | | | |
|---|---|---|---|---|
| | Access to healthcare | Chronic disease management | Food insecurity | Mental health & substance use disorders |
| Community Healthcare Access Team | X | X | X | X |
| Community Lunch on Capitol Hill | | | X | |
| Companis | X | | X | X |
| Congregational Health Ministries | | X | | |
| Conifer Health | X | | | |
| Crohn's and Colitis Foundation | | X | | X |
| Denise Louise Education Center | | | | X |
| Distinguished Gentleman's Ride | | X | | |
| Eastside Friends of Seniors | X | | | X |
| El Centro de la Raza | X | | X | X |
| Emergency Food Network | | | X | |
| Empower Youth Network | | | | X |
| Entre Hermanos | X | | | X |
| Fred Hutchinson Cancer Center | | X | | |
| Friends of Youth | X | | | X |
| Friendship Circle | | | | X |
| HealthierHere | X | X | | X |
| Healthline | X | X | | |
| Indian American Community Services (formerly IAWW) | | X | | |
| KD Hall Foundation | | | | X |
| King County Sexual Assault Resource Center | X | | | |
| Lake Washington School District | X | | | X |
| Lake Washington Schools Foundation | | | | X |
| Lifelong | X | X | X | X |
| Lifewire | | | | X |

# Appendix D: Community Assets & Resources

Continued

| Organization Name | 2021/2022 CHNA: HHC Joint Priority | | | |
|---|---|---|---|---|
| | Access to healthcare | Chronic disease management | Food insecurity | Mental health & substance use disorders |
| March of Dimes | | | X | |
| Medical Teams International | X | | | |
| Mental Health First Aid USA | | | | X |
| National Alliance for Mental Illness (NAMI) Eastside | | | | X |
| National Multiple Sclerosis Society Greater Northwest Chapter | X | X | | |
| Neighborcare Health | X | | | |
| Northshore School District | X | | | X |
| Northshore Senior Center | X | X | | |
| Phenomenal She | X | | X | X |
| Project Access Northwest | X | | | |
| Rainier Foothills Wellness Foundation | X | | | |
| Rebuilding Hope | X | | | X |
| Refugee Artisan Initiative | | | | X |
| Rivkin Center | | X | | |
| Seattle Pride | X | | | |
| Somali Health Board | X | | | X |
| Standup for the Cure | | X | | |
| Urban League of Metropolitan Seattle | X | | X | |
| Washington State Department of Health | | X | | |
| West Seattle Helpline | | | X | |
| Youth Eastside Services | X | | | X |
| YouthCare Orion Center | X | | | X |