

# 2022

Community Health  
Needs Assessment

Seattle   
Cancer Care  
Alliance

Fred Hutch · Seattle Children's · UW Medicine



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# Introduction

## About Seattle Cancer Care Alliance

Seattle Cancer Care Alliance (SCCA) brings together the leading research teams and cancer specialists of Fred Hutchinson Cancer Research Center, Seattle Children’s Hospital and UW Medicine to translate scientific discovery into the prevention, treatment and cure of cancer. We transform groundbreaking research ideas into lifesaving realities for cancer patients, improving the standard of care regionally and beyond.

Our alliance partners had an ambitious vision two decades ago: to lead the world in translating scientific discovery into the prevention, treatment and cure of cancer. As we celebrated our 20<sup>th</sup> anniversary in 2021, that same pioneering vision inspires our work today.

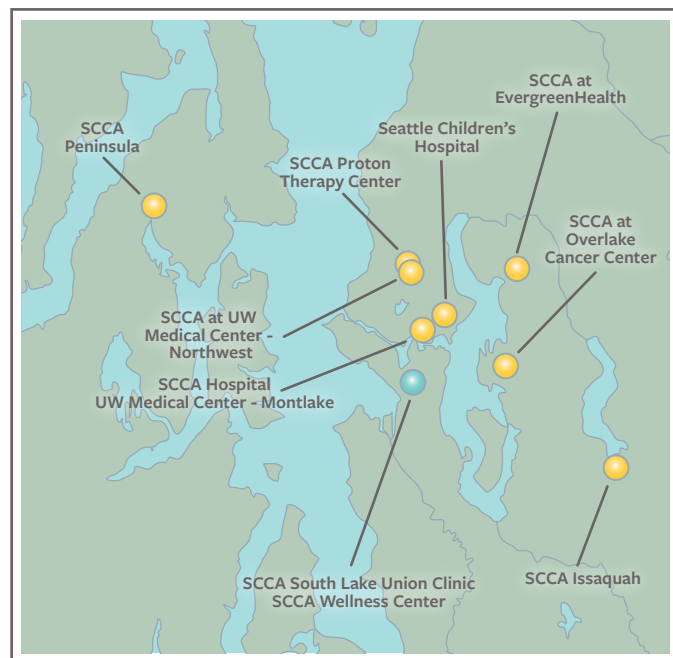
SCCA combines innovative research with exceptional care. We provide state-of-the-art, patient- and family-centered care; run hundreds of clinical trials that advance the standard of care; support education; and enhance access to improved cancer interventions.

As of April 2022, to deepen our commitment to delivering the highest-quality, most advanced cancer care, we have evolved our structure and partnerships to create the Fred Hutchinson Cancer Center. This unified adult cancer care and research center brings together SCCA and Fred Hutchinson Cancer Research Center into a single, independent, nonprofit organization that is also a clinically integrated part of UW Medicine and UW Medicine’s cancer program. A new Fred Hutchinson Cancer Center brand will be introduced later in 2022, and SCCA’s eight clinical care sites will eventually be rebranded as Fred Hutchinson Cancer Center sites.

## Treatment centers

Based in Seattle’s South Lake Union neighborhood, SCCA is the only National Cancer Institute (NCI)-designated cancer center in Washington state. At SCCA, putting our patients first has always been our guiding principle. This commitment has remained top of mind as we have expanded our footprint, adding clinical sites to bring our world-class care to more people throughout the region.

SCCA has two patient housing services and eight treatment centers in the greater Seattle region, encompassing hematology/medical oncology, radiation oncology and infusion services, as well as Network affiliations with hospitals in five states. Since January 2019, we have opened three new community practice locations — SCCA Peninsula in Poulsbo, SCCA Issaquah and SCCA at Overlake Cancer Center in Bellevue. By partnering with existing, well-regarded institutions such as Overlake Medical Center and the former Peninsula Cancer Center, we are proud to increase regional access to our unparalleled care at locations that are closer to home for our patients.



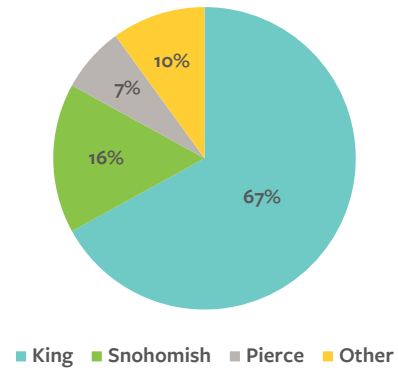
### Patients

Most of SCCA’s patients live in the Puget Sound region, but we also have patients from every county in Washington state. With a reputation for innovative care, SCCA also has patients who travel from across the country to receive treatment.

**45,876:** Served in FY 2021

**6,256:** Treated in FY 2021

FY21 Washington Patient County of Residence



### People

Our dedicated staff ensures our patients are supported throughout their time at SCCA, from screening and diagnosis to treatment, supportive services, recovery and survivorship.

**1,944**  
Employees

**128**  
Oncologists

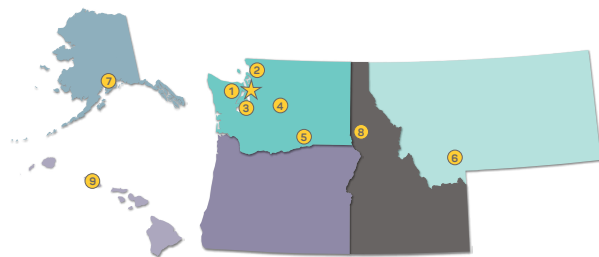
**195**  
Advanced practice providers

**2,094**  
Affiliates

### Research and innovation

Every advance in cancer treatment in recent years has come out of clinical trials — and the physician-scientists at SCCA and Fred Hutchinson Cancer Research Center have led the way for decades. Researchers work behind the scenes at Fred Hutch to develop new, more effective ways to target cancer cells with fewer side effects. The next great breakthroughs are already underway in their labs. Together with SCCA physicians, these innovators translate the most promising options into therapies that our patients receive in clinic.

**183** New clinical trials in FY 2021  
**1,045** Clinical trials active at any given time in FY 2021  
**5,648** Patients enrolled in a clinical trial in FY 2021



- ★ Seattle Cancer Care Alliance
- 1 Olympic Medical Center (Sequim, WA)
- 2 Skagit Regional Health (Mount Vernon, WA)
- 3 MultiCare Regional Cancer Center (Tacoma, WA)
- 4 Confluence Health (Wenatchee, WA)
- 5 Kadlec Clinic Hematology & Oncology (Kennewick, WA)
- 6 Bozeman Health Cancer Center (Bozeman, MT)
- 7 Katmai Oncology Group (Anchorage, AK)
- 8 St. Joseph Regional Medical Center (Lewiston, ID)
- 9 Hawai'i Pacific Health (Honolulu, HI)

### Affiliate network

The SCCA Network Affiliate program supports SCCA’s mission of advancing the standard of oncology care by partnering with community health care organizations across a five-state region including Alaska, Idaho, Montana, Hawaii and Washington. Oncologists and their patients have access to the latest cancer treatments, diagnostics, and clinical trials.

## Our commitment to the community

As a nonprofit, mission-driven organization, SCCA takes seriously our commitment to partnering with our community to create longer, healthier and richer lives for our patients and everyone living in our service area. The work we do in the community is an extension of our core mission.

Our Community Benefit priorities are informed by the Community Health Needs Assessment (also called the CHNA), which we conduct every three years. The CHNA gathers information on both health needs and community assets, with the following goals:

- Get to know the communities we serve, their strengths and the important issues impacting them.
- Highlight disparities and articulate how they will be addressed in our implementation strategy to ensure the end goal of equitable care for diverse communities.
- Engage internal and external stakeholders in a manner that ensures they feel meaningfully included in both process and product.
- Develop structures to ensure that the CHNA informs strategic planning process and resource allocation, maximizing assets across SCCA and the community.
- Satisfy the CHNA report requirement under Internal Revenue Code Section 501(r) and in accordance with the provisions of the Patient Protection and Affordable Care Act, as well as Washington state's ESHB 2341.

We are committed to continuing to learn and respond to pressing needs, such as the impacts of COVID-19 on our patients and their families and communities. We can continue to build our understanding of what factors

influence disparities — as well as support assets and strengths — by building relationships and listening to local organizations and families.

The Community Health Needs Assessment report will help us identify opportunities, build on strengths and continue to invest in community health toward the goal of achieving more equitable care.



# Community Health Needs Assessment Process

## Social Determinants of Health



## A focus on social determinants of health

There are factors not related to a person's biological makeup that can impact the early detection, care and survival of cancer. The conditions in which we are born, live, learn, work and play contribute to our overall well-being and are known as **social determinants of health**.

To illustrate the continuing inequities facing our community and to provide context to the health priorities identified through this CHNA, this report focuses on the social and economic factors that impact the health of our communities with the goal of achieving health equity.

“Social determinants are the major drivers of health inequities — unfair, avoidable and remediable differences in health between social groups” (World Health Organization, 2021). These differences

occur because of systemic and preventable social, economic and geographic disadvantages and are linked to unfair distribution of resources, discrimination, exclusion and racism (Alcaraz et al., 2019). Social and economic determinants of health are intertwined and influence one another.

## Quantitative data analysis

This report presents data on indicators about individuals in our community residing in King, Pierce and Snohomish counties, from publicly available datasets cited in Appendix A, most of which are maintained by national, state and county government agencies. We accessed data for the whole three-county region directly from these datasets when possible. In other instances, we queried data for each county separately and combined them into a weighted average. In most cases, we benchmarked the three-county region numbers against Washington state data or Healthy People 2030. This data was then analyzed and interpreted to understand the community and its cancer burden overall, as well as the disparities of certain populations within the community.

With assistance from Public Health — Seattle & King County, we queried the Behavioral Risk Factor Surveillance System, The Washington state Center for Health Statistics (Washington Vital Records) and Washington state Cancer Registry datasets for cancer-related incidence and mortality data across racial and ethnic populations, as well as some of the behaviors that have been linked with certain types of cancer and the uptake of recommended cancer screenings.

We incorporated relevant information from the joint Community Health Needs Assessment (CHNA) that SCCA publishes together with the King County Hospitals for a Healthier Community (KCHHC) collaborative. Through this effort, 10

hospitals and health systems in King County identify significant health needs and assets in the communities we serve.

We also reviewed community health assessments and reports in Pierce and Snohomish counties published in the last three years and made available to the public, with the purpose of avoiding duplication and to honor the efforts of hospitals, local health departments and community leaders who summarize the needs and strengths of the communities they know best.

We gathered data prior to the onset of the COVID-19 pandemic and some compiled in the midst of it. Data are presented for the most recent years we have data available — in most cases as early as 2019. Where applicable, we have also integrated recent data collected during 2020 as well as some of the known impacts of the pandemic.

### Interviews and listening sessions to solicit community input

After gathering and analyzing the secondary data, we designed semi-structured interview and listening session protocols to solicit community input. The protocol included questions about the interviewee's organization and the services they provide; their perspectives about the most pressing health issues facing our communities; the root causes and determining factors for these issues, gaps or concerns specific to cancer prevention and care; and the current strengths and assets of the community served. We also asked interview and listening session participants how SCCA can be involved in addressing the issues or building on the strengths that they identified.



We interviewed a variety of constituents from across the three-county area. They represented Federally Qualified Health Centers, research centers, local public health agencies, Native tribes and community-based organizations working alongside people from a wide range of races and ethnicities, families and individuals with low income, seniors, recent immigrants and refugees, and other groups who face significant barriers to accessing cancer services due to current and historical structural and systemic racism and discrimination.

We conducted a listening session with SCCA's Patient and Family Advisory Council to hear their firsthand perspectives around seeking treatment, barriers to care and opportunities for education and information offerings about healthy behaviors and recommended screenings. We also met with a group of SCCA leaders and staff to specifically talk about social determinants of health. In all, 30+ individuals participated in the interview and listening session process. (See Appendix B for a list of interview and listening session participants).

The insight of these community constituents helped us understand the context surrounding cancer-related health issues identified in the qualitative data and allowed us to overcome some of the limitations in the quantitative data.

We transcribed, coded for themes and analyzed the completed interviews and listening sessions, which are summarized in the following sections. (See Appendix C for interview and listening session questions.)

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## Consultants contracted to conduct the CHNA

Victoria García Tamayo from Contacto Consulting provided support with secondary and primary data collection, data analysis and the writing of this report. Contacto Consulting brings together people and organizations to foster equitable communities and belonging. Contacto is committed to elevating community voices and centering Black, Indigenous and people of color, immigrants, refugees, and other groups whose brilliance is ready to be shouted out and shared with the world. Contacto has designed and led multiple statewide assessments and strategic planning and implementation processes using a variety of methods, including community conversations, photo-storytelling and interactive priority setting.

## Limitations

We encountered several limitations as we conducted this assessment. Sometimes, the data we wanted simply did not exist: Not all the indicators we hoped to review were available for all three counties, and local sample sizes were sometimes too small to yield meaningful results. Data disaggregation continues to lack in both internal SCCA information and publicly available reports. It is important to acknowledge that there are many racial/ethnic sub-categories within the racial/ethnic groups presented, which may mask underlying disparities or health outcomes. Additionally, data sets used in our analysis do not include data from Indigenous tribes and therefore are not representative of all Indigenous peoples in our community. As such, data must be interpreted carefully. Additional social and environmental conditions may impact the ability for populations to access resources, including immigrant populations, individuals who are uninsured or underinsured, and people who are monolingual in languages other than English. In addition, most data don't account for intersectionalities with other factors such as immigration and refugee status, language, age or income. For example, cancer surveillance mechanisms do not capture sexual orientation and gender identity data, and we therefore cannot compare cancer incidence or deaths for these communities.

Limited resources restricted our ability to broaden our reach to more community constituents in our region. The input from the interview and listening session participants should be interpreted as the perspectives of the people who participated and, in some cases, the organizations they represent. The list of organizations, people and resources that work advancing equity doesn't capture the richness of assets we have available in our community.



# Our Community

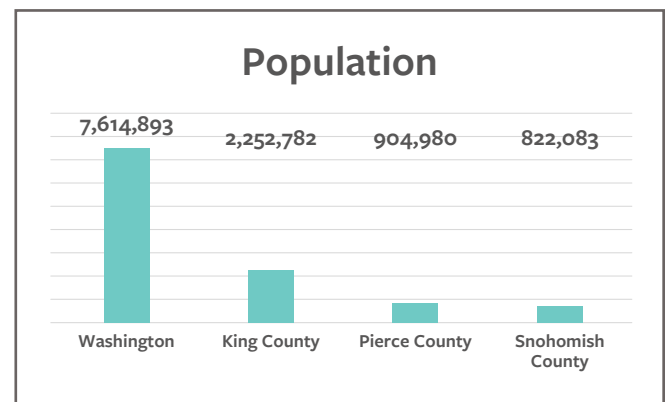
SCCA's reach extends far and wide, with patients from across the Puget Sound region, Washington state, and the world. For the purposes of our community-based efforts toward health equity and improved cancer-related population health outcomes, we focus our efforts locally, where we can have the greatest impact. Consistent with our previous community health needs assessments, we define our community as everyone in King, Pierce and Snohomish counties.



Covering 6,309 square miles, King, Pierce and Snohomish are situated in the original lands of the Coast Salish peoples, the first people of the Salish Sea.

## Population count

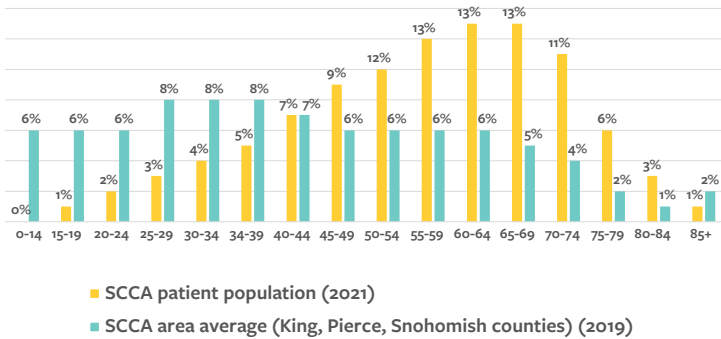
The total population in our community is 3.98 million people, which accounts for more than half of the state's population. King County and Seattle are the most populous county and city in Washington state, respectively. Further, over half the area's population and 58 percent of SCCA's patients reside in the county. Pierce and Snohomish have less than one million residents each, and about 14 percent and 6 percent of SCCA patients come from these counties, respectively.



Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>



### Age makeup of our community



Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov> and SCCA data, 2021.

### Age and sex distribution

The adult population in the SCCA community is slightly lower than in the state: 14 percent of people are 65 and older and 62 percent are between 18 and 64 years old, compared to 16 percent and 62 percent of Washingtonians who fall within those age ranges, respectively. Pierce County has the largest percentage of youth in the SCCA community area; this is also higher than the average youth population in the state.

Census data indicate that females comprise exactly half the population in the state as well as in the SCCA community.

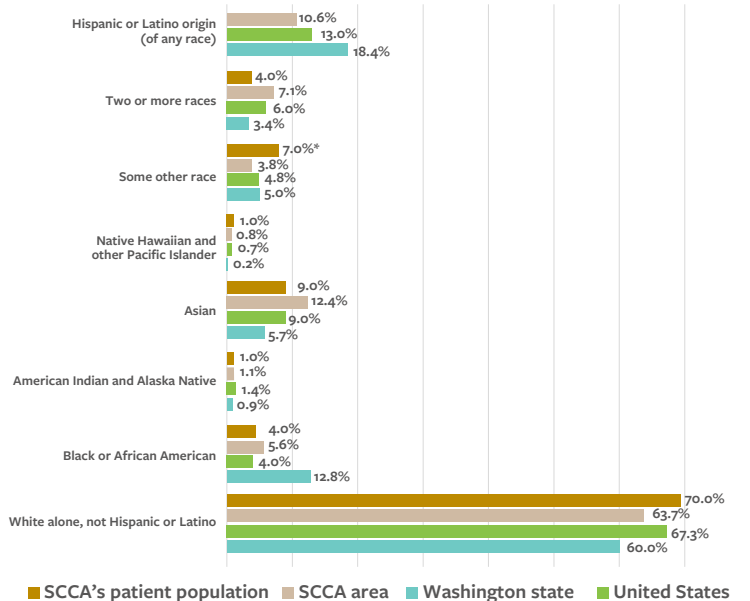


### Race and ethnicity

A growing demographic diversity continues to shape and enrich the landscape of our region. A larger proportion of our community’s population identify as Asian, Black, Hispanic/Latino or racially mixed. Increasing racial and ethnic diversity among children is a continuing demographic trend. The population of children under age 18 is now 53 percent people of color.

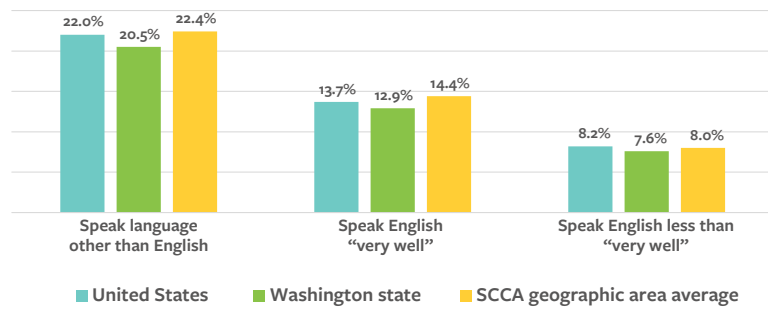
Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>

### Racial/ethnic makeup of our community



\*Data is unavailable/unknown

### Languages spoken at home and English-speaking ability in our community



Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>

### Languages spoken at home

Our region has a wide range of cultural and linguistic diversity. About one in five individuals (one in three in King County) live in a household where a language other than English is spoken. The most spoken languages outside of English are Spanish, Chinese and Vietnamese. Almost 75,000 people in our community report that they speak English less than “very well.” These findings indicate a strong need to ensure health care and information are linguistically responsive and relevant to the patients, families and communities in our area.



# Social and Economic Context of Our Community

Although Washington state, and our community area specifically, generally perform better than other states in terms of health indicators, health inequities do exist, and not all communities show consistently good-quality health. Further, although cancer mortality rates have declined in our region and in the United States, populations such as American Indian/Alaska Native (AIAN) and Black and African American continue to experience higher mortality rates than the national rates and that of other racial and ethnic groups in our community.

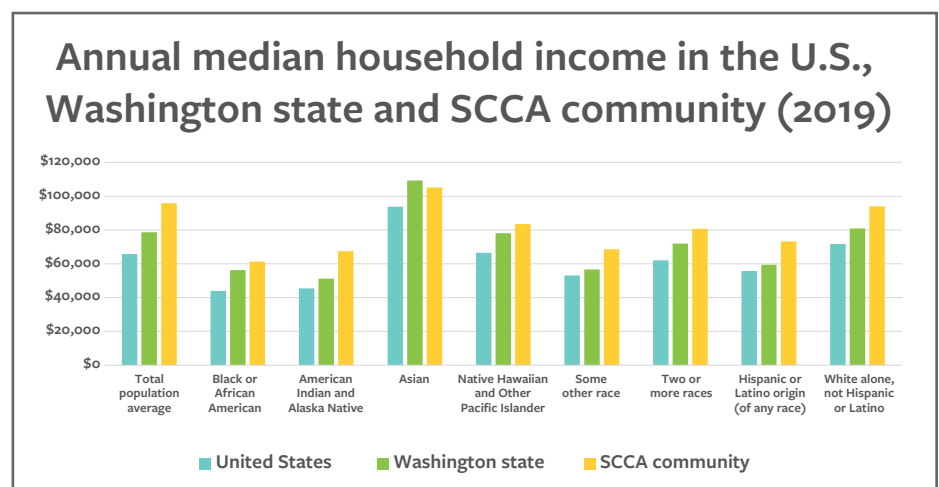
## Economic stability and well-being

Economic well-being means having present and future financial security. This includes the ability for people to meet their daily basic needs, make choices that give them a sense of security and fulfillment, build financial wealth, and maintain adequate income throughout their lives (Council on Social Work Education, 2016).

Because well-being is determined by many correlating factors, and current metrics often look at individual or household outcomes rather than the collective well-being, there are increasing concerns about the relevance of traditional economic indicators to measure well-being (Organisation for Economic Co-operation and Development, 2013). For example, the number of people living below the poverty line does little to show a community's overall well-being (The New Economy Washington Report, 2019). Further, disparities exist by race and place in all indicators of economic health.

## Income and poverty

In the SCCA community, the median household income in 2019 was estimated at \$95,850 — above the Washington estimate of \$78,700. Data show disparities in income by race and ethnicity, with Black/African American and Hispanic/Latino households averaging \$34,600 and \$22,705 below the SCCA community average, respectively. American Indian and Alaska Natives in King County have the lowest household incomes of all races and ethnicities in the three-county area (\$40,306).



Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>

In 2019, before the staggering economic impacts of the COVID-19 pandemic, 7.8% of people in the SCCA community were living below the poverty level. Findings further demonstrate the disparate rates of poverty across sex and place: more females than males were below poverty rate by almost 2 percentage points (8.7% vs. 7%), while Pierce had the highest poverty rate (9.1%) of the three counties in our community area.

Data also show disparities by race and ethnicity: 14.4% of Black/African American, 14.1% of Native Hawaiian/Pacific Islander, 13.2% American Indian/Alaska Native, and 11% of Hispanic/Latinx residents live in poverty as compared to just 6.5% of white residents.

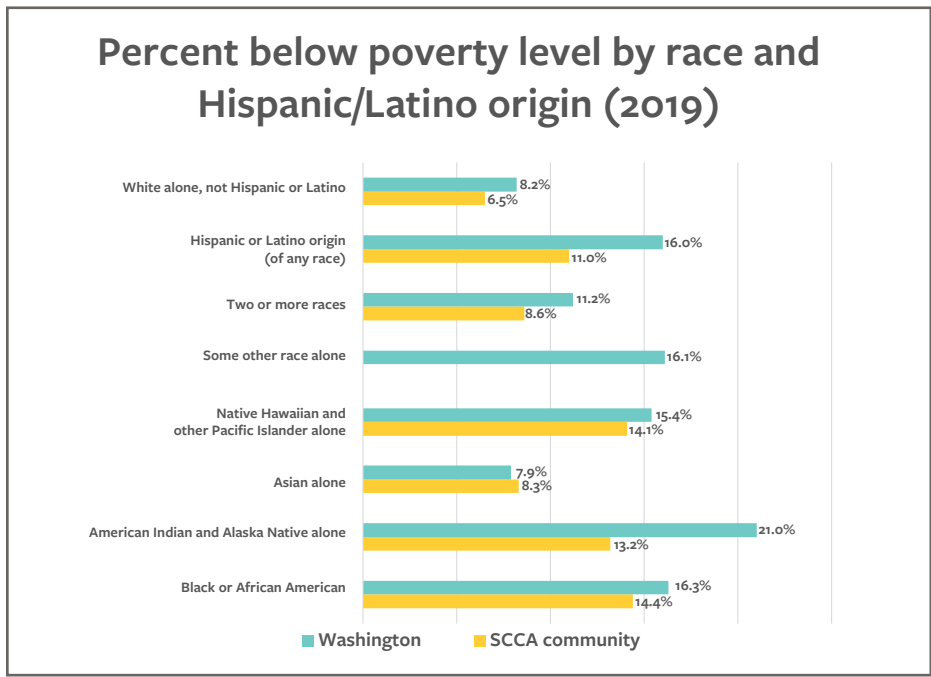
*“The pandemic has caused a financial hardship on everyone. People have lost their cars. You’ve got rent moratorium, but there’s no moratorium in car payments. There’s no moratorium in mortgages. Homeowners that may have lost their job because of COVID, there’s not a mortgage moratorium.”*

— Community clinic leader

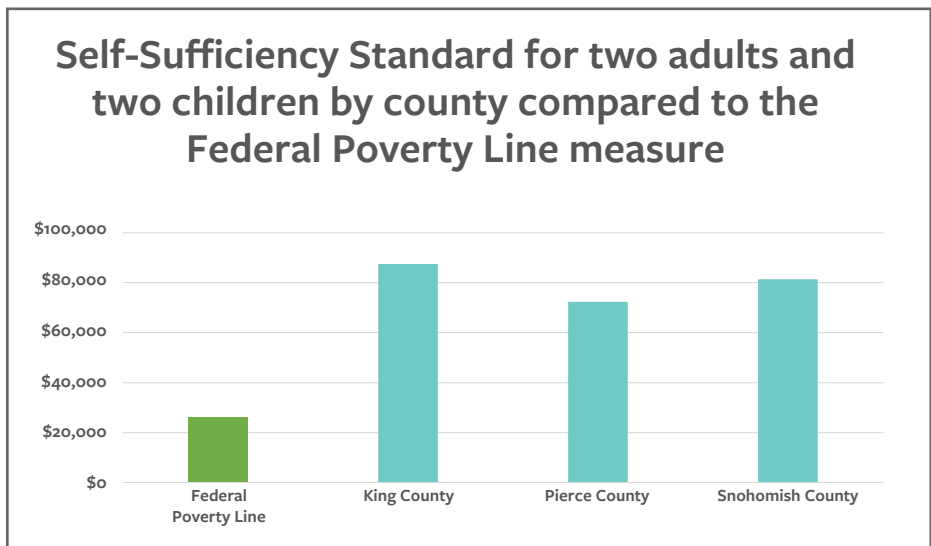
### Self-Sufficiency Standard

The Self-Sufficiency Standard calculates how much income a family must earn to meet basic needs without public subsidies (such as food stamps, Medicaid, public housing, childcare) or private/informal assistance (such as free babysitting by a relative, food provided by food banks). The standard considers family composition and where a family lives.

Different from the poverty measure, which only takes into consideration the cost of food, the Self-Sufficiency Standard calculates the costs of housing, childcare, food, transportation and other basic needs. For example, the federal poverty guidelines establish that the cost of expenses for a family of four in the United States is \$26,200 annually. Conversely, the Self-Sufficiency Standard estimates expenses for the same family in King County at \$87,533 annually (average).



Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>



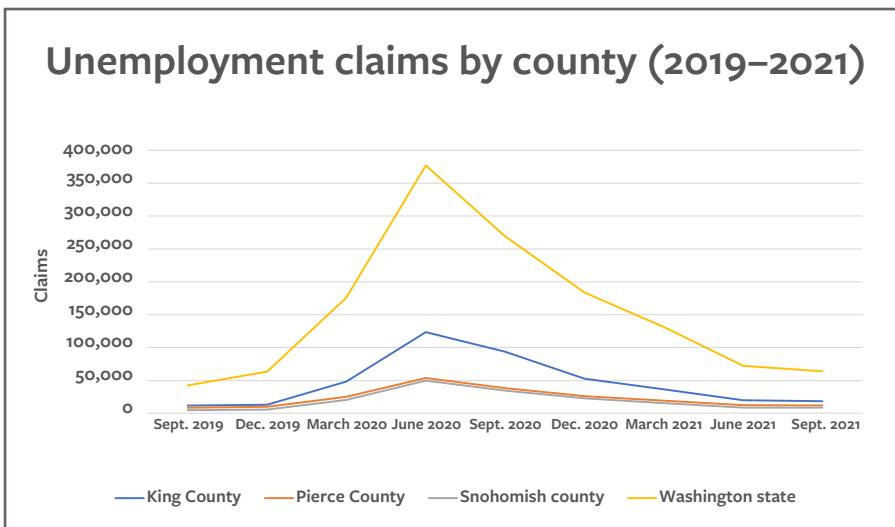
*“Income is an issue because we live in a very expensive region, and Federally Qualified Health Centers use the Federal Poverty Line, which is not sensitive in terms of the variation and cost of living across the United States.”*

— Community clinic leader

**Income inequality**

Income inequality is the income gap between richer and poorer households. Income inequality has social, economic and health impacts, including increased risk of mortality and poor health (County Health Rankings, 2021).

A higher inequality ratio indicates greater division between the richer and poorer households. Pierce and Snohomish counties have slightly lower income inequality ratios than Washington (3.9 and 3.8 respectively vs. 4.4, state), while King County has a higher income inequality than the state at 4.6.

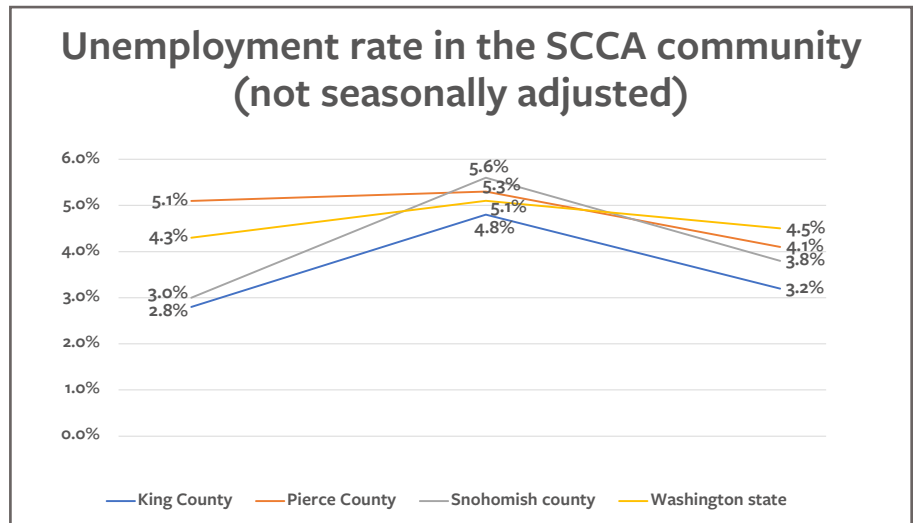


Source: WA Employment Security Department, 2021 ([https://esd.wa.gov/labormarketinfo/unemployment-insurance-data?utm\\_medium=email&utm\\_source=govdelivery](https://esd.wa.gov/labormarketinfo/unemployment-insurance-data?utm_medium=email&utm_source=govdelivery))

**Employment**

People who are employed experience better health and lower mortality rates than those who are unemployed. Unemployment leads to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, and exercise, which can lead to increased risk for disease or mortality. “Because employer-sponsored health insurance is the most common source of health insurance coverage [in the United States], unemployment can also limit access to health care.” (County Health Rankings, 2021).

Mandated closures of nonessential businesses began on March 15, 2020, as one of many community mitigation efforts to slow the spread of COVID-19. With the resulting job losses, the number of people seeking unemployment benefits in Washington state increased rapidly. At the beginning of the pandemic (April 2020), the state unemployment rate hit 16.3%. Since then, it has been dropping steadily. It was 4.5% in December 2021.

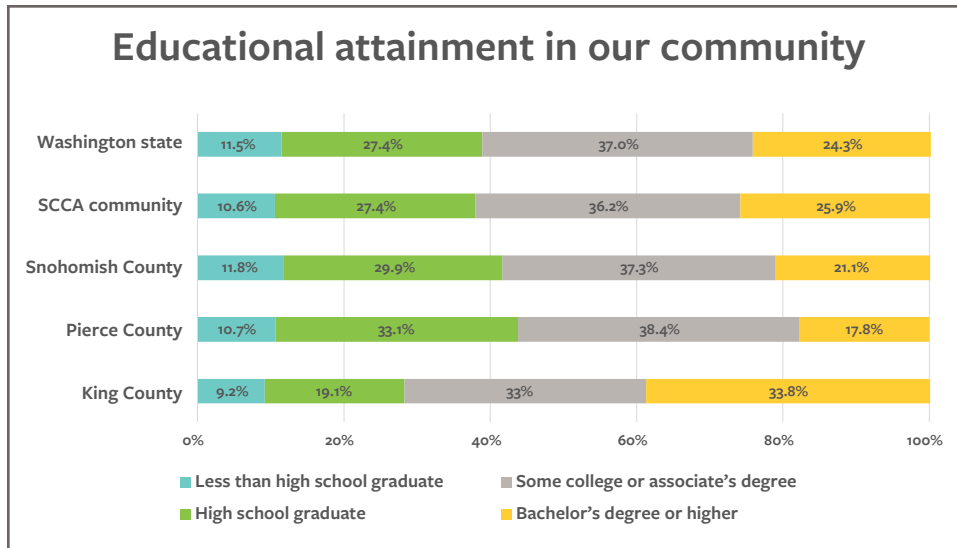


Source: WA Employment Security Department, 2021 (<https://esd.wa.gov/labormarketinfo/unemployment-insurance-data>) \*Seasonally adjusted

## Educational attainment in our community

### Education access and quality

Education is associated with better health, access to better jobs and increased income (Washington state Health Assessment, 2018). There is growing interest in tracking educational equity. The National Academies of Sciences, Engineering, and Medicine (2019) proposes tracking both indicators related to students' educational outcomes (such as educational attainment) and indicators related to students' access to resources and opportunities to identify disparities such as racial, ethnic and economic segregation).



Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>



### Educational attainment

In our society, graduating from high school is considered an important step toward a successful adulthood. Educational attainment is associated with income, employment, housing and access to services. Educational attainment in the SCCA community is comparable to Washington state's rates. Significant disparities exist between places within the SCCA community. While almost 40% of people in King County have a college degree, less than 20% of Pierce County residents do.

There are also disparities in educational attainment by race/ethnicity. In fact, 9% of Native Hawaiian/Pacific Islander, 20% of American Indian or Alaska Native, 23% of Hispanic/Latino, and 24% of Black adults in the SCCA community have a bachelor's degree or higher compared to 40% of white adults.

## Educational attainment by race/ethnicity

	King	Pierce	Snohomish	SCCA community
<b>White</b>				
High school graduate or higher	97.3%	93.9%	95.1%	95.4%
Bachelor's degree or higher	58.2%	29.7%	31.8%	39.9%
<b>Black</b>				
High school graduate or higher	86.6%	95.4%	91.0%	91.0%
Bachelor's degree or higher	27.4%	23.0%	20.8%	23.7%
<b>American Indian or Alaska Native</b>				
High school graduate or higher	79.8%	82.6%	84.2%	82.2%
Bachelor's degree or higher	27.4%	14.0%	18.1%	19.8%
<b>Asian</b>				
High school graduate or higher	89.4%	87.0%	88.8%	88.4%
Bachelor's degree or higher	63.6%	33.9%	50.6%	49.4%
<b>Native Hawaiian and other Pacific Islander</b>				
High school graduate or higher	84.6%	87.0%		85.8%
Bachelor's degree or higher	10.8%	7.7%		9.3%
<b>Some other race</b>				
High school graduate or higher	64.4%	74.3%	75.8%	71.5%
Bachelor's degree or higher	16.9%	16.5%	16.6%	16.7%
<b>Two or more races</b>				
High school graduate or higher	94.0%	91.7%	92.9%	92.9%
Bachelor's degree or higher	44.7%	26.5%	32.1%	34.4%
<b>Hispanic or Latino origin</b>				
High school graduate or higher	73.5%	79.2%	78.3%	77.0%
Bachelor's degree or higher	28.1%	19.1%	22.8%	23.3%

Source: U.S. Census Bureau, American Community Survey, 2019 from <https://data.census.gov>



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## Neighborhood and built environment

Where people live impacts their health and well-being. This is because there are often disparities in features such as grocery stores, open space and sidewalks between neighborhoods, even those next to each other. Ensuring access to healthy food, affordable housing, parks and reliable transportation for everyone improves health in communities (Robert Wood Johnson Foundation, 2021).

### Housing

Quality, safe, and affordable housing is critical for people's well-being. Households who pay more than they can afford for housing may not have enough left to cover other basic needs. The U.S. Department of Housing and Urban Development defines families who are housing cost-burdened as those who pay more than 30 percent of their income for housing.

In the SCCA community, as in Washington, nearly half of renters (49.2% and 47.7%, respectively) and nearly a third of mortgage holders (29% and 28.8%, respectively) are considered cost-burdened.

Housing cost burden has been greatly impacted by the pandemic. The Washington State eviction moratorium put in place in 2020 ended in June 2021. The governor continued some protections for tenants through October 2021.

Housing was identified as a community health priority in the 2018–2019 Community Health Assessments in all Snohomish, Pierce and King counties. Interview and listening session participants named the lack of affordable housing and the expansion of gentrification across the Puget Sound region as a critical issue impacting access to health care as people have to travel further for services. They also called out housing needs for, and the unaffordability of, temporary relocation for long-term patients who travel for treatment from rural areas.

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*“[People] are further out from where the resources are located, so we have to think about how to get the population to the services that we are providing. Maybe identifying mobile units that can be extended out to these areas or opening up various clinics where populations are residing.”*

— Health care provider

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### Houselessness/housing instability

Houselessness is defined as the lack of stable, safe, permanent and adequate housing. People experiencing houselessness may be unsheltered or staying in emergency shelters or transitional housing. “Homelessness is often caused by a complex combination of interwoven social and health factors. Poor physical and mental health can both cause and result in homelessness. Illness or injury can lead to lost income, the loss of a job and health insurance, leading to a downward spiral in health” (Washington Department of Health, 2018).

Patients experiencing houselessness have high rates of cancer risk factors, later stage diagnoses and increased rates of cancer death (Bingham, et al., 2019).

In January 2020, approximately 14,780 individuals were unhoused within the SCCA community, according to the annual Point-in-Time Count.

### 2020 Point-in-Time Count

	People experiencing homelessness	Sheltered	Unsheltered	Change from 2019
<b>King</b>	11,751	53%	47%	+5%
<b>Pierce</b>	1,897	52%	48%	+27%
<b>Snohomish</b>	1,132	41%	59%	+1.4%
<b>SCCA community</b>	14,780	49%	51%	+11%

Source: Point-in-Time (PIT) Count King, Pierce and Snohomish counties, 2020

### Transportation

Transportation, including access to transportation, income spent on transportation and active transportation (walking, biking), is another factor that impacts health. For individuals with cancer, who need to travel regularly for treatment, transportation may be an obstacle to accessing care. Transportation barriers may impact people's decisions regarding stopping or continuing treatments, delaying medical care, missing appointments and more.

Transportation barriers have disproportionate impacts on individuals with disabilities, older adults, youth, immigrants, refugees and individuals who are poor, are monolingual in languages other than English proficiency, are experiencing homelessness or who have chronic conditions, including cancer.

The 2021 [King County Mobility Coalition Transportation Needs Assessment](#) reviews the state of the transportation system as it relates to these and other marginalized communities in King County. The report identified three health care-related transportation needs:

- Individuals impacted disproportionately by displacement and isolation need guaranteed access to health care. In particular, older adults, people who live in rural areas, people of lower income, veterans, and more vulnerable communities with specific needs face unique difficulties when looking for transportation for their health care.
- Transit riders face barriers in finding or using programs because of cumbersome or restrictive eligibility requirements.
- Riders need temporary support when their usual transportation option is not feasible.

Interview participants agreed and mentioned transportation as a barrier to accessing health care. They named the need for health care providers to offer bus tickets, rail passes and cash to pay for taxi and ride share services. Not owning a car, lack of nearby public transit and having to travel long distances were all identified as barriers for racial and ethnic groups, rural areas and low-income individuals in our community.

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## Food security

Food security means a person has socially acceptable access to enough, adequate and safe food to have a healthy life (Weisberg, 2020). According to Feeding America, one in 10 people in Washington state were food insecure before the pandemic. In general, the food environment index (percentage of limited access to healthy foods and food insecurity) is slightly better in King and Snohomish counties than statewide, and worse in Pierce County than statewide.

Studies have suggested that cancer risk is higher among individuals living in food-insecure households (Patel et al., 2019). A 2017 USDA study among working-age adults living in low-income households found that, in general, lower food security is associated with higher probability of cancer, with 5.8% of “very low” food-secure households reporting cancer compared to 3.9% households overall. “The association between food insecurity and a cancer diagnosis persists after adjusting for other socioeconomic factors” (USDA cited by Patel et al., 2019).

Similarly, studies have shown a high prevalence of food insecurity among patients with cancer. A recent survey reported a food insecurity prevalence of 28% among individuals in the United States who had received a cancer diagnosis (Patel et al, 2019).

Diets that contain a variety of vegetables, fruits and whole grains contribute to overall good health, including a reduced risk of cancer. Healthy People 2030 goals focus on helping people eat nutritious foods and get enough physical activity to reach and maintain a healthy weight.

Interview and listening session participants highlighted the importance of access to healthy foods during the entire cancer continuum. Some spoke about how accessing healthful foods would support wellness and prevent chronic illness, including cancer. Others shared how it can be difficult to access healthy food options during treatment, especially when patients travel from afar to SCCA. How the pandemic increased food insecurity was also a topic they raised.

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*“Food access is a huge issue. People can’t get to the store. They’re afraid to go to the store [because of COVID-19]. And maybe individuals that already had daily living challenges aren’t able to move forward.”*

— Community-based organization leader

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Related specifically to Native peoples, participants spoke about the loss of transmission of traditional food knowledge and changes in eating patterns and preferences due to past and current policies, including a history of generations of children being sent to boarding schools and Native people receiving government rations of highly processed foods.

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*“There are federal, state, local and even tribal policies that inhibit people’s access. A lack of access to land, to time off, to money to pay for going out and harvesting and hunting and fishing. Those things are all really expensive in our modern world. People being fed army rations that not only diminished the knowledge of the culture and cultural practices, it altered our taste buds, which altered our genetics. People don’t know how to get deer. They can’t afford the bullets. Don’t have the skill. Everything is a sea of obstacles that forces you to conform to eat a standard American diet that does not actually feed us. We’re being stuffed and starved at the same time.”*

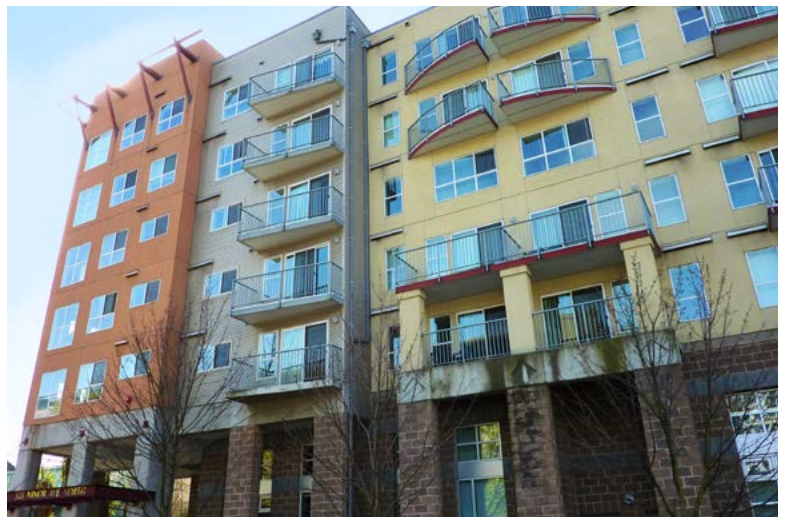
— Native community health provider

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### Community assets and resources

Some of the available resources that contribute to better neighborhoods and built environments in the SCCA community area include:

- SCCA’s two residential temporary housing options for patients traveling from outside the Seattle area to receive care. The SCCA House has 80 units with kitchenettes and allows extended stays. The Pete Gross House offers 70 apartments designed for patients recovering from a stem cell or bone marrow transplant. Both housing options are located a few blocks from the main SCCA clinic.
- The Accessible Transportation Community Initiative, a project to improve access to and use of transportation options in the community. It offers information about specific providers and their transportation services, bus passes, route planning and resources for individuals who use wheelchairs or who have Medicaid assistance.
- The SCCA Family Assistance Fund, which helps SCCA patients and families with critical financial needs brought about by their treatment. Assistance typically includes transportation, food and/or housing. The fund is supported by donations from individuals and community groups.
- Community organizations who are committed to food sovereignty and promote and provide sufficient, healthy and culturally relevant foods to the communities.
- Affordable housing organizations, such as Mercy Housing, that work to prevent and eliminate housing insecurity for families, seniors, and individuals who are low income. Many of them also provide onsite health care and social services.



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## Social and community context

The social and community context domain includes issues related to social cohesion, safety, civic participation and other factors, all of which impact health broadly and cancer care specifically.

Interview and listening session participants said that the health care and social and human services systems are disjointed and fragmented. More progress needs to be made in developing a comprehensive continuum that connects resources and services across systems. Several participants applauded the efforts of Accountable Communities of Health and other agencies trying to accomplish more cohesion and said that much more is needed.

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*“There’s plenty of organizations out there to address pretty much the entire spectrum of social determinants of health. But having those services be well known to the communities that need them and that they can deliver those services in a way that is easy for these populations to access is still the biggest barrier.”*

— Community clinic leader

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*“[We need an] organized approach where it is truly wrap-around to where it is not just taking the vaccine; it’s not just eating vegetables; it’s not just living in a decent neighborhood; it’s not just going to the best schools — it’s all of those things.”*

— Community-based organization leader

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*“When we think about our patient or client, that we know the full story about how they’re presenting at our clinic versus, you know, maybe at a food bank. And we all are aware of all the issues and barriers they are facing, and so all the things we recommend are really feasible for them to actually do for their health and wellness.”*

— Community clinic leader

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## Racism and discrimination

Historic systems of racist policies and practices have shaped and continue to shape access to resources and opportunities for Black, Indigenous and communities of color. They have created disparities in home and land ownership, educational and employment opportunities, safety and health. The COVID-19 pandemic has further exposed the intersection of structural racism and health.

Significant racial disparities have been documented for most cancers. Race was viewed as a biological factor to explain the disparities. Evidence now suggests that “the predominant risk factors are rooted not in biological differences but rather in deeply ingrained social inequities such as structural racism” (Nelson, 2020).

In June 2020, Public Health — Seattle & King County declared racism a public health crisis. The King County Hospitals for a Healthier Community, of which SCCA is a member, has collectively acknowledged the historical and present-day impacts of systemic oppression and racism on the well-being of children, youth, adults and families in King County.

People interviewed for this report wholeheartedly agreed that racism permeates all other social determinants of health.

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*“Communities of color continue to experience systemic racism across the lifespan, which impacts a community’s ability to access resources, which has a direct impact on the health and well-being of communities. Creating a system that advances equitable access to resources and programs for diverse communities across the three-county region will be critical in supporting local communities.”*

— Public health officer

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*“Understanding how communities of color approach things are going to be different than, say, the status quo, and the reason they know how to do this is because they’re connected to their communities. They know how to address some of these gaps that we’ve identified. They know how to get people screened or how to get people to the place where things are going to be screened. The strengths come from the community and their trusted source.”*

— Public health officer

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*“Be more colorful in your approach: Meet people where people are at as opposed to saying, here’s what you got to do. Whenever possible, go to the community. Promote the healthier lifestyle, but promote the healthier lifestyle within the confines of where the people are at, as opposed to a healthier lifestyle if you are a 50-year-old white male earning \$145,000 a year.”*

— Community-based organization leader

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### **Racial, ethnic and economic segregation**

Racial/ethnic residential segregation is defined as the degree to which two or more groups live separately from one another in a geographic area. Residential segregation impacts health, housing, safety, educational and employment opportunities, among other factors (County Health Rankings, 2021).

Racial/ethnic segregation is measured using the index of dissimilarity. For the SCCA community, the index score is 33, while for Washington, it is 38. The score represents the percentage of residents that would have to move to different geographic areas to produce a distribution that matches that of the larger area. Higher values indicate greater residential segregation between non-white and white county residents.

### **Immigration and refugee status**

Immigrants and refugees enrich our communities. Human migration is a consequence of social and environmental determinants of health, including poverty, climate change and political persecution. Migration itself, either forced or voluntary, is also a determinant of health. In 2018, there were 44.8 million foreign-born individuals in the United States. Most immigrants (77%) are in the country legally and 23% (approximately 11 million people) are unauthorized (Budiman, 2020). Around 15,000 refugees were admitted into the country every year since 2016, a number much lower than the ceiling of 85,000 people per year.

It is estimated that 240,000 people who are undocumented live in Washington state. Of them, 46% are also uninsured. In the SCCA three-county area, there are approximately 54,000 people who are undocumented and uninsured (Migration Policy Institute, 2018). Immigrant populations who are undocumented have limited access to health insurance due to eligibility restrictions (Washington state Health Equity for Immigrants Report, 2020). Certain refugees may be eligible for limited refugee medical assistance in Washington state.

Immigrants in general are less likely than the U.S.-born population to receive screening tests for cervical, breast and colorectal cancers. Limited access to care and cultural barriers contribute to this disparity (CDC, 2021). “Refugee populations are at a disproportionately increased risk for cancers that occur in the developing world, such as cancers of the liver, esophagus, and stomach” (Ibid.).

While immigrants and refugees are normally grouped together, some interview participants encourage researchers and health care systems to dig deeper and disaggregate data to provide better, focused services according to the needs of specific populations.

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*“The year of entry for any immigrant makes a big difference in how they came; whether it was a refugee or immigrant is really telling in terms of the trajectory of what the ceiling is for their optimum health. If they came as refugees from war, obviously they are coming here with nothing, similar to our recent Afghan refugee crisis.”*

— Community clinic leader

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### Community assets and resources

Below are some of the available resources that strengthen social and community context and are located within the SCCA community area:

- First and foremost, as indicated by interview participants, there is a lot of community support and leadership. There is a strong support system, from “old-fashioned, pick-up-the-phone support” to mutual aid and solidarity organizations to coalitions “willing to work together and leverage their collective power and voices to advocate on behalf of our communities.”
- Community-based organizations such as Cierra Sisters, Korean Women’s Association (KWA), Stilly Valley Health Connections, Communities of Color Coalition and more. Many organizations, such as Casa Latina, El Centro de la Raza, the Somali Health Board Coalition, Refugee Women’s Alliance and others, focus on working alongside specific immigrant or refugee communities.

### Health care access and quality

The health care access and quality domain includes issues related to opportunities to access health care that is affordable, timely, close to home and culturally sensitive. Adequate health literacy is another key component of accessible and quality care.

### COVID-19 pandemic

On March 13, 2020, the United States government declared a national emergency concerning the novel coronavirus disease, COVID-19, officially marking the start of the pandemic in the country. Washington state was the first area in the United States to report a case. To slow the spread of the virus, health departments put in place community mitigation and physical distancing measures that in turn impacted the economic, social, mental, physical and behavioral health of communities.

The pandemic has disproportionately affected communities of color. Communities of color are overrepresented in COVID-19 cases, deaths and hospitalizations. They are also more likely to be negatively impacted by community mitigation strategies due to social or economic conditions preceding the pandemic. The pandemic exacerbated long-standing systemic racism. Racism is the reason that Black, Indigenous and people of color have been disproportionately impacted by COVID-19 (CDC, 2021; Mental Health America, 2020; and others).



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*“[During the] COVID-19 pandemic, there’s also been a rise of anti-Asian hate and discrimination, which has exacerbated the stress, anxiety and fear many of our patients and community members are experiencing.”*

— Community-based organization leader

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Further, the pandemic and measures to prevent infection have had consequences on individuals across the cancer continuum, from delays and cancellations of treatments to economic challenges affecting their ability to pay for care to stress and anxiety related to the pandemic, which influence their healing.

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*“‘Reachable’ care during COVID-19 has been a challenge. However, even without the challenges of COVID-19, I continue to experience difficulty navigating an adequately networked system of care in survivorship, and the constant self-advocacy and retelling of my medical history can be draining — or worse yet, unheard.”*

— Former patient

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During the early months of 2020, SCCA developed new protocols to maintain safety and the highest-quality cancer treatment in the face of uncertainty and rapid change. These procedures included:

- Triage patients with respiratory symptoms before entering clinics or the hospital to reduce exposure.
- Scaling up COVID-19 testing.
- Creating educational materials and a section on the website for patients.
- Setting up a phone triage line for patients with mild symptoms, minimizing exposure in the clinic.
- Providing masks for all clinic staff and face shields for all health care workers, and requiring all patients, visitors and staff to wear masks.
- Providing flu shots to SCCA patients and caregivers, as flu vaccines have been shown to reduce the risk of flu illness, hospitalization and death.
- Increasing access to telehealth. In 2019, SCCA conducted a total of 30 telehealth visits. In 2020, due to COVID-19 and remarkable efforts by the clinical teams, SCCA provided nearly 25,000 telehealth visits.
- Broadly sharing SCCA’s organizational response to the pandemic in more than 25 publications, including the Journal of the National Comprehensive Cancer Network. The article, “Managing Cancer Care During the COVID-19 Pandemic: Agility and Collaboration Toward a Common Goal,” laid out SCCA’s comprehensive approach, covering topics including managing outpatients and inpatients, revamping treatment approaches and ethical considerations.



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## Delaying care

Before the pandemic (averaging data from 2014 to 2018), 13 percent of adults in Washington reported they needed to see a doctor in the past 12 months but could not due to cost. The percent of people who did not see a doctor due to cost was higher in Pierce County (15 percent) and lower in King County (10.8 percent) and Snohomish County (9.9 percent).

The COVID-19 pandemic intensified delays in care. By April 2020, 41.3 percent of working-age adults in the SCCA community delayed getting medical care because of the pandemic. While this rate improved in the subsequent months, 25 percent of adults in the SCCA community still delayed getting medical care in the last four weeks. This occurred across all demographic groups (PHSKC, 2021).

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*“With the delays in health care from the pandemic and delay in diagnostic workup, we’re seeing more advanced cancers, and we’re seeing more stress from the patients coming into the system.”*

— SCCA Medical Staff Services leader

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A national study found delays in medical care during the pandemic were mainly attributed to non-financial barriers, such as being unable to get an appointment, to find a provider who would see them or to access the care location. Individuals also cancelled elective medical procedures because of mitigation measures such as guidance to avoid non-urgent medical care.

Interview participants from organizations serving different populations agreed that there have been delays in preventive care screenings and treatment due to the pandemic.

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*“The messaging was very clear when the pandemic started: ‘Don’t leave your house. Don’t go anywhere. Emergency rooms are jam-packed. You can pick up COVID-19 there.’ So, the Black community is afraid based off of the messaging. The messaging was don’t go, so they’re not going. And now they aren’t going [even if] they’re having chest pains. ‘Well, I don’t want to go to the hospital because I could catch COVID-19.’”*

*“A lot of people have been missing appointments and not doing preventative health care. We want to highlight that, so that people get back in the habit of going back to the doctor and making sure their health is a priority.”*

*“Those who are in actual cancer treatment, they are feeling like yes, the pandemic is there, but can I continue to go to my treatment? If I need to have surgery, surgeries are being delayed. Medicines are being held back because they’re given to the COVID-19 patients first.”*

— Community-based organization leaders

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# The Impact of Cancer

An estimated 1.9 million new cancers were expected to be diagnosed in the U.S. in 2021, including 42,170 new cases in Washington state. As health care providers who focus exclusively on cancer and blood disorders, we see the impact of cancer on patients and their families every day.

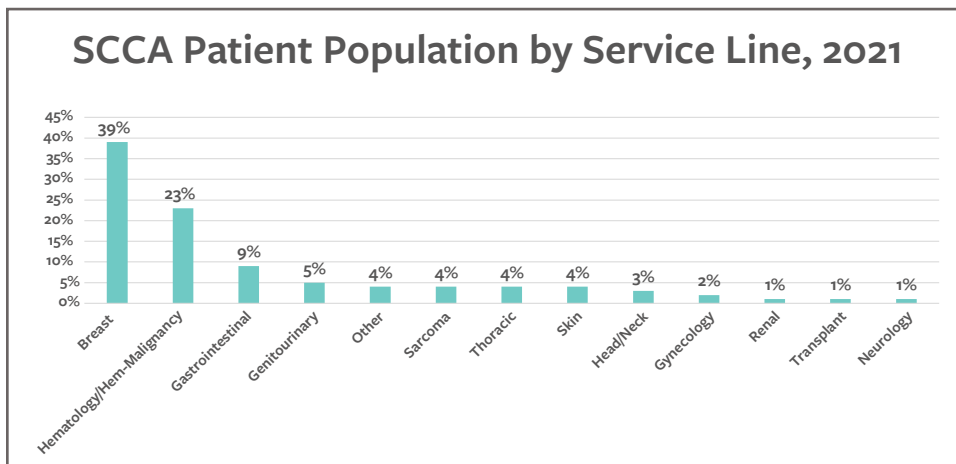
## Leading cause of death

Cancer is the leading cause of death in Washington state. It is estimated that 13,130 Washingtonians will die of cancer in 2021.

Cancer is the leading cause of death in Pierce County, followed by heart disease and lower respiratory disease. In King County, cancer is the first leading cause of death for both males and females. It is also the leading cause of death for children 1–14 and adults 45–65, and among both Medicaid members and the overall population. In Snohomish County, cancer remains the leading cause of death, followed by heart disease.

In 2020, cancer was the second leading cause of death in the United States after heart disease. A total of 598,932 people in the U.S. died of cancer. COVID-19 was the third cause of death (Ahmad & Anderson, 2020).

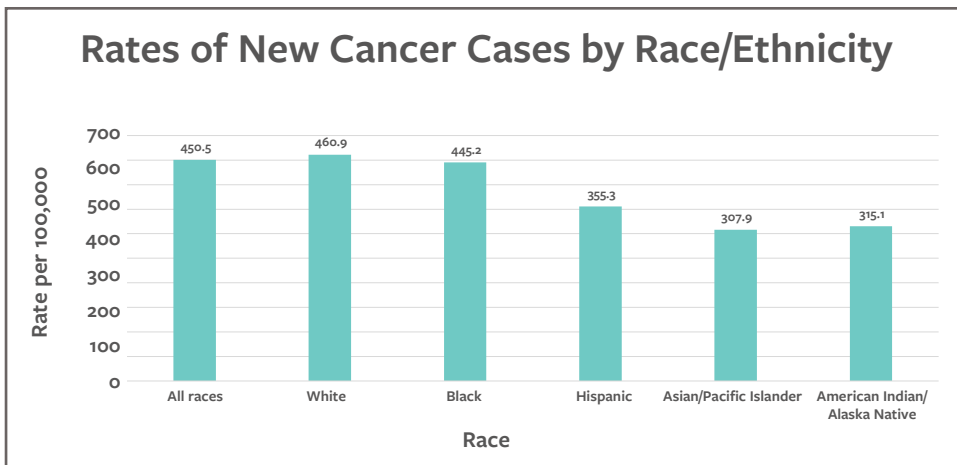
## Inequitable burden of cancer



Cancer can impact anyone, but some people are at higher risk than others. Some risks have to do with host factors related to inherited or genetic changes. Lifestyles and environmental factors can also strongly influence cancer risk. Preventing cancer depends on creating an environment that reduces environmental carcinogens and encourages lifelong wellness.

Individuals in our community who are diagnosed with cancer have better survival rates. At 446.2 cases per 100,000 people, Washington state has a higher rate of people diagnosed with cancer compared to the national average of 442.4 cases per 100,000 people. This incidence rate is contrasted with lower cancer mortality rates in Washington (151.9 per 100,000 people) compared to national rates (158.3 in 2013–2017; 146.2 in 2019) and the Healthy People 2030 goal (122.7). However, there are disparities by race and ethnicity. American Indian/Alaska Native (AIAN), Black, Native Hawaiian/Pacific Islander (NHPI) and white populations in the combined King, Pierce and Snohomish counties share a disproportionate burden of cancer incidence and/or mortality compared to the total population in the combined counties.

It is important to acknowledge that there are many racial/ethnic sub-categories within these aggregate racial/ethnic groups, which may mask underlying disparities or health outcomes. Additional social and environmental

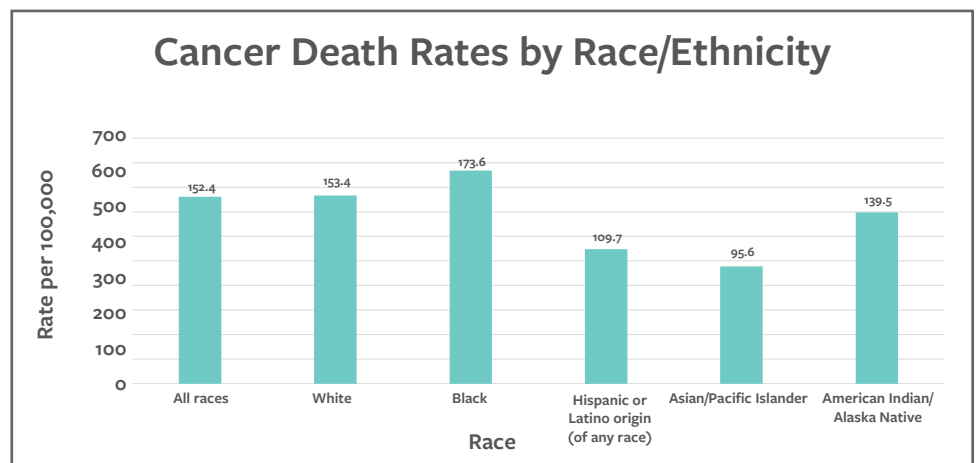


Source: SEER 21 2014-2018, Age-Adjusted Rate per 100,000

conditions may impact the ability of populations to access resources, including migration, lack of insurance and lack of care in the patient’s language. Additionally, communities of color often face increased risk and likelihood of cancer, as well as worse health outcomes, due to inequitable access to resources and environmental factors.

While this data provides an overview of incidence and mortality for all cancer types, it is important to look at specific cancers, since experiences and outcomes vary across populations by cancer type. For example, while rates of new cancer cases in the United States were higher for white people, followed by Black people and Hispanic or Latino origin (of any race), more Black individuals died of cancer than white people, followed by American Indian/Alaska Natives.

While the local health department’s cancer surveillance mechanisms do not capture sexual orientation and gender identity (SOGI) data and we therefore cannot compare cancer incidence or deaths for these communities, we do know that LGBTQ2S+ communities are disproportionately impacted by many risk factors. For example, they are about 1.8 times more likely to smoke than other populations (Gomez et al., 2019). Some recommendations to support these communities include investing in provider education and resources to ensure inclusive and equitable care for LGBTQ2S+ populations.



Source: U.S. Mortality 2015-2019, Age-Adjusted Rate per 100,000

While this data provides an overview

## New cancer cases (incidence)

Between 2016–2018, all races and ethnicities in the combined King, Pierce and Snohomish counties had higher rates of cancer incidence compared to the same races and ethnicities in Washington state. American Indian/Alaska Native (AIAN), Native Hawaiian/Pacific Islander (NHPI) and white populations had consistently higher rates of cancer incidence when compared to Washington state and the total population in the combined counties. However, not all estimates have a statistically significant difference.

### Cancer Incidence (avg. 2016–2018)

Population	SCCA Community Per 100k	Washington state Per 100k
<b>Total</b>	534	491
<b>Race/Ethnicity</b>		
AIAN	581	542
Asian	360	345
Black	490	477
Hispanic	480	392
Multiple	376	250
NHPI	555	540
White	557	503
<b>Age</b>		
<18	19	19
18–24	36	35
25–44	160	154
45–64	834	788
65+	2305	2107
<b>Gender</b>		
Male	559	502
Female	526	490

Source: Washington state Department of Health, Washington state Cancer Registry

Produced by: Public Health — Seattle & King County, Assessment, Policy Development & Evaluation, October 2021

American Indian/Alaska Native (AIAN), Native Hawaiian/Pacific Islander (NHPI), and white populations experience higher rates of cancer incidence and mortality compared to the total population in the combined King, Pierce, and Snohomish counties.

## Cancer deaths (mortality)

In the combined King, Pierce and Snohomish counties, American Indian/Alaska Native (AIAN), Black, Native Hawaiian/Pacific Islander (NHPI) and white populations had higher rates of cancer mortality compared to the total population in the combined counties. However, not all estimates have a statistically significant difference because the confidence intervals overlap.

### Cancer Mortality (avg. 2017–2019)

Population	SCCA Community Per 100k	Washington state Per 100k
<b>Total</b>	143	144
<b>Race/Ethnicity</b>		
AIAN	175	160
Asian	113	108
Black	162	165
Hispanic	118	108
Multiple	121	105
NHPI	191	201
White	146	147
<b>Age</b>		
<18	2	2
18–24	3	3
25–44	14	16
45–64	147	161
65+	800	797
<b>Gender</b>		
Male	170	166
Female	125	128

Source: Washington state Department of Health, Center for Health Statistics, Death Certificate Data

Produced by: Public Health — Seattle & King County, Assessment, Policy Development & Evaluation, October 2021

While Black populations experience lower rates of cancer incidence compared to the total population in the combined counties, they experience higher rates of cancer mortality compared to the total population in the combined counties.

The distribution of cancer mortality across our geographic service area is uneven, with higher mortality rates in certain counties, cities and neighborhoods.

## Trends in incidence and mortality

While the rate of cancer-related deaths has declined over time, cancer continues to be the leading cause of death in King, Snohomish and Pierce counties.

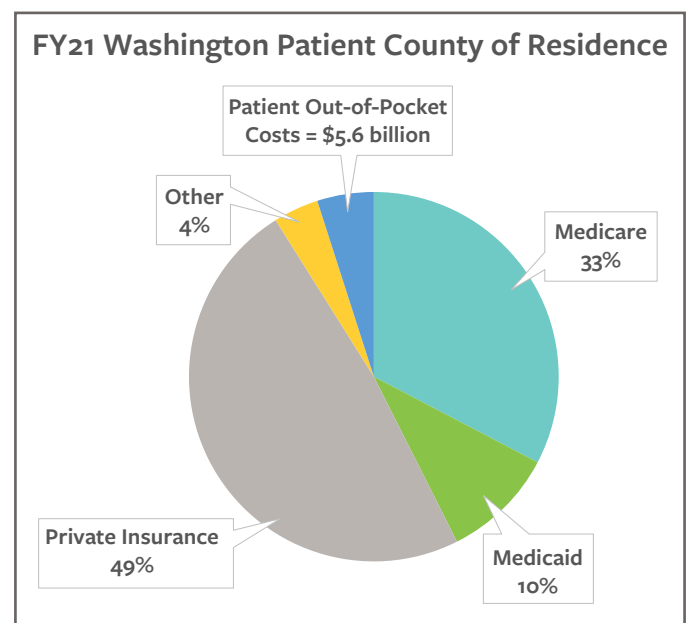
- Breast cancer, prostate cancer and lung cancer continue to be the most common types of cancer for the total King County population (2013–2017).
- In Native Hawaiian/Pacific Islanders, uterine cancer (88.5 per 100,000) took the second spot over prostate cancer (133.6 per 100,000), which was the fourth leading cause of cancer in this population (King County, 2013–2017).
- Cancer among children and young adults is relatively rare compared to adults. In King County, leukemia was the most common cancer type in children aged 1–14 (5.1 per 100,000). Among adolescents and young adults aged 15–24, thyroid cancer was the leading type of cancer (5.7 per 100,000) (2013–2017).
- Snohomish County’s rate of new cancer diagnoses in 2018 was 518.4 diagnoses per 100,000 people. This was much higher than the state (479.9 per 100,000). The rate was highest in those age 65 and older.
- The mortality rate for Snohomish County was similar to the mortality rates for the state in 2018, with 140.9 cancer-related deaths per 100,000 people in Snohomish County and 144.5 per 100,000 statewide.
- In 2018, Snohomish County had an incidence rate of 61.2 per 100,000 for cases of skin cancer (melanoma). This was higher than the state (51.0) and national (12.7) rates. The county rate was higher for males (78.5) than for females (48.7). In 2018, the melanoma mortality rate was 1.5 deaths per 100,000 people, which was lower than the state (2.3) and country (2.1) rates.
- In 2018, mortality rates in Pierce County were highest for lung and bronchus (33.2), prostate (18.8) and breast (18.4). The lung cancer mortality rate was higher than the state (30.9).

## The cost of cancer

The financial consequences of cancer care are significant for individuals, families and entire communities. Cancer represents a significant portion of total national health care spending. An estimated \$200.7 billion was spent on cancer-related health care in 2020. Cancer patients paid \$5.6 billion out of pocket for cancer treatments in 2018.

The costs of cancer do not impact all patients equally. Cancer patients who are people of color, have less than a high school diploma, are younger and are lower- or middle-income are more likely to experience financial hardship.

Several factors contribute to the cost of cancer. They include lack of insurance or type of insurance coverage, treatment plans, geographic location of the patient and where they receive treatment. There are also indirect costs



Source: Cancer Action Network, 2020 \*Percentages in chart have been rounded.

that are significant for cancer patients and their families: transportation, housing or lodging if they need to travel for treatment; lost income; caregiving; and secondary effects (Cancer Action Network, 2020).

*“I just had this conversation with someone whose husband had stomach cancer. The cost of cancer. He went into serious debt because his former company ended up letting him go during the middle of treatment because he was having issues with being at work during designated periods. The cost just outside of the routine treatment and care was exorbitant.”*

— Cancer survivor

## Cancer incidence and mortality by type of cancer

### Blood disorders

Blood cancers and other disorders affect the blood, bone marrow or immune system. Blood disorders include blood cancers, like leukemia and lymphoma, and nonmalignant blood diseases (also called benign hematology) such as aplastic anemia, inherited bone marrow failure syndromes, sickle cell disease and many others.

Leukemia incidence in the SCCA community area is higher than in the state (15.6 average compared to 14.5 age-adjusted rate per 100,000 people). The mortality rate in the three-county area is slightly higher than the state’s rate (6.4 vs. 6.2). Leukemia incidence and mortality are higher in males than females in all three counties. Twenty-three percent of SCCA patients are treated for blood disorders.

### Leukemia incidence and mortality in the SCCA community (age-adjusted rate per 100,000) (2014–2018)

Geography	Incidence	Mortality
King	15	5.6
Pierce	15.9	6.6
Snohomish	16.1	7
SCCA Community Average	15.6	6.4

Source: Washington state Incidence and Mortality Data: Washington state Department of Health, Center for Health Statistics, 2019



## Lung cancer

While lung cancer incidence in the SCCA community is higher than the national average (52.9 vs. 43.2 per 100,000), mortality rates are lower in our community (30.8 average vs. 34.8 per 100,000 in 2018). Smoking and tobacco use are associated with an increased risk of lung and other types of cancer. Non-ceremonial tobacco use remains a concern for some groups within our community.

- Lung cancer was the most common type of cancer among King County adults over age 65 (278.8 per 100,000).
- In King County, lung cancer was the third most common cancer type (47.9 per 100,000) among residents reporting multiple races (2013–2017).
- The incidence of lung cancer in Pierce County is significantly higher than in Washington. In Pierce County, lung cancer incidence is higher among American Indian and Alaska Native, Native Hawaiian and Pacific Islander, and white residents (2011–2015).
- Lung cancer is more common among males compared to females.
- In the SCCA community, Pierce County has the highest incidence and mortality rates of lung cancer over Snohomish and King counties.
- Native Hawaiian or other Pacific Islanders have the highest lung cancer mortality rates in the state, followed by white people and American Indian or Alaska Natives.

### Lung cancer incidence and mortality in our community (age adjusted rate per 100,000)(2018)

Geography	Incidence	Mortality
King	50.7	27.8
Pierce	57.1	33.2
Snohomish	50.9	31.5
SCCA community average	52.9	30.8

Source: Washington state Cancer Registry, <https://fortress.wa.gov/doh/wscr/Query.mvc/Query>

## Breast cancer

SCCA's community has a higher incidence of breast cancer (174.3 per 100,000) across all racial/ethnic groups, compared to the national average (128.8 per 100,000). Despite high incidence rates, our community generally has lower mortality rates (17.9 per 100,000) for breast cancer than the national rate (19.8 per 100,000).

- Averaging data from 2013–2017, the leading cause of cancer in King County was breast (female).
- While Pierce County has fewer new breast cancer cases (160.0 per 100,000) than King and Snohomish counties, the mortality rate (18.4 per 100,000) is slightly higher.
- In Pierce County, breast cancer incidence is higher among Black, white and Native Hawaiian or Pacific Islander individuals.
- Snohomish County saw 169.8 new cases of breast cancer per 100,000 females in 2018. This is similar to the state rate (161.2 per 100,000) but both are higher than the U.S. (128.8 per 100,000) incidence rate.

### Breast cancer incidence and mortality in our community (age-adjusted rate per 100,000 people) (2018)

Geography	Incidence	Mortality
King	193.2	18.3
Pierce	160.0	18.4
Snohomish	169.8	17.1
SCCA community average	174.3	17.9

Source: Washington state Mortality Data, Washington state Department of Health, Center for Health Statistics, 2019

## Colorectal cancer

Colorectal cancer is the third most common cancer for both males and females in the country and the second-leading cause of cancer deaths (CDC, 2020). Incidence rates for colorectal cancer in our community are higher than the national average of 34.8 cases per 100,000.

- Males have a higher colorectal cancer incidence and mortality than females. There are no significant differences by race.
- Snohomish County has the highest colorectal cancer incidence and mortality rates in the SCCA community.

### Colorectal cancer incidence and mortality in our community (rate per 100,000) (2018)

Geography	Incidence	Mortality
King	36.0	11.0
Pierce	34.4	9.0
Snohomish	38.9	13.9
SCCA community average	36.4	11.3

Source: Washington state Mortality Data, Washington state Department of Health, Center for Health Statistics, 2019

## Cervical cancer

Overall, our community's cervical cancer rates are lower than the national average for both incidence and mortality. In 2018, the rate of new cervical cancer cases in the United States was 7.5 per 100,000 individuals, and the death rate was 2.2 per 100,000, compared to 7.3 and 1.6 per 100,000 respectively in the SCCA community area.

### Cervical cancer incidence and mortality in our community (rate per 100,000) (2018)

Geography	Incidence	Mortality
King	6.3	1.3
Pierce	8.0	2.0
Snohomish	7.6	1.5
SCCA community average	7.3	1.6

Source: Washington state Mortality Data, Washington state Department of Health, Center for Health Statistics, 2019

### Prostate cancer

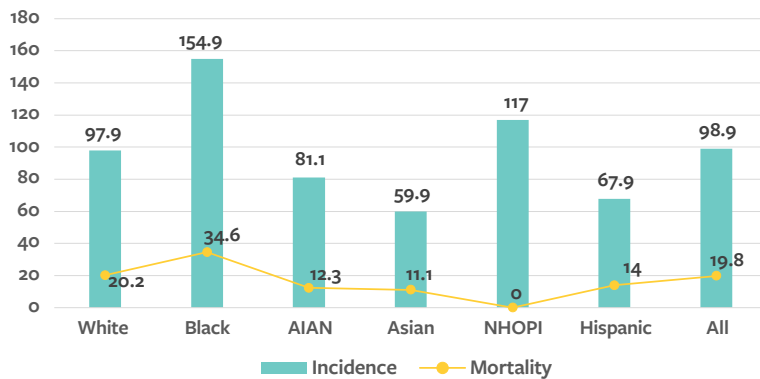
The trend for new cases of prostate cancer in our community has shown significant improvement. The incidence rate 10 years ago was 156.8 per 100,000 males, compared to 112.8 per 100,000 now. The rates for prostate cancer mortality in our community are worse than the Healthy People 2030 goal of 16.9 per 100,000.

#### Prostate cancer incidence and mortality in our community (per 100,000 individuals) (2018)

Geography	Incidence	Mortality
King	133.6	21.2
Pierce	101.4	18.8
Snohomish	103.5	20.0
SCCA community average	112.8	20.0

Source: Washington state Mortality Data, Washington state Department of Health, Center for Health Statistics, 2019

#### Prostate cancer incidence and mortality by race/ethnicity in Washington state (2016–2018), age-adjusted rate per 100,000



Source: Washington state Mortality Data, Washington state Department of Health, Center for Health Statistics, 2019

In Washington state, the rate of new prostate cancer cases (measured per 100,000 people) among Black males is much higher than the country average (106.8) and state rate (101.9). The mortality rate due to prostate cancer is also much higher for Black males (34.6) than the state (19.3) and national (18.9) rates. Incidence rates for Native Hawaiian or other Pacific Islanders is also higher than of the state overall.

### Cancer screening

#### Breast cancer screening

Mammograms are recommended to detect breast cancer in females, since early detection greatly increases the odds of survival. The U.S. Preventive Services Task Force recommends women 50–74 years old receive mammogram screening once every two years. Still, 23 percent of women in our community in that age range have not received breast cancer screening according to guidelines. This is barely meeting the Healthy People 2030 objective of 77.1% of women screened (22.9% not screened).

Females with annual household incomes below \$35,000 are less likely to have had a recent mammogram. American Indian/Alaska Native and white individuals in our community are also more likely to have unmet breast cancer screening needs.

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Compared to commercially insured adult residents of King County, Medicaid adults responding to surveys were less likely to follow breast, cervical and colon cancer screening recommendations (King County Regional Health Needs Inventory, 2017).

Further, the COVID-19 pandemic has disrupted preventive care, including cancer screening. According to one study conducted in Washington state, there was a 49% decrease in screenings from April to December 2019 compared to the same period in 2020. Reductions in the number of screenings were greater and more significant in females who identified as Hispanic/Latina (64.2%), American Indian/Alaska Native (60.9%), mixed race (56.2%), Native Hawaiian or Pacific Islander (54.5%), Asian (54.5%) and Black (53.9%) compared with females who identified as white (49.2%). The study also saw greater reduction in screening among females living in rural areas and those who self-paid for treatment and who were insured by Medicaid (Amram et al., 2021).

Interview participants called out the need for free comprehensive screening that encompasses easy-to-understand information, as well as education, support and services after a positive screening. They mentioned that cancer prevention programs must do proactive scheduling and education, making sure that “the patient feels confident enough to understand why it’s important to have cancer screenings.”

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*“Folks have come through the mammogram screenings that we’ve done and have gotten a diagnosis. Because they’ve come through [our] program, they’re covered. You know, that just needs to be the ongoing statement. There’s got to be access to services.”*

— Community-based organization leader

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*“Preventative screenings are something that many of our patients are not used to based on the health care system they experienced growing up or within their home country... They only see the doctor when there is an issue.”*

— Community clinic leader

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### **Colorectal cancer screening**

The U.S. Preventive Services Task Force (USPSTF) has found direct evidence that screening reduces deaths from colorectal cancer among adults aged 50–75. Screenings consist of either a colonoscopy once every 10 years, a virtual colonoscopy once every five years or an annual stool-based screening. The USPSTF recommends offering screening starting at age 45.

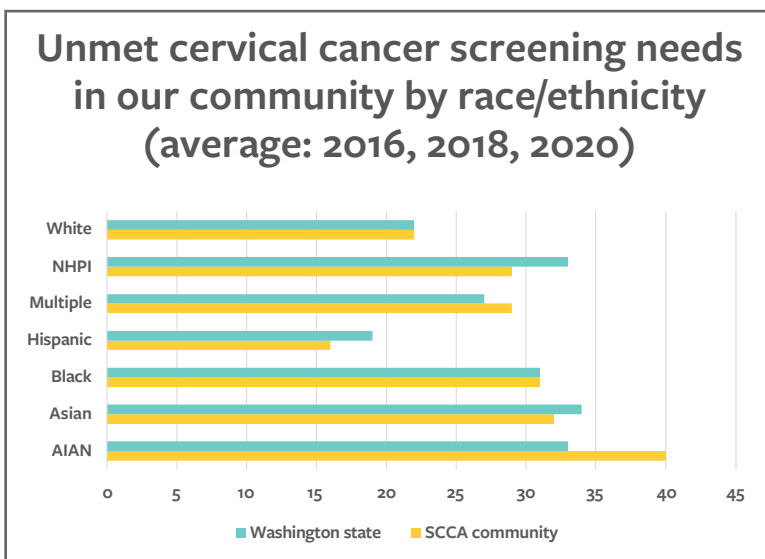
In our community, 29 percent of the overall population aged 50–75 have unmet colon cancer screening needs. This rate falls below the Healthy People 2030 goal of 25.6% of individuals unscreened. A number of racial and ethnic groups in our community, including Latinos (42%), Asian (32%) and Black (30%), have a higher proportion of unmet colon cancer screening needs, as do individuals in households with annual household incomes below \$35,000 (39%).

- Colorectal cancer screening rates have been improving in King County since 2010.
- In 2018, 27% of adults age 50–75 had not met screening guidelines.
- Among Hispanic/Latino residents, 41.1% did not meet screening guidelines — higher than the King County average.
- Cancer is the leading cause of death among Hispanic/Latino King County residents, with colorectal cancer as the third most common cancer type among this group.

### Cervical cancer screening

Significant unmet cervical cancer screening needs remain for individuals in our community. Clinical guidelines recommend women 21–65 years old receive a Pap smear screening once every three years. In the three-county area, 24 percent of females have not received a Pap smear as recommended, up from the last Community Health Assessment, which reported 19 percent.

- Neither the state (76.6%) nor the country (79.9%) are currently meeting the Healthy People 2030 goal of 84.3% of women aged 21 to 65 meeting the screening guidelines.
- Pierce County has higher cervical cancer incidence and mortality rates than Snohomish and King counties.
- In 2018, 76.9% of women in Snohomish County were meeting those guidelines, similar to the state rate.



Source: Behavioral Risk Factor Surveillance System, 2015, 2016, 2018  
Produced by: Public Health - Seattle & King County, Assessment, Policy Development & Evaluation, October 2021

The unmet cervical cancer screening need of American Indian/Alaska Natives is more than twice the Healthy People 2030 goal of 15.7 percent not screened. Asian, Black, Native Hawaiian/Pacific Islander and those who identify as multiple races also have higher rates of unmet cervical cancer screening needs.

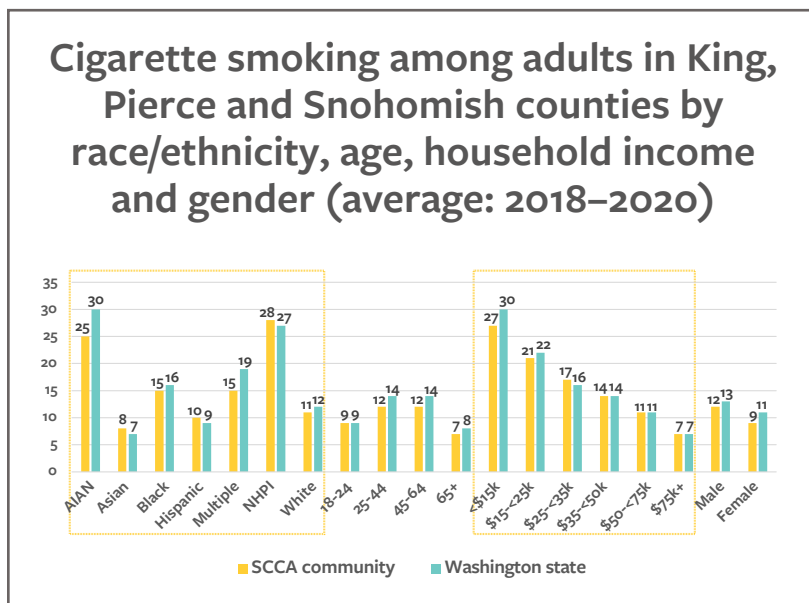
In addition, individuals from households with incomes of less than \$15,000 are most likely to have not received a Pap smear as recommended. Almost half of females aged 21–24 are not receiving the recommended cervical cancer screening. Compared to commercially insured adult residents of King County, Medicaid adults responding to surveys were less likely to follow cancer screening recommendations for cervical cancer.

## Behaviors related to cancer

### Non-ceremonial tobacco use

Tobacco use remains the leading cause of preventable death and disease across the United States and in Washington state. Eleven percent of adults in our community report smoking cigarettes regularly, compared to the Healthy People 2030 objective of 5.0%. The smoking rates are higher for individuals in households earning less than \$50,000 per year, for individuals who identify as Native Hawaiian/Pacific Islander or American Indian/Alaska Native, and for males.

- Cigarette use is more common among males than females.
- Cigarette smoking is more common in Pierce County than in Washington overall.
- Cigarette smoking continues to decline among King County adults. Averaging data from 2014–2018, 11.1% of King County adults reported that they currently smoked cigarettes every day or on some days — down from 13.9% in 2011–2013.
- Smoking among individuals with household income less than \$15,000 (24.4%) was almost four times the rate of individuals in households earning \$75,000 or more (6.9%).



Source: Behavioral Risk Factor Surveillance System, 2018, 2019, 2020  
 Produced by: Public Health — Seattle & King County, Assessment, Policy Development & Evaluation, October 2021

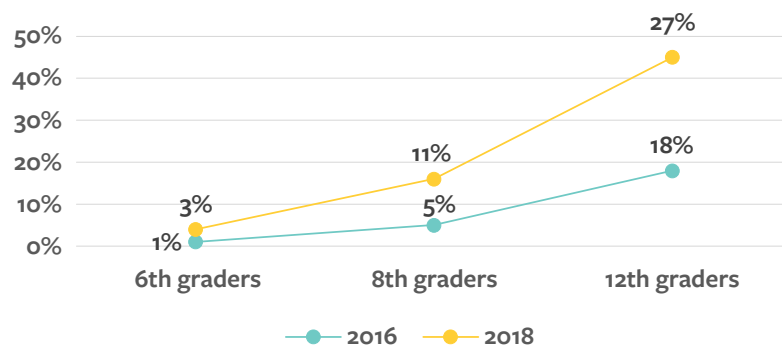
Although rates of cigarette smoking among American Indian/Alaska Native individuals have been declining, they are still significantly more likely to use cigarettes than all other racial/ethnic groups.

The rate of smokeless tobacco use is two percent in our community. Smokeless tobacco use in our community is highest among individuals earning more than \$75,000 per year, who are between the ages of 25–64, and who identify as Native Hawaiian/Pacific Islander or white. No females in our community reported using smokeless tobacco.

Vapor products are the most common nicotine product used by youth. Youth and young adults under age 25 are far more likely to start using tobacco than adults.

- As rates of youth who report smoking cigarettes have continued to decline, youth who report using e-cigarettes have continued to increase.
- In Washington state, 10th and 12th graders who identify as American Indian/Alaska Native have the highest rates of vapor product use.

## Vapor product use (youth) in our community



Source: Healthy Youth Survey, 2018, <https://www.askhys.net/>

According to public health officers interviewed for this report, “there is great potential for a comprehensive tobacco and vapor product prevention program, as Washington state taxes on these products are among the highest in the nation. Unfortunately, none of these tax dollars are being spent on tobacco/vapor prevention or cessation. This has left a gap in services for school and community education, cessation and policy development and no ability to focus on the extreme disparities among those who use tobacco and

vapor products. Adding fuel to this fire is the fact that the tobacco/vapor product industry continues to aggressively market to youth and the most vulnerable in our community.”

### Alcohol use

There is strong evidence that drinking alcohol is linked to several cancers, including mouth, throat, esophagus, breast, liver and colorectal cancers. This risk is higher the more a person drinks, particularly over time — whether that is one drink per day or many at once, also known as binge drinking (National Cancer Institute, 2021).

Alcohol disorder is a leading cause of emergency department visits. In 2019 in King County, it was the third leading cause of ED visits among males overall, predominantly American Indian/Alaska Natives and Hispanic/Latinos, followed by white, Asian and Black males. While alcohol disorder was not one of the top 10 leading causes of ED visits for females overall, it was the fourth leading cause of ED visits for American Indian/Alaska Native females.

Average rates of binge drinking in our community between 2018–2020 were slightly higher (16%) than the state average (15%). They were highest among Native Hawaiian/Pacific Islanders (24%) followed by Hispanic/Latinos (19%) and individuals who identified as mixed-race (19%). Males engaged in binge drinking at higher rates than females (19% compared to 12%).

### Alcohol drinking among youth

In Washington state, alcohol drinking among youth is documented through the Healthy Youth Survey. The survey establishes different levels of alcohol drinking, from none to experimental to heavy/binge drinking (3-5 days drinking in the past 30 days or five or more drinks in a row) to problematic (6+ days drinking and/or 2+ binges). Self-reported rates for current youth alcohol use are not significantly different between our community and Washington state. The majority of youth report not having had alcohol in the past 30 days. In general, alcohol consumption increases as youth grow older, with 2% of 6th graders to 27% of 12th graders reporting having had alcohol in the past 30 days.



### Prevalence of alcohol use among youth (past 30 days)

Location	6th Grade	8th Grade	10th Grade	12th Grade
Washington	2%	8%	18%	28%
SCCA community	2%	8%	18%	27%

Source: Healthy Youth Survey, 2018, <https://www.askhys.net/>

### Community assets and resources

Below are some of the available assets and resources in the SCCA service area related to access to health care, cancer prevention and cancer care:

- The Breast, Cervical, Colon Health Program (BCCHP) at Public Health — Seattle & King County is a program that provides cancer-related screenings and resources to underinsured and uninsured populations. It serves King, Clallam, Jefferson and Kitsap counties.
- Salish Cancer Center offers evidence-based conventional cancer treatment as well as complementary medicine. Salish Center's integrative care includes naturopathic medicine focusing on therapeutic nutrition, diet and herbal medicine, acupuncture and traditional spiritual healing. Care is available to individuals of both tribal and non-tribal origin.



# Significant Health Needs Identified

Through the primary and secondary data collection, seven areas rose to the top as significant community health needs. These community health needs are intertwined, and several issues have persisted from previous community health needs assessments and exacerbated by the COVID-19 pandemic.



## Access to affordable, comprehensive and reachable care

Access to high-quality health care is a key contributor to physical and mental health. Lack of adequate insurance, the cost of care and limited availability of services and providers close to where people live impact how likely it is for someone to access medical care.

Having a primary care provider or a medical home contributes to improved access to care. A primary care provider guides individuals on preventive efforts such as smoking cessation, follow-up on screenings and managing their overall health, including chronic conditions.

One of the constituents who spoke with us to inform this assessment shared that many people in their communities don't have a relationship with a primary care provider.

### Top issues identified

- Financial support
- Location (issues of gentrification, rural access)
- Digital literacy and in-person services
- Transportation
- Wraparound services through partnerships: affordable housing, food security, childcare, community support

*“Many people don’t have a primary care physician that they can go to, and so you give them this information that they have cancer and there aren’t efforts that are part of this whole system that will provide some level of empathy.”*

— Community-based organization leader

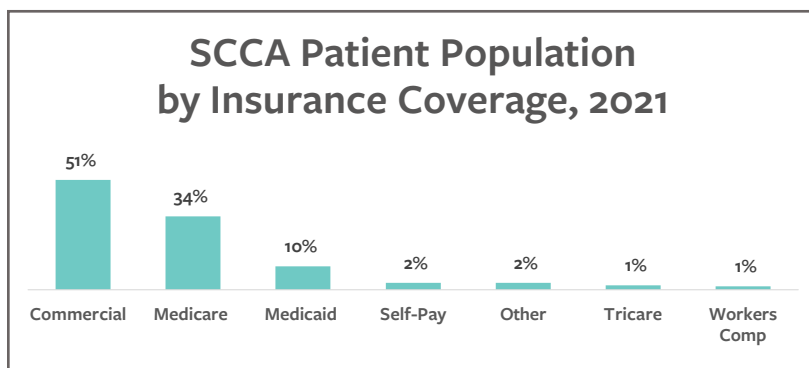
The lack of representation among health care providers has implications in the care patients receive.

*“A lack of providers that look like me that offer these services, and there goes that level of trust and empathy as well.”*

*“Staff need to represent the patients. People can look around and see themselves.”*

— *Community clinic providers*

Other issues related to access to care addressed in this section include policy and systems changes, digital health equity, care navigation and care provided in the languages of patients and families. The COVID-19 pandemic has altered all aspects of life and has had the potential to increase the risk of adverse outcomes for people with cancer, particularly through the lens of social determinants of health. We mention some of its impacts (such as delayed care for other health care conditions, including cancer).



### Access to health care insurance

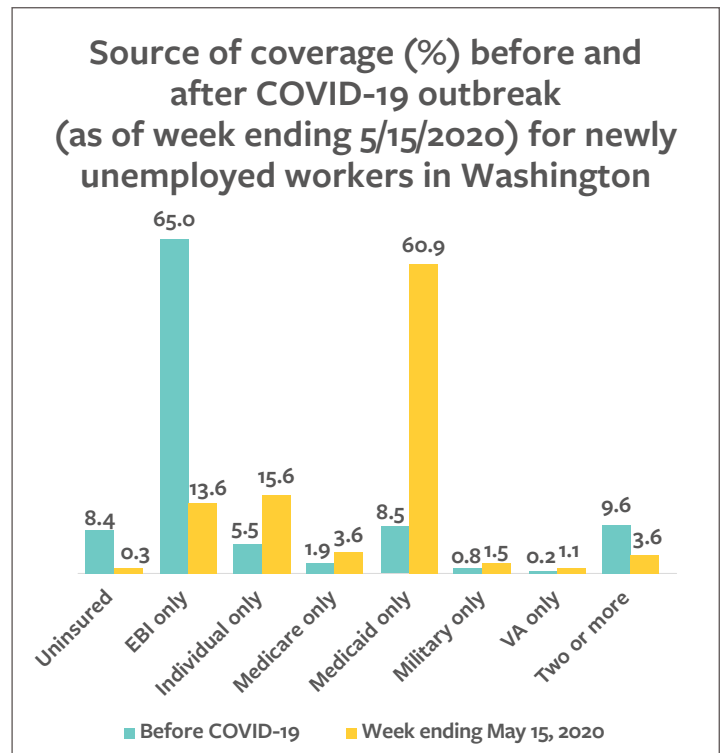
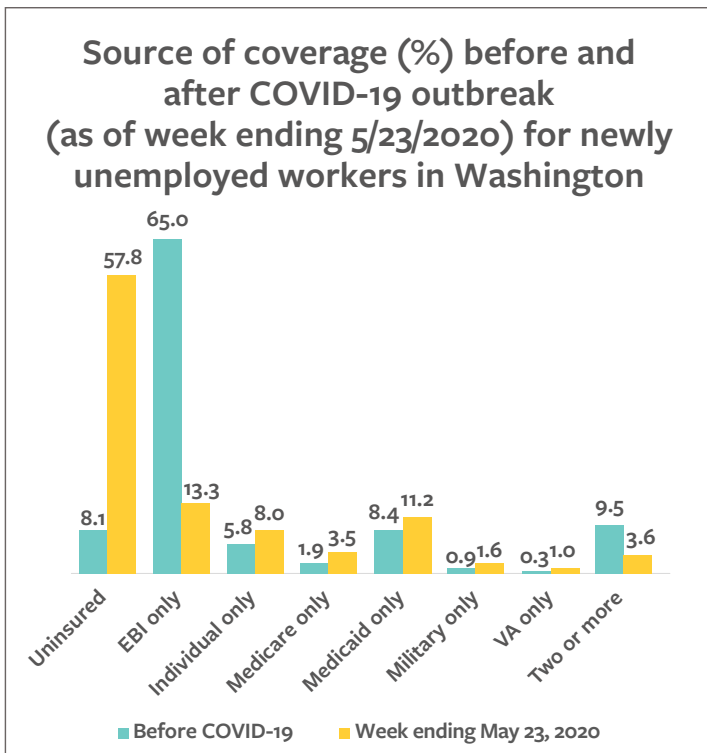
Insurance coverage allows individuals to access free preventive care, reduces the cost of unexpected medical expenses and encourages them to engage the health care system early in their diagnosis.

After the implementation of the Affordable Care Act (ACA), the number of individuals without health insurance decreased significantly. In 2019,

the overall uninsured rate was 6.1 percent for adults 18-64 in Washington state. Yet communities of color have been disproportionately uninsured, before and after implementation of the ACA.

Further, the pandemic has exacerbated existing health disparities. During the early months of the COVID-19 pandemic, many “non-essential” businesses statewide were ordered to close temporarily. Thousands of workers lost their employment as a result. Because health insurance benefits are tied to employment in the United States — “roughly half of all U.S. workers receive health insurance through their own employer’s provided coverage” (Economic Policy Institute, 2020) — many people lost their health insurance. In April 2020, the rate of uninsured Washingtonians climbed to 8.7 percent (6.9 percent of working adults in the SCCA community). In May–June 2020, rates peaked at 12.6 percent in Washington and 11.8 percent for working-age adults in the SCCA community lacking health insurance.

By June 2021, the overall uninsured rate statewide had dropped to 5.2 percent (OFM, 2021), with disparities across populations based on race/ethnicity and other socioeconomic factors. Individuals were most likely to be uninsured if they identified as Hispanic/Latino (17.8 percent), Black (11.1 percent), and mixed-race, American Indian or Alaska Native (AIAN), Native Hawaiian or Pacific Islander (NHPI), or another race (12.6 percent). Individuals with lower incomes, less than high school education and unemployed or experiencing/expecting a job loss are more likely to be uninsured. These trends are similar for Washington state.



Source: Source of coverage before and after COVID-19: Coverage changes among newly unemployed as of May 23, 2020, and as of May 15, 2021 (State of Reform, 2021)

Interview and listening session participants noted that financial barriers still exist for many individuals, even if they have insurance. Finding a provider who accepts their insurance plan can be a challenge, and insurance plans with high-cost deductibles can discourage patients from accessing care.

*“Specialty care has been a challenge, like referrals to other providers for our patients, primarily due to the cost and language capacity of the provider we refer them to, or the wait time.”*

— Community clinic provider

### Digital health equity

While increasing access to telehealth was a welcome change for many during the pandemic, this switch to online services has had enormous implications for people in rural areas, those without broadband access, people with limited digital literacy and those who can’t afford Internet access, among others. For many people, telehealth also comes with a set of trust concerns: Many prefer meeting with their health care providers in person or may be wary of privacy issues and sensitive patient health information being available online.

Digital health equity was brought up as a need and a concern by most of the community-based organization leaders interviewed.

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*“Telehealth is not accessible to everyone; others prefer in-person care. Individuals that would prefer to see their doctors in person, the doctors are scheduling virtual meetings. There are problems in connecting because there may not be Internet access in the home. They don’t have money for Internet, and they’re being offered a virtual meeting only. That’s not being sensitive to the individuals that don’t have a disposable income.”*

— Community-based organization leader

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*“A lot of our population doesn’t have comfortable access to those technologies, so it might kind of widen some of the health care disparities that already existed because of this technology gap. It may not be so much that our patient base doesn’t have access to smartphones or data or Wi-Fi. A lot of is a comfort level with it, and a cultural or personal preference for in-person interactions with people as opposed to technology. Spanish-speaking patients are using this technology less than English-speaking patients. Even with their online patient portal, there’s a very wide disparity of patients taking advantage of that that are Spanish-speaking compared with English-speaking. There are education, comfort, and problems with adoption of it.”*

— Community clinic provider

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Interview participants called on health care providers to support legislation that would create systemic change toward digital access, making sure that every home has access to the Internet, particularly during emergencies. Interview participants also encouraged health care providers to support digital literacy programs for patients and their families.

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*“How do we empower patients and foster comfort with new technology? If they can have their entire health record on their phone or computer, that’s really important to be able to communicate well, so that’s a big need is trying to foster a comfort with the new technologies.”*

— Community clinic provider

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### Care navigation

Interview participants indicated that most hospitals and health care providers do not provide services that are linguistically and culturally attuned with the communities they serve. The complexity of the health care system has created care navigation barriers that still haven’t adapted and responded to the needs of patients, families and communities.

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*“I think that it’s really difficult to find cancer care that is culturally appropriate for people, and that also helps them navigate all of the things that are happening at that very moment.”*

— Community clinic provider

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*“It is increasingly important to engage with communities to understand community narratives about their health and lived experience, as well as to ensure health and social services are culturally and linguistically appropriate.”*

— Public health officer

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*“Not everyone has as much expertise in providing services in a way that’s linguistically and culturally sensitive to these populations. So, they still can access care, but maybe it’s not in the way they would prefer.”*

— Community clinic provider

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Confusing enrollment and benefits, difficult-to-understand medical information, unavailable in-language services and health education and other factors related to care navigation prevent people from accessing care.

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*“I don’t know if we get comprehensive, good quality treatment, or I mean prevention, screening. When you know someone is diagnosed, I was really shocked to have experienced and see this happen quite frequently, but it feels like you’re getting a brochure and go figure it out. I had a hard time helping [him] out and I’m in the system and I know it.”*

— Health care provider

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*“Trust needs to be built with the BIPOC community; meet people where they are at and tailor outreach and education to the community’s needs.”*

— Community-based organization leader

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Patient and cultural navigators play a role in improving access to and quality of care, eliminating health disparities related to cultural norms and language, and addressing the deep-rooted mistrust of the health care system due to historical trauma, mistreatment and racism by helping people navigate their care. Community clinics and community-based organizations act as patient and community navigators. Using the words of one of the interview participants, these providers “really are more aligned or more humble in approaching care in a way that is aligned with people’s beliefs culturally.”

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*“A barrier is not recognizing the power of these community organizations or these community FQHCs. These health centers are actually where people, communities of color, particularly Indigenous populations, trust what is being provided to them.”*

— Public health officer

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### Community assets and resources

Some of the community resources that contribute to ensuring access to affordable, comprehensible and reachable health care in the SCCA community area include:

- *Accountable Communities of Health (ACH)*, which were designed to be a coordinating body and connection point between the health care delivery system and local communities. There are nine ACHs in Washington state and three within the SCCA service area: North Sound, HealthierHere and Elevate Health. Each ACH is run independently, and they all share a common approach to improving the health of their communities and changing health care delivery. ACHs play an integral role in Washington’s Medicaid Transformation Project (MTP) efforts, which aim to improve the state’s health care system and benefit 2 million people enrolled in Apple Health (Medicaid).
- *Federally Qualified Health Centers (FQHCs)*, including Sea Mar Community Health Centers, International Community Health Services and Seattle Indian Health Board, have roots in different populations and connect patients with community resources. They provide a full scope of primary care, medical, dental, behavioral health, pharmacy, and nutrition services. Some provide other services such as traditional medicine and senior services. While they are required to serve everyone, their primary populations are people who are low-income, uninsured, underinsured, immigrants, refugees and those who are monolingual in languages other than English.

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*“We really are of the community within the community and listen to the community’s needs in order to develop the scope of our services. Our aim is that our patients can come to us and access all the services they need in terms of primary care under one roof.”*

— Community clinic provider

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*“This is a safe place. [Patients] are going to be cared for in a way that is culturally attuned. Communities of color (...) want to go to a place where they recognize you. Who you are. Where you came from. What your culture is like. Our approaches may be different than the status quo, and I think it’s important that those other facilities look to us for guidance on how to provide these resources instead of saying oh no, we have the answer.”*

— Community clinic provider

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- *Urban Indian Health Institute*, one of 12 tribal epidemiology centers in the United States. The other 11, the Urban Indian Health Institute is the only national tribal epidemiology center and works with urban American Indian/Alaska Native community organizations throughout the United States. The other centers are regionally based and focus on the tribal communities within their region. The Urban Indian Health Institute provides data assistance, analysis and interpretation to 72 organizations. The institute also works directly with 27 departments of health within 28 metropolitan areas in the United States.



### Culturally-attuned prevention, education and screening

The risk for some cancers can be reduced substantially with lifestyle and behavior changes. Non-ceremonial tobacco use remains the leading cause of preventable death and disease across the U.S. While smoking rates among youth have continued to decline, e-cigarette use has continued to increase. Identifying cancer in early stages has a significant impact on treatment and survival outcomes. In some cases, screening can even prevent cancer. Unmet needs for

screenings and evidence-based recommendations are shown to impact our community.

#### Top issues identified

- Awareness about delayed screening and care
- Focus on populations with higher incidence
- Focus on youth
- Expansion to cancers beyond breast, cervical and colon
- In-language and culturally-based education (as opposed to just translating materials)
- Education to primary care providers about cancer diagnoses

#### In-language care

One of the biggest strengths interview participants observe in our community is what someone called “a hunger for knowledge,” an “enthusiastic interest and willingness” of BIPOC and other community members who have been historically disenfranchised from the health care system to learn and take ownership of their health by taking part in cancer screening, genetic testing, and health education. To maximize that interest from patients and communities, hospitals and health care providers must make care, health information and resources available in the languages that patients and caregivers speak.



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*“[Ensuring] that our services are accessible means that people can actually get there, and once they get there, they can really listen and really understand the kind of care and services and options they have in terms of the treatment program. Language is a big thing. Being able to access services that are culturally appropriate and relevant for you, know where you’re coming from.”*

— Community clinic leader

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Interview participants urged SCCA and other health care providers to “work directly with communities to create education materials that are culturally relevant”.

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*“We need to start [materials] from scratch with people that live in that culture to get it done. And that might mean that the English versions and the Spanish versions and Vietnamese versions are nothing alike. But it’s intentional because it speaks to the particular needs of the community.”*

*“[Offer] education programs with someone who speaks the language. Because when you translate it, it doesn’t work. It has to be a dialogue in that language so that people can ask questions and they don’t have to go through somebody to ask their questions. They can just ask it directly.”*

*“Not all providers have the same capacity to deliver services in the languages our patients need them, so we can partner to reduce that barrier. Just leveraging each of our limited resources in a way to have that impact would be very helpful.”*

— Community clinic providers

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### Community assets and resources

Some of the available resources that are working to offer culturally-attuned prevention, education and screening are:

- SCCA’s *mammogram mobile van*, a 42-foot vehicle affectionately known as the MammoVan that offers mammograms through walk-ins and appointments. The Mammogram Van’s mission since its opening in 2007 is to bring screening to where people live, work or shop. The SCCA Mammogram Van travels to different locations within Seattle and the surrounding Puget Sound area.
- *Community-based organizations* such as APICAT, which addresses commercial tobacco prevention and control within Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities with a youth focus. One of the community leaders interviewed for the report mentioned the opportunity to “leverage the power and agency of our youth who want to be more engaged and make a difference in their communities to help spread the messages that we would like to share.”



### Policy and systems change while increasing capacity of community-based organizations and community clinics

Comprehensive cancer risk reduction and treatment should be a coordinated approach to reduce burden and operationalize policy, systems and environmental (PSE) change strategies. Health disparities are systemic, preventable, and suffered by socially, economically, or geographically disadvantaged groups. They cut across multiple factors historically linked to discrimination or exclusion.

In addition to digital access, in terms of access to care, interviewees were adamant about the need for changes at the policy and systems levels, from support to organizations working with Black, Indigenous and people of color from government entities to changes in how funders and larger organizations, including SCCA, distribute funds to these organizations.

#### Top issues identified

- Funding for all cancer prevention and treatments
- Infrastructure, capacity and sustainability of community clinics and Community Based Organizations
- Evaluation of reduction of inequities
- Unrestricted funding support
- Non-geographically-based insurance policies

*“Work is taking place at the grassroots level, but there needs to be more policy change and reform. There needs to be the top level looking down some policy change, some initiatives that really support the community. Obviously at the grassroots level we try to center the voices and the needs of the BIPOC community, but it has to be from a legislative perspective as well.”*

*“[Grassroots organizations] can’t effectively meet the needs because we don’t have the infrastructure to do that, although we do our best. That takes resources, manpower and money. And so, as a larger institution, you could be another resource or infrastructure for those that don’t have a bigger support system.”*

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*“Funders put on these weird restrictions and you’re like, really, is it more important to get the money and people accessing it, or is it more important that we dot I’s and cross T’s?”*

*“The way we’ve set up our program has been a function of the funding. It’s not necessarily a function of need. So, when we focus on breast and cervical and colon cancer, it’s because that’s how the different fundings have been set up, but it doesn’t mean that that’s the only kinds of cancers that people need help with.”*

— Community-based organization leaders

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Participants also called out issues of reimbursement for social services, as well as lack of coordination between cities, counties and the state.

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*“Our ability to address social determinants of health as a system is challenged because of how services are reimbursed or paid for. It’s still very much health care-focused and prioritized. It’s tough to create that kind of systematic change when there will be winners and losers in some of those changes that we would need to see to make it better for everyone.”*

— Community clinic provider

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*“Each county operates differently. Each county has its own set of providers that are Breast, Cervical and Colon Health Program (BCCHP) approved. In King County, as long as the primary care provider approves a referral, then that’s fine. Then we can get somebody who has BCCHP get a mammogram at SCCA. In Pierce County, a clinic that we work with has been fantastic about providing referrals for mammograms, BCCHP. But the geographical area for BCCHP patients for SCCA is King County, not Pierce County.”*

— Community-based organization leader

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### Community assets and resources

Some of the available resources that could contribute to policy and systems change while increasing capacity of community-based organizations and Federally Qualified Health Clinics include:

- Organizations such as the Washington state Hospital Association (WSHA) and King County Hospitals for a Healthier Community collaborative, which promote learning, advocacy and collaboration to address issues common to all within Washington state.

- *Financial assistance resources from SCCA*, which are offered to Washington state community-based organizations and to residents based on family need and SCCA resources. Financial support may be available to help pay for cancer treatment, medication and other expenses.

*“Being able to get financial assistance to pay deductibles and co-pays and things like that (...) We’ve actually used an SCCA grant to pay for those types of deductibles.”*

*“Grants like SCCA’s are super important because it pays for our navigation for the non-Medicaid population, and it also basically allows us to pay for these deductibles and these different kinds of costs.”*

— Community-based organization leaders



### Trust and relationship building

The lack of trust in health care remains an issue among Black, Indigenous and people of color, those who identify as LGBTQ+, people who are poor and in rural communities. Mistrust in health care is founded in both the historical legacy and the current experiences of undertreatment, mistreatment, discrimination and racism. Increasing diverse access to clinical trials was a community health need identified in SCCA’s previous needs assessments and is an ongoing challenge. Members of many communities of color distrust clinical research due to historical medical ethics violations, health beliefs, a medical system that is difficult to navigate, and other factors.

“Many factors are thought to contribute to the declining trust in clinicians and organized medicine, including the rise of managed care and related financial incentives, highly publicized conflicts of interest between clinicians and pharma and device manufacturers, limited time for communication, fragmentation of the patient-clinician relationship, and consumerism (...) The coronavirus disease (COVID-19) pandemic has created new threats to trust” (Baker, 2020).

Interview and listening session participants consistently spoke about the lack of trust toward the health care system and many providers among most communities of color.

### Top issues identified

- Root causes of mistrust
- Accessibility to Black, Indigenous and people of color (BIPOC) communities
- Partnerships with trusted clinics, organizations and tribes
- BIPOC representation in decision-making and advisory groups
- Medical biases and indifference

*“There is no price tag on good health and there should probably not be a price tag on how SCCA goes into the community, and they need to go into the community in different ways... [When] you’ve reached out enough to where they can trust you, you’re creating those bonds of trust. Until those bonds of trust are created, it’s just not going to happen.”*

— Community based organization leaders

Trusted relationships between health care providers, their patients and the communities to which they belong are critical to individual and community health. Trust encompasses building and nurturing real partnerships with patients, community leaders and organizations; increasing and retaining diverse representation across health care staff, providers and leadership; and continually and actively listening to communities of color.

*“Even when people do advocate for themselves in our system, they’re dismissed.”*

— Native leader and health care provider

*“There’s this total distrust (...) and then not acknowledging that actually those community centers have that relationship, have that trusted relationship. They are the trusted source to access services. So, why not work with them, right?”*

— Public health officer

Trust also requires ongoing and lasting quality care for BIPOC patients, families and communities.

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*“Trust and the relationship building is so important. We also have to make sure that we’re simultaneously working on the housekeeping within our institution... to make sure that everyone is on the same page so that when we bring guests into the house, everything is a stellar experience for them and they will bring that back to the community. So, we have these wraparound services. We have the resources they need to help them get the care and complete their care. And that ... will help with this trust and relationship building, so it’s all kind of an interwoven cycle.”*

— Health care leader

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*“We’d encourage SCCA to identify opportunities for communities to shape and provide feedback for outreach plans as well as seek opportunities to develop sustainable relationships with trusted community partners.”*

— Public health officer

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### Community assets and resources

Some of the valuable people and entities that continue to guide SCCA into how to become a trusted organization include:

- *Community leaders.* Highly regarded within their communities, they “are the ones rallying people to go get their shots, or the ones calling up and saying there’s not enough food, or advocating for other folks.”
- *Local tribes and organizations* led by and work alongside Native people.



Photo by Robert Hood



## Mental health for patients, families and community

A cancer diagnosis and treatment can be emotionally overwhelming. The fear, health consequences and financial burden of cancer can have a significant impact on the emotional health of a person and their loved ones. About one-third of people receiving cancer treatment in hospitals have a mental health condition. The COVID-19 pandemic and its health, social and economic effects have caused enormous distress. Cancer survivors and those with a cancer diagnosis face the threat of COVID-19 on top of the stress of coping with a chronic condition.

### Top issues identified

- Related to cancer and emotional, socioeconomic consequences
- Related to pandemic and socioeconomic consequences
- Alcohol and drug abuse
- Building emotional stamina

Mental health was at the top of the list for all interview and listening session participants, particularly as it relates to social determinants of health.

*“In the land of COVID-19 and with the eviction moratoriums lifting, there is so much distress for people and staff.”*

— Community clinic provider

*“The amount of permanent housing concerns that our patients are experiencing is just astronomical (...) [They have] difficulty providing with the payments they have from their life and you throw in the disruption of cancer care on top of that. In general, community resources for mental health in the area are way overburdened (...) Mental health for older adults is particularly challenging, isolation included. Especially regarding housing and the social safety net that has been overburdened now.”*

— SCCA health care provider

Experts advise health care providers to talk openly about the economic and psychological distress of a cancer diagnosis. Focusing on wellness also helps with mental health. As a community health provider suggested, “Sometimes, even if you are experiencing cancer, it is about your mindset and your perspective, too. Building emotional stamina is really important and learning to manage stress and demonstrating that for the next generation.”

### Community assets and resources

Resources that work to improve the mental and behavioral health and well-being of patients, families and communities in the SCCA region include:

- SCCA *Psychiatry & Psychology Services*, which has mental health counselors who help patients with the emotional and psychological part of cancer treatment.
- SCCA *patient navigators*, culturally sensitive individuals who are available to listen and help patients and families navigate through SCCA and provide community resources. SCCA’s patient navigation program works to better serve specific populations who experience a disproportionate cancer burden, including Indigenous, Black/African American, Asian American and Pacific Islander populations.

### Health equity

Health equity is the notion that every person has the opportunity to attain their full health potential (CDC, 2020). Health equity doesn’t mean sameness; some populations need more or different access and services to achieve health.

#### Top issues identified

- Staff that represent patient population
- Prevention and treatment care inequities
- Specific concerns by population: racism, deportation, refugee status, tribal sovereignty, Asian hate, anti-Blackness, Islamophobia
- Data disaggregation
- Acceptance and inclusion of traditional medicine

*“I don’t think that there is one solution for all communities. I think each one is different. I think there’s a lot of similarities, but there’s also not [just one homogenous “community of color”]. One of the things that I see when I work with different organizations is that they will put all communities of color into one pot and say, okay, this is how we’re going to address it because there’s a lot of those similarities. But I think you do a disservice to that. You don’t recognize individuals or communities as their own communities. It’s like individuals who say I don’t see color, but then you don’t see me, right?”*

— *Public health officer*



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*“Being a woman of color, I don’t see a lot of people of color at SCCA, and this is one of my biggest concerns. We need access, we need treatment.”*

— Cancer survivor

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Significant racial disparities have been documented for most cancers. In the past, race was viewed as a biological factor to explain the disparities. Evidence now suggests that the predominant risk factors are rooted not in biological differences but rather in deeply ingrained social inequities, such as structural racism.

### Community assets and resources

Some of the resources that keep health equity at the center of our work include:

- *The Office of Community Outreach and Engagement* at Fred Hutch, which has a vision to promote health equity through cancer research that addresses and reduces cancer health disparities. It provides community engagement, community-based participatory research and education.
- *The SCCA Patient and Family Advisory Council*, which was created in 2012. SCCA advisors are current and former patients and caregivers who volunteer their time to help SCCA establish systems that are easier for patients to understand and help us better understand patient needs.
- *The SCCA Health Equity Advisory Group*, which was established in 2021 to advise, consult and support health equity projects and initiatives throughout SCCA.



### Environmental health and climate change

The physical environment of a community (the human-made or modified structures where we live) impacts people’s health and well-being. In Washington state, rural areas have fewer walkable destinations or convenient parks and recreational facilities. Some urban neighborhoods lack convenient food access as well as tree density, especially where there are more communities that are low-income and populated Black, Indigenous or people of color.

Studies conducted since 2010 provide evidence that neighborhood social and built environment factors have impacts across the cancer continuum (Gomez

et al., 2015). The built environment influences people’s behaviors such as physical activity and food choices, while environmental factors like air quality, land use, and housing characteristics all shape cancer risk (Wray & Minaker, 2019).

### Top issues identified

- Environmental policies
- Malnourishment and food sovereignty
- Air pollution and increased fires

“Environmental pollution can increase the risk and prevalence of cancer, and climate change may increase such exposures. For example, increased risk of floods near Superfund sites means the potential release of carcinogens into the community when floods occur. Wildfire smoke contains particulate matter, which contributes to cancer risk, and climate change has increased the number and extent of wildfires. Recent studies of airport-related air pollution shows that particulate matter occurs in jet fuel exhaust as well as ground transportation exhaust, and exposure to fine and ultrafine particulate matter increases the risk of cancer,” shared an officer from Public Health — Seattle & King County.

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*“Environmental factors contribute to higher incidence of cancer [more] than anything else when you start looking at disparities: jobs, living conditions, where people are forced to live and the traumas associated with them.”*

— Community-based organization leader

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*“[There is the] fishermen’s concern about spending a lifetime fishing the Duwamish River, which is a Superfund site. It’s toxic. The fish are not toxic. But they’re putting their nets in the water and all those contaminants touch their skin. I wish that there was some kind of thoughtful program that didn’t raise alarms about our food economy, but that addresses how people are exposing themselves frequently over a lifetime to extra toxicity. SCCA would be a really wonderful advocate for environmental health issues like that.”*

— Native community health leader

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*“I see the environmental health and climate change priority area as a place where we can promote social determinants of health and environmental justice focused bench/translational research. There are also numerous community-based organizations that we can consider partnering with in this area.”*

— Community health leader

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## Community assets and resources

Below are a few available resources supporting cancer-related environmental health in our community:

- *The Muckleshoot Food Sovereignty Project*, which was founded in 2010 to promote a return to traditional foods and food practices among the Muckleshoot and other Salish-speaking peoples of the Pacific Northwest. The project also has the mission of understanding of Native foods and building community food security by exploring the Muckleshoot Tribe's food assets and access to local, healthy and traditional foods.
- *Programs that distribute HEPA portable air filtration units*, such as pollution mitigation programs previously implemented by the Port of Seattle.



# Impact of Previous Community Health Implementation Plan



From 2019–2021, SCCA invested more than \$207 million — almost 9.2 percent of our operational costs — to community benefit activities. A significant portion of this funding extended our high-quality clinical services to those who could not otherwise afford them, providing subsidized care and offering needed services at a financial loss. We also invested in community health improvement activities aimed at reducing the burden of cancer among high-needs populations through programs such as mobile mammography screenings and grants to community health organizations.

During the 2019–2021 Community Health Needs Assessment, we identified significant health needs, which we grouped into four priority areas: cancer prevention and screening; access to care, culture and language; and strategies to address specific health needs of the local Indigenous peoples as a focused population. These priorities were interwoven with the goal to provide

equitable care for our diverse community. Strengthening our internal infrastructure and our relationships with community partners was fundamental to effectively and genuinely implementing our community benefit activities.

We prioritized these significant health needs based on the data available to us, input from many community constituents, and feedback received about our previous health needs assessment and implementation strategies. We also took into consideration areas in which SCCA's involvement could contribute to meaningful health improvement.

The following is a summary of some of the actions we took along with our community partners to address the significant health needs identified in the 2019–2021 CHNA.

## Access to care

- We brought hematology and oncology services closer to home for patients and families in East King County and Kitsap County through the opening of two community clinics in Issaquah and Poulsbo.
- With the goal to reduce financial barriers to care, we trained four additional staff members to help community members looking for health insurance coverage options through Washington Healthplanfinder.
- We exceeded the goal of providing at least \$600,000 in assistance to patients and families who have non-medical financial needs for transportation, lodging, food security and other needs.

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## Cancer prevention and screening

- We distributed \$100,000 in grants to community organizations to support cancer education and screenings.
- We delivered over 10,000 mammogram screenings via the mammogram van in FY20/FY21 to underserved communities.
- We approved a second mammogram van to begin operation in 2022.
- We partnered with the American Cancer Society on their Return to Screening initiative to help increase screening rates that declined due to the COVID-19 pandemic. We hired a breast health coordinator to connect with patients who were overdue for screenings, provided resources to non-English speaking patients and helped remove transportation barriers.
- We co-sponsored two community events to provide breast health education, perform mammograms, and schedule community members for future screenings.

## Community benefit infrastructure

- For SCCA to effectively implement its community benefit activities, our program must operate with a strong foundation. That is why we focused resources strategically and sustainably to enhance the ability to meet and meaningfully address current and emerging community health needs. We established an SCCA Community Benefit Coordination Committee to track progress on the Community Benefit Implementation Plan and invested in a staff member dedicated to community health and benefit.
- We worked to enhance our ability to analyze data at a granular level to better understand the burden of cancer in our communities, including greater SCCA patient segmentation by race and ethnicity. We assessed opportunities to reduce the percentage of SCCA patients and clinical trial enrollees whose race/ethnicity is marked as “unknown” in their patient profiles.

## Culture and language

- We assessed the needs of our populations who are monolingual in languages other than English or prefer visual communication for cancer prevention and screening education materials. We translated mammography materials into eight languages and adapted resources to be culturally attuned with local Indigenous communities.
- We expanded SCCA’s patient navigation program to better serve specific populations who experience a disproportionate cancer burden, including Asian American and Pacific Islander, Indigenous and Black/African American populations. We added three staff members.

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## Indigenous health

- Building internal capacity and cultural responsiveness so that every patient who identifies as Indigenous receives support according to their preferences was a priority these last three years. We provided a one-on-one consultation with an SCCA Indigenous community health worker (CHW) to every patient who identifies as Indigenous.
- We launched the hēliʔil (become well/heal) Program, an Indigenous health promotion program to proactively engage the local Indigenous community to enhance access to state-of-the-art oncology care and to provide outreach and treatment for commercial tobacco cessation.
- We facilitated and staffed 19 in-person and 20 virtual commercial tobacco cessation and cancer prevention education events for local communities and tribes.
- We connected with each of the community health representatives (CHRs) in the 46 tribal communities in Washington state.

A few aspects of SCCA's 2019–2022 strategic plan have not been fully implemented due to organizational shifts, resource constraints and COVID-19 setbacks — specifically, investing in a mobile unit with low-dose CT scanning capabilities to screen for early-stage lung cancer and partnering with transportation agencies to provide additional support for patients.

## COVID-19 response

As the COVID-19 vaccine became available, SCCA was among the first Washington health care providers to receive the COVID-19 vaccine.

- We developed educational materials and online information for patients and the community.
- We operated a community mass vaccination site at the SCCA South Lake Union clinic that provided over 62,000 doses.
- We also established a Community Vaccine Program to help address vaccine access inequities faced by Black, Indigenous and other people of color (BIPOC). This included a fixed-site clinic in Kent with African Americans Reach and Teach Health Ministry, as well as a mobile vaccine clinic active throughout King County primarily run in partnership with Public Health — Seattle & King County. We collaborated with community-based organizations, public schools, faith-based organizations, low-income/high-density housing groups, and production and manufacturing facilities to deliver over 23,000 doses.

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# Appendix

## Appendix A: Secondary Data Sources

### Sources

#### SCCA Internal Dataset

#### Published Community Health Needs Assessments

- Healthier Here Consumer Voice Listening Project Report
- King County (2018–2019)
- King County 2018/2019 CHNA LGBTQ Community Spotlight Report
- Pierce County (2019)
- Snohomish County (2018)

#### WA State Datasets

- King County Communities Count
- King County Regional Health Needs Inventory
- King County Regional Homelessness Authority Point-In-Time Count
- Pierce County Point-In-Time Count
- Public Health — Seattle & King County APDE Death Certificate Data
- Public Health — Seattle & King County Health Care Access in King County
- Snohomish County Point-In-Time Count
- Washington state Cancer Registry
- Washington state Department of Health Data and Statistical Reports
- Washington state Healthy Youth Survey
- Washington state Office of Financial Management Impact of COVID-19 on Health Coverage

#### National Datasets

- American Cancer Society's Cancer Statistics Center
- Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System
- Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System
- Centers for Disease Control and Prevention, Health Equity
- Centers for Disease Control and Prevention, Leading Causes of Death 2019
- National Academies of Sciences, Engineering, and Medicine
- National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Cancer Incidence and Mortality

- National Institutes of Health National Cancer Institute State Cancer Profiles
- U.S. Cancer Statistics Working Group Data Visualizations Tool
- U.S. Census Bureau 2014–18 American Community Survey
- U.S. Department of Health and Human Services Healthy People 2030

## Appendix B: Interview and Listening Session Participants

### Key Stakeholder Interviews

- African Americans Reach & Teach Health Ministry (AARTH)
- Cierra Sisters
- Communities of Color Coalition
- International Community Health Services (ICHS)
- Korean Women's Association
- Mercy Housing
- Muckleshoot Food Sovereignty Project
- Public Health – Seattle & King County
- Sea Mar Community Health Centers
- Seattle Indian Health Board
- Stilly Valley Health Connections
- Urban Indian Health Institute

### SCCA Patient and Family Advisory Council Listening Session

- Current and former SCCA patients and caregivers

### SCCA Staff Listening Session

- Community & Network Quality
- Medical Nutrition Therapy
- Patient Engagement & Equity
- Patient Navigation
- Rehabilitation Therapies
- Social Work
- Supportive Care Services

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## Appendix C: Interview and Listening Session Protocols

### Interview Protocol

1. How long have you been with the <ORGANIZATION> and what is your role?
2. For the purpose of the community health assessment, we're looking at the areas represented by King County, Snohomish County and Pierce County. So, with that in mind, what do you feel are the most pressing health issues facing the communities you serve?
3. What do you think creates these issues (e.g., economic factors, societal/social factors, environmental factors, health behaviors, misinformation, barriers to accessing care)?
4. What are the main gaps or concerns specific to cancer prevention and care?
5. Do you consider that these issues are being addressed in some way, and if so, how?
6. What are the current strengths and assets of the community served by your organization related to community health and well-being?
7. What resources exist in the community to help people lead healthy lives and reduce cancer risk? Are there specific organizations, leaders, coalitions, initiatives, policies?
8. How can SCCA be involved in addressing the issues or building on those strengths that you identified?
9. Is there anything else about health in the community, particularly around cancer, that you would like to share? Or any other thoughts you would like to share that we have not already discussed?

### Listening Session Protocol

1. When you or your loved one were diagnosed with cancer, did you know how to access services?
2. What do you feel are the most significant gaps and barriers to cancer care and prevention?
3. Do you consider these issues are being addressed? If so, how?
4. How can SCCA improve the education and information offerings about healthy behaviors and recommended screening to reduce cancer?
5. Is there anything else about cancer related-health in your community that you would like to share?

