



2019

Community Health
Needs Assessment

Seattle
Cancer Care
Alliance



Fred Hutch · Seattle Children's · UW Medicine

Better
together.

Table of Contents

Introduction	3
About Seattle Cancer Care Alliance	3
The community we serve	6
Our commitment to the community	8
Previous community health priorities	8
Recent community benefit activities	9
Community health needs	11
The impact of cancer	11
Insights from the data	12
Input from community stakeholders	20
Existing resources	23
Community health priorities, 2019–2022	25
Cancer prevention and screening	25
Access to care	26
Culture and language	26
Indigenous health	26
Appendices	27
Appendix A: Community health needs assessment process	27
Appendix B: References	30
Acknowledgments	33

Front cover: Bridgette Hempstead, SCCA patient and founder of Cierra Sisters, an African-American breast cancer support organization.

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. We transform groundbreaking research ideas into lifesaving realities for cancer patients.

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Our vision is to lead the world in translating scientific discovery into the prevention, diagnosis, treatment and cure of cancer.

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SCCA is the only National Cancer Institute-designated comprehensive cancer center in the WWAMI region (Washington, Wyoming, Alaska, Montana and Idaho). Only hospitals with an established track record of expertise and excellence are awarded this distinction in recognition of their work to advance cancer treatment best practices.

SCCA is also one of 11 Dedicated Cancer Centers in the U.S., which are recognized by Congress and Centers for Medicare and Medicaid Services (CMS) as hospitals that exclusively treat cancer and contribute value to the U.S. health care system with breakthrough clinical research and advancements in cancer treatment.

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Our purpose is to provide state-of-the-art, patient- and family-centered care; support the conduct of cancer clinical research and education; enhance access to improved cancer interventions; and advance the standard of cancer care regionally and beyond.

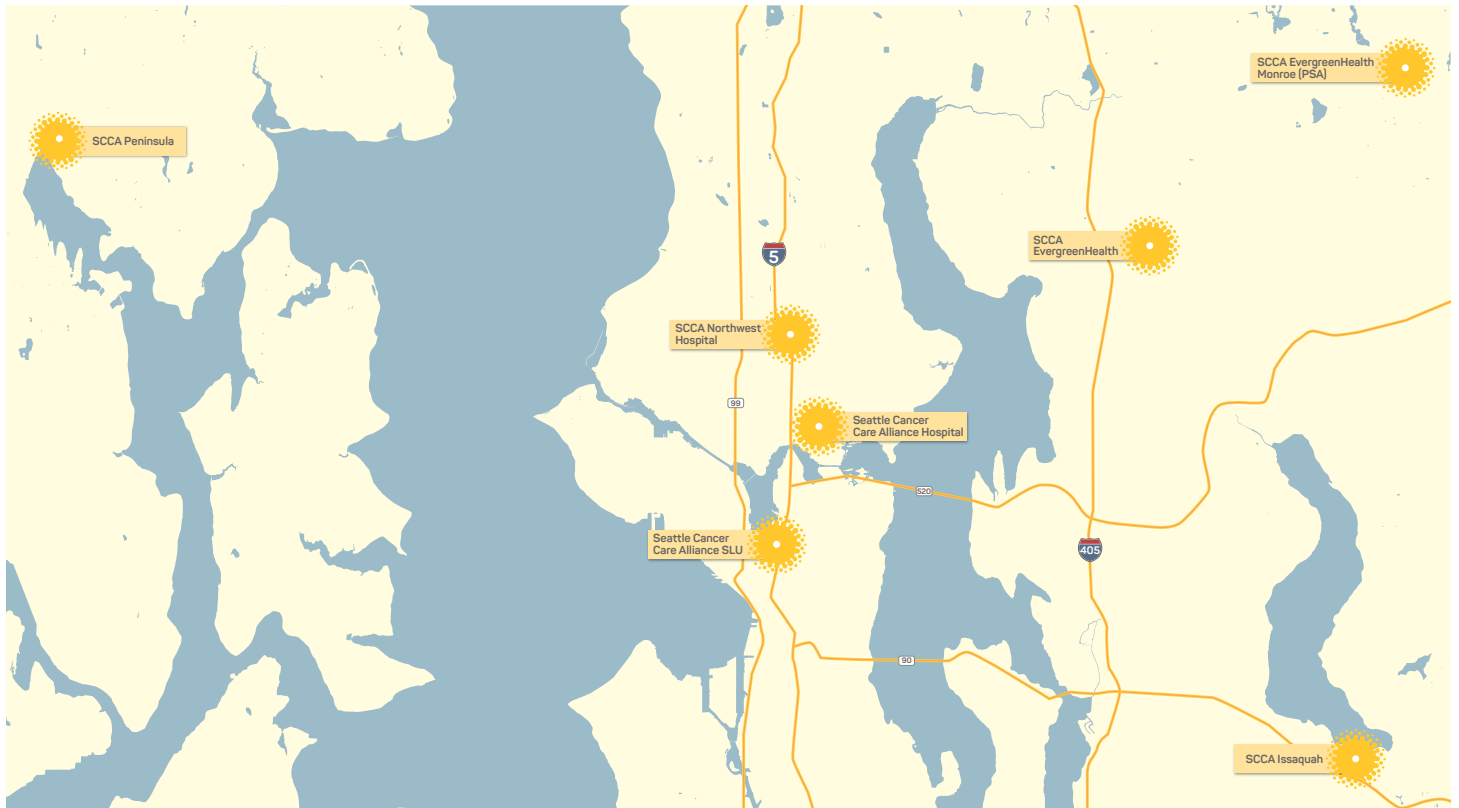
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Recognized nationally and internationally for our clinical research, cutting-edge treatment and superior outcomes for our patients, SCCA has been ranked one of the top 10 cancer hospitals in the country by *U.S. News & World Report* for 13 years running.



Treatment centers

SCCA has six treatment centers, including our main clinic in Seattle's South Lake Union neighborhood, our inpatient hospital at the University of Washington Medical Center, community clinics in Issaquah, Poulsbo, Kirkland (at Evergreen Health), and greater Seattle at Northwest Hospital & Medical Center. We also have two patient housing buildings in South Lake Union: SCCA House and Pete Gross House.



Patients

Most of SCCA's patients reside in the Puget Sound region surrounding Seattle, but we also have patients hailing from every county in Washington state. Due to our internationally-recognized and innovative care, SCCA also has patients who travel from across the country and around the world to receive treatment.

40,482: Served in FY 2018

7,916: Treated in FY 2018

People

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

169 Oncologists

143 Advanced practice providers

1,765 Employees

2,512 Affiliates

Research and Innovation

SCCA's clinical research and innovative care has changed how cancer is treated around the world. Bone marrow transplantation (BMT) was first developed at Fred Hutchinson Cancer Research Center more than 40 years ago, and doctors at the Fred Hutch Bone Marrow Transplant Program at SCCA have performed over 16,000 bone marrow transplants — more than any other institution in the world.

Immunotherapy is one of the greatest advancements in cancer care in our time, and SCCA's clinicians are the leaders in this revolutionary field. SCCA is the only center in the Northwest selected to offer two FDA-approved immunotherapy treatments, called CAR T-cell infusions, for people with certain blood cancers, including lymphoma. SCCA has administered more CAR T-cell immunotherapy infusions than any other hospital in the country.

130 New clinical trials each year

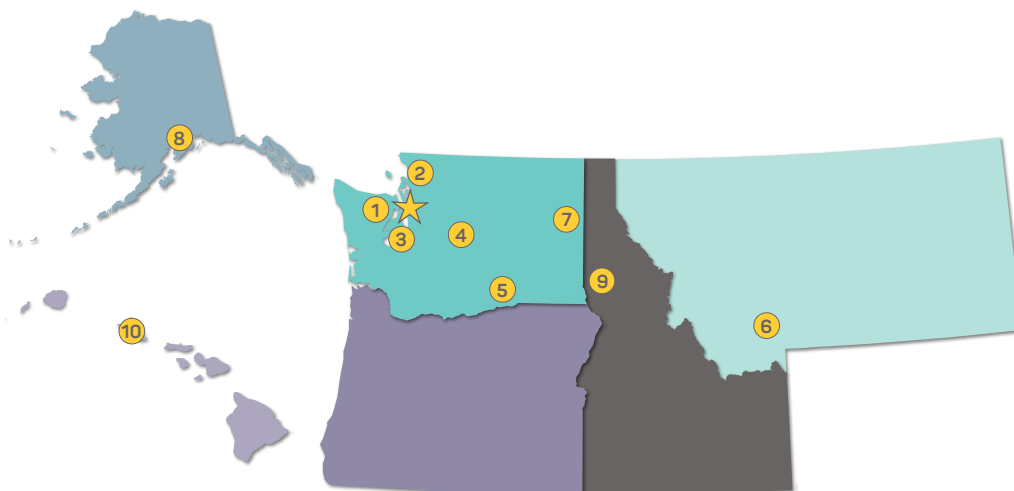
520 Clinical trials active at any given time

1,000 Patients enrolled in a clinical trial each year

Affiliate Network

Through our Network Affiliate program, SCCA works with community-based physicians at partner organizations throughout the Pacific Northwest, Alaska and Hawaii to provide access to the latest information in cancer research and treatment to oncologists and patients far beyond SCCA's treatment centers. Oncologists and their patients at our Network Affiliates benefit from educational opportunities, access to clinical trials and the ability to easily consult with an SCCA physician about their diagnosis and treatment plans.

SCCA Network Members



★ Seattle Cancer Care Alliance

- | | |
|---|---|
| 1 Olympic Medical Center (Sequim, WA) | 6 Bozeman Health Cancer Center (Bozeman, MT) |
| 2 Skagit Regional Health (Mount Vernon, WA) | 7 Summit Cancer Centers (Spokane, WA) |
| 3 MultiCare Regional Cancer Center (Tacoma, WA) | 8 Katmai Oncology Group (Anchorage, AK) |
| 4 Confluence Health (Wenatchee, WA) | 9 St. Joseph Regional Medical Center (Lewiston, ID) |
| 5 Kadlec Clinic Hematology & Oncology (Kennewick, WA) | 10 Hawai'i Pacific Health (Honolulu, HI) |

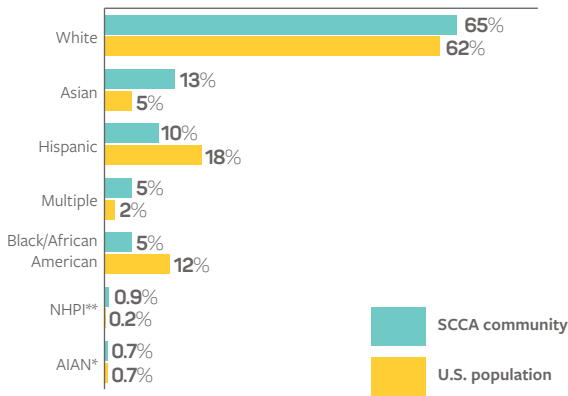
The community we serve

SCCA’s reach extends far and wide, with patients from across the state, region and world, but for the purposes of our community-based efforts to improve 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.



The total population in our community is 3.7 million, and the region continues to experience historic growth. King County is the most populous; over half the area’s population and 52 percent of SCCA’s patients reside in the county. Pierce and Snohomish are smaller, with less than one million residents in each county, and about 13 percent and 6 percent of SCCA patients come from these counties, respectively.

Racial/ethnic makeup of our community



Diversity

Our community is becoming increasingly diverse, particularly in urban centers and suburban areas. A larger proportion of our community’s population are Asian or multiple races compared to the U.S. population overall. There are also areas in our community where dozens of languages are spoken, and vibrant immigrant and refugee communities are growing. For example, in the city of SeaTac, approximately 62 percent of the population is non-white, with more than 80 nationalities and 70 languages represented.

* AIAN: American Indian/Alaska Native

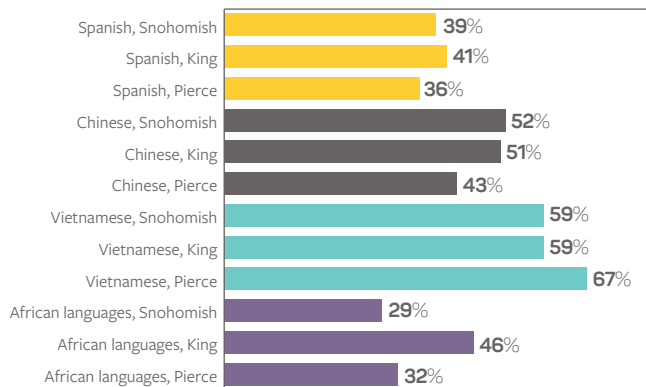
** NHPI: Native Hawaiian/Pacific Islander

Note: For all charts in this report, categories are mutually exclusive. Hispanic is categorized as a race. Other race groups are non-Hispanic.

Language

In addition to more diverse languages being spoken in our community, there are also sizable portions of the population with limited English proficiency, or individuals who speak English less than “very well.” This influences how health services or community outreach should be delivered, using interpreter services or translated materials to make health care services and information accessible for all individuals.

Limited English proficiency in our community

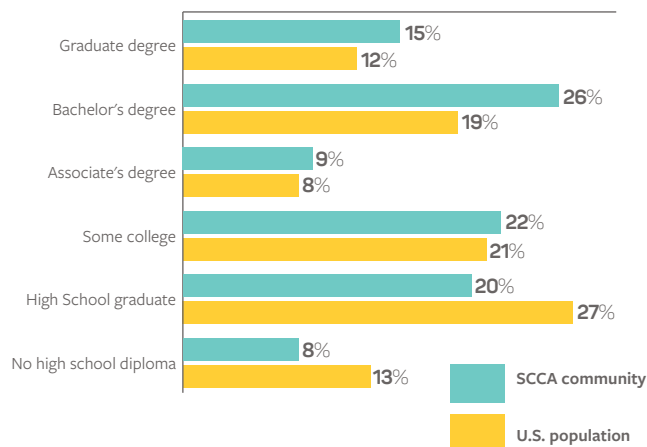


Percent of foreign language speakers who speak English less than “very well.”

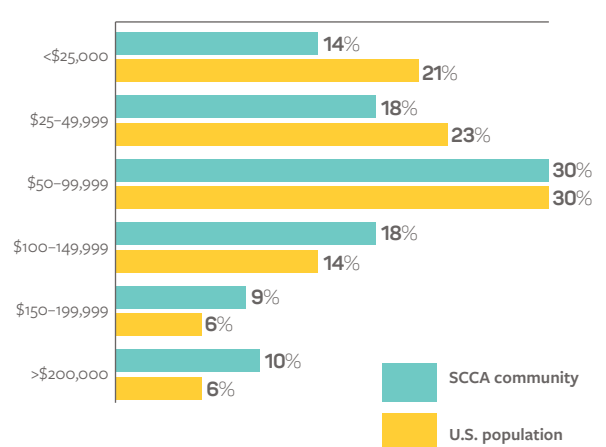
Socioeconomic indicators

Our community performs slightly higher on indicators of socioeconomic status, such as education, income and health insurance coverage, compared to the U.S. overall.

Educational attainment

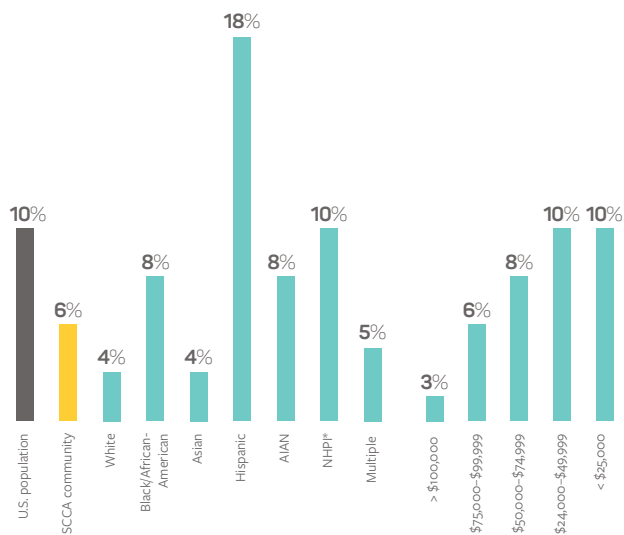


Annual household income



However, within these indicators there is variation and racial/ethnic disparities that make it more challenging for certain populations to live in a safe environment, engage in healthy behaviors or access health care services. For example, only 5.6 percent of our community does not have health insurance, compared to 10 percent in the U.S., yet 18 percent of Hispanic individuals in our community are uninsured. Rural communities, primarily in the eastern parts of King, Pierce and Snohomish counties, also experience higher rates of poverty and barriers to accessing health care. SCCA takes these factors into consideration when working to support underserved individuals in our community.

Individuals without health insurance in our community



*Estimate for Native Hawaiian/Pacific Islander includes only King and Pierce counties. Due to small numbers, the Census Bureau did not produce an estimate for NHPI in Snohomish County.

Our commitment to the community

As a nonprofit, mission-driven organization, SCCA takes seriously our commitment to serving our community. The work we do in the community is an extension of our core mission, and our Community Benefit program takes our aim to provide longer, better, richer lives for our patients and extends it to everyone living in our service area.

Previous community health priorities

SCCA has conducted two community health needs assessments in the past. Our first needs assessment, in 2013, identified tobacco cessation education, Hispanic community outreach, mobile mammography outreach, colon cancer educational outreach and access to health care as priority health needs. SCCA awarded Community Health Improvement Grants to seven organizations working toward similar health goals. SCCA also provided tobacco cessation counseling and education to community members, engaged in health outreach to the Hispanic and Latino community, and provided mammography services on our mobile mammography van for women facing financial barriers in our service area.

Our second needs assessment, in 2016, identified similar opportunities and SCCA broadened our priority health needs to address the continuum of cancer care, including:

High needs populations — Seniors were identified as having a higher cancer burden. Individuals with lower income, limited English proficiency, or who are refugees or recent immigrants were also identified as facing significant barriers to accessing cancer services.

Community health infrastructure — Limitations in existing data make it difficult to accurately identify small subpopulations who may be most in need of services.

Cancer prevention and screening — Tobacco use prevention and cessation, as well as HPV vaccination, were identified as health behaviors with strong cancer prevention evidence that need additional promotion in the community. Cancer screening education was also found to need further promotion in the community, particularly among identified high-needs populations.

Access to services — Many community members, including high-needs populations, face barriers to receiving necessary care, such as finances, transportation, language, limited health literacy and distrust of the medical system.

Survivorship — Cancer survivors often need additional screening and follow-up care after treatment and may also need support and integration into a medical home to ensure their primary care and cancer survivor needs are met.

Recent community benefit activities

SCCA devoted more than \$158 million — almost 10 percent of our operational costs — to community benefit activities from fiscal year 2016 through fiscal year 2018. 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, grants to community health organizations and advocating for public policies that will reduce cancer-related risk factors.

The following list highlights completed activities from SCCA's 2016–2019 strategic implementation plan to address priority health needs. Across these activities, special attention was paid to the high-needs populations identified in the 2016 needs assessment.

Community health infrastructure

- Dedicated staff to report patient-level data, including demographics, clinical data, and outcomes, to state and national cancer registries for both solid tumor and transplant (e.g., bone marrow transplant) populations.
- Conducted a landscape study of population health data to identify racial/ethnic or socioeconomic sub-populations with unmet needs that SCCA can target with cancer-related community health interventions.



Cancer prevention and screening

- Provided tobacco cessation counseling and education to community members, at-risk populations and employees of local companies.
- Offered counseling and nicotine replacement therapy (NRT) to more than 100 caregivers/family members of SCCA patients, totaling 150+ hours of staff time and over \$7,500 in NRT supplies.
- Delivered over 3,000 mammograms through SCCA's mobile mammography van to high-needs community members with limited access to breast cancer screening.
- Awarded grants to community health organizations for tobacco cessation, teen e-cigarette awareness, health education, and breast and colorectal cancer screening programs.
- Advocated for stronger tobacco use prevention regulations in Washington state, including raising the legal age for purchasing tobacco to 21.
- Educated community members about lung cancer screening through radio media.

Access to Services

- Dedicated four full-time employees to financial coordination services for patients, including navigation of the Washington Health Plan Finder, eligibility screening and enrollment for Medicaid coverage, and application to SCCA's financial assistance program (charity care).
- Provided transportation assistance and taxi vouchers to SCCA patients and their families through SCCA's Family Assistance Fund.
- Provided more than \$11 million in uncompensated care for patients facing financial barriers.
- Sustained more than \$85 million in Medicaid losses.

Survivorship

- Provided medical nutrition education to community cancer support groups, wellness conferences and cancer survivorship conferences.
- Provided cancer survivors with financial barriers access to mastectomy, compression and other care products through the Shine Assistance Fund.
- Provided survivorship education and outreach through monthly presentations and attendance at community health events.

A few aspects of SCCA's 2016–2019 strategic plan have not been fully implemented due to organizational shifts and resources constraints — specifically, outreach for diverse clinical trial enrollment and clinical trial education and navigation for limited-English-proficiency individuals — but these activities are being discussed as part of SCCA's ongoing community benefit efforts.

Community health needs

The impact of cancer

As clinicians, researchers and staff who focus exclusively on cancer, we see every day the impact cancer has on individuals and their families. Looking at the impact of cancer at a population level also highlights the significant need to address cancer-related community health.

An estimated 1.7 million new cancers will be diagnosed in the U.S. in 2019, including 39,000 cancers in Washington state. Cancer is the leading cause of death in Washington, claiming the lives of more than 12,000 Washingtonians every year. Cancer is also the second leading cause of death in the United States: more than 600,000 Americans will die due to cancer in 2019 — 1,660 people per day.

Cancer treatment results in over \$80 billion in direct medical costs annually, to say nothing of the lost wages that often accompany a cancer diagnosis or the cost of family and friends taking leaves of absence to serve as caregivers.

The burden of cancer is also unevenly distributed across the population, with some groups facing disproportionate challenges in cancer incidence, treatment and survival. The data and community stakeholder input in the following sections outline the impact of cancer and cancer-related health needs in SCCA's service area, as well as the health disparities between populations within our community that we can help to address.



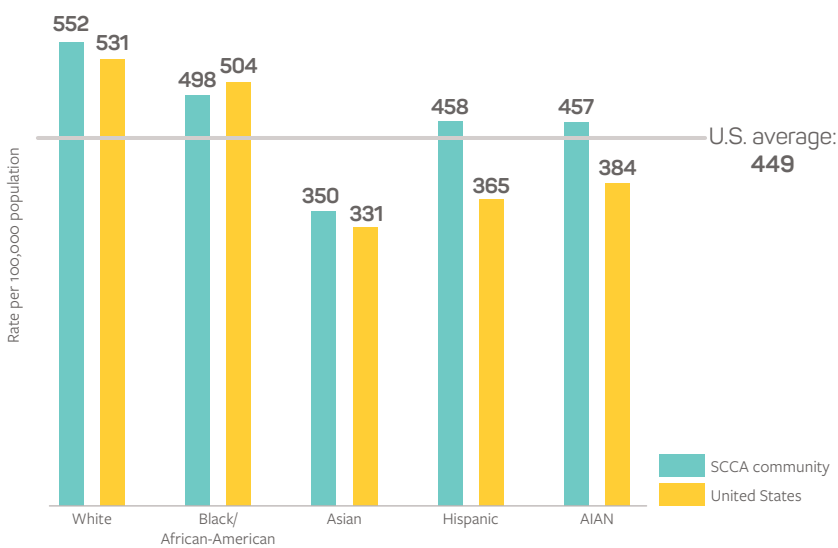
Insights from the data

Burden of cancer

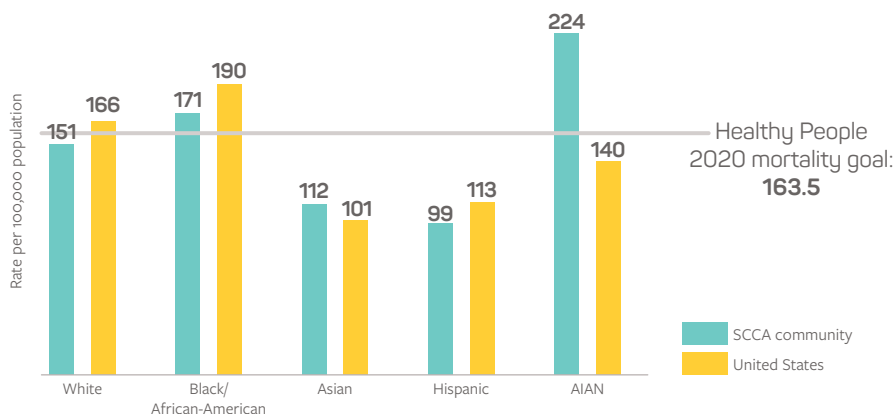
Our community has a higher incidence of cancer — or rate of people diagnosed — compared to the national average of 449 cases per 100,000 people. This incidence rate is contrasted with slightly lower cancer mortality rates in our community compared to national rates and the Healthy People 2020 goal (Healthy People 2020, administered by the U.S. Department of Health and Human Services, is a nationwide program for setting population health improvement goals). Individuals in our community who are diagnosed with cancer have better survival rates. However, the data for the American Indian/Alaska Native (AIAN)¹ population in our community is a concern. The AIAN cancer incidence in our community is higher than the national rate, and the AIAN mortality rate is significantly

higher than both the national AIAN mortality rate and other racial/ethnic groups in our community.

Cancer incidence in our community



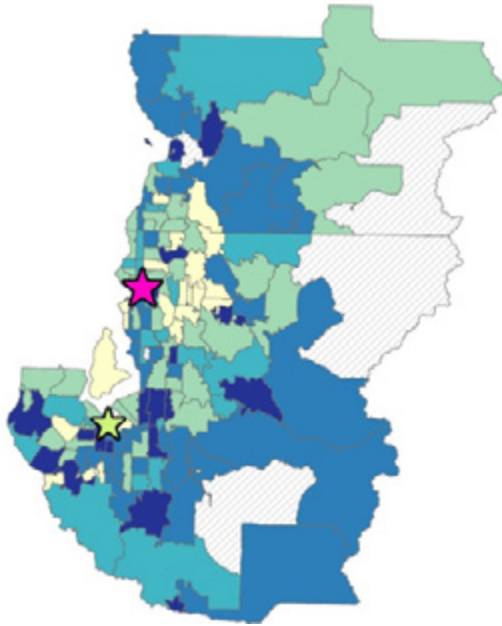
Cancer mortality in our community



¹ Data sources included in the needs assessment process use the term “American Indian/Alaska Native (AIAN),” as used by the U.S. Census Bureau. Report content that discusses data will use the term “American Indian/Alaska Native (AIAN)” for clarity and consistency. Please note that SCCA uses the term “Indigenous” for our activities, which is inclusive of all Indigenous peoples, rather than “American Indian/Alaska Native (AIAN).”

Mortality per 100,000

- ≤120.0
- 120.1-145.0
- 145.1-155.0
- 155.1-180.0
- 180.1+
- No ZCTA Data
- ★ SCCA
- ☆ SCCA Partners



Cancer mortality by ZIP code

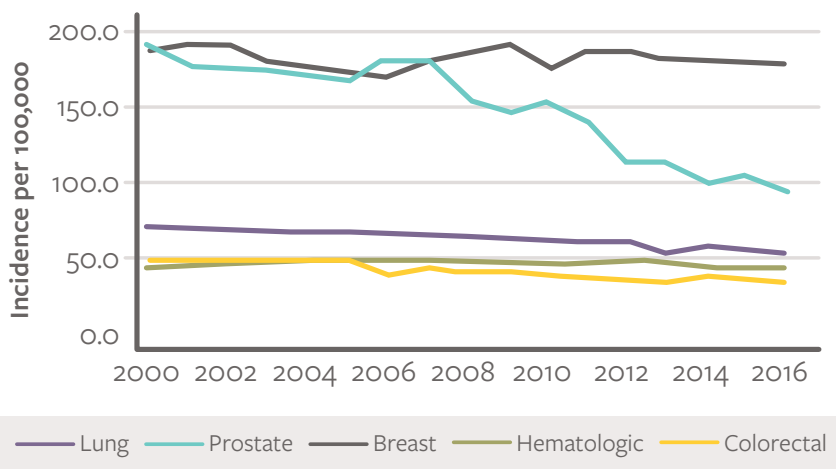
The distribution of cancer mortality across our geographic service area is uneven, with higher mortality rates in certain cities and neighborhoods. Areas of concern (with cancer mortality rates above 180.1 cases per 100,000 residents) include south Seattle, Everett, Lake Stevens, Kenmore, south Renton, Federal Way, Auburn, south Tacoma and some rural areas in southeast King County and west Pierce County.



Trends in cancer incidence and mortality

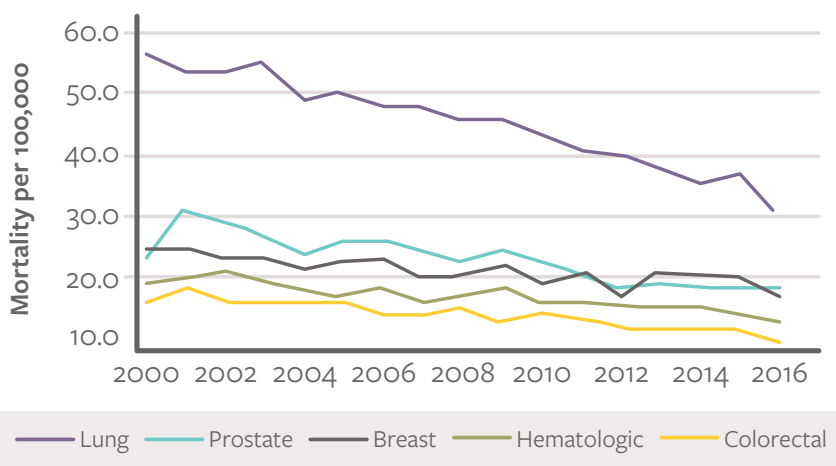
Historic data for our community shows that cancer incidence for the five most common types of cancer has held steady or decreased since 2000. Prostate cancer incidence has dropped dramatically compared to other cancer types, due in part to changes in cancer screening guidelines to prevent over-treatment. Mortality data over the same period shows that mortality rates for the same common cancer types have been decreasing, particularly for lung cancer. These data trends align with current data showing that our community has a lower-than-average cancer mortality compared to national data.

Top 5 incident sites in King/Pierce/Snohomish, 2000–2016



Source: SEER*Stat and CSS, 2000–2016. Age-standardized to U.S. population, 2000.

Top 5 mortality sites in King/Pierce/Snohomish, 2000–2016



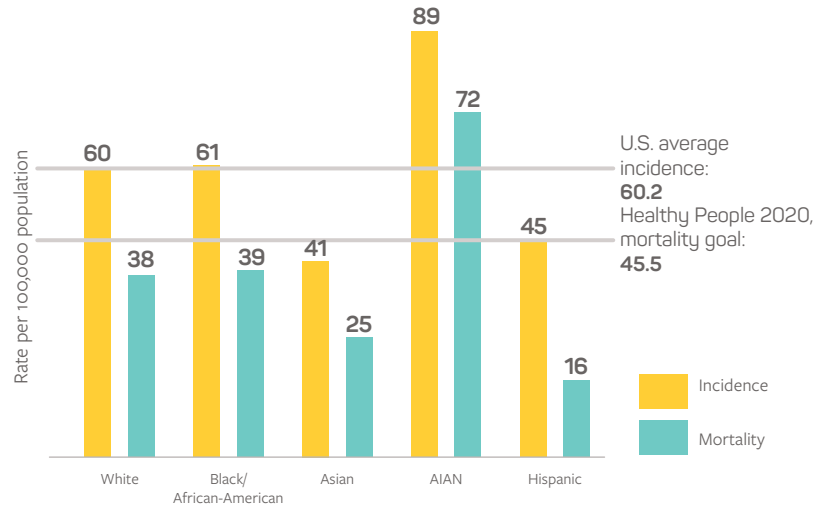
Source: WA State death certificates, 2000–2016. Age-standardized to U.S. population, 2000.

Lung cancer and tobacco use

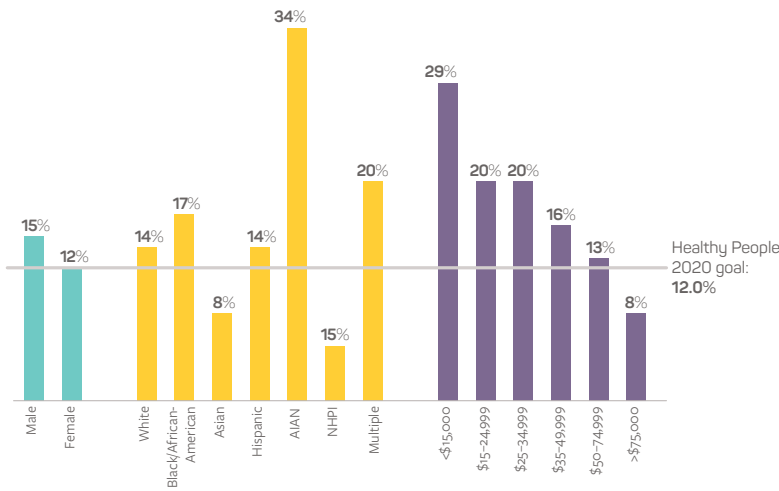
Lung cancer incidence and mortality rates in our community are lower than the national average and outperform the Healthy People 2020 goal for mortality rates for most populations, but not all.

Smoking and tobacco use are associated with an increased risk of lung cancer as well as several other types of cancer. Tobacco use remains a concern for some groups within our community. Thirteen percent of adults report smoking cigarettes regularly. Smoking rates are higher for individuals in households earning less than \$50,000 per year and for individuals who are black/African-American, AIAN, or multiracial. The rate of smokeless tobacco use is 3 percent in our community — significantly higher than the Healthy People 2020 goal of 0.2 percent. Men use smokeless tobacco at a rate five times greater than women in our community.

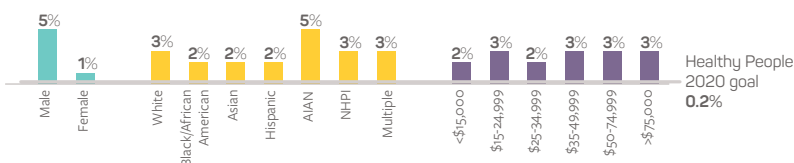
Lung cancer incidence and mortality in our community



Rate of smoking in our community



Rate of smokeless tobacco use in our community



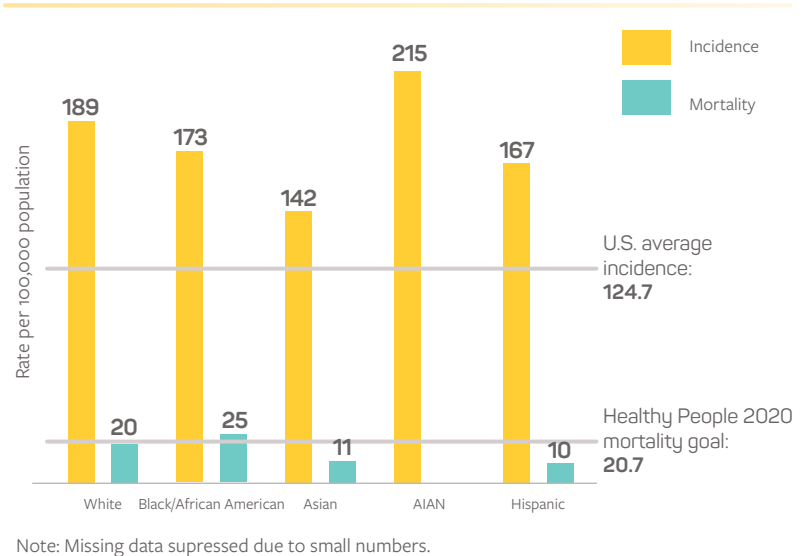
Youth tobacco and nicotine use are also a concern locally and across the U.S., with policymakers wary of the increase in youth e-cigarette use. The 2016 Healthy Youth Survey reports 7.1 percent of 10th-grade students and 12.5 percent of 12th-grade students in Washington state smoke cigarettes. In addition, 14.6 percent of 10th-grade students and 22.4 percent of 12th-grade students use e-cigarettes or vape devices. Both cigarette smoking and e-cigarette use are higher among male students in Washington. Smoking is high among AIAN students and e-cigarette use is high among AIAN, black/African-American and multiracial students.

In April 2019, the Washington state Legislature passed a new law that raises the legal age for purchasing tobacco and vape products from 18 to 21. The new law becomes effective January 1, 2020, and may affect the rate of youth tobacco and nicotine use.

Breast cancer and mammography

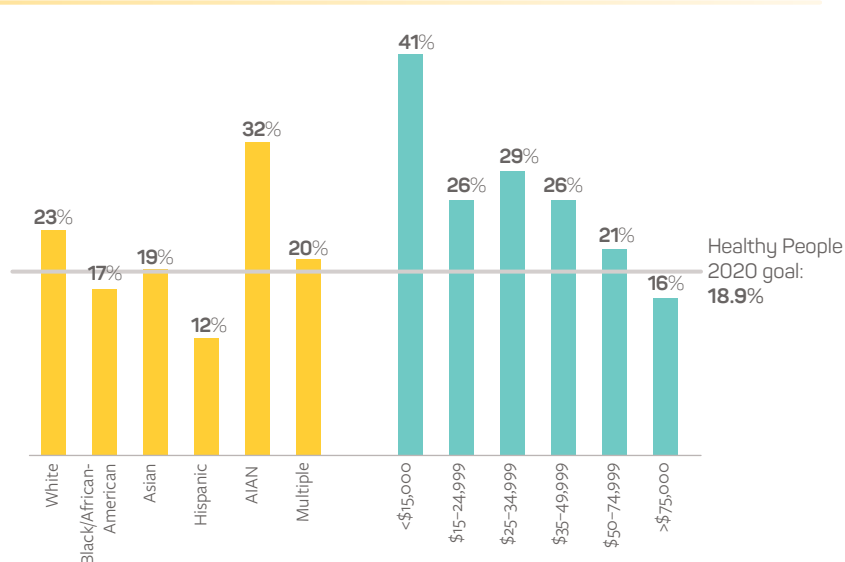
SCCA’s community has a higher incidence of breast cancer across all racial/ethnic groups, compared to the national average. Breast cancer incidence for the AIAN population is particularly high, although interpretation of the rate calculation may be limited by a small number of cases and small population. Despite high incidence rates, our community generally has lower mortality rates for breast cancer compared to the Healthy People 2020 goal. The black/ African-American population is one exception of concern, however, with a higher mortality rate than the Healthy People 2020 goal and other racial/ethnic groups in our service area.

Breast cancer incidence and mortality in our community



The U.S. Preventive Services Task Force recommends women 50–74 years old receive mammogram screening once every two years. However, 22 percent of women in our community within the 50–74 age range have not received breast cancer screening according to guidelines. Women with lower incomes are more likely not to have had a recent mammogram, especially those with annual household incomes below \$15,000, where the rate of unmet breast cancer screening needs are twice as high as the Healthy People 2020 goal. AIAN and white women in our community are also more likely to have unmet breast cancer screening needs.

Unmet mammography screening needs in our community

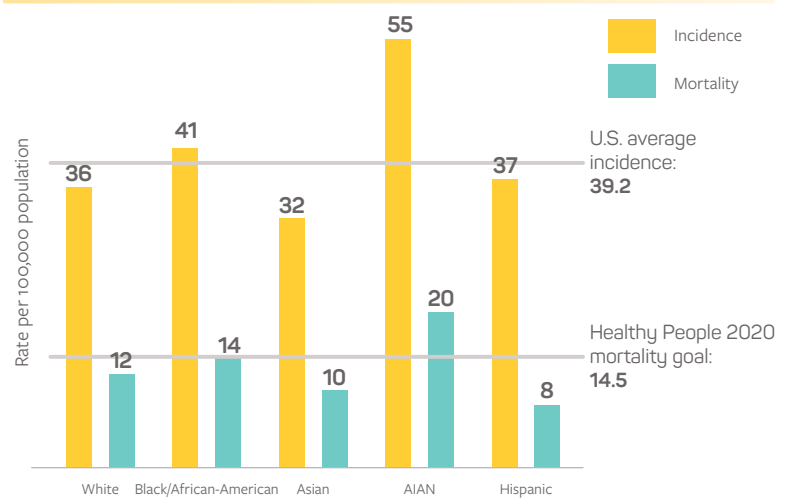


Colorectal cancer and screening

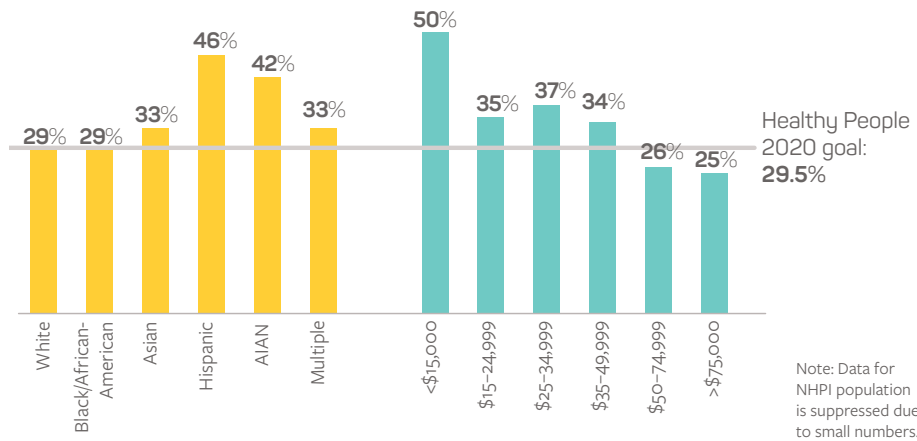
Incidence rates for colorectal cancer in our community are comparable to the national average of 39.2 cases per 100,000, although the Asian population in our area has a slightly lower incidence rate. Mortality rates for colorectal cancer in our community are also generally lower than the Healthy People 2020 goal. However, the AIAN population in our community has higher incidence and mortality rates for colorectal cancer compared to other racial/ethnic groups, which is a concern.

There are clinical guidelines for adults 50–75 years old to receive colorectal cancer screening on a regular basis, which consists of either a colonoscopy once every 10 years, a CT colonography once every 5 years, or an annual stool-based screening. Thirty percent of the overall population aged 50–75 in our community have unmet colon cancer screening needs, which is in line with the Healthy People 2020 goal. However, a number of racial/ethnic groups in our community have a higher proportion of unmet colon cancer screening needs, as do individuals with lower household incomes.

Colorectal cancer incidence and mortality in our community



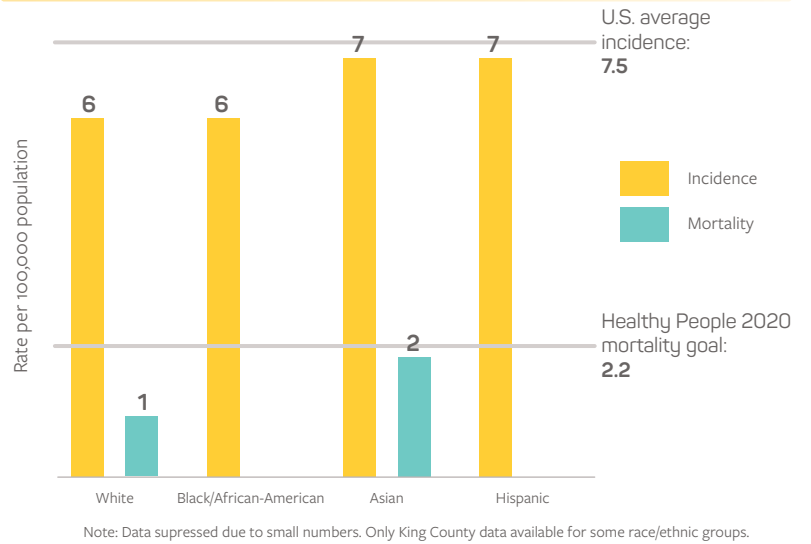
Unmet colon cancer screening needs in our community



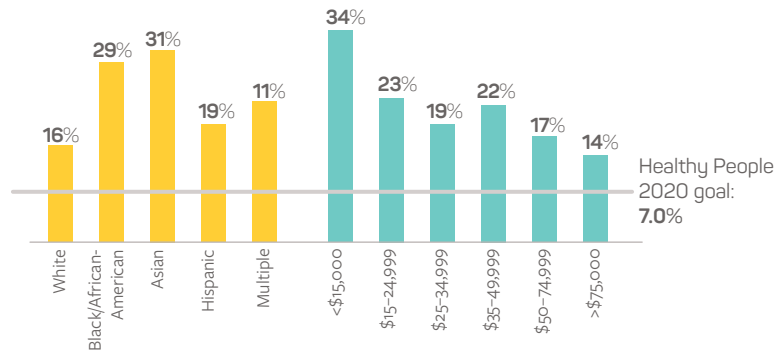
Cervical cancer and screening

Overall, our community outperforms the national average and Healthy People 2020 goal for cervical cancer incidence and mortality. Rates for cervical cancer are generally low. However, significant unmet cervical cancer screening needs remain for women in our community. Clinical guidelines recommend women 21–65 years old receive a Pap smear screening once every three years. Nineteen percent of women in our community have not received a Pap smear as recommended — the rate of unmet cervical cancer screening needs in our community is more than twice the Healthy People 2020 goal. The black/African-American and Asian populations in our community have higher rates of unmet cervical cancer screening needs at 29 percent and 31 percent, respectively. In addition, women with annual household incomes of less than \$15,000 are most likely to have not received a Pap smear as recommended.

Cervical cancer incidence and mortality in our community



Unmet cervical cancer screening needs in our community

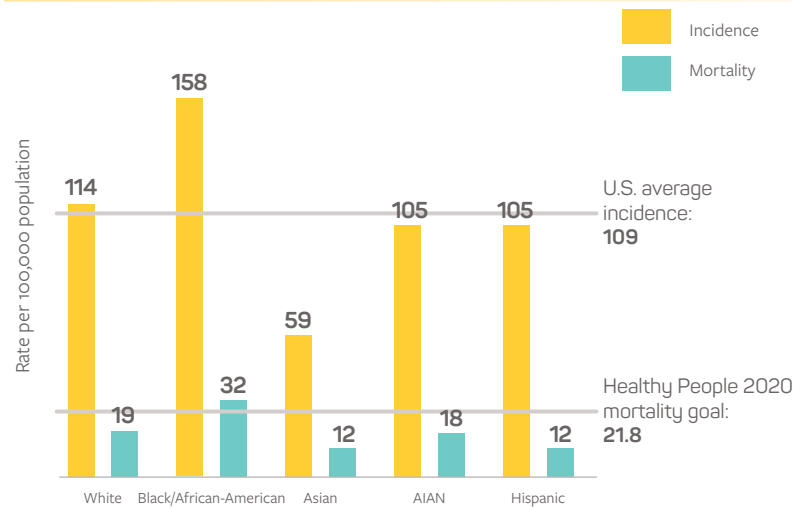


Note: Data for AIAN and NHPI populations are suppressed due to small numbers.

Prostate cancer rates

Prostate cancer incidence and mortality rates are varied among men in our community. Most of the local population outperforms the Healthy People 2020 goal for prostate cancer mortality. The black/African-American population, however, is an outlier, with much higher incidence and mortality rates for prostate cancer compared to other groups in our community as well as national rates and the Healthy People 2020 goal.

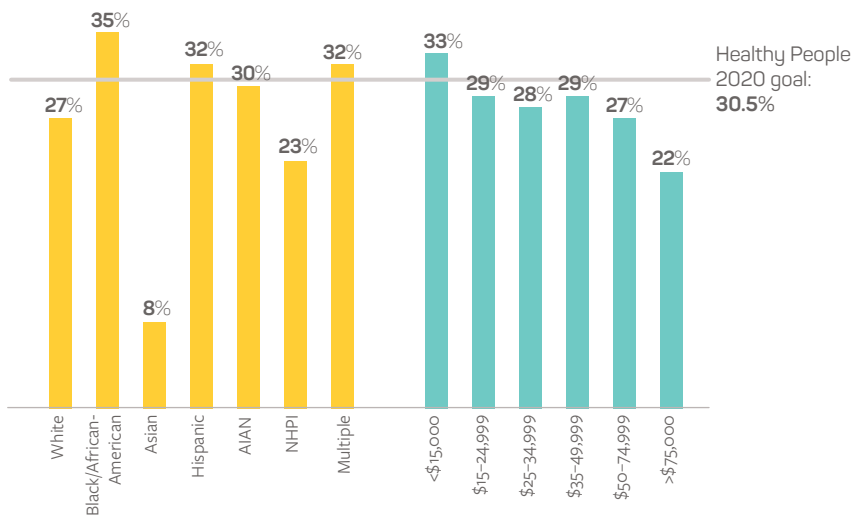
Prostate cancer incidence and mortality in our community



Health behaviors related to cancer

Certain behaviors, such as diet, exercise and alcohol intake, are known to affect risk for certain types of cancer. Healthy eating is associated with decreased risk for some cancers, while obesity and alcohol consumption are associated with increased cancer risk.

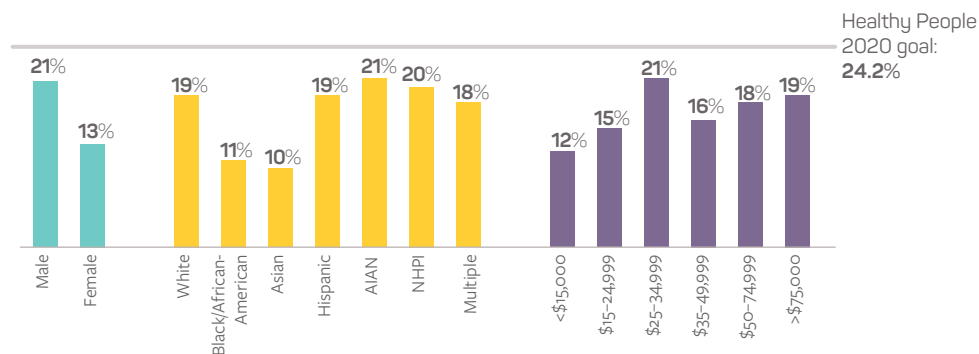
Rate of obesity in our community



Overall, our community has an obesity rate of 25 percent and performs better than the Healthy People 2020 goal. The rate for women is 24 percent and for men, it is 26 percent. The Asian population has a remarkably low obesity rate. However, obesity is more common among individuals with lower household incomes. The black/African-American, Hispanic, AIAN and multiracial populations in our community also experience obesity rates above the Healthy People 2020 goal.

For alcohol consumption, binge drinking is defined as having five or more drinks per occasion for men, or four or more drinks per occasion for women. Our community outperforms the Healthy People 2020 goal for binge drinking across all racial, ethnic and income groups. Overall, the binge drinking rate is 17 percent in our service area.

Rate of adult binge drinking in our community



Input from community stakeholders

SCCA recognizes that data available about cancer, screenings, and health behaviors among our local populations are only part of the story of our community's health needs. For example, data available by race and ethnicity cannot convey the nuance of some subpopulations that have different health outcomes depending on their social, cultural or economic experiences. Health indicators also vary by geographic location; the health needs of rural regions in our community differ from health needs in the urban cores of Seattle, Tacoma or Everett. Therefore, it is essential to learn from stakeholders throughout the community about the contextual factors that influence the health disparities we observe in the quantitative data, as well as the landscape in which we need to partner with other organizations on community health improvement.

We conducted interviews with stakeholders from a range of community-based organizations that provide outreach, education, navigation, social services or health care. These organizations work with a variety of populations in our community, including specific racial/ethnic, immigrant, low-income, and urban, suburban or rural populations. Feedback received from these interviews fell into several themes, including health literacy and norms, prevention, built environment and location, transportation, access to services and language. These themes intersect with each other to create barriers to cancer prevention, screening and treatment.

Health literacy and norms

Stakeholders indicated that members of several populations in our community are uncomfortable seeking health care due to limited health literacy. For example, immigrants may not be familiar with how to navigate the U.S. health care system. Health insurance enrollment and benefits may be confusing. Preventive health care services may be an unfamiliar concept, or health education and medical information may be difficult to understand. As a result, individuals do not receive care, either because they are intimidated by the complexity of the system, or because they have not received helpful information about available services.

- ***“[Patients] want the navigator with them because of intimidation with the medical system, which works very differently from their country of origin.”***
- ***“Men don’t understand colon cancer or getting a colonoscopy. It’s a foreign concept. The same for women and breast cancer [...] A lot of education needs to be done. There is not currently culturally appropriate education where they get care.”***
- ***“With regard to cancer, knowledge is poor; people don’t understand the importance of screening so don’t prioritize it. They don’t fully understand the idea of prevention and only hear about it occasionally. It’s out of sight, out of mind.”***

Cultural norms or health beliefs among some populations may be a barrier. Fear about a diagnosis may lead to avoiding preventive services or screenings. Stigma around being sick may also keep individuals from seeking care. Distrust of the health care system, due to historical trauma and oppression, can also be a significant barrier to accessing health services.

- ***“Some people feel like cancer is a punishment from God. We educate people to get diagnosed early. Attitudes are changing, but the biggest challenge is getting folks to understand they need to be screened.”***
- ***“The final piece is fear. If they do have cancer, they don’t have resources to deal with it, so they ignore symptoms and don’t want to get screened.”***
- ***“Distrust of the medical system is a huge factor [...] Some still feel uncomfortable with big hospitals or clinics. It takes a long time to develop rapport and trust.”***

Prevention

Interviews identified certain health behaviors that are a concern for multiple populations in our community. Diet, exercise and obesity were mentioned prominently by most stakeholders, not only as they relate to cancer prevention but also to other chronic conditions like hypertension and diabetes. Tobacco and smoking cessation are also a concern, with some stakeholders discussing cultural norms around smoking for immigrant groups and others focusing on the rise in youth tobacco use and vape devices.

- ***“Diet is probably the most important behavior overall because obesity and poor nutrition leads to a whole host of other chronic diseases that are leading to high morbidity and mortality.”***
- ***“For Asians, alcohol and tobacco are a real risk, especially for men. Women, too — even if they don’t smoke, they likely live with a husband who does.”***
- ***“Vaping is something the health awareness coalition brought to our attention — the extent of the problem and growing popularity. [Vaping] is happening in middle schools. That’s a highlight for concern. A policy officer told me they’re scrambling to show parents what vaping looks like and how to spot it.”***

Built environment

Stakeholders also noted that adopting healthy behaviors or accessing health care is influenced by neighborhood environment and location. For example, diet and obesity are influenced by access to nutritious food. Food deserts in certain areas of our community make access to inexpensive, unhealthy food more convenient than healthy food. Housing availability and affordability is also a community-wide concern. Urban areas are becoming unaffordable for diverse populations, leading to relocation to less expensive suburban areas. Meanwhile, rural areas are experiencing high poverty rates and limited resources.

- ***“In the South End area, there is not a proper grocery store. I think Grocery Outlet is the only grocery in the area.”***
- ***“The food desert thing is real. There are stretches with affordable housing, but no healthy markets. It’s easier to get fast food than fruits and vegetables.”***
- ***“Housing stability is a major issue and fundamental piece. I think if we get better at that, we can address a whole host of issues.”***
- ***“The further you go [east], the needs are higher and it’s poorer [...] They have a clinic and one grocery store [...] A lot of commuting long distances.”***

Transportation

Challenges around transportation to access health care were mentioned prominently by most, if not all, stakeholders. 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.

- ***“Everyone is being forced farther and farther south or north. People are taking the bus for a few hours to reach us.”***
- ***“For the first time, we’re seeing addresses in Puyallup and Sumner. People looking for rental space that’s affordable. What comes with that is moving far from limited resources they had access to.”***

Access to services

Although insurance coverage has improved as a result of the Affordable Care Act, stakeholders still 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 sharing can discourage patients from accessing care.

- ***“Insurance coverage is a big barrier. Some have had multiple interactions where clinics or pharmacies don’t take plans. Managed care plans are not reimbursing clinics, pharmacies or dentists adequately, so people are pushed to different places. Folks are trying to navigate the system, but it’s so complicated.”***
- ***“People may have insurance, but high deductibles, so they don’t get screened because they’re worried about a positive finding and not being able to afford the care.”***

There are also some gaps in the cancer screening services available for low-income patients. For example, the Breast, Cervical, and Colon Health Program (BCCHP) is a robust program providing screening for a few types of cancer, but other cancer types do not have similar screening programs, and diverse patients and low-income patients may have difficulty getting screened.

- ***“It’s hard to cobble together resources to help men.”***
- ***“For breast, cervical, and colon cancer, there are very established programs [...] We’re more concerned about other cancers — liver, lung, stomach, prostate.”***
- ***“For Japanese, Korean, Chinese populations, we’re very passionate about stomach cancer. It’s hard to get funding because [stomach cancer] affects Asian-Americans and minorities, so hasn’t reached mainstream.”***
- ***“I think our community members need to push when they have symptoms and the doctor says, ‘Let’s wait and see.’ That’s the biggest thing they’re told, but then find out it’s late-stage cancer and the doctor wasn’t willing to do screening at that time.”***

Language

Finally, language and interpreter services were noted by stakeholders as an important consideration. With an increasing proportion of residents in our community being foreign-born, the need for health care services and navigation in multiple languages will persist.

- ***“Language is a barrier, especially for older generations. Newcomers are trying to navigate a system where interpretation and translation are limited. Phone interpretation isn’t always authentic.”***
- ***“The language barrier is very real. Our navigators provide translation — they need to be bilingual.”***
- ***“We’re still learning how to work and understand the needs of subpopulations who have different cultural and linguistic needs.”***

Existing resources

When examining the needs of our community, SCCA believes it is vital to also consider existing resources in our area. This provides balance to our assessment, making sure we consider areas of strength and opportunity, rather than focusing solely on gaps, barriers, or poor health outcomes.

Our community is fortunate to have a range of resources dedicated to population health and cancer-related health needs, providing many opportunities for collaboration. SCCA is proud to have partnered with many of these community-based organizations and looks for opportunities to work with others in the future.

For health care services, there are several federally-qualified health centers (FQHCs) and community health clinics in our service area, including Sea Mar Community Health Centers, Neighborcare Health, HealthPoint, International Community Health Services, Seattle Indian Health Board and the Puyallup Tribal Health Authority. These clinics provide a range of preventive health services, cancer screenings and health education.

For health promotion, there are myriad organizations that conduct outreach, education and patient navigation. Some examples are Cierra Sisters, El Centro de la Raza, Korean Women’s Association, Stilly Valley Health Connections, Somali Health Board and the Center for MultiCultural Health, although there are many more. Many of these organizations have programs focused on cancer-related education, screening and navigation.

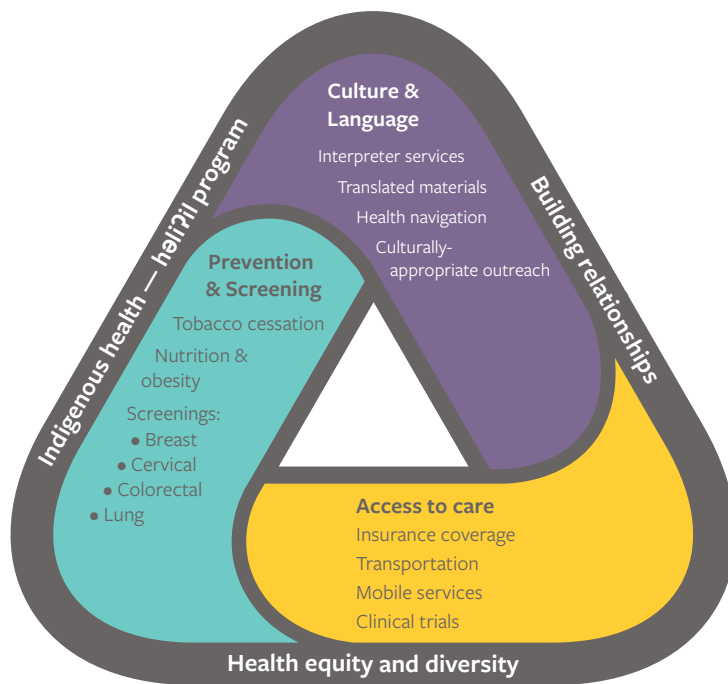
There are also many housing, social service and faith-based organizations that provide services to population groups with unmet cancer-related health needs. These potential partners for health outreach include Mercy Housing, Chief Seattle Club, Mother Nation, Chinese Information and Service Center, Asian Counseling and Referral Service, Homage Senior Services, Catholic Community Services, Lutheran Community Services, Together Center and others.

Finally, there are several local cancer support and advocacy organizations in our community, including Cancer Pathways, Team Survivor Northwest, Cancer Lifeline, Komen Puget Sound and the American Cancer Society. These organizations provide health education, as well as adult and family support groups, patient navigation and financial assistance and survivorship groups and activities.

With such a variety of local organizations available to align resources with and close service gaps, there are many opportunities for SCCA to collaborate and address the significant cancer-related health needs that persist in our community.



Community health priorities, 2019–2022



SCCA is dedicated to ensuring our efforts to advance the standard of cancer care extend into our community to address population health needs — from prevention and diagnosis, to treatment and survivorship. The data available to us, our community stakeholders’ input, existing resources and feedback on our previous health needs assessment and implementation strategy led us to prioritize cancer-related health needs that are clearly identified in the community and for which an evidence-based intervention exists. We also prioritized needs related to equitable health care for our diverse community.

Using this framework, we were able to prioritize community health needs where SCCA’s involvement can contribute to meaningful health improvement. We identified many health needs,

which we grouped into four areas of focus: prevention and screening, access to care, culture and language, and Indigenous health.

Cancer prevention and screening

The risk for some cancers can be reduced significantly with lifestyle and behavior changes. Two possible areas of improvement that were raised by data and stakeholder input are tobacco cessation and nutrition and obesity. Despite its well-documented connection to lung cancer and other health problems, tobacco use is still a problem in our community, with some groups using tobacco at significantly higher rates than the Healthy People 2020 goal (see p. 15). Recent trends in youth tobacco and e-cigarette use are also worrisome and indicate an emerging need for prevention. Nutrition and obesity prevention are another concern, especially among underserved communities and neighborhoods without easy access to fresh fruits and vegetables and other nutritious foods. Healthy eating and healthy weight are not only associated with decreased risk for some cancers, but are also important for overall health improvement and the prevention of many chronic health conditions.

Identifying cancer in early stages also has a significant impact on treatment and survival outcomes, and in some cases, screening can even prevent cancer. Screening tests and evidence-based recommendations exist for many types of cancer, including screening for breast, cervical, colorectal and lung cancer, all of which have unmet needs that were shown to significantly impact our community. Low-dose CT-scan screening for lung cancer is also relatively new compared to other cancer screenings, and data from our needs assessment indicates that there are opportunities to increase awareness in our community about lung cancer screening availability and recommendations.

Access to care

Despite the Affordable Care Act, a significant portion of certain groups in our community remain uninsured, putting them at risk of being unable to afford cancer screening and treatment. Expanding access to health insurance continues to be an opportunity to improve outcomes for a significant number of individuals in our community. However, low-income individuals who have health coverage still face other barriers to accessing health care services. Transportation to screening and treatment was identified as one of those barriers, as well as access to mobile health services for rural communities or underserved neighborhoods. Traveling to a health care provider can be expensive and time-consuming, especially when individuals must take time off from work to make an appointment, and individuals often forgo necessary health services due to these barriers.

Finally, equitable access to clinical trials continues to be a need, particularly for low-income, minority and other underrepresented groups in our community. Increasing diverse access to clinical trials was a community health need identified in SCCA's previous needs assessment report and is an ongoing challenge. Participation in clinical trials can pose additional barriers for patients, including insurance coverage complexity and the need for additional appointments, as well as associated transportation, time away from work and other costs. Furthermore, certain members of the population distrust clinical research for a variety of reasons, including health beliefs, difficulty navigating the medical system and historical medical ethics violations.

Culture and language

Demographic data highlights an increasingly diverse community surrounding SCCA, with myriad populations and a significant proportion of foreign-language speakers with limited English proficiency. Feedback from stakeholder interviews highlighted how some populations face additional challenges when trying to navigate the health system due to language barriers, culture norms and beliefs, and limited health literacy. There is a need for interpreter services that provide authentic communication between individuals and health care providers, as well as translated health materials that make information accessible for individuals with limited English proficiency. There is also a need for culturally-appropriate outreach that acknowledges and incorporates cultural norms and beliefs to make health education and promotion relatable to the target populations. Finally, health navigation services are needed to support individuals who have limited health literacy or may be hesitant to engage with the health system.

Indigenous health

During our review of data and interview input, we identified our community's Indigenous populations as a group with a consistently high burden of cancer morbidity, mortality and tobacco use. There are five federally recognized Indigenous tribes, as well as other tribes and many Indigenous individuals, throughout SCCA's community. SCCA has created a new program called *həliʔil* Indigenous Tribal Liaison — named after the Lushootseed word for “heal” — and has identified a need to build relationships across our three-county area, where SCCA can be a collaborative partner in Indigenous health promotion. We see this community health priority as being interwoven with our three other priority areas, with Indigenous-specific needs that can be addressed across our cancer prevention and screening, access to care, and cultural and language activities.

Appendices

Appendix A: Community health needs assessment process

SCCA's needs assessment process consisted of four components: quantitative data analysis, qualitative stakeholder interviews, community asset mapping and a facilitated data dive workshop.

Quantitative data analysis

We gathered data about individuals in our community residing in King, Pierce, and Snohomish counties, from publicly available datasets cited in Appendix B, most of which are maintained by government agencies or programs. We accessed data for the whole three-county region directly from these datasets when possible. In other instances, we needed to query data for each county separately and combine them into a weighted average. These data were then analyzed and interpreted to understand the community and its cancer burden overall, as well as the disparities of certain populations within the community.

We used demographic data from the U.S. Census Bureau's 2013–2017 American Community Survey five-year estimates to describe the three-county region's demographics, including age, race, ethnicity, insurance coverage and socioeconomic status. We combined county-specific data into a weighted average for our three-county community and benchmarked these numbers against national data.

With assistance from the Fred Hutchinson Cancer Research Center, we queried the Washington State Cancer Registry and the National Cancer Institute's Surveillance, Epidemiology, and End Results dataset for cancer-related incidence and mortality data to understand the distribution of the community's cancer burden across racial and ethnic populations. Cancer rates for each county were combined into a weighted average and benchmarked against national data. Cancer mortality rates by ZIP code were mapped across our three-county community to understand the geographic distribution of cancer burden and outcomes. Historic cancer rates for the five most common cancer types were also graphed from 2000–2016 to understand trends in incidence and mortality.

With assistance from Public Health — Seattle & King County we combined data from the 2014–2016 Behavioral Risk Factor Surveillance System for each county and, using weighting adjustment, analyzed it by age, sex, race, ethnicity and income level to identify the distribution of cancer-related health behaviors in our community as well as the uptake of recommended cancer screenings.

Qualitative stakeholder interviews to solicit community input

In collaboration with the Center for Community Health and Evaluation (CCHE), we designed a semi-structured interview protocol to solicit community input. The protocol included questions about the interviewee's organization and the services they provide, their experience working with medically underserved populations, unmet health and cancer-related needs in the community, socioeconomic factors that contribute to health disparities, and existing resources or opportunities to collaborate in the community.

SCCA solicited the perspective of community stakeholders with deep connections in low-income, minority and medically underserved populations, who have significant experience working with these communities. These organizations serve low-income individuals; a wide range of racial and ethnic minorities, including Asians, Hispanics, blacks and American Indian/Alaska Natives; recent immigrants; and other marginalized groups with significant barriers to accessing cancer services.

Between October 2018 and April 2019, the following organizations graciously agreed to share their experience and expertise in interviews with SCCA or CCHE staff:

- Cierra Sisters
- City of Issaquah Office of Sustainability
- Fred Hutchinson Office of Community Outreach and Engagement
- International Community Health Services
- Korean Women's Association
- Public Health — Seattle & King County
- Sea Mar Community Health Centers
- Seattle Indian Health Board
- Somali Health Board
- Stilly Valley Health Connections
- Tacoma-Pierce County Health Department

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

Community asset mapping

SCCA engaged a group of graduate students from the University of Washington School of Public Health between September and December 2018 to identify organizations, coalitions or other 'assets' in the community that SCCA could collaborate with to address cancer-specific community health needs. The students conducted an online environmental scan of community-based organizations, identified potential partners for SCCA, mapped organization service areas in relation to SCCA's community and compiled a roster of community assets for SCCA's reference. We drew upon the students' final report to follow up with a subset of organizations for stakeholder interviews and to inform the section of our CHNA focused on community strengths and existing resources.

Data dive workshop

SCCA has a Community Benefit Steering Committee to guide our community benefit strategy. Committee members represent a range of functions across SCCA, both clinical and administrative, including departments engaged in conducting SCCA's community benefit activities on a day-to-day basis. We facilitated a data dive workshop where committee members reviewed qualitative and quantitative data from the CHNA and posted their observations next to each data chart. Next, we engaged in a group discussion to review all the posted observations and identify themes in the data, which outlined the universe of cancer-related health needs in our community. Finally, we reached consensus on which health needs were priorities for SCCA. Criteria for prioritization included the severity of health disparities, the geographic scope of need, the size of affected subpopulations and the availability of evidence-based activities and resources to address the need.

Limitations

We identified several data limitations as we sought to understand our community. Often, the data we wanted simply did not exist: Not all the measures we hoped to review were available for all three counties, local sample sizes were sometimes too small to yield meaningful results, and data were aggregated into broad categories (particularly racial and ethnic groups) that concealed significant variation between subpopulations. For example, breast cancer screening data for all Asians does not reveal the differences between screening data for Chinese, Vietnamese, Japanese, Indian, and other Asian subpopulations. In addition, many racial and ethnic groups have wide variation between recent immigrants, who may have significant cultural and linguistic barriers to care, and second- or third-generation members of that group. Furthermore, recent immigrants with limited English proficiency are less likely to respond to surveys, so their experience is less likely to be reflected in the data.

We also encountered limitations in how local data are calculated and compared to national benchmarks. Particularly for racial/ethnic groups with small local populations, such as AIAN, the health indicators we analyzed have much wider confidence intervals compared to other groups. This may be due to the limitation of small numbers as well as less accurate population estimates. 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.

Finally, we recognize there are other medically underserved or disadvantaged populations whose health needs we were not able to accurately distill. For example, most of the survey data we utilized to understand cancer-related health needs does not identify members of the LGBTQ community, and we anticipate there are other community groups whose needs are not apparent due to data limitations.

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