Fred Hutch Cancer Center

2025 Community Health Assessment

CANCER CONSORTIUM
FRED HUTCH • UNIVERSITY OF WASHINGTON • SEATTLE CHILDREN'S

Office of Community Outreach & Engagement


Fred Hutch Cancer Center
UW Medicine

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Executive Summary

Background

Federal and state regulations, including IRS requirements, the Affordable Care Act and Washington State Engrossed Second Substitute House Bill 1272, mandate that nonprofit hospitals conduct a Community Health Assessment (CHA) every three years. This process evaluates community health needs, gathers input from varied stakeholders and public health experts, prioritizes key issues, identifies available resources and reports on progress from previous assessments.

Fred Hutch Cancer Center's CHA also fulfills the Fred Hutch/University of Washington/Seattle Children's Cancer Consortium's objective to describe the population and factors influencing the cancer burden in Washington state. The hospital's governing body must approve the CHA report, ensuring alignment with institutional priorities and public health mandates.

2022–2024 Community Benefit Accomplishments

From FY22 to FY24, Fred Hutch invested over $364 million — 7% of its operational costs — into community benefit initiatives. These efforts focused on expanding access to clinical care, funding publicly accessible research, supporting community health programs and training health care professionals.

The 2022 Community Health Needs Assessment (CHNA) identified three key health priorities centered on equitable care. Fred Hutch strengthened internal infrastructure and expanded community partnerships to address these priorities. Key accomplishments include:

Expanding Community Engagement and Access

- Increased representation from various populations in decision-making roles at Fred Hutch from 0% to 19% and women leaders to 57%.
- Grew Fred Hutch faculty from various populations from 34% in FY23 to 36% in FY24.
- Distributed over $400,000 in grants to 42 community organizations.

Enhancing Culturally Responsive Prevention, Education and Screening

- Participated in more than 300 community events promoting cancer prevention, screening and vaccine education.
- Provided 14,418 mammograms through Fred Hutch's Mammogram Van, focusing on underserved communities around the state, including people overdue for screening.

Increasing Access to Comprehensive and Affordable Care (Including Mental Health Services)

- Held more than 30 policy education sessions advocating for improved access to cancer prevention, screening, treatment and clinical trials.
- Established formal partnerships with community-based mental health providers and implemented a suicidal ideation assessment for patients.

2025 CHA Process

The 2025 CHA emphasizes social determinants of health as key contributors to cancer disparities. Using public data and population-based cancer statistics, the report identifies inequities in cancer outcomes across Washington state and suggests strategies for achieving more equitable health access.

To complement quantitative data, 93 individuals from clinics, public health agencies, Native tribes and community organizations participated in interviews and listening sessions, providing valuable insights. Additionally, the Fred Hutch Patient and Family Advisory Council shared firsthand experiences of navigating cancer care.

Identified Community Health Needs

The CHA identified six key health needs across Washington state. Many of these challenges have persisted from previous assessments and remain deeply interconnected:

1. Access to Care

Barriers include provider shortages, rural healthcare challenges, suboptimal health insurance, transportation difficulties, complex care systems, poor coordination, and digital health inequities.

2. Culturally and Linguistically Responsive Care

Historical trauma and systemic barriers contribute to mistrust in health care. Key concerns include stigma around cancer and a lack of culturally and linguistically appropriate care and resources.

3. Social Determinants of Health

Major issues include lack of affordable childcare and housing, houselessness, food insecurity, climate-related health impacts and social isolation.

4. Preventive Care

Persistent disparities in cancer screening access, late-stage diagnoses, and mortality rates continue, alongside low awareness of available prevention resources.

5. Healthcare Affordability and Cost of Living

The high cost of lodging, hospital bills, and transportation, coupled with limited financial aid, remains a significant barrier to care.

6. Mental Health

Challenges include limited access to mental health services, the emotional and socioeconomic toll of cancer, and substance use disorders.

Looking ahead, Fred Hutch will prioritize collaborative, community-driven strategies that address barriers to cancer care. The institution is committed to deepening partnerships, expanding access to services and using data-driven approaches to improve health outcomes across Washington state.

Introduction

Letter to the Community

Dear Community Members,

As president and director of Fred Hutch Cancer Center and director of the Fred Hutch/University of Washington/Seattle Children's Cancer Consortium (the Consortium), it's my great pleasure to present the 2025 Community Health Assessment (CHA).

As a nonprofit, mission-driven cancer center, it is our duty to conduct our work in a way that is responsive to the needs of our community. Comprehensive cancer control requires monitoring the cancer burden in the state and identifying the significant disparities that underserved populations experience.

In this report, we explore social determinants of health as contributors to the disproportionate burden of cancer. We also identify community strengths, assets, barriers and needs that impact access to cancer care and health outcomes for individuals across the state. In addition to describing cancer incidence and mortality, the CHA also presents ideas for how we can create improved health outcomes for all communities across Washington State. The findings outlined here will be used to inform our research priorities in the coming years, and will also guide our efforts to develop resources for the community and make our services more accessible to the individuals that we serve.

Alongside quantitative data, this report emphasizes the importance of hearing directly from individuals across Washington state to understand their experiences and priorities. This combination is emblematic of our mission at Fred Hutch: to unite cutting-edge research and medicine with a human-centered, compassionate approach to cancer care.

This report fulfills Fred Hutch's obligations as required under Internal Revenue Code Section 501(r)(3)(A)(iii) and the Patient Protection and Affordable Care Act, and aligns with Washington State Engrossed Second Substitute House Bill 1272. The report also satisfies the Consortium's requirement to describe the population and the major factors that characterize and influence the cancer burden of Washington state, the catchment area for Fred Hutch and the Consortium.

We are deeply grateful to the community members and partners who contributed to and supported this report. We also thank the researchers and staff who worked to bring it to completion.

Thomas J. Lynch Jr., MD
President and Director
Raisbeck Endowed Chair for the President and Director
Fred Hutch Cancer Center

About Fred Hutch Cancer Center

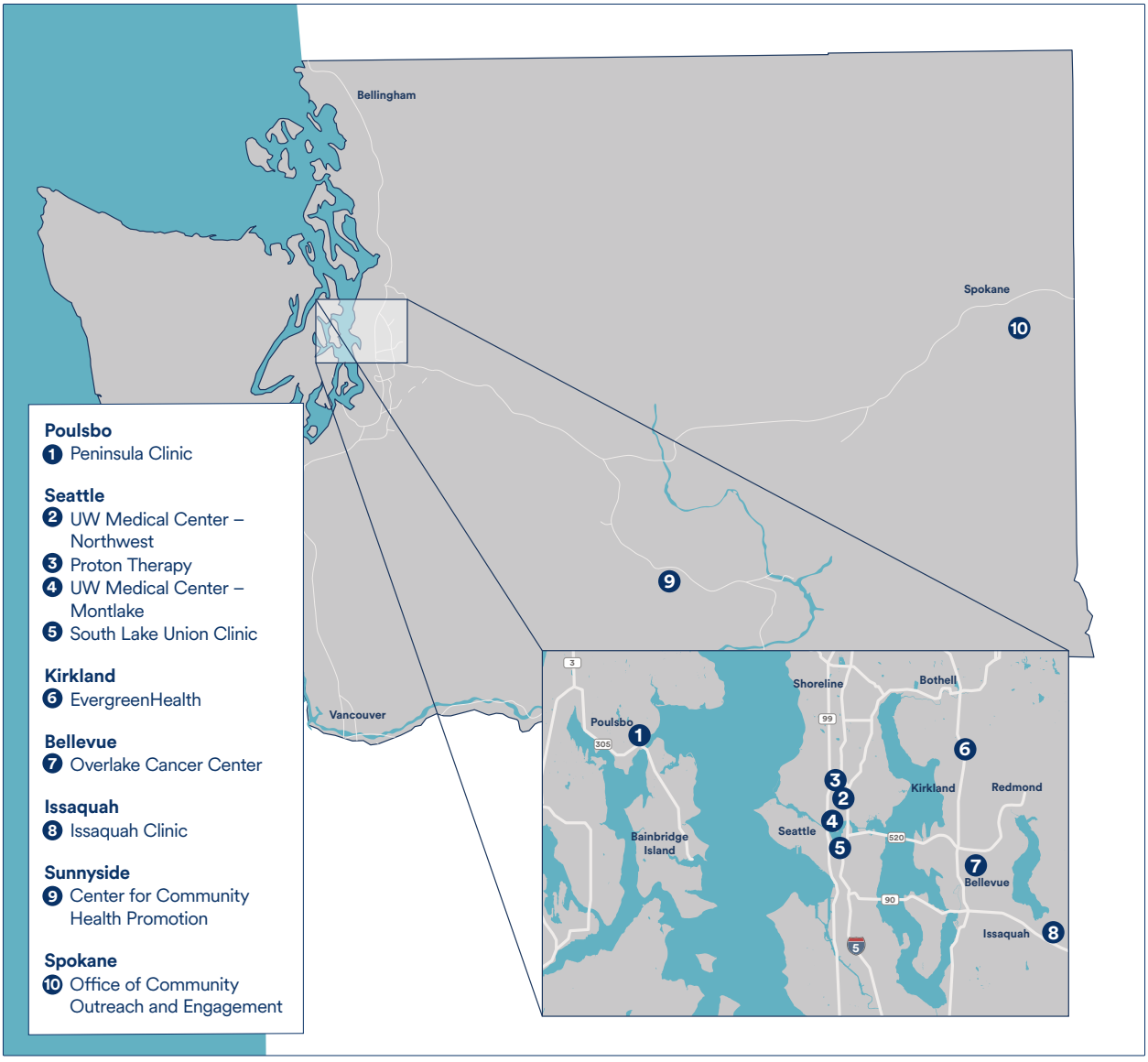
At Fred Hutch, our interdisciplinary teams of world-renowned scientists — including three Nobel laureates — seek new and innovative ways to prevent, diagnose and treat cancer, HIV/AIDS and other life-threatening diseases. Fred Hutch's pioneering work in bone marrow transplantation led to the development of immunotherapy, which harnesses the power of the immune system to treat cancer. An independent, nonprofit research institute, Fred Hutch houses the nation's first National Cancer Institute-funded cancer prevention research program, as well as the clinical coordinating center of the Women's Health Initiative and the international headquarters of the HIV Vaccine Trials Network.

Fred Hutch represents a union between the former Fred Hutchinson Cancer Research Center and Seattle Cancer Care Alliance. Our cancer center, which was officially formed in 2022, is clinically integrated with UW Medicine and serves as UW Medicine's cancer program.

2024 Fred Hutch/UW Oncology Patients

Fred Hutch is based in Seattle's South Lake Union neighborhood. Our main campus includes research facilities; two clinic buildings that provide outpatient care; a wellness center focused on preventive care and survivorship services; and imaging facilities. Inpatient services are available at UW Medicine's treatment facilities, where Fred Hutch operates as the cancer program for UW Medicine. UW Medical Center – Montlake houses three Fred Hutch cancer care units: Radiation Oncology and Medical Oncology serve adults who need treatment for primary cancer, while Fred Hutch Cancer Center – Proton Therapy, a partnership with ProCure Treatment Center, currently offers the only proton therapy within 1,000 miles of Seattle. Since 2019, Fred Hutch has added regional locations to respond to patient population growth, including outpatient treatment facilities in Bellevue at Overlake, Kirkland at EvergreenHealth, Issaquah and the Olympic Peninsula. This latter location in Poulsbo houses a radiation oncology clinic and an adjacent medical oncology clinic. Two regional outreach and education offices, located in Sunnyside and Spokane, are further detailed in the Office of Community Outreach and Engagement section.

Figure 1: Fred Hutch Treatment Centers and Community Sites



Patients

Fred Hutch serves a diverse patient base, many of whom travel long distances to receive care. Patients come from every county in Washington state (Washington), 10% come from out of state and less than 1% come from out of the country. Almost 90% of the patients treated at Fred Hutch live in Washington.

Total Numbers of Patients in 2024

72,488 patients with appointments

15,633 patients treated

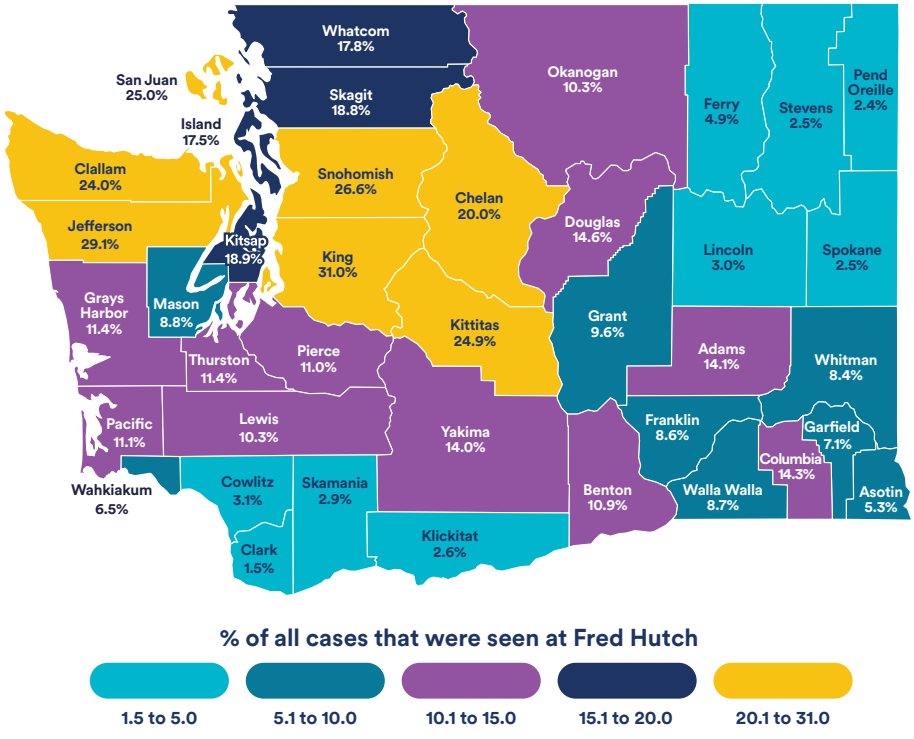
65,080 patients within Washington State

9,213 newly registered patients

Case Density

Case density is an estimate of the proportion of all cancer cases in a county that present to the cancer center from that county.[1] Figure 2 shows the estimate of case density for each of the 39 counties in Washington. Thirty-one percent of cancer cases from King County, where the campuses of Fred Hutch, University of Washington, and Seattle Children's are all located, present to Fred Hutch. In contrast, fewer than 5% of cancer cases from counties along the Washington-Oregon border closest to Portland (Cowlitz, Clark, Skamania, Klickitat Counties) and in the Northeast corner of the State (Ferry, Stevens, Pend Oreille, Lincoln, Spokane Counties) present to Fred Hutch.

Figure 2: Approximate Case Density by County, 2024



Source: Fred Hutch Clinical Analytics

1 Tai, C. G.; Hiatt, R. A. "The Population Burden of Cancer: Research Driven by the Catchment Area of a Cancer Center." *Epidemiol Rev* 2017

Staff

Fred Hutch is made up of more than 5,750 dedicated employees, including physicians, advanced practice providers, clinical staff, scientists, research administrators, support staff and more.

Research and Innovation

Our physicians and researchers work together to translate scientific discoveries into promising new therapies, which are then made available to our patients through clinical trials. Clinical trials and volunteer studies are a vital and critical component of disease research. Through these clinical trials, our researchers make discoveries that lead to new ways to prevent, detect, diagnose and treat diseases. For example, bone marrow transplantation, which is considered the most important advancement in cancer treatment of the last quarter-century, started at Fred Hutch.

In FY24, the Fred Hutch/University of Washington/Seattle Children's Cancer Consortium had:

180 new clinical trials

1,014 active treatment and non-treatment clinical trials

7,331 patients enrolled in a clinical trial

1,082 interventional treatment accruals

2,006 interventional non-treatment accruals

About the Fred Hutch/University of Washington/Seattle Children's Cancer Consortium

The Fred Hutch/University of Washington/Seattle Children's Cancer Consortium (the Consortium) unites these three institutions in their mutual goal to provide compassionate, highly effective cancer care. The Consortium is designated as a Comprehensive Cancer Center by the National Cancer Institute (NCI) and is federally funded by a Cancer Center Support Grant (CCSG). In 2024, the Consortium served a total of 74,609 patients with appointments, treated 16,324 patients, and had 9,542 newly registered patients.

For more than 20 years, the Consortium has fueled advances in cancer research and care by combining the strengths of its member institutions to serve the state of Washington.

OCOE staff and community member at the Colorectal Cancer Community Awareness Event at First African Methodist Episcopal Church.

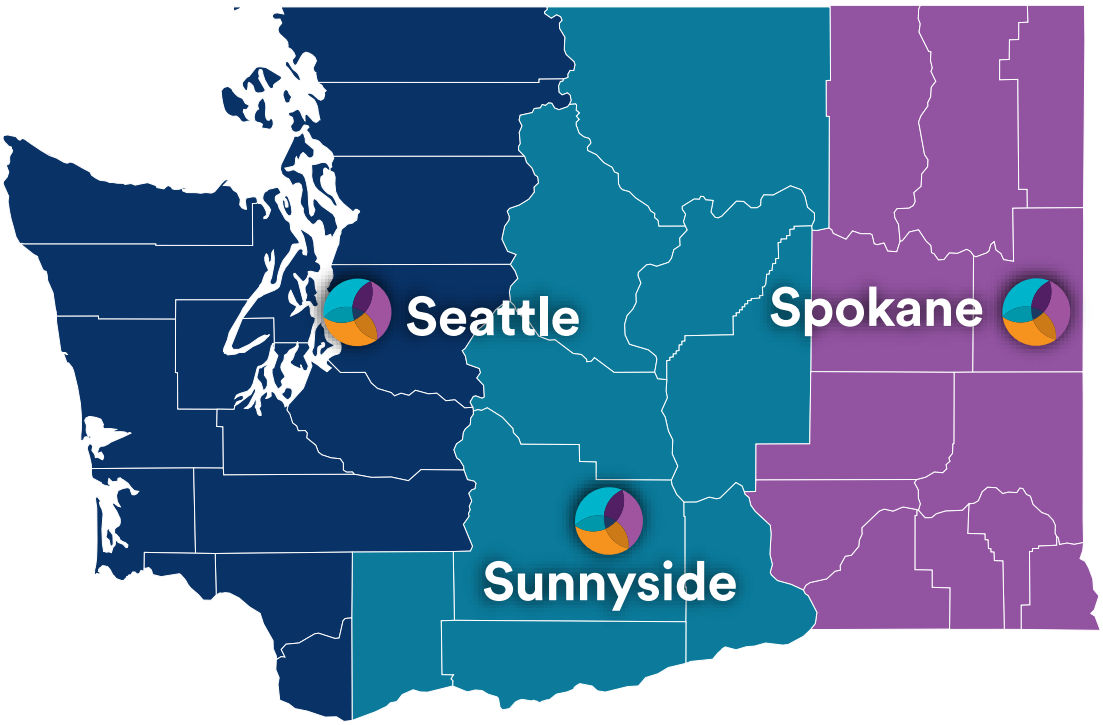
Office of Community Outreach and Engagement (OCOE)

The Office of Community Outreach and Engagement (OCOE), a required component for NCI-Designated Clinical and Comprehensive Cancer Centers, is supported and operated by Fred Hutch on behalf of the Consortium. The OCOE acts as a bridge between Fred Hutch, the Consortium and the communities they serve. By monitoring the cancer burden in Washington and keeping researchers informed about community priorities and health disparities, the OCOE ensures that the research conducted at Fred Hutch and across the Consortium is bidirectional and responsive to the needs in Washington.

OCOE community health educators serve communities with regional offices in Seattle, Sunnyside and Spokane as well as partnerships across the state. They collaborate with three regional community coalitions, cancer programs, and community partners to build sustainable outreach and research collaborations.

In 2022, the OCOE launched the Indigenous Cancer Health Equity Initiative (ICHE-i) to address health disparities among American Indian/Alaska Native (AI/AN) populations. The ICHE-i cultivates relationships between Tribal, academic, health and research entities, centers Tribal Sovereignty and increases patient advocacy efforts.

Figure 3: The OCOE's Three Regional Offices are Located in Seattle, Sunnyside and Spokane.



Community Health Assessment Process

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

- Describe and define the population, health needs and cancer burden for Washington.
- Improve people's health by identifying social and structural factors that impact well-being and use that information to create solutions for all.
- Guide our initiatives in research, care and outreach.
- Incorporate input from a variety of populations to ensure relevance and impact.
- Prioritize investments and programs based on data-driven insights.
- Foster collaboration with local organizations and partners.
- Provide a baseline for tracking progress and evaluating outcomes over time.

A Focus on Social Determinants of Health

There is consistent evidence that social determinants of health (SDOH) — the conditions in which people are born, grow, live, work and age — shape health. SDOH impact health outcomes, both positively and negatively, by as much as 50%. These social, economic and environmental factors operate independently from a person's biological makeup and can impact people's risk of cancer, the early detection of cancer, the care and treatment that patients receive, and their survival.

> **Health disparities** are differences in health outcomes and access to care among population groups, often influenced by factors like race, ethnicity, income, or where people live. These differences can be measured, though they don't always result from systemic causes.
>
> Some differences in health outcomes and access to care are preventable and often linked to long-standing social, economic, and environmental conditions. These patterns can result from policies and practices that have not supported equal access or opportunity for all communities.

Social determinants of health (SDOH) are both shaped by and contribute to differences based on race, ethnicity, socioeconomic status, and other marginalized identities. These differences can affect health outcomes, including mortality rates, and continue to impact cancer survivors in the United States. This assessment uses SDOH as a framework to better understand the varied health experiences across our community and to inform the priorities identified.[2]

2 Huang, H. et al. "Association between social determinants of health and survival among the US cancer survivors population." *BMC Med 2024.*

SDOH provide context for the health priorities identified in the assessment, aiming to reduce health disparities.

> **"The most pressing health issues and what creates them are so very vast.** There are many different factors that these issues have been born out of it, from politics to socioeconomic factors to economics, education, employment, social capital. Your ZIP code basically equals your health outcomes."[3]
> — Community Partner (Northeast Region)[4]

Definitions and Methods

Cancer Statistics

The following terms appear frequently throughout this report to define the cancer burden.

Incidence Rate: The count of new cancer cases diagnosed per 100,000 people in the population per year.

The 2020 incidence rate is displayed but not used in the fit of the trend line(s) to account for the impact of COVID-19 on delays in cancer screening and diagnosis.

Mortality Rate: The incidence of fatal cases of cancer per 100,000. The lower the number, the lower the rate of cancer deaths in the community.

Historical Trends: Patterns or changes that have occurred over time; regression lines are calculated using the Joinpoint Regression Program (Version 5.1)[5].

Trends are characterized as follows:

- Rising when 95% confidence interval of average annual percent change is above 0.
- Stable when 95% confidence interval of average annual percent change includes 0.
- Falling when 95% confidence interval of average annual percent change is below 0.

95% Confidence Intervals (CI): A measure of uncertainty around the estimate. A 95% confidence interval is a numerical range which, upon repeated sampling, will contain the true value 95% of the time.

Annual Percent Change (APC): Calculated as the annual change in the age-adjusted incidence rates over the stated time period.

Age-Adjustment: All rates are age-adjusted to the 2000 U.S. Census standard population (19 age groups: <1, 1-4,5-9,...80-84, 85+).

3 Quotes have been edited for length and clarity.
4 For the purposes of this report, Washington geographic regions are defined as: Peninsula/Coastal, Northwest, North Puget Sound, South Puget Sound, Southwest, North Central, South Central, Northeast and Southwest.
5 Kim HJ, Fay MP, Feuer EJ, Midthune DN. Permutation tests for joinpoint regression with applications to cancer rates. Stat Med 2000;19:335-51 (correction: 2001;20:655).

Rural and Urban: Rural-Urban Continuum Codes provided by the United States Department of Agriculture (USDA) are used to classify counties as rural or urban.[6] The 2023 Rural-Urban Continuum Codes distinguish U.S. metropolitan (metro) counties by the population size of their metro area, and non-metropolitan (non-metro) counties by their degree of urbanization and adjacency to a metro area. For the 2023 version, the threshold for urban area population was raised from at least 2,500 to 5,000 people.

Race and Ethnicity: We acknowledge that the standard practice of aggregating racial and ethnic data into broad categories obscures differences within groups and minimizes the rich variety of lived experiences of people. This classification of race as a social construct has often been used as a tool of oppression and violence. Recognizing the limitations of this approach, we use the Office of Management and Budget (OMB) data collection and reporting standards to describe the catchment area demographics and cancer burden for the following racial and ethnic groups:

- American Indian and Alaska Native, not Hispanic (abbreviated as AI/AN and synonymously referred to as Indigenous and Native);
- Asian, Non-Hispanic;
- Native Hawaiian and Other Pacific Islander, Non-Hispanic (NHOPI);
- Asian and Pacific Islanders (Asian/PI);
- Black or African American, Non-Hispanic (Black);
- White, Non-Hispanic (White); and
- Hispanic of any race.

Our goal in characterizing the population and cancer burden by race and ethnicity is to identify and monitor disparities and co-develop solutions to reduce the disproportionate burden of cancer with communities throughout the state.

Hematologic Malignancies: A group of diseases, including various types of leukemia like acute lymphocytic (ALL), chronic lymphocytic (CLL), acute myeloid (AML), chronic myeloid (CML), myeloma, Hodgkin lymphoma and non-Hodgkin lymphoma (NHL). These were combined into a single group to examine the burden of these cancers that affect the blood, bone marrow and lymph nodes of individuals living in Washington.

6 https://www.ers.usda.gov/data-products/rural-urban-continuum-codes

Quantitative Data Analysis

Comprehensive cancer control requires monitoring the cancer burden in the state and identifying differences between population groups. The CHA uses population-based statistics to characterize the burden and differences of cancer in Washington.*

United States Census Bureau: This report uses data from the 2000 Census, 2020 Census, and the American Community Survey to describe the demographics of Washington, as the denominator population for cancer incidence (new cancer cases) and mortality rates (death rates from cancer, and for age-adjustment.

Behavioral Risk Factor Surveillance Survey (BRFSS): BRFSS collects data through state-based telephone surveys, where adult U.S. residents are interviewed about their health-related risk behaviors, chronic health conditions, and use of preventive services. We use BRFSS data to characterize cancer health behaviors including diet, obesity, alcohol, physical activity, use of preventive screening tests and smoking prevalence in Washington.

National Immunization Survey (NIS)-Teen; Data on human papillomavirus (HPV) vaccination coverage come from NIS-Teen, an annual random-digit-dialed telephone survey that estimates vaccination coverage among adolescents aged 13–17 years. Data was accessed using the Centers for Disease Control TeenVaxView Interactive! data dashboard.

Surveillance Epidemiology and End Results (SEER)/National Program of Cancer Registries (NPCR): Rates are for invasive cancer (cancer that has spread beyond its original location) only except for bladder cancer, which is invasive and in situ (cancer that has not spread beyond its original location), unless otherwise specified. Rates are calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The U.S. population data file is used for SEER and NPCR incidence rates.

Washington State Department of Health, Washington State Office of Financial Management, Washington Employment Security Department. Data and statistical reports research and databases ranging from health care, education, demographic characteristics, and economic trends.

*Sources provided in full in the References Section.

Qualitative Data

A major component of the CHA is the interviews conducted with a variety of partners from across Washington representing the broad interests of communities, including those with expertise in public health. We designed semi-structured interview and listening session protocols to solicit community input to better understand their needs, strengths, and how we can be involved in addressing the issues or building on those resources. (See Appendix A for interview and listening session questions.)

Interviewees were selected based on their work with specific organizations or identified by the OCOE Community Health Education team as individuals who could share their insights about the health of our communities. They represented Federally Qualified Health Centers, colleges and schools, local public health agencies and community-based organizations working alongside a wide range of community members. These included AI/AN and Black individuals, people of color,

seniors, individuals residing in rural areas, recent immigrants and refugees, LGBTQ+ people and other groups who face significant barriers to accessing cancer prevention and care. Interviews were conducted primarily virtually; when possible, some were conducted in person.

We conducted listening sessions with each of the OCOE's community coalitions in western, central and eastern Washington. The coalitions comprise groups of individuals working toward decreasing health disparities in cancer prevention and care, collaboration and resource sharing, and advising and informing the Consortium/Fred Hutch. The sessions were conducted both in person and virtually. We also conducted a listening session with the Fred Hutch Patient and Family Advisory Council to hear their firsthand perspectives around seeking treatment, barriers to care and opportunities for improved education and information offerings. In all, we received input from 93 individuals. (See Appendix B for a list of organizations represented in interviews and listening sessions.) Once completed, each interview or listening session was then transcribed, coded for themes and analyzed. These findings are summarized in the following sections.

Limitations

We encountered several limitations as we conducted this assessment.

- Some data did not exist. Not all of the indicators were available for all counties.
- Some sample sizes were too small to yield meaningful results.
- The lack of data disaggregation, both internally at Fred Hutch and in publicly available reports, remains a persistent problem. As mentioned previously, there are many subcategories within the racial/ethnic groups presented, which may mask underlying disparities or health outcomes. It is also important to note that populations are not monolithic, and everyone has unique strengths, barriers and challenges that have the potential to impact their experience.
- Most data do not account for multiple factors an individual may have or experience with regard to 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 therefore we cannot compare cancer incidence or deaths for these communities.
- Moreover, we recognize that the socioeconomic and environmental conditions represented in this report are by no means a comprehensive list; other socioeconomic and environmental conditions may exist that impact the ability of populations to access resources.

The input from the interview and listening session participants should be interpreted as the perspectives of the people who participated. The list of organizations, people, and resources that work to improve opportunities for all doesn't capture the richness of assets available in our community. Consequently, data must be interpreted carefully.

Our Community

The catchment area of Fred Hutch and the Consortium includes all 39 counties of the state of Washington. The "catchment area" refers to the self-defined geographic area that each NCI-Designated Cancer Center serves or intends to serve in the research it conducts, the communities it engages and the outreach it performs.[7]

Population Count, Age and Sex Distribution

Nearly 8 million people live in Washington. Approximately 30% are under the age of 25, while 17% are age 65 or older. Females slightly outnumber males.

Race and Ethnicity

Overall, 14% of people in Washington identify as Hispanic, compared to nearly 20% of the U.S. population. However, the populations of several counties in central and eastern Washington are more than 50% Hispanic, including Adams, Franklin and Yakima counties.

The demographic characteristics of Washington state are presented in Figure 4 and compared proportionately to the United States (US).

7 https://gis.cancer.gov/ncicatchment

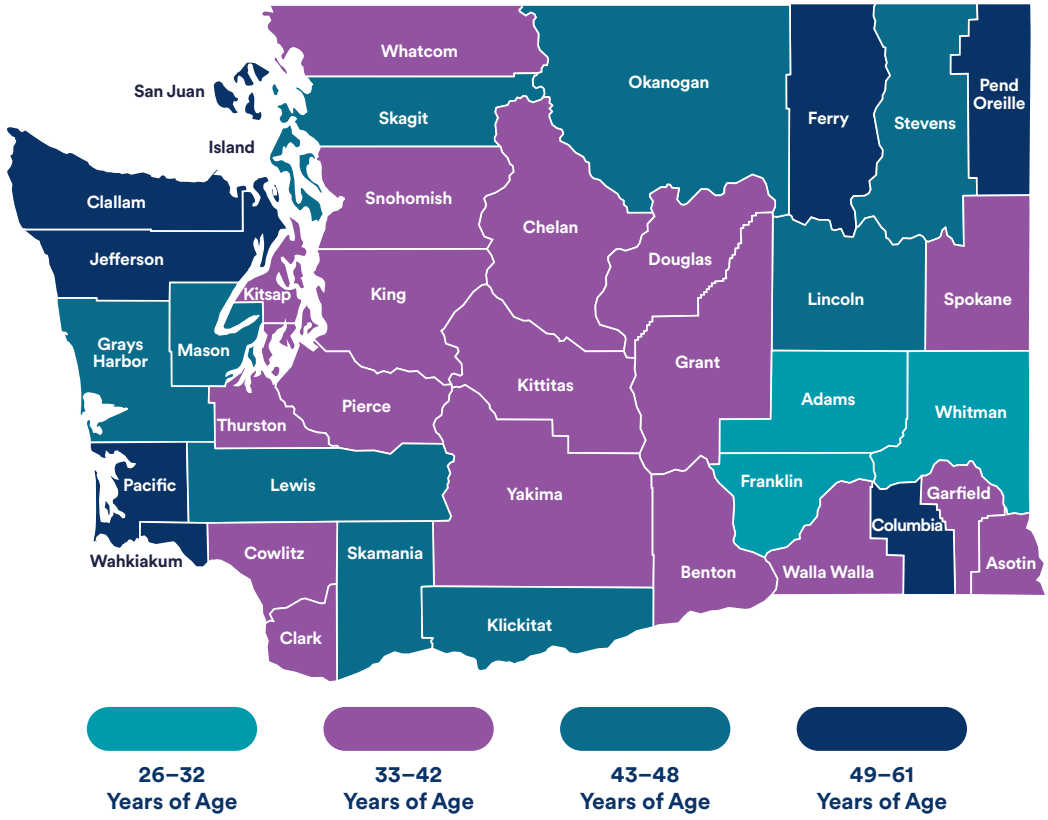
Table 1: Demographic Characteristics of Washington

Sex	Washington		United States	
	n	%	n	%
Male	3,930,411	50.5%	166,757,003	49.6%
Female	3,855,375	49.5%	169,752,348	50.4%
Age	**Washington**		**United States**	
	n	%	n	%
<5	421,722	5.4%	18,457,631	5.5%
5-9	464,035	6.0%	19,903,509	5.9%
10-14	473,406	6.1%	21,390,971	6.4%
15-19	457,060	5.9%	21,982,854	6.5%
20-24	499,354	6.4%	22,662,811	6.7%
25-34	1,176,297	15.2%	45,639,098	13.6%
35-44	1,115,638	14.4%	44,446,393	13.2%
45-54	936,835	12.1%	40,881,168	12.1%
55-59	451,753	5.8%	20,768,827	6.2%
60-64	450,544	5.8%	21,796,928	6.5%
65-74	786,321	10.1%	34,282,051	10.2%
75-84	390,798	5.0%	18,040,213	5.4%
85+	132,023	1.7%	6,256,897	1.9%
Race	**Washington**		**United States**	
	n	%	n	%
AIAN	99,306	1.3%	3,212,301	1.0%
Asian	762,339	9.8%	19,702,751	5.9%
Black	309,488	4.0%	40,791,803	12.1%
NHOPI	54,087	0.7%	665,900	0.2%
White	5,129,500	65.9%	203,737,749	60.5%
Other	451,361	5.8%	25,385,971	7.5%
More Than One	979,705	12.6%	43,012,876	12.8%

Table continues on next page >

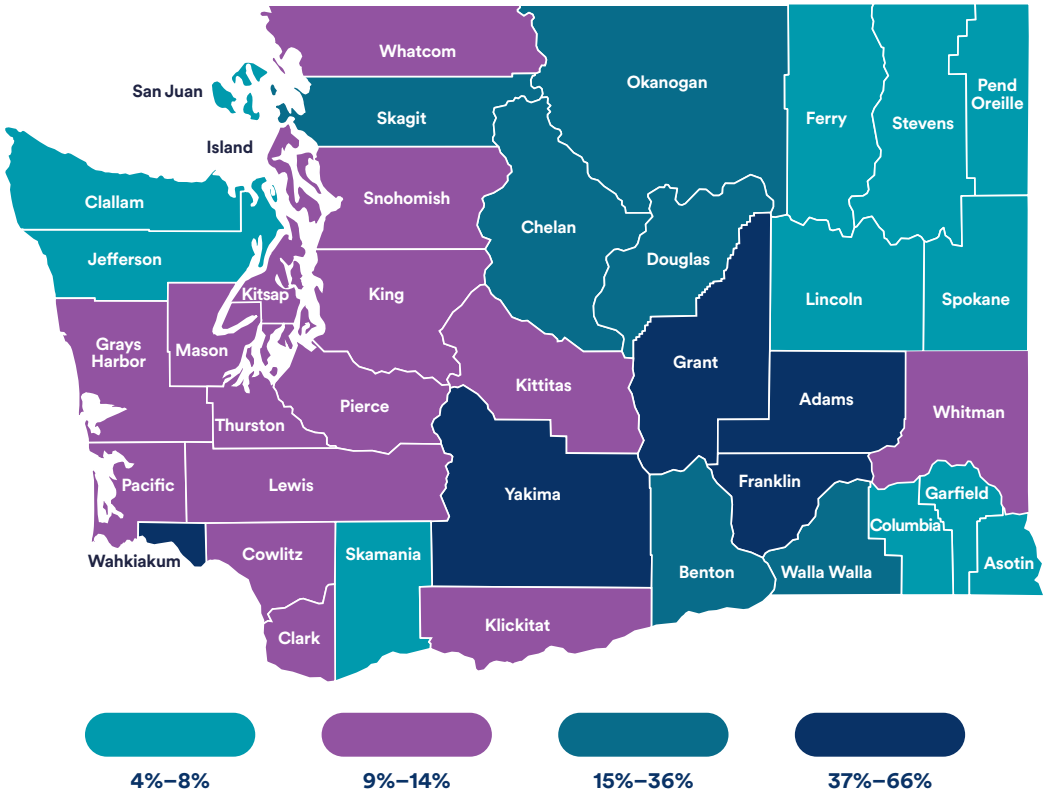
Hispanic	Washington		United States	
	n	%	n	%
Not Hispanic	6,692,473	86.0%	269,765,573	80.2%
Hispanic	1,093,313	14.0%	66,743,778	19.8%
Race/Ethnicity	**Washington**		**United States**	
	n	%	n	%
NH-AIAN	69,024	0.9%	1,750,489	0.5%
NH-Asian/PI	808,063	10.4%	20,008,261	5.9%
NH-Black	299,537	3.8%	39,587,049	11.8%
Hispanic	1,093,313	14.0%	66,743,778	19.8%
NH-White	4,941,456	63.5%	192,170,802	57.1%
NH-Other/Unknown	574,393	7.4%	16,248,972	4.8%

Figure 4: Washington Median Age, Years, 2023



Map source: https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/population-age-mapped-county

Figure 5: County Map of Washington by Percent Hispanic, 2023

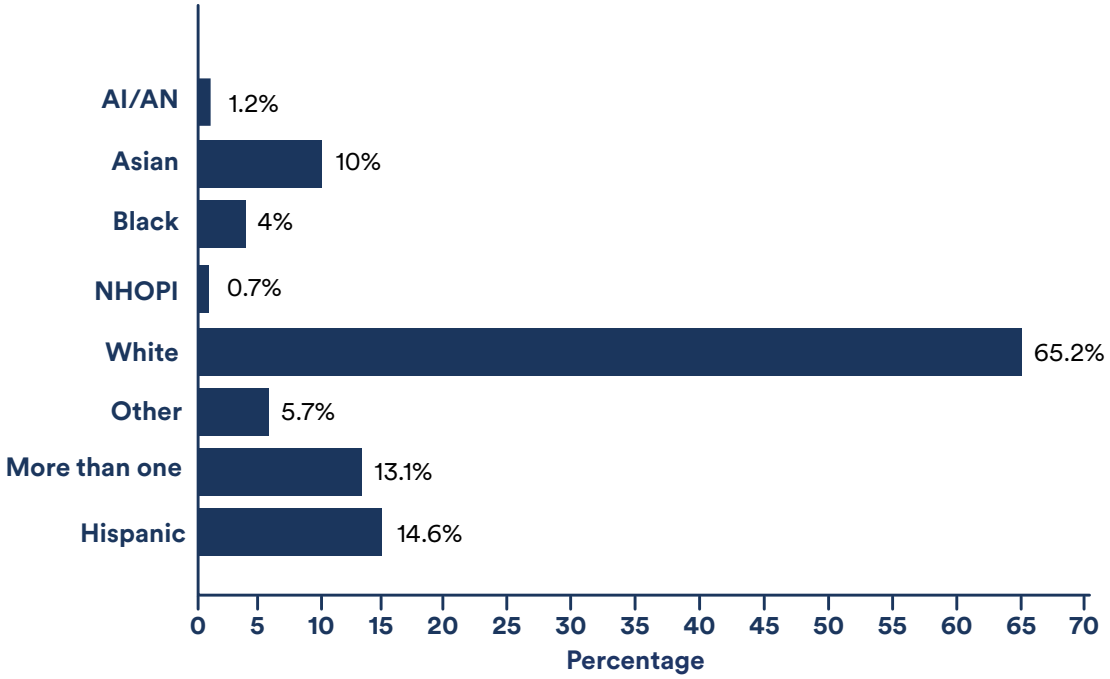


Source: U.S. Census Bureau

In 2023, the highest percentages of Hispanic residents were found in central Washington, including Adams (65.5%), Franklin (55.4%) and Yakima (55.4%) counties. Although representing a lower proportion of the total counties' population, large numbers of persons of Hispanic origin lived in western Washington's largest metropolitan counties, notably King (266,462), Pierce (125,001) and Snohomish (107,120) counties.

Approximately 65.2% of the population of Washington is non-Hispanic White, compared to 60.5% of the U.S.

Figure 6: Washington Population by Race and Ethnicity, 2023



Compared to the U.S. as a whole, a larger proportion of the population of Washington is Asian (10.0% v. 6.0%), NHOPI (0.7% v. 0.2%), whereas a smaller proportion is Black (4.0% v. 12.1%).[8] (Table 1). More than 95,000 people in Washington are AI/AN (1.2%). The AI/AN population includes members of 29 sovereign Tribal Nations in Washington, members of other federally recognized tribes in the U.S., and urban Indian communities.

8 Source: U.S. Census Bureau (2023). American Community Survey 1-year estimates. Tables DP05, B16001. Retrieved on 2/7/25.

Of people aged 5 years and older, nearly 8% report speaking English less than very well (Table 2). Seventy-eight percent of the Washington population primarily speaks English at home. Spanish (9%) is the second most common language spoken at home in Washington, followed by Chinese languages (2%) and Vietnamese (1%). In total, over 1.5 million people (21%) over the age of 5 years in Washington speak a language other than English at home.

Table 2: Languages and English-speaking Ability

Speak English (population 5+ years)	Washington		United States	
	n	%	n	%
Only or Very Well	6,782,883	92.1%	273,681,581	90.8%
Less than Very Well	581,436	7.9%	27,606,796	9.2%
Language Spoken at Home (population 5+ years)	**Washington**		**United States**	
	n	%	n	%
English	5,807,193	78.5%	245,472,067	77.5%
Spanish	684,332	9.3%	43,369,734	13.7%
Chinese (incl. Mandarin, Cantonese)	140,748	1.9%	3,531,221	1.1%
Vietnamese	71,990	1.0%	1,570,595	0.5%
Tagalog (incl. Filipino)	66,089	0.9%	1,803,005	0.6%
Russian	61,285	0.8%	998,179	0.3%
Korean	52,440	0.7%	1,079,420	0.3%
Hindi	45,393	0.6%	947,550	0.3%
Amharic, Somali, or other Afro-Asiatic languages	41,429	0.6%	611,987	0.2%
Ilocano, Samoan, Hawaiian, or other Austronesian languages	37,720	0.5%	500,493	0.2%
Ukrainian or other Slavic languages	36,658	0.5%	484,892	0.2%
Other languages	350,281	4.7%	16,212,056	5.1%

Source: U.S. Census Bureau (2023). American Community Survey 1-year estimates. Tables DP05, B16001. Retrieved on 2/7/25.

Social Determinants of Health in Our Community

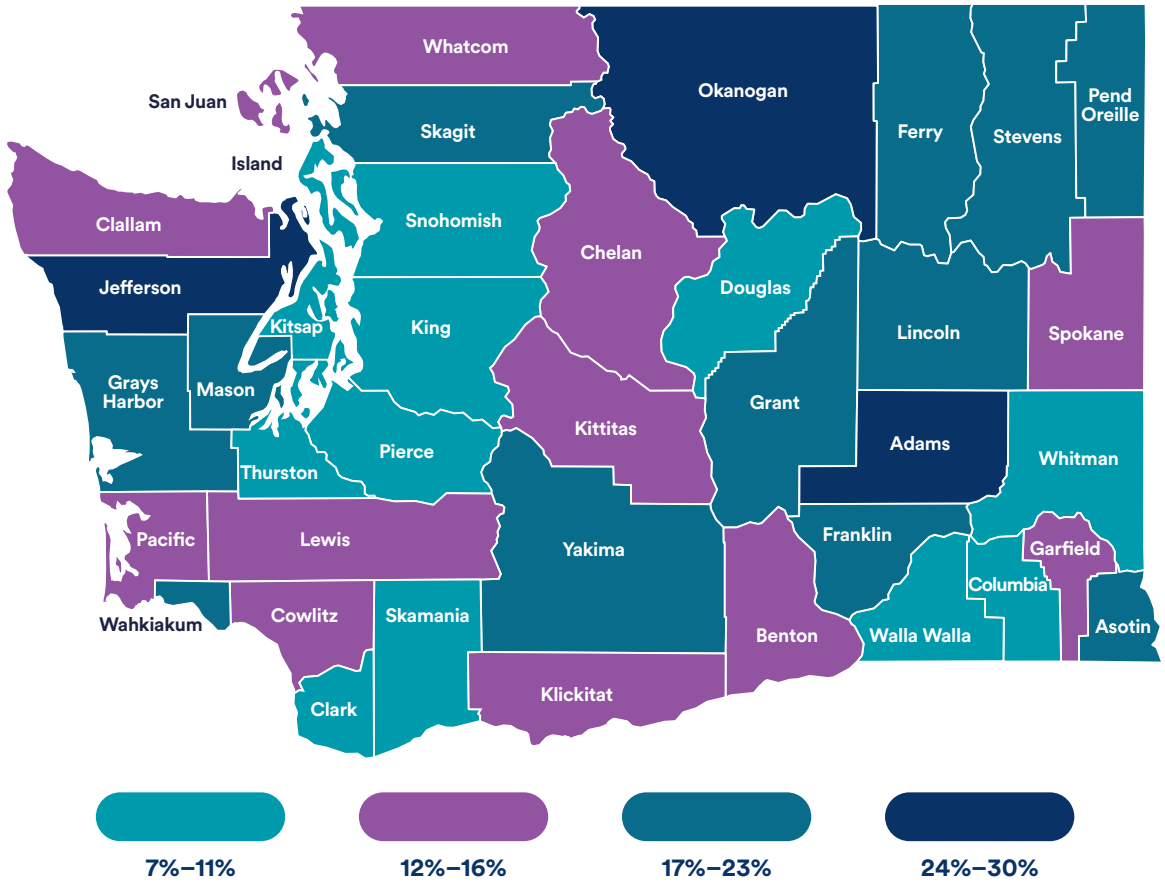
Figure 7: Social Determinants of Health

Social determinants of health include economic, social and environmental factors. Social determinants of health are often compounded by racial and ethnic differences and can have a big impact on health outcomes and mortality.

Economic Stability and Well-Being

Income and Poverty: Nearly 10% of households in Washington have an annual income of less than $20,000, compared to 13% of U.S. households. Conversely, 28% of Washington households have an income greater than $150,000, compared to 22% of U.S. households. The percentage of people living in poverty is lower in Washington than in the U.S. across every age group. For a family or household of four persons living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2024 is $31,200. (CIB: 2020 Federal Poverty Level Standards). However, considerable variation in the distribution of poverty exists by race and ethnicity. Specifically, AI/AN, Black and NHOPI people in both Washington and the U.S. are approximately twice as likely to live in poverty as Asian or White people.[9]

Figure 8: Proportion of Families in Poverty by County, 2022



Source: Washington state Office of Financial Management (2022).

9 U.S. Census Bureau. American Community Survey 1-year estimates. Table S1701. 2023.

> **"Poverty is a big contributor to [the barriers to health in our region].** I think poverty can tend to just beat down a person's self-worth. It becomes such a burden to try to make ends meet that people almost become numb. They're just in this frozen state of 'I don't even know where to start.' And so the care coordinators work with the individual to find a goal. What is magical is that people take one tiny baby step at a time until they accomplish something and feel that sense of empowerment."
> — Community Partner (North Central and Eastern Washington)

> **"We have a lot of health care entities, but nothing that really serves our underserved populations.** And certainly nothing that helps remove the barriers and obstacles to care for our population as a whole."
> — Community Partner (North Puget Sound)

Self-Sufficiency Standard: The Self-Sufficiency Standard is an affordability and living wage measure that serves as an alternative to the official poverty measure. It determines the income families need to meet basic needs. Family composition, ages of children and geographic differences are taken into consideration to calculate the costs. While the poverty level is established at $31,200 for a family of four anywhere in the contiguous U.S. in 2024, the annual Self-Sufficiency Standard for a Washington household with two adults and two children ranges from $72,014.78 (in Franklin County) to $123,297.59 (in east King County) (Table 3).

Table 3: Self-Sufficiency Standard Comparison Between Lowest and Highest Washington Geographic Area

Household Expenses	Franklin	East King
Housing	$1,070	$2,746
Child Care	$1,531	$2,867
Food	$893	$1,217
Transportation	$681	$198
Health Care	$717	$724
Other Needs (including Internet, Cell Phone)	$619	$905
Taxes	$923	$1,752
Earned Income Tax Credit (-)	$0	$0
Child Care Tax Credit (-)	($100)	($100)
Child Tax Credit (-)	($333)	($333)
Self-Sufficiency Wage		
Hourly	$17.05	$28.34
Monthly	$6,001	$9,976
Annual	$72,015	$119,707
Emergency Savings Fund (Monthly Contribution)	$120	$201

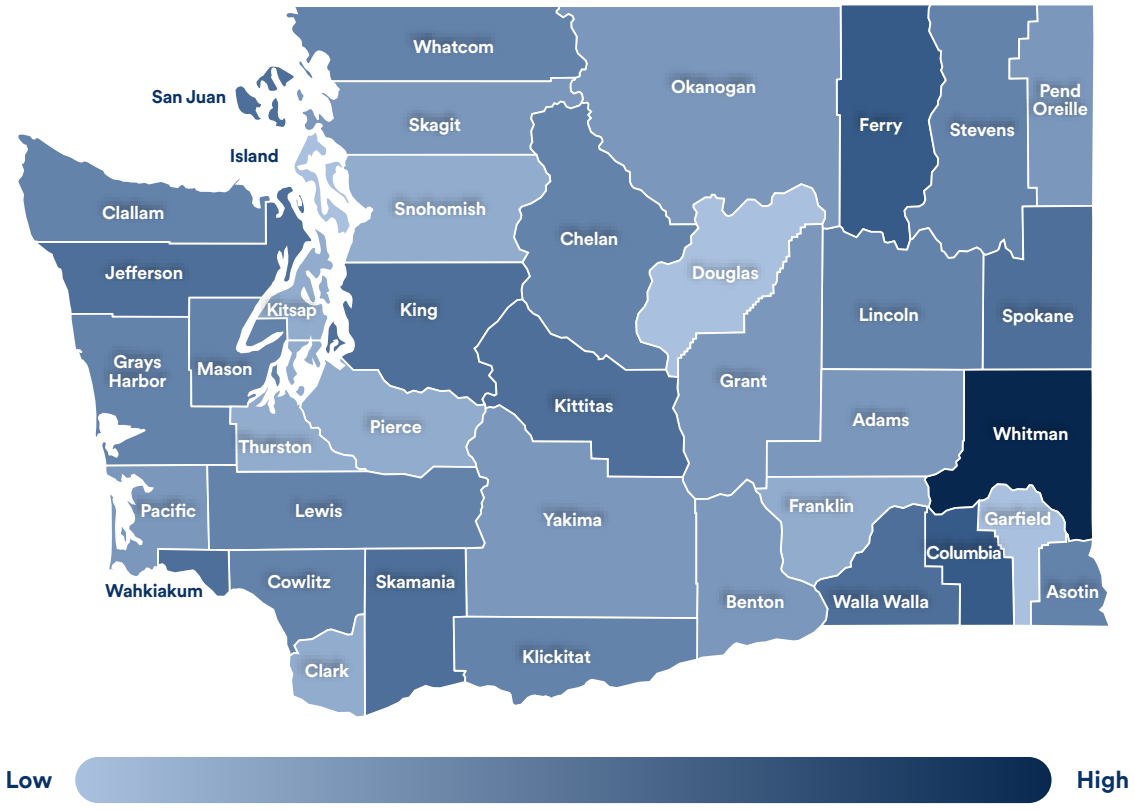
Source: https://selfsufficiencystandard .org/washington/

> **"I've certainly met with a few patients who have chosen not to pursue treatment** because they didn't want to become destitute, and whether or not that's actually an outcome, it's a perceived concern. What is driving these factors is certainly societal, a high cost of living area."
> — Health Care Provider

Income Inequality: Income inequality is the difference in how income is distributed among the population. "Income inequality in a society has a strong causal connection to health, independent of the income of individuals."[10] Societies with high income inequality can experience pronounced differences in social class, loss of social cohesion and decrease in trust and a sense of community for all residents. In Washington, households with higher incomes had income 4.4 times greater than that of households with lower incomes (Figure 9). This inequality ranged from 3.5 times (Garfield County) to 7.3 times (Whitman County) across the state.[11]

On County Health Rankings & Roadmaps, income inequality is defined as the ratio of household income at the 80th percentile to the household income at the 20th percentile. In other words, it measures the disparity between the incomes of the wealthiest 20% of households and the incomes of the poorest 20%. A higher ratio indicates greater inequality.

Figure 9: Washington Income Inequality, 2024



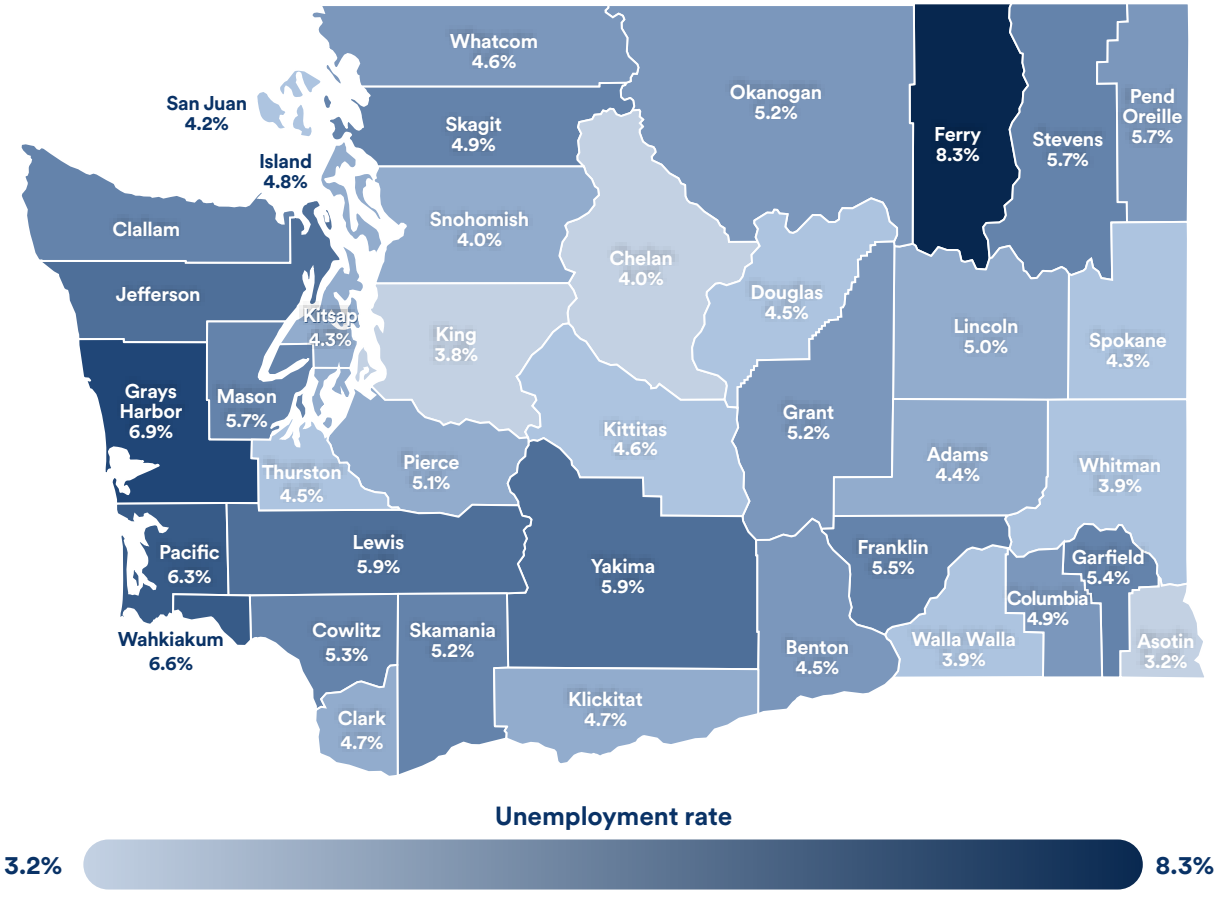
Source: https://www .countyhealthrankings .org/health-data/ washington?year=2024&measure=Income+Inequality

10 County Health Rankings & Roadmaps. *Income Inequality, Washington 2024* (5-year estimated data from 2018–2022). University of Wisconsin Population Health Institute 2024.

11 County Health Rankings & Roadmaps. *Income Inequality, Washington 2024* (5-year estimated data from 2018–2022). University of Wisconsin Population Health Institute 2024.

Employment: Different aspects of employment may impact health positively or negatively, depending on job security, the work environment, job demands and compensation and benefits. With the majority of non-elderly U.S. residents (60%) receiving employer-sponsored health insurance, this is a significant factor in the lives of many workers.[12] Washington's seasonally adjusted unemployment rate for November 2024 (the latest confirmed rate at the time of this publication) was 4.6%, compared to the 4.2% unemployment rate in the U.S.[13] Figure 10 shows the unemployment rate by county. Ferry (8.3%) and Grays Harbor (6.9%) counties had the highest unemployment rates, whereas Asotin (3.2%) and King (3.8%) counties had the lowest rates.

Figure 10: November 2024 Unemployment Rates by County



Source: https://esd.wa.gov/jobs-and-training/labor-market-information/reports-and-research/monthly-employment-report

12 Goodman, N. *The Impact of Employment on the Health Status and Health Care Costs of Working-age People with Disabilities*. The Lead Center 2015.

13 Employment Security Department. *The Monthly Employment Report, November 2024.* Washington State, 2024. Retrieved 2/10/2025.

"One person was told she should probably stop working due to the length of time she would need to be at [Fred Hutch]. The first questions she asked were, 'How do I afford treatment and not work? How do we go from two incomes to one?'"
— Health Care Staff Member

> **"A lot of the agricultural workers that we serve often don't have transportation,** or don't have time, or they're not aware of how to take time off to go to their appointments."
> — Community Partner (South-Central Region)

The Thriving Natural World

A healthy environment is another vital condition of well-being. A thriving natural world includes clean air, water and land, and healthy and resilient ecosystems. Black, Indigenous and people of color (BIPOC) communities, as well as individuals with lower incomes and less access to education and health care, are often disproportionately impacted by environmental pollution and the effects of climate change.

Social and Community Context

Social support, fulfilling relationships and a sense of belonging provide a foundation for individual and community health broadly, and cancer care specifically.

Social Connection: Social connection has been associated with positive health outcomes, including improved cancer survival. Conversely, social isolation and loneliness have been suggested as risk factors for cancer mortality. For example, a recent study concluded that women who experience social isolation had a higher risk of mortality after a female breast cancer diagnosis, likely because of a lack of access to caregiving from family or friends.[14]

> **"We have someone here who had a colonoscopy coming up and didn't have anyone who could take them or pick them up.** You don't think about that necessarily as being [a barrier]. Yes, of course, someone's gonna get you to your colonoscopy. Well, not if you don't have anybody."
> — Community partner (North and South Puget Sound Regions)

More information on the impact of social isolation can be found in the "Significant Health Needs Identified" section.

Racism and Discrimination: Systemic racism, both historical and current, has created disparities in health and health care, as well as in access to housing, education, employment and many other opportunities for BIPOC peoples. Significant racial disparities have been documented for most cancers. Evidence suggests that "the predominant risk factors are deeply ingrained social inequities such as structural racism."[15]

Issues of racism and discrimination in the delivery of culturally sensitive care are significant health needs. See more in the "Significant Health Needs" section.

Immigration and Refugee Status: The recent immigration increase has been the largest in U.S. history. Even after adjusting for today's larger population, this surge is still slightly larger than the average historical migration rate.[16] The annual 2023 Census shows that 15.5% of the Washington population is foreign-born.[17] Washington is one of the top 10 resettlement states in the country for people who have received refugee status. From October 2022 to December 2024, there have been 18,269 unduplicated newly arrived refugees in Washington.[18]

14 Kroenke, C. H. et al. "Social networks, social support, and survival after breast cancer diagnosis." *Journal of Clinical Oncology* 2006.
15 Nelson, B. "How Structural Racism Can Kill Cancer Patients." *Cancer Cytopathology* 2020.
16 Leonhardt, D. "Recent Immigration Surge Has Been Largest in U.S. History". *The New York Times* 2024.
17 United States Census Bureau. *2023 American Community Survey: Selected Social Characteristics in the United States.* U.S. Department of Commerce.
18 University of Washington Department of Environmental & Occupational Health Sciences, and Washington Department of Health (DOH). *Washington Environmental Health Disparities Map: Cumulative Impacts of Environmental Health Risk Factors Across Communities of Washington State* (Technical Report Version 2.0). 2022. Retrieved 2/6/2025.

The Migration Policy Institute estimates that 246,000 people who are undocumented live in Washington.[19] Of those, 49% are uninsured. In 2024, the Washington State Legislature approved funding for Apple Health Expansion for adults aged 19 or older earning up to 138% of the federal poverty level (FPL), regardless of immigration status. The program went into effect in July 2024. The Health Care Authority (HCA) estimated that around 13,000 eligible individuals would be able to enroll in the Apple Health Expansion (Washington State Hospital Association, 2024).[20]

19 Migration Policy Institute. *Profile of the Unauthorized Population: Washington.* Migration Policy Institute NA.
20 Washington State Hospital Association. *Coverage for Undocumented Individuals in Washington State.* Washington State Hospital Association NA.

Neighborhood and Built Environment

Physical and mental well-being starts with healthy places for people to live, learn, work, play, worship and age. Access to clean soil, air and water; nutritious food; affordable and humane housing; reliable transportation and a thriving natural world all have the power to shape people's health. Historic and recent decisions have affected how the natural and built environments have changed since White settlers occupied the U.S.; these changes, in turn, have had an impact on wealth and health disparities.

> **"A lot of it is systemic and has to do with barriers that were built into our government structure** and the way that resources are accessed. So the reservation systems, for instance, it's really hard for people to get transportation to get health care. There are food deserts on reservations, so someone might have to drive 40 miles or something to get to a grocery store that has fresh fruits and vegetables. Many people are facing poverty. A lot of folks are low income, also because there's not always a lot of opportunities for employment."
> — Tribal community partner (Washington)

> **"[A main gap that communities face specific to cancer prevention and care is] being able to stay physically active.** There are equity issues to how communities are built and who has access to free fitness."
> — Tribal community partner (Washington)

Housing: Safe, stable and affordable housing affects health outcomes.[21] Households are considered housing cost-burdened when they spend more than 30% of their income on rent, mortgage or other housing expenses.[22] In Washington, nearly a third (28.9%) of homeowners and nearly half (48.9%) of renters are considered cost-burdened. These figures are similar for renter and owner households in the U.S. (27.3% and 49.9%, respectively). Pacific, San Juan, Jefferson and Ferry counties have the highest percentage of both renter and owner cost-burdened households in the state.

> **"[Many LGBT seniors have been] priced out, forced to move from LGBT-affirming areas.** Historical wealth isn't something that a lot of LGBT seniors have. Many of them have been discriminated against in employment, in job searches, for the majority of their lives."
> — Community Partner (North Puget Sound Region)

The number of individuals who are unhoused has increased in recent years in both Washington and the U.S. Rising rents, low vacancy rates and substance use disorder are among the factors associated with this increase.[23] Individuals who are unhoused include those living outside;

21 U.S. Census Bureau. (2022). American Community Survey 5-Year Estimates, Table DP04: Selected Housing Characteristics.
22 U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates.
23 Washington State Department of Commerce. *Homelessness in Washington.* Washington State 2023.

in structures not meant for human habitation or which they have no legal right to occupy; in emergency shelters; or in temporary, transitional and supportive housing programs.[24] In 2024, approximately 31,040 individuals were unhoused in Washington, according to the annual Point-in-Time Count. Over half of them were located in King County.

According to a recent study, mortality rates among people who are unhoused throughout the country more than tripled between 2011 and 2020. Deaths attributed to cancer among individuals who are unhoused had a 320% increase in the 10-year period.[25]

> **"Competing needs. Whether that's somebody dealing with houselessness, so health isn't a priority.** Or whether that's somebody with a lot of health concerns, that cancer screening isn't a priority 'cause they have other priorities that need to be addressed."
> — Health Care Organization Staff Member, Washington

See more in the "Significant Health Needs" section.

Transportation: Access to transportation is a major factor impacting health. Policies and programs supporting and improving public and active transportation (walking, biking) can help protect the environment and improve health. People who live in rural areas, older adults, people of lower income, those who are monolingual in languages other than English, people who are unhoused and individuals with mobility issues face disproportionate difficulties when accessing transportation for their health care. While not a perfect measure, one indicator available to track access to transportation is vehicles available in the household. Some 205,391 households in Washington (6.9% of the total occupied housing units) do not have a vehicle available[26]. See more about transportation issues related to care in the "Significant Health Needs" section.

Food Security: Access to nutritious food is a basic human need.[27] Households who are food secure always have access to enough food to live an active, healthy life.[28] A wide range of factors may influence food security, including income, employment, race and ethnicity, disability, neighborhood conditions, transportation options, equitable distribution of places to access food and economic structures.[29] In 2022, an estimated 891,960 people in Washington were food insecure, representing approximately 11.2% of the state's population (Feeding America, 2024).[30] By comparison, in 2023, 13.5% of U.S. households experienced food insecurity (USDA, 2024).[31]

24 Homeless housing and assistance. Revised Code of Washington Section 43 § 185C.
25 Fowle, M. and Routhier, G. "Mortal Systemic Exclusion Yielded Steep Mortality-Rate Increases in People Experiencing Homelessness, 2011–20." *Health Affairs* 2024.
26 U.S. Census Bureau. American Community Survey 5-Year Estimates, Table B25044: Tenure by Vehicles Available (2022).
27 National Institute on Minority Health and Health Disparities. *Food Accessibility, Insecurity and Health Outcomes.* National Institutes of Health, U.S. Department of Health & Human Services 2024.
28 Feeding America. *Food Insecurity among the Overall Population in Washington.* Food Insecurity Report Briefs: Map the Meal Gap (2022 data) 2024.
29 National Institute on Minority Health and Health Disparities. *Food Accessibility, Insecurity and Health Outcomes.* National Institutes of Health, U.S. Department of Health & Human Services 2024.
30 Feeding America. *Food Insecurity among the Overall Population in Washington.* Food Insecurity Report Briefs: Map the Meal Gap (2022 data) 2024.
31 U.S. Department of Agriculture. (2024). Household Food Security in the United States in 2023.

Food insecurity is defined as the lack of consistent access to enough food for every person in a household to live an active, healthy life. It reflects both the quantity and quality of available food, and may result from limited financial resources, availability, or access to food sources. Food insecurity is associated with a higher probability of cancer.[32] A USDA study found that the prevalence of cancer increases as food insecurity worsens, and this association between food insecurity and cancer continues after adjusting for other socioeconomic factors. This pattern is similar for other chronic diseases.[33]

For Fred Hutch patients, food insecurity is the most common social need identified through the Supportive Care Questionnaire, a health screening tool distributed to new patients at all Fred Hutch sites. Approximately 5% of patients identified as food insecure in the last year. The questionnaire also assesses housing, transportation, financial and interpersonal safety needs.

32 Coleman-Jensen, A. & Gregory, C. "Adults in Households with More Severe Food Insecurity Are More Likely to Have a Chronic Disease." Economic Research Service, U.S. Department of Agriculture 2017.

33 Patel et al. "Food insecurity screening: A missing piece in cancer management." *Cancer* 2019.

Education Access and Quality

Higher levels of education are associated with better health and longer lives. Improving educational attainment can improve health outcomes in a number of ways, such as by increasing health literacy, shaping employment opportunities and thus affecting income and health insurance.[34] In a recent Reasons for Geographic and Racial Differences in Stroke (REGARDS) study, low education was strongly associated with higher cancer mortality.[35]

> **"Educating the community on cancer awareness,** screening and resources — these are problems in underrepresented areas."
> — Community Partner (Washington)

Among people 25 years or older, 8% of individuals in Washington have less than a high school degree or its equivalent. Sixteen percent of people in Washington have a graduate degree. In comparison, 10% of the population of the U.S. have less than a high school degree and 14% have a graduate degree (U.S. Census Bureau, 2022)[36].

Table 4: Education (population 25+ years)

	Washington		United States	
	n	%	n	%
Education (population 25+ years)				
Less than HS	420,991	7.6%	23,698,453	10.2%
HS Grad	1,188,673	21.6%	60,105,924	25.9%
Some College / Associates	1,672,195	30.3%	64,170,652	27.7%
Bachelors	1,340,967	24.3%	50,567,878	21.8%
Graduate	888,371	16.1%	33,248,210	14.3%

Source: U.S. Census Bureau (2023). American Community Survey 1-year estimates. Tables B06009, DP02, S2503, S1701, DP03. Retrieved on 2/12/25 from https://data.census.gov/

34 National Academies of Sciences, Engineering, and Medicine. *Communities in Action: Pathways to Health Equity.* 2017.
35 Gupta, A. et al. "Association of educational attainment with cancer mortality in a national cohort study of black and white adults: A mediation analysis." SSM – *Population Health* 2023
36 U.S. Census Bureau. (2022). American Community Survey 1-Year Estimates, Table S1501: Educational Attainment.

Health Care Access and Quality

Access to affordable, timely, reliable and culturally sensitive health care is also an important factor in staying healthy. Access to care is multifaceted: it encompasses the ability to obtain health insurance, availability of providers within a reasonable distance, support navigating health care systems, opportunities to gain health literacy skills, transportation to care and access to early prevention and screening options. Access to care was one of the three priority areas identified in the previous Fred Hutch CHA and the top health need of the community identified through the current CHA. Please see the “Significant Health Needs Identified” section for more information about the significant need for improved access to care.

Behaviors Related to Cancer

Maintaining a healthy weight, protecting against UV radiation and staying up to date with vaccinations, including human papillomavirus (HPV) and hepatitis B, are important cancer prevention measures. The prevalence of established cancer risk factors, including commercial tobacco use, poor dietary habits, excessive alcohol consumption and physical inactivity, is collected annually by BRFSS.

Alcohol Use

Alcohol use is the third leading preventable cause of cancer in the U.S., after tobacco and obesity. In 2024, the surgeon general issued an advisory highlighting the causal relationship between alcohol use and increased risk for cancer.[37] Alcohol contributes to nearly 100,000 cancer cases and about 20,000 cancer deaths in the U.S. each year.[38] In Washington in 2023, 58.2% of adults reported having at least one drink of alcohol within the past 30 days, while 16.5% of adults reported having five or more drinks (males) or four or more drinks (females) on one occasion.

Commercial Tobacco[39] Use

Commercial tobacco use continues to be the leading cause of preventable death in the country and in Washington. It causes about 1 in 5 of all deaths in the U.S. Cigarette smoking is the primary cause of lung cancer. Nine percent of adults in Washington report smoking cigarettes regularly, compared to the Healthy People 2030 objective of 5.0%.[40] While cigarette smoking among U.S. adults has declined by more than 70% since 1965, disparities persist in tobacco product use and exposure to secondhand tobacco smoke.[41] The prevalence of commercial tobacco[42] smoking is highest among AI/AN adults (25.7%) and lowest among Asian/PI adults (6.1%) (Figure 11). Smoking prevalence is also highest among adults with an annual household income <$15,000 (27.8%) and those with less than a high school degree (20.2%). Importantly, males in Washington are about 26% more likely to smoke than females.[43]

37 Islami F, Marlow EC, Thomson B, et al. 2019 as cited in the Office of the Surgeon General. *Alcohol and Cancer Risk 2025, The U.S. Surgeon General's Advisory.*

38 Ibid.

39 Tobacco that is not used for sacred or ceremonial purposes.

40 U.S. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS): Tobacco Use. U.S. Department of Health and Human Services. Retrieved Jan 22, 2025.

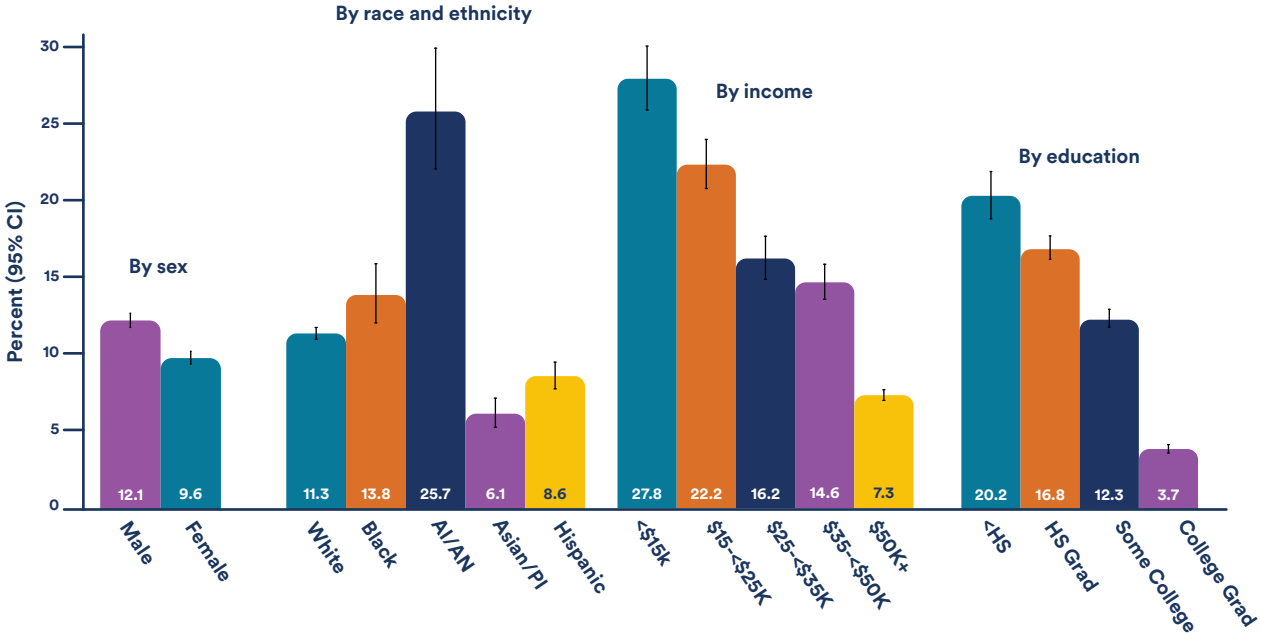
41 Office of the Surgeon General. Eliminating Tobacco-Related Disease and Death: Addressing Disparities, Your Guide to the Surgeon General's Report (2024). Centers for Disease Control & Prevention, U.S. Department of Health & Human Services.

42 "'*Commercial tobacco*' means harmful products that are made and sold by tobacco companies. It does not include 'traditional tobacco' used by Indigenous groups for religious or ceremonial purposes." (U.S. Centers for Disease Control and Prevention. American Indian and Alaska Native People and Commercial Tobacco: Health Disparities and Ways to Advance Health Equity.

43 U.S. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS): Tobacco Use. U.S. Department of Health and Human Services. Retrieved Jan 22, 2025.

> **"In the LGBT community, bar culture is such a huge thing.** And when we look at the social aspects of smoking that go with that, there's more smoking in the LGBT community than in the community at large. For older folks, I think a lot of them view quitting smoking as something, well, it's too late for them to do."
> — Community Partner (Puget Sound Region)

Figure 11: Smoking in Washington



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2019-2023. Age-standardized to US Population, 2000

Vaping products are the most common nicotine product used by youth.[44] In 2023, 14% of 12th graders in Washington reported having used vape products, 6% had used smokeless tobacco and 5% had used cigarettes in the past 30 days. Twelfth graders who identified as non-Hispanic AI/AN had the highest rates of vaping use.[45]

44 Centers for Disease Control and Prevention. E-Cigarette Use Among Youth. U.S. Department of Health and Human Services 2024.
45 Washington State Healthy Youth Survey Results: 2023. The Washington State Office of Superintendent of Public Instruction (OSPI); Department of Health (DOH); Health Care Authority Division of Behavioral Health and Recovery (DBHR); and Liquor and Cannabis Board (LCB) NA.

Nutrition and Physical Activity

Obesity, defined as a body mass index of 30kg/m^2 or greater, increases the risk of 13 types of cancer.[46] In the U.S., 40% of adults are obese, a prevalence that remains above the Healthy People 2030 goal of 36.0%.[47] In Washington, 30.8% of adults are considered obese (BMI 30.0–99.8), while 34.9% are considered overweight (BMI 25.0–29.9).

Behaviors related to healthy body weight, including fruit and vegetable consumption and physical activity, are associated with access to healthy food and safe spaces for exercise and leisure time activity. Diets rich in fruits, vegetables and legumes are associated with lower risk of mouth, pharynx, larynx, esophagus, stomach, lung, colon, pancreas and prostate cancers.[48] Plant-rich diets may also help people maintain a healthy weight.[49] More than 3 out of 5 people in Washington (63%) report consuming fruit one or more times per day and 4 in 5 people (81%) report consuming vegetables one or more times per day.[50]

Being physically active lowers the risk for developing at least eight types of cancer, including breast, colon, kidney and lung.[51] One-third of Washingtonians (31.5%) participated in enough aerobic and muscle strengthening exercises to meet CDC guidelines of at least 150 minutes of moderate-intensity physical activity and two days of muscle-strengthening activity each week.[52]

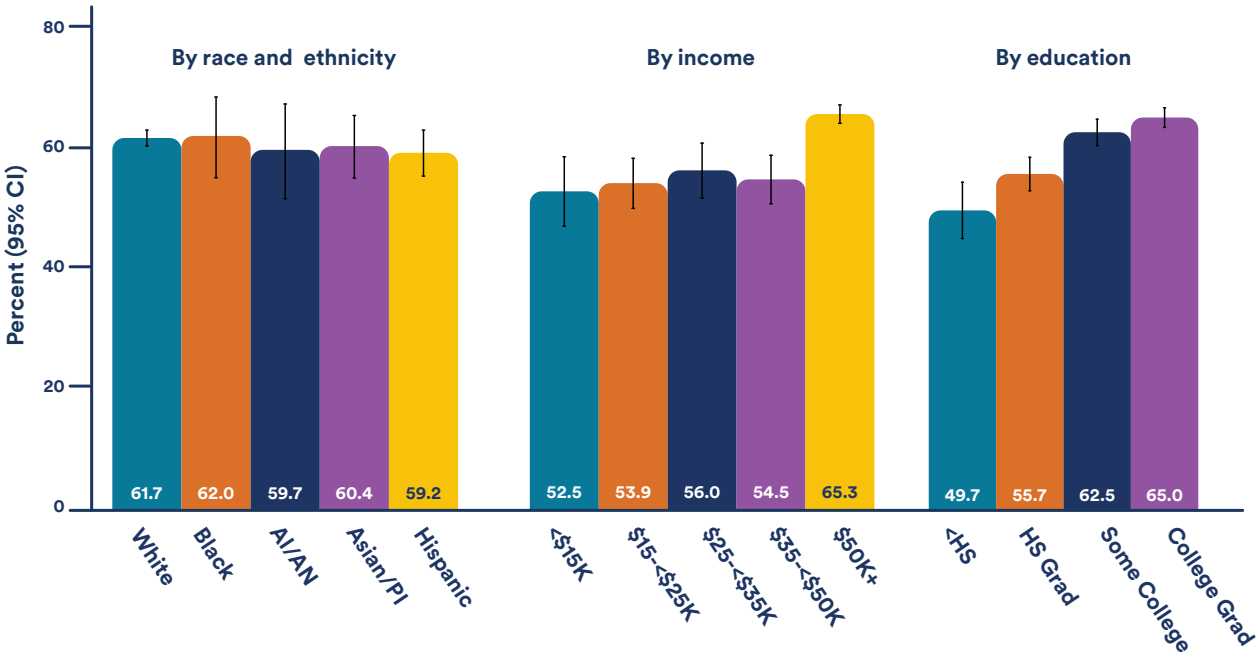
46 Centers for Disease Control and Prevention. E-Cigarette Use Among Youth. U.S. Department of Health and Human Services 2024.
47 Emmerich, SD et al. *Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023.* National Center for Health Statistics 2024.
48 National Cancer Institute, NIH, DHHS. *Cancer Trends Progress Report.* Bethesda, MD, March 2024.
49 National Cancer Institute. *Cancer Trends Progress Report: Fruit and Vegetable Consumption.* National Institutes of Health, U.S. Department of Health and Human Services 2024.
50 U.S. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS): Vegetable Consumption. U.S. Department of Health and Human Services. Retrieved Jan 22, 2025.
51 U.S. Centers for Disease Control and Prevention. "Physical Activity and Cancer." Department of Health and Human Services 2024.
52 U.S. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS): Physical Activity Index. U.S. Department of Health and Human Services. Retrieved Jan 22, 2025.

Cancer Screening

Regular screening for colorectal, female breast, and cervical cancers all increase the likelihood that a cancer will be detected early, when it is more treatable. Many interview participants reported that unmet cancer screening needs is a health barrier in their communities.

While the prevalence of mammography screening in Washington does not appear to differ significantly by race or ethnicity, a socioeconomic gradient in the pattern of screening is observed (Figure 12). Individuals with higher incomes and more education are more likely to report a mammogram than those with lower incomes or education, respectively.

Figure 12: Prevalance of Mammography in Washington

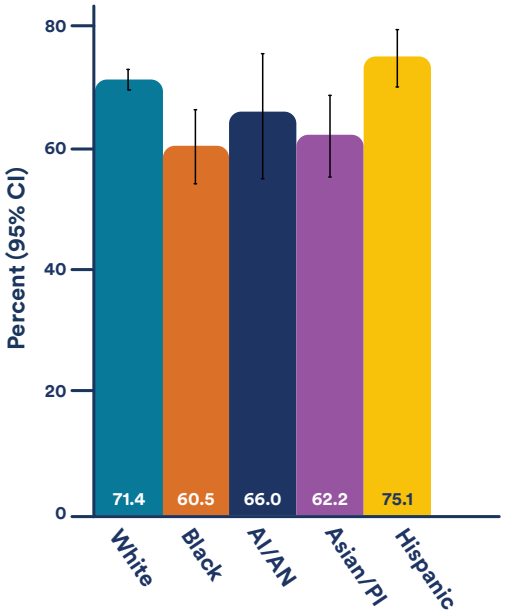


Source: Behavioral Risk Factor Surveillance System (BRFSS), 2018-2022. Age-standardized to U.S. population, 2000

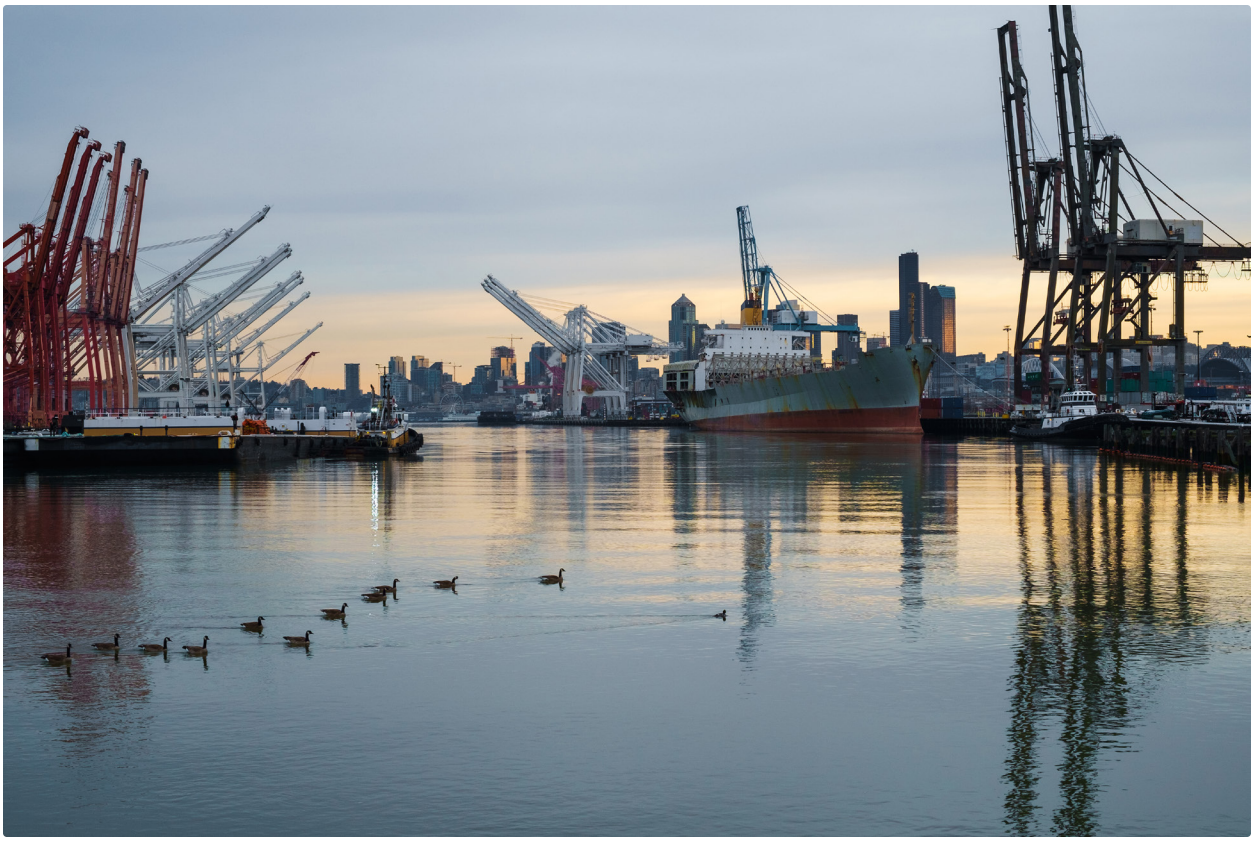
The prevalence of cervical cancer screening varies considerably by race and ethnicity. Only 60.5% of Black individuals in Washington were up to date with cervical cancer screening recommendations, compared to 75.1% of Hispanics (Figure 13).

Colorectal cancer screening is defined by BRFSS as a receipt of one or more of the recommended screening tests, including a blood stool test in the past three years and sigmoidoscopy or colonoscopy in the past 10 years. According to the American Cancer Society, about 1 in 3 people in the U.S. who should be screened for colorectal cancer have never been screened.

Figure 13: Prevalence of Cervical Screening by Race and Ethnicity

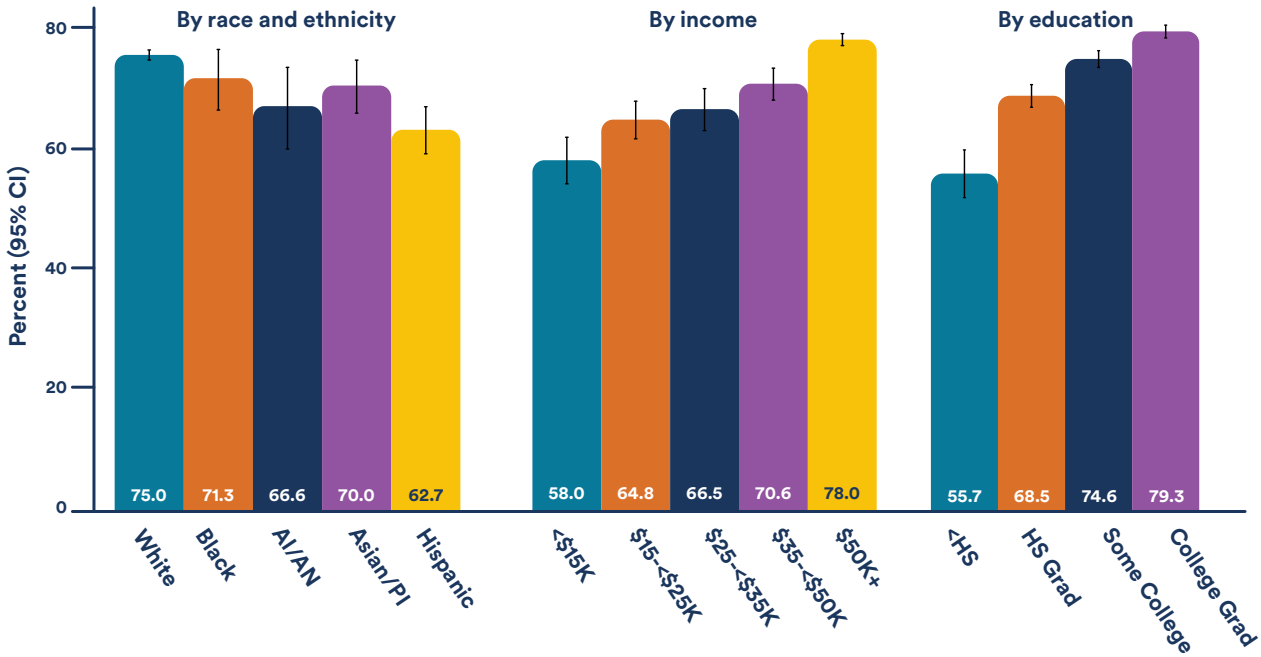


Source: Behavioral Risk Factor Surveillance System (BRFSS), 2018-2022. Age-standardized to US Population, 2000



Hispanic individuals in Washington were significantly less likely to be up to date with colorectal cancer screening recommendations than Whites (Figure 14). Moreover, socioeconomic disparities in the prevalence of colorectal cancer screening persist.

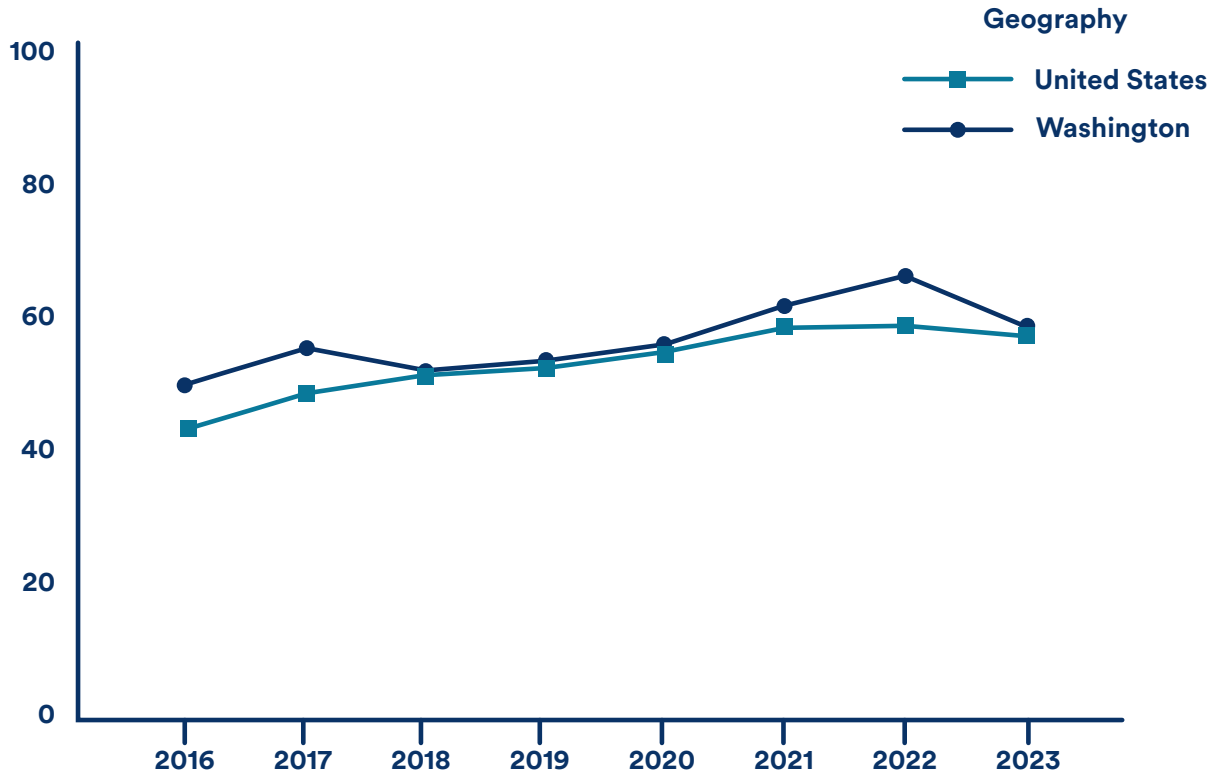
Figure 14: Prevalence of Colorectal Cancer Screening in Washington



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2018-2022. Age-standardized to U.S. population, 2000

> **"Cancer screening is a need.** We [have] high rates of cancer, death from cancer. We are getting really high rates of diagnosing at the end stage."
> —Community Partner (Western Washington)

Figure 15: HPV Vaccination Coverage by Year, 13–15 Year Olds



Source: Up-to-date HPV vaccination coverage by year among adolescents age 13-15 years, National Immunization Survey-Teen

While the human papillomavirus (HPV) is widely recognized for its role in cervical and other anogenital cancers, emerging research suggests a potential association between HPV infection and colorectal cancer. Increasing HPV vaccination coverage may offer broader cancer prevention benefits. The figure above shows HPV vaccination rates from 2016 to 2023 in Washington State compared to national averages.[53]

53 Damin DC, Ziegelmann PK, Damin AP. Humanpapillomavirus infection and colorectal cancer risk: a meta-analysis.Colorectal Dis. 2013;15(8):e420-e428. doi:10.1111/codi.12257a

The Burden of Cancer in Washington

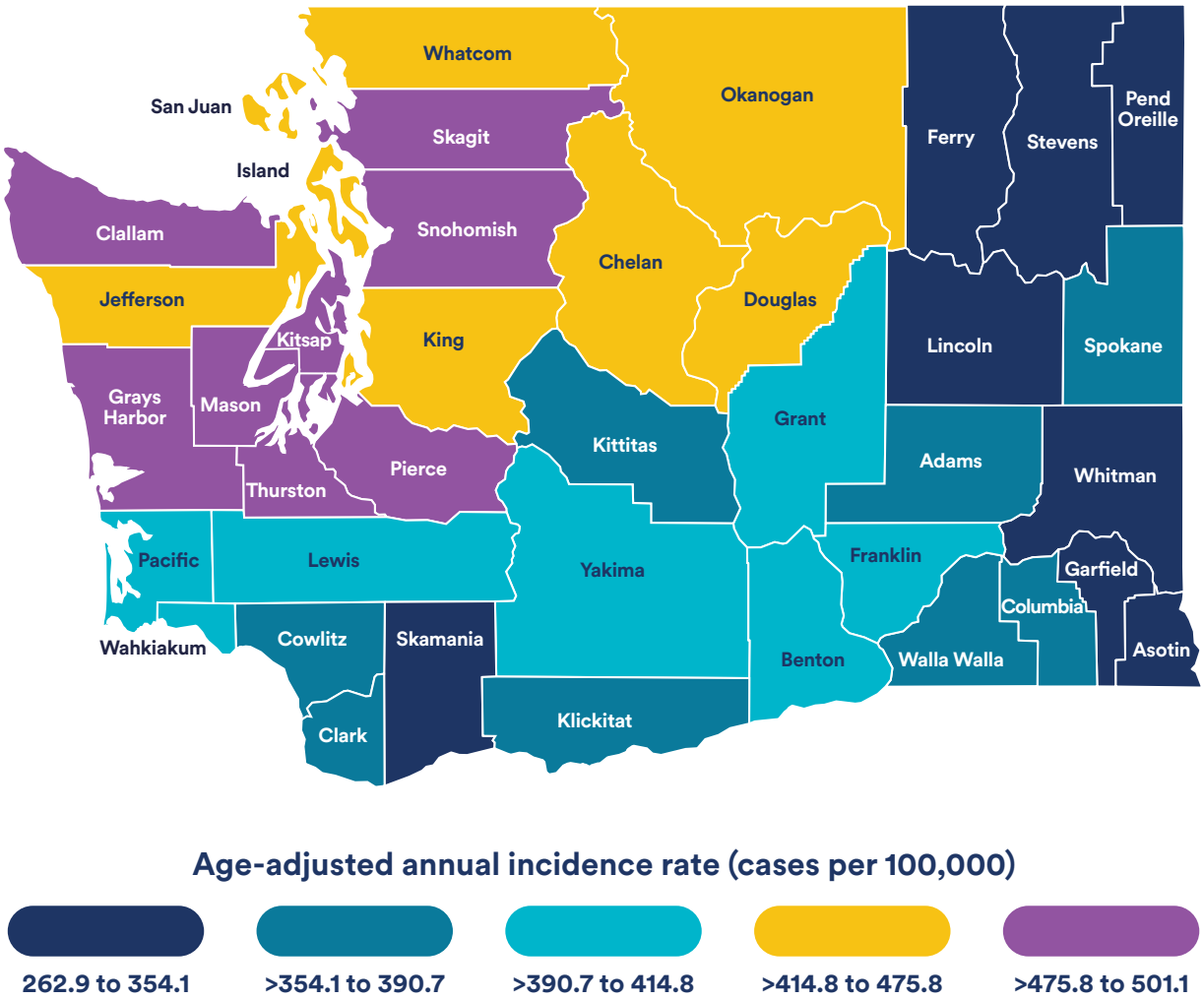
From 2017–2021, a total of 197,059 cases of invasive cancer were diagnosed among people living in Washington. The top five most common types of new cancer diagnoses in Washington, 2017–2021 overall (i.e., across all population subgroups) included:

Table 5: Most Common Sites of New Cancer Cases in Washington, 2017–2021

Incidence per 100,000 (2017–2021)			
	Annual Average Count	**Rate**	**95% Confidence Interval**
Female breast	6205	137.1	(137.1-135.6)
Prostate	4815	104.0	(102.6-105.3)
Lung	4513	49.0	(48.4-49.7)
Hematologic malignancies	3729	42.6	(42.0-43.2)
Colorectal	2964	34.2	(33.7-34.8)

Source for WA Cancer Incidence and Mortality tables:
Source: Data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

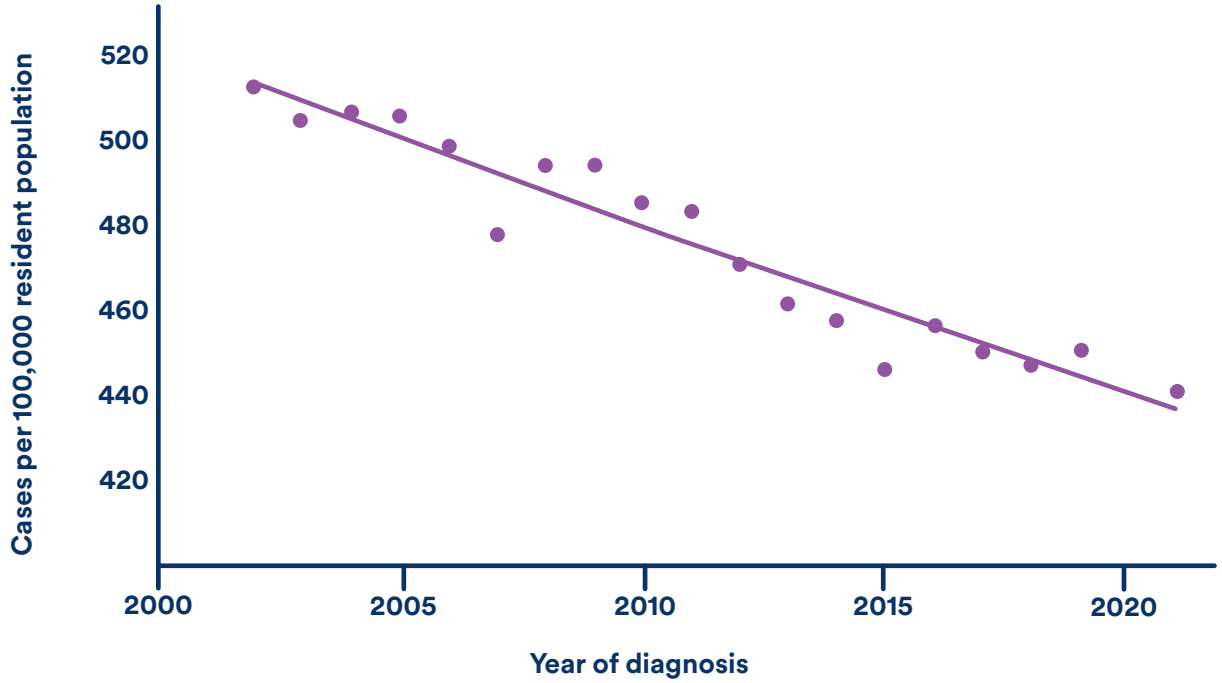
Figure 16: Incidence Rates for Washington by County, 2017-2021



Source: https://statecancerprofiles.cancer.gov/map/map.withimage.php?53&county&001&001&00&0&01&0&1&5&0#results

Figure 16 depicts the age-adjusted cancer incidence rates for Washington by county. Clallam (501.1), Mason (492.0), Grays Harbor (489.7) and Skagit (489.2) Counties had the highest incidence rates. Whitman (262.9), Ferry (298.0) and Asotin (324.0) Counties had the lowest incidence rates, compared to the overall Washington state rate of 439.7 per 100,000.

Figure 17: Trends in Cancer Incidence Rates, 2002–2021



Source: Incidence data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Based on figure created by statecancerprofiles.cancer.gov on 12/27/24.

Figure 17 shows a declining trend in overall cancer incidence from 2002 to 2021. The 2020 incidence rate is displayed but not used in the fit of the trend line to account for COVID-19 pandemic-related delays in cancer diagnosis and screening.

Cancer is the leading cause of death in Washington. The top five most common causes of cancer death in Washington, 2018-2022 overall (i.e., across all population subgroups) included:

Table 6: Overall Washington State Cancer Mortality

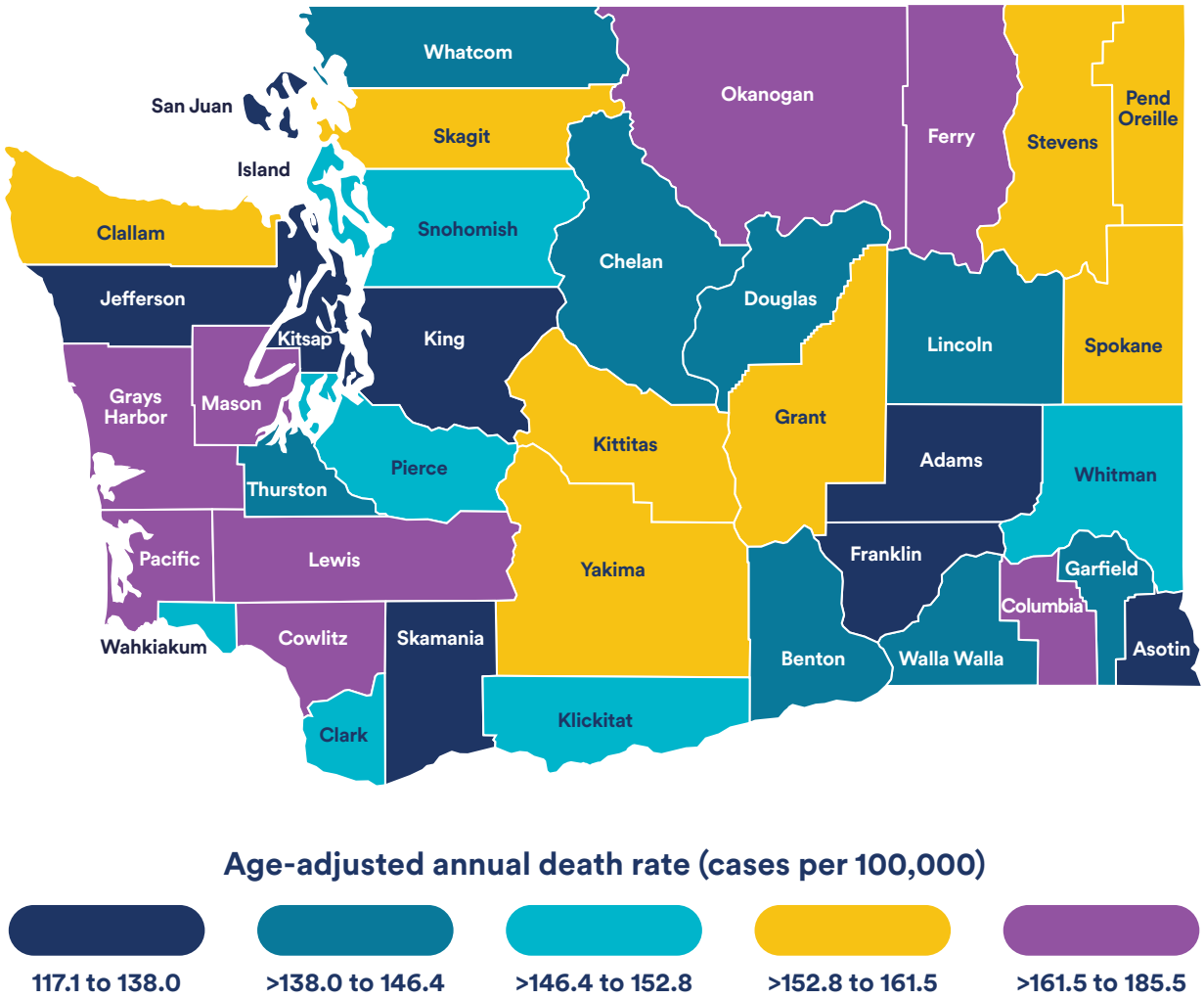
Mortality per 100,000 (2018–2022)			
	Annual Average Count	**Rate**	**95% Confidence Interval**
Female breast	904	18.7	(18.2-19.3)
Prostate	770	20.5	(19.8-21.2)
Lung	2762	29.8	(29.3-30.3)
Hematologic malignancies	1291	14.6	(14.2-14.9)
Colorectal	1065	11.9	(11.6-12.2)

Source for WA Cancer Incidence and Mortality tables:
Source: Data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

A total of 13,432 Washingtonians died of cancer in 2022. Figure 18 depicts the age-adjusted mortality rates for Washington by county.

The following counties had the highest cancer death rates for all cancer sites, between 2018-2022 (Age-Adjusted Annual Death rate – Deaths per 100,000): Cowlitz (185.5), Grays Harbor (175.4), Columbia (174.7), Lewis (174) Okanogan (171.4), Ferry (169.7) Mason (168.1) and Pacific (166.8).

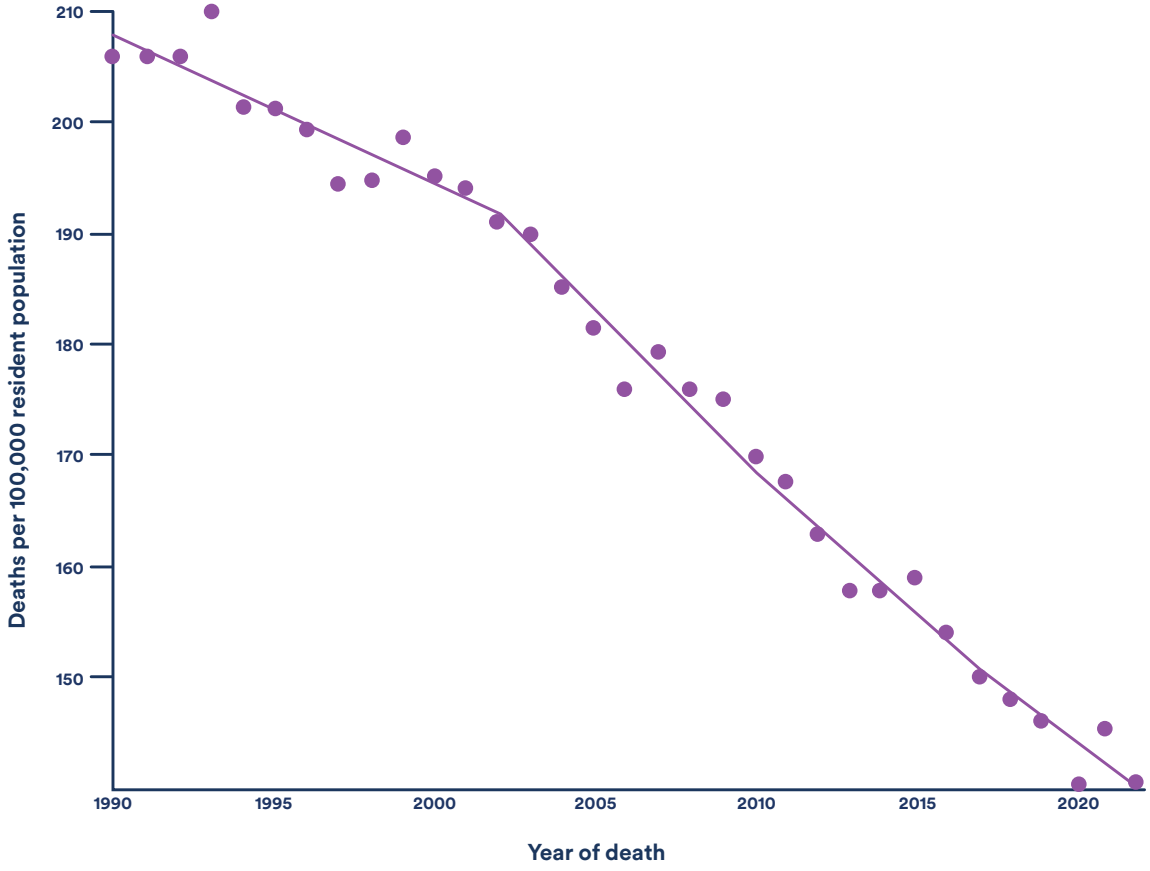
Figure 18: Mortality Rates for Washington by County



Source: https://statecancerprofiles.cancer.gov/map/map.withimage.php?53&county&001&001&00&0&02&0&1&5&0#results

Trends in cancer mortality rates are the best measure of progress against cancer. Figure 19 shows a declining trend in overall cancer mortality in Washington state from 1990–2022.

Figure 19: Trends in Cancer Mortality Rates, 1990–2022



Incidence data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Based on figure created by statecancerprofiles.cancer.gov on 06/06/2025.

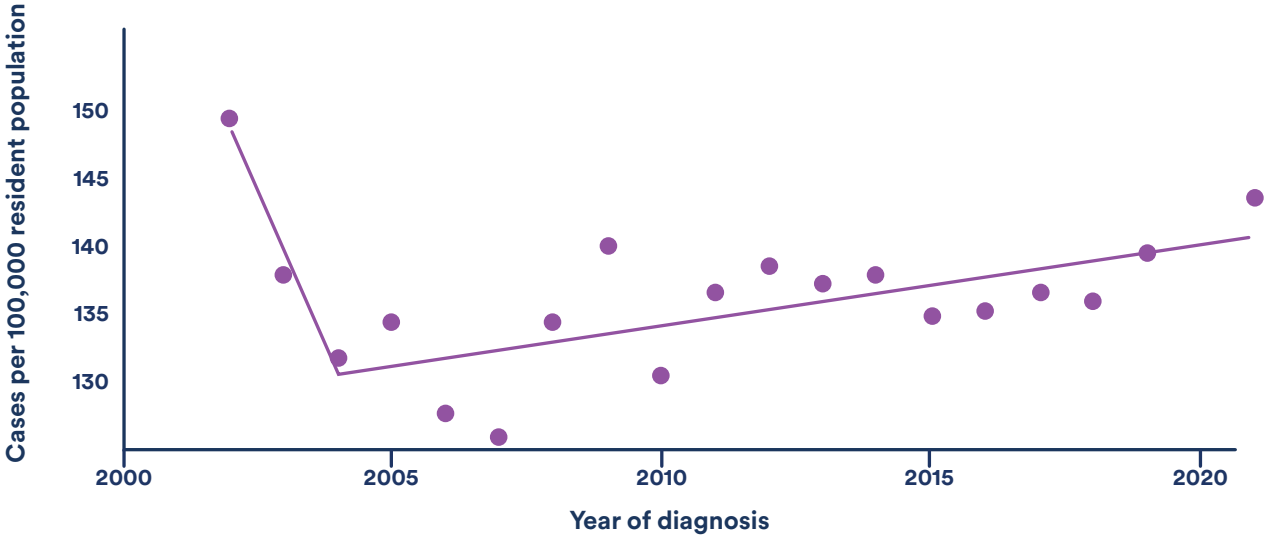
Most Common Types of Cancer in Washington

Female Breast Cancer

On average, 6,205 new cases of female breast cancer are diagnosed in Washington each year. The age-adjusted incidence rate of female breast cancer in Washington (137.1, 95% CI 135.6-138.7) is significantly higher than the incidence rate for the U.S. (129.8, 95% CI 129.5-130.0).[54]

Female Breast Cancer Incidence Trends in Washington. Between 2002–2004, the incidence of female breast cancer declined sharply (Figure 20). However, since 2004, the incidence rate of female breast cancer increased by 0.4% (95% CI 0.1% - 1.2%) annually. The increasing female breast cancer incidence trend seen in Washington is similar to that in the U.S. as a whole (0.6%, 95% CI 0.4%-0.8%).

Figure 20: Trends in Female Breast Cancer Incidence, 2002–2021

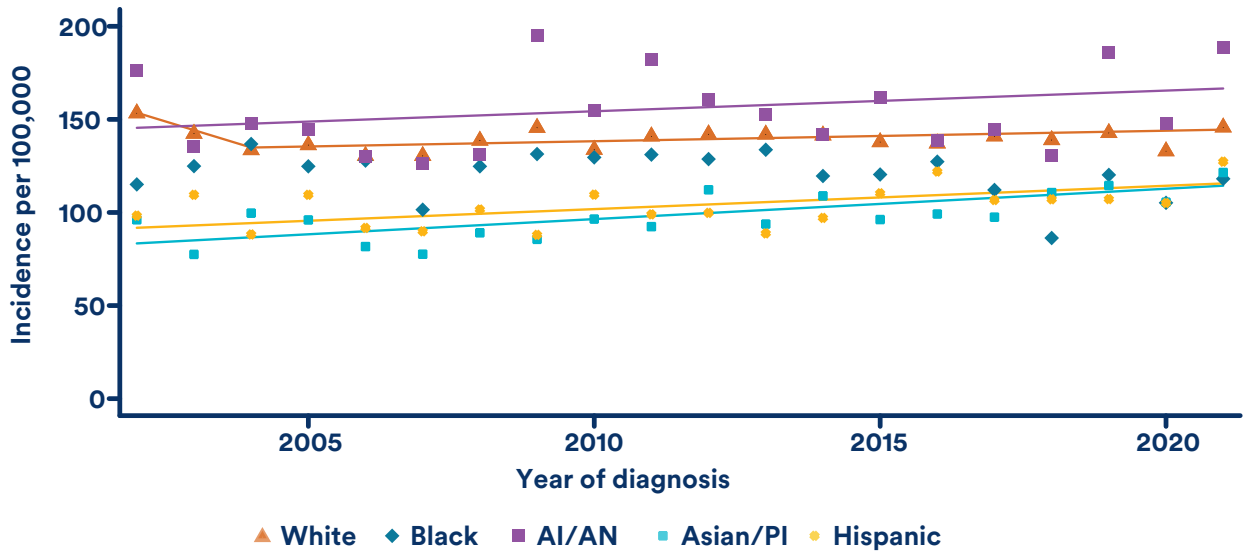


Source: Incidence data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Based on figure created by statecancerprofiles.cancer.gov on 12/27/24.

> "**[Funding for the Breast, Cervical and Colon Health Program (BCCHP) is a concern.]** Money gets moved around depending on the volume that's being served."
> — Community Partner (North and South-Central Regions)

54 National Cancer Institute. (2024). State Cancer Profiles: Breast cancer incidence, Washington vs. United States (2016–2020). Surveillance Research Program, National Cancer Institute.

Figure 21: Invasive Female Breast Cancer Incidence, Washington state, 2002–2021

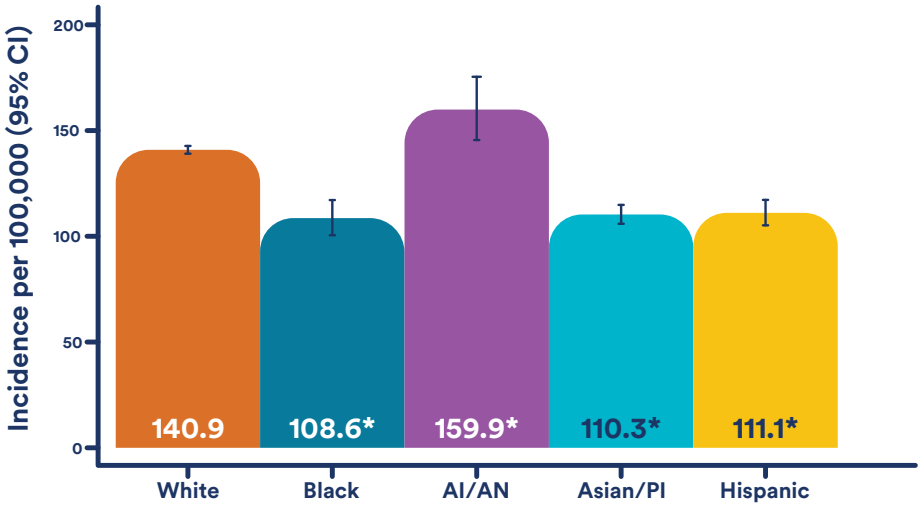


Source: State Cancer Profiles. Regression lines calculated using the Joinpoint Regression Program (Version 5.1). Age-standardized to US Population, 2000

Disparities in Female Breast Cancer Incidence by Race and Ethnicity. When examining female breast cancer incidence trends by race and ethnicity, increasing incidence is most apparent among the Asian/PI (1.7%, 95% CI 0.8%-2.7%) and Hispanic populations (1.2%, 95% CI 0.3%-2.4%) (Figure 21). Conversely, female breast cancer incidence rates among AI/AN (0.7%, 95% CI -0.8%-2.5%) and Black (-0.6, 95% CI -1.6%-0.4%) populations in Washington remained stable or possibly decreased between 2002–2021.

Incidence rates of female breast cancer for the most recent years of data available (Figure 22), 2017–2021, show striking disparities by race and ethnicity. Specifically, AI/AN women have the highest incidence of breast cancer, while Black women have the lowest rate.

Figure 22: Invasive Female Breast Cancer Incidence in Washington
By race and ethnicity, 2017–2021

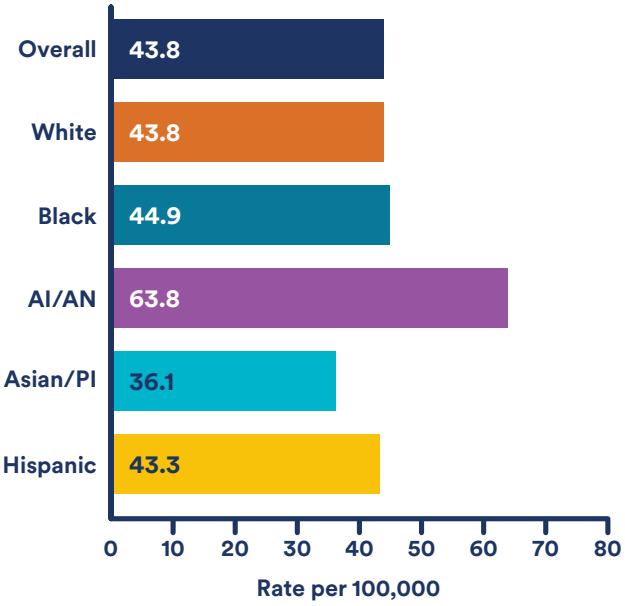


Source: NPCR/SEER, 2017-2021 Age-standardized to US Population, 2000
*rate differs from that in White people

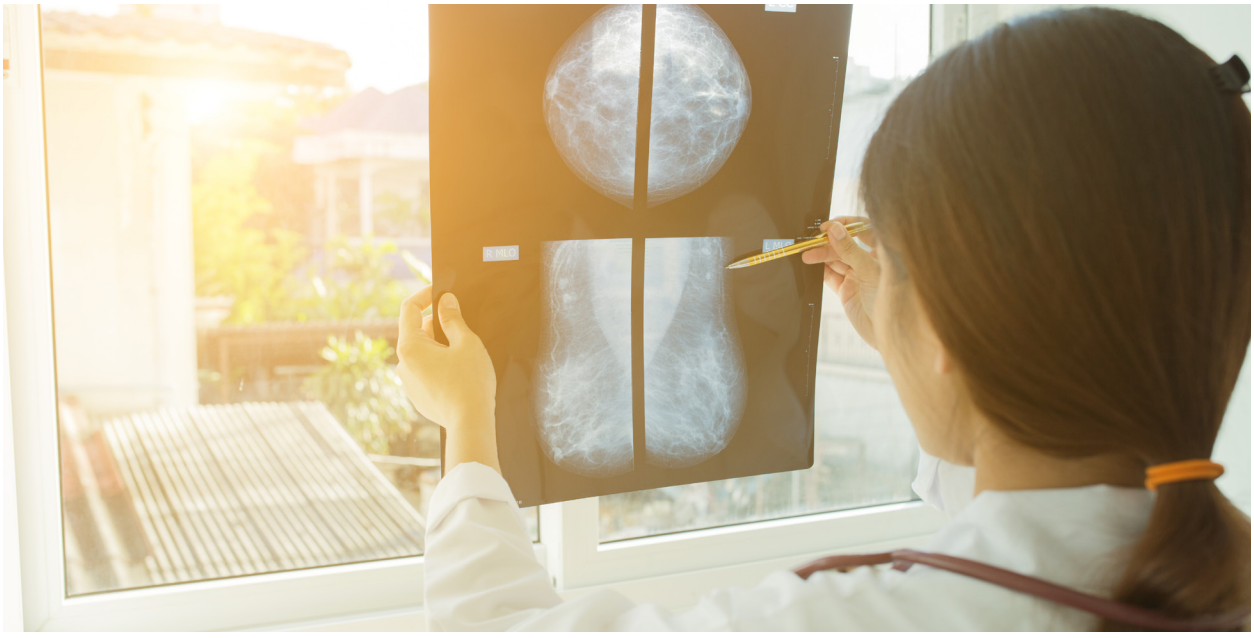
Patterns of Late-Stage Female Breast Cancer Incidence. Nearly 2,000 cases of late-stage female breast cancer are diagnosed annually in Washington, representing approximately 30% of all female breast cancer diagnoses. Late-stage female breast cancer is defined by SEER/NPCR as cases determined to be regional or distant stage at diagnosis. Monitoring the burden of late-stage female breast cancer is important because cases diagnosed at late stage may indicate missed opportunities for or lack of access to early-detection screening or particularly aggressive cancers that spread beyond the local site between screening intervals.

From 2017–2021, the incidence rate of late-stage female breast cancer in Washington (43.8, 95% CI 42.9-44.7) was higher than the rate in the U.S. (42.0, 95% CI 41.9-42.2) (Figure 23). Incidence rates of late-stage female breast cancer in Washington vary considerably by race and ethnicity. AI/AN people in Washington have the highest rate of late-stage female breast cancer (63.8, 95% CI 54.7-74.0), which is more than 75% higher than the rate of Asian/PI peoples (36.1, 95% CI 33.6-38.7).

Figure 23: Incidence Rates of Late-Stage Female Breast Cancer By race and ethnicity, 2017–2021



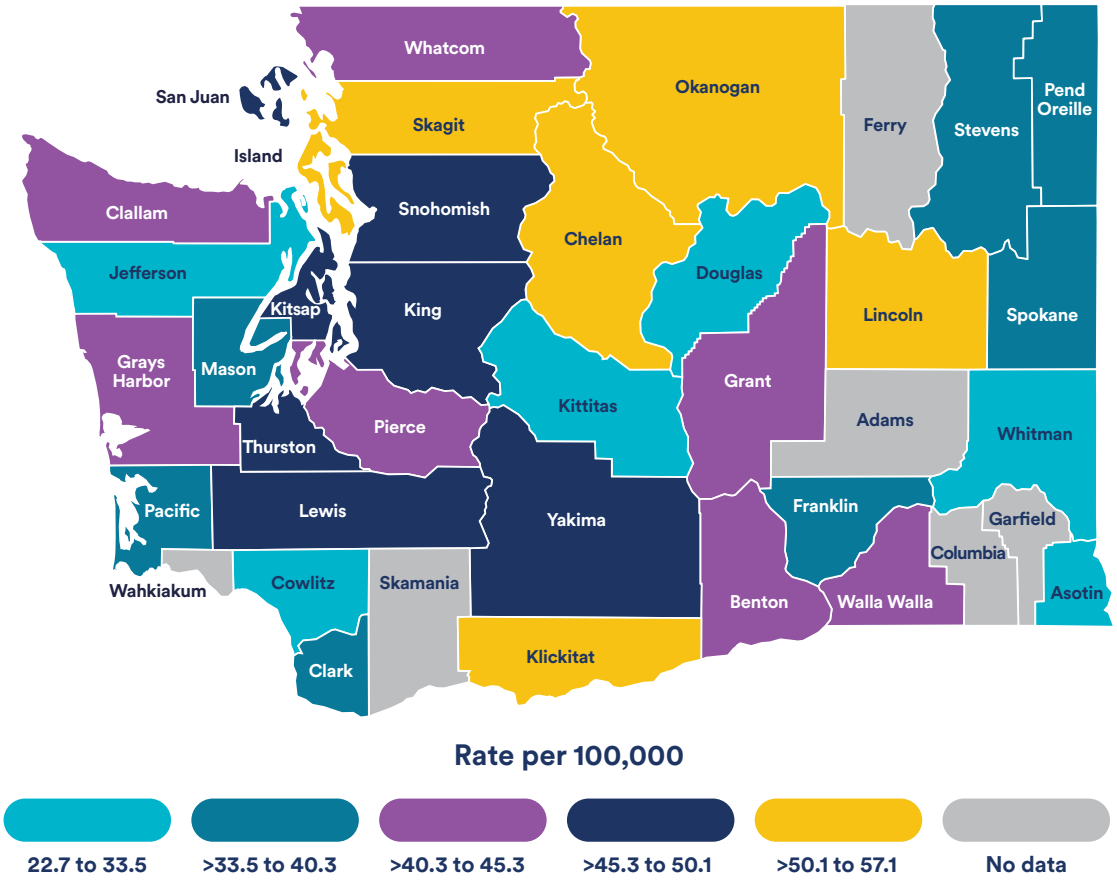
Source: SEER November 2023 submission.
https://statecancerprofiles.cancer.gov/incidencerates/



Geographic variation in the incidence of female late-stage breast cancer is highlighted in Figure 24. Chelan County had the highest incidence of late-stage female breast cancer and Asotin County had the lowest incidence. Chelan (57.1 per 100,000) Asotin (22.7 per 100,000).

Chelan, Skagit and Snohomish counties all experienced late-stage female breast cancer incidence rates that significantly exceeded the rate in Washington as a whole. Washington state overall late stage female breast cancer rate = 43.8 per 100,000. Conversely, Spokane, Clark, Cowlitz, Kittitas, Douglass, Whitman and Asotin counties all experienced significantly lower late-stage female breast cancer incidence than the rate for Washington as a whole.

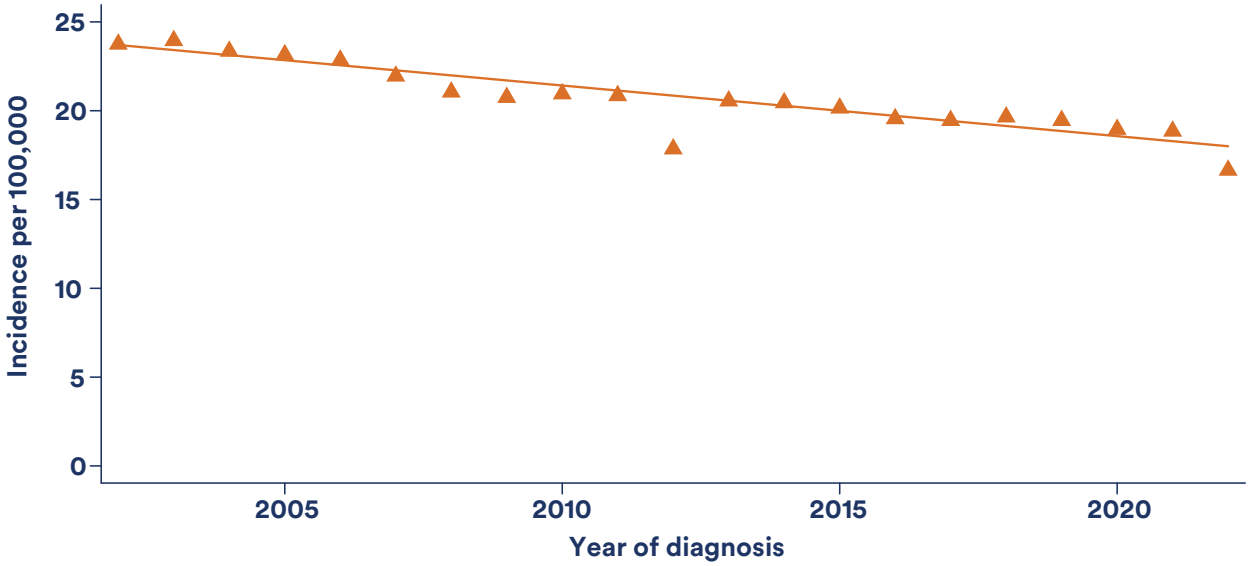
Figure 24: Incidence of Late Stage Female Breast Cancer, 2017–2021



Source: SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. November 2023 submission.

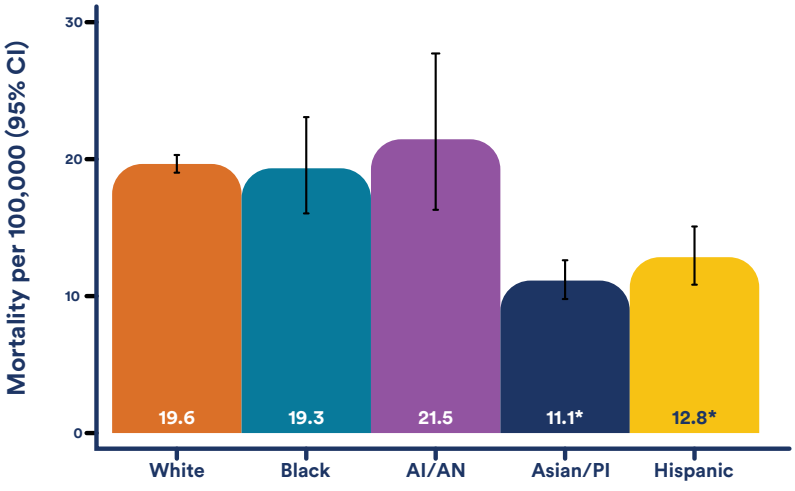
Female Breast Cancer Mortality. On average, 904 people die from female breast cancer each year in Washington.[55] The female breast cancer mortality rate (18.7, 95% CI 18.2-19.3) is decreasing by 1.4% (95% CI -1.7% - -0.2%) per year[56] (Figure 25), but has yet to reach the Healthy People objective of 15.3 per 100,000.

Figure 25: Invasive Female Breast cancer mortality, Washington, 2002–2022



AI/AN people in Washington had the highest female breast cancer mortality rate of any group (21.5, 95% CI 16.3-27.7) (Figure 26), although it was not statistically significantly higher than the mortality rates for Black (19.3, 95% CI 16.0-23.1) or White (19.6, 95% CI 19.0-20.3) individuals. Conversely, Asian/PI (11.1, 95% CI 9.8-12.6) and Hispanic (12.8, 10.8-15.1) individuals had significantly lower female breast cancer mortality rates than other groups.

Figure 26: Female Breast Cancer Mortality in Washington By race and ethnicity, 2018–2022



Source: SEER Mortality, 2018-2022. Age-standardized to US Population, 2000
* rate differs from that in Whites

55 National Cancer Institute. State Cancer Profiles. *Mortality Rate and Trends for Female Breast Cancer, Washington State (2016–2020).*

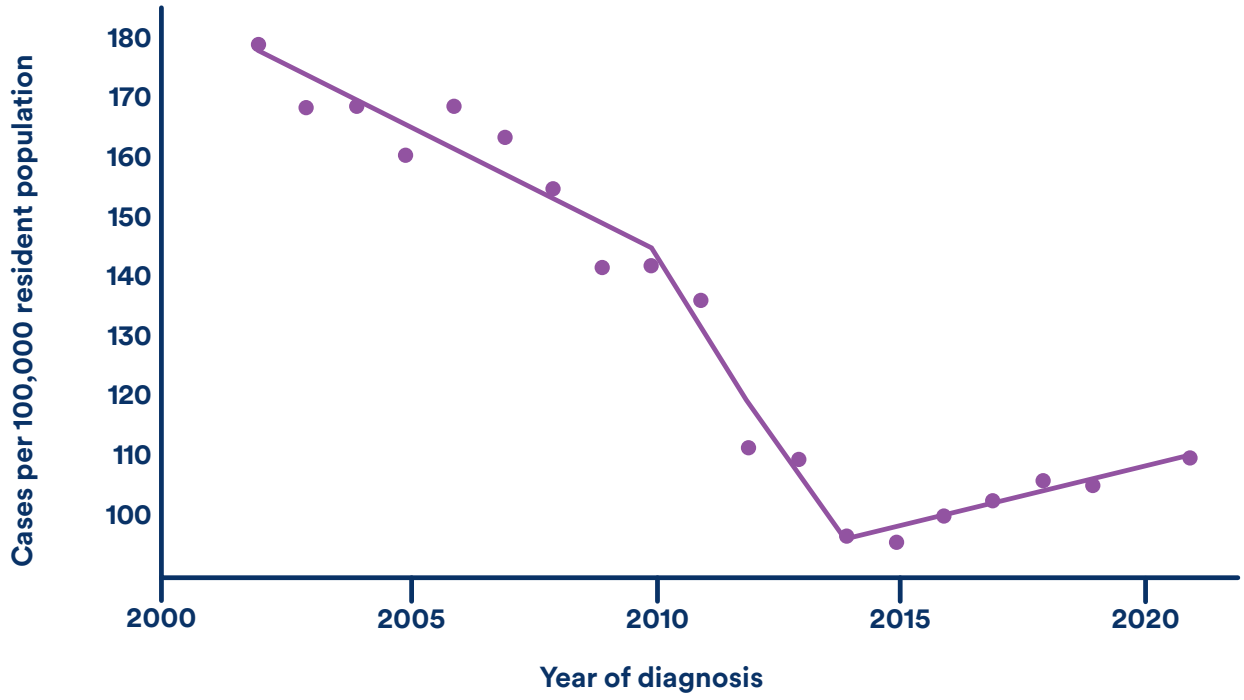
56 National Cancer Institute. (2024). State Cancer Profiles: Female breast cancer mortality, Washington vs. United States (2016–2020). Surveillance Research Program, SEER*Stat Database: Mortality – All COD, Aggregated With State, Total U.S. (1969–2020)

Prostate Cancer

Approximately 4,815 new cases of prostate cancer are diagnosed in Washington state each year. The age-adjusted incidence rate of prostate cancer in Washington (104.0, 95% CI 102.6-105.3) is significantly lower than the incidence rate for the U.S. (113.2, 95% CI 113.0-113.4).[57]

Prostate Cancer Incidence Trends in Washington. Mirroring trends in the U.S., the incidence of prostate cancer in Washington declined substantially from 2002–2014 (Figure 27). However, between 2014–2021, the incidence of prostate cancer in Washington increased by 2% per year (95% CI 0.5%-4.0%), similar to the 1.9% (95% CI 0.3%-3.8%) increase observed over the same period in the U.S.

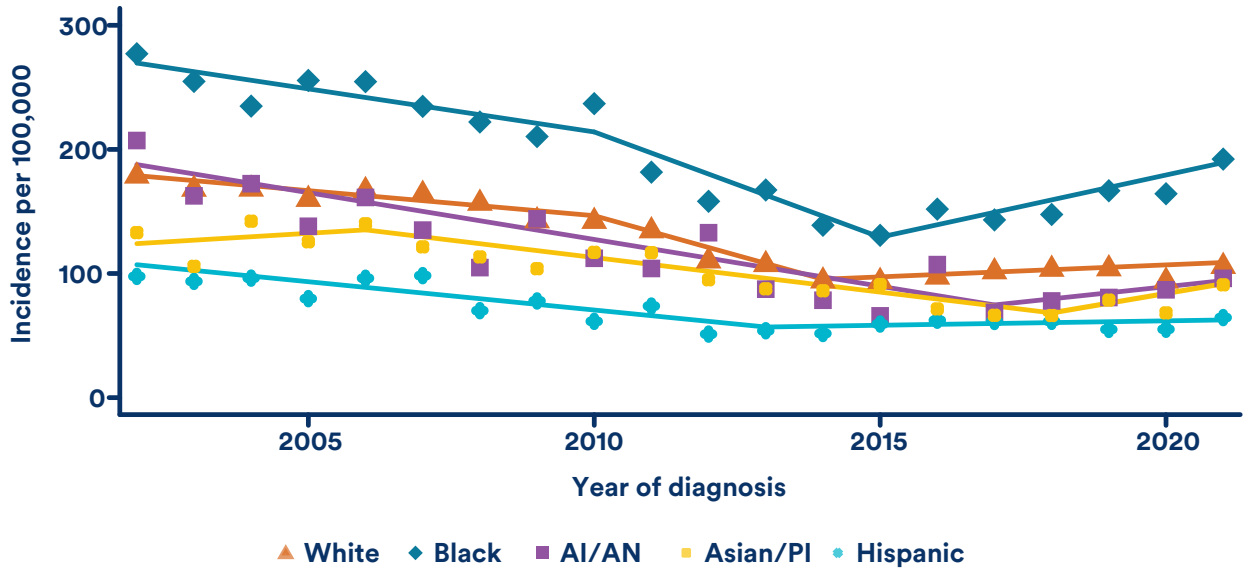
Figure 27: Trends in Prostate Cancer Incidence, 2002–2021



Source: Incidence data provided by the National Program of Cancer Registries. SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention.

57 National Cancer Institute. *State Cancer Profiles: Prostate Cancer Incidence, Washington vs. United States (2016–2020).* Bethesda, MD: Surveillance Research Program, National Cancer Institute.

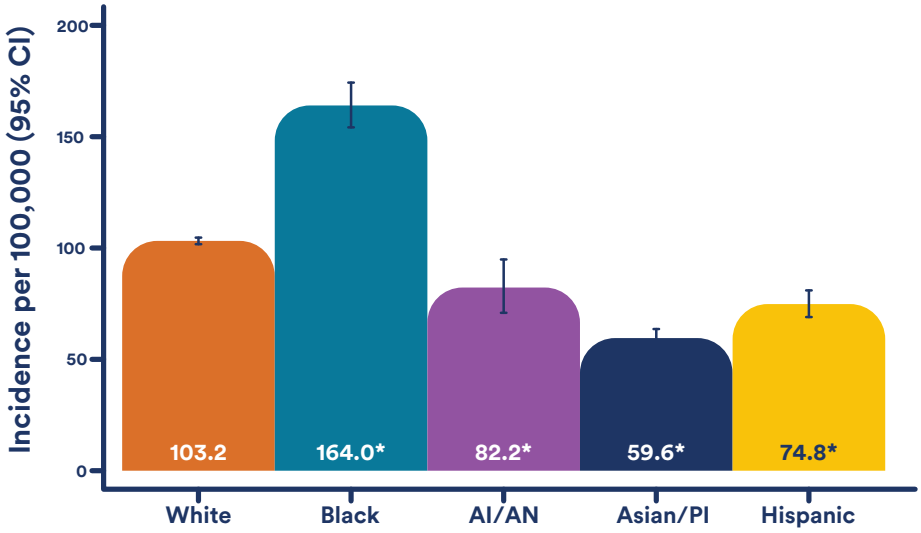
Figure 28: Invasive Prostate Cancer Incidence
Washington, 2002–2021



Source: State Cancer Profiles. Regression lines calculated using the Joinpoint Regression Program (Version 5.1). Age-standardized to US Population, 2000Washington, 2002–2021).

Disparities in Prostate Cancer Incidence by Race and Ethnicity. While all groups appear to be experiencing an increase in the incidence of prostate cancer in the most recent five years (Figure 28), the timing and magnitude of the increase varies by race and ethnicity. Statistically significant increases in the incidence of prostate cancer are only observed among Black and White populations in Washington state, with Black Washingtonians experiencing a 6.6% (95% CI 3.8%-10.8%) increase in prostate cancer incidence annually from 2017–2021. Black men in Washington have a significantly higher incidence rate of prostate cancer than any other racial or ethnic group (Figure 29).

Figure 29: Invasive Prostate Cancer Incidence in Washington
By race and ethnicity, 2017–2021

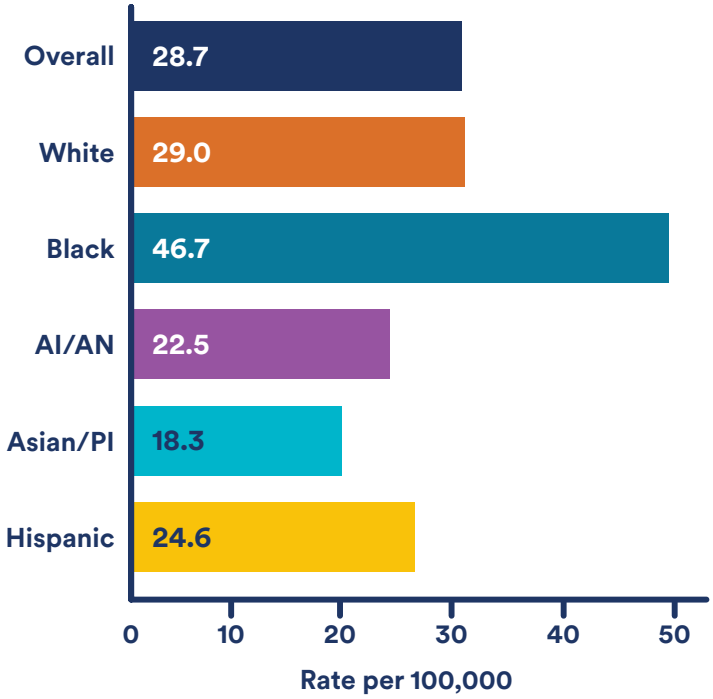


Source: NPCR/SEER, 2017-2021. Age-standardized to US Population, 2000
* rate differs from that in whites

Patterns of Late-Stage Prostate Cancer Incidence. Approximately 1,288 cases of late-stage prostate cancer are diagnosed in Washington annually. Late-stage prostate cancer, defined by SEER/NPCR as cases determined to be regional or distant stage at diagnosis, is an important indicator of cases requiring treatment. Moreover, understanding patterns of late-stage diagnosis may inform shared decision-making about prostate cancer screening.

Late-stage prostate cancer represents 26.7% of all prostate cancer diagnoses in Washington compared to 21.5% of prostate cancer diagnoses in the U.S. Importantly, the risk of late-stage disease among the Black population (46.7, 95% CI 41.2-52.6) is more than 2.5 times as high as the incidence rate among the Asian/PI populations (18.3, 95% CI 16.1–20.7) (Figure 30).

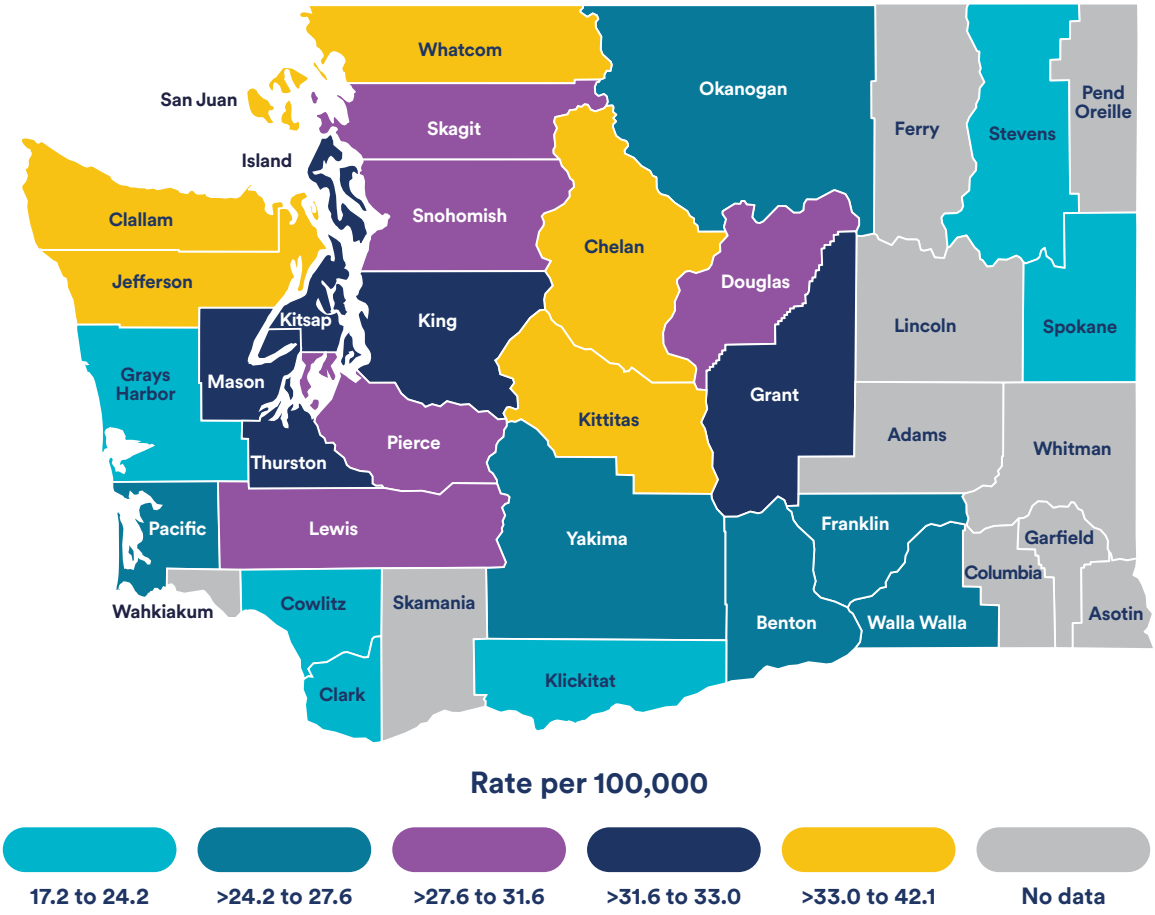
Figure 30: Incidence Rates of Late-Stage Prostate Cancer
By race and ethnicity, 2017–2021



Source: SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Based on the 2023 submission.

Considerable geographic variation in the incidence rate of late-stage prostate cancer exists throughout Washington. San Juan County had the highest incidence of late state prostate cancer and Stevens County had the lowest incidence (Figure 31). San Juan, Clallam, Whatcom and King counties all have significantly higher incidence rates of late-stage prostate cancer than Washington as a whole. Conversely, the late-stage prostate cancer incidence rate in Clark, Spokane, Cowlitz and Stevens counties are significantly lower than the rate in Washington, 28.7 per 100,000.

Figure 31: Incidence of Late-Stage Prostate Cancer, 2017–2021

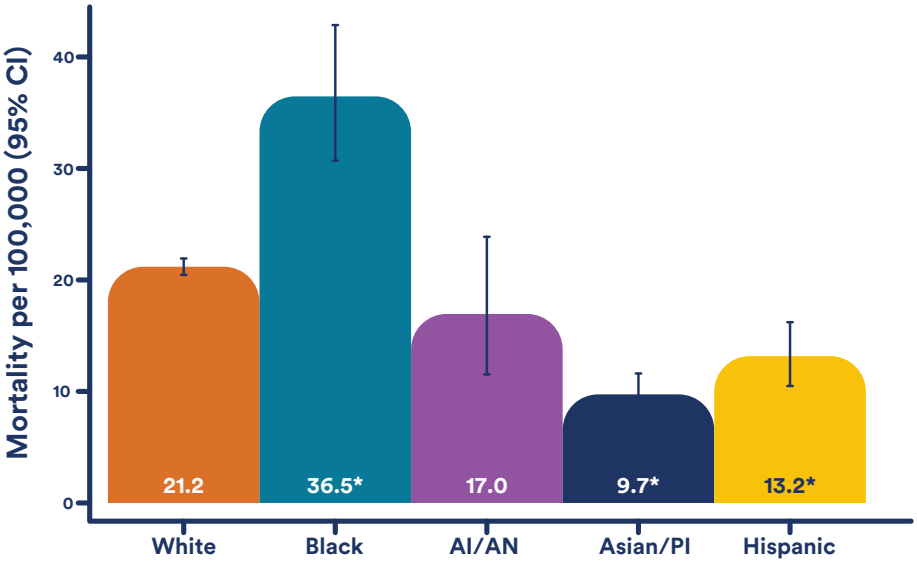


Source: SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Based on the 2023 submission.

Prostate Cancer Mortality. On average, 770 people die from prostate cancer in Washington each year. The prostate cancer mortality rate in Washington (20.5, 95% CI 19.8-21.1) is slightly higher than the rate in the U.S. (19.0, 95% CI 18.9-19.1).[58] Neither Washington nor the U.S. is meeting the Healthy People objective of 16.9 per 100,000.

The prostate cancer mortality rate among Black people in Washington (36.5, 95% CI 30.7-42.9) is nearly four times as high as the rate among Asian/PI peoples (9.7, 95% CI 8.1-11.6) (Figure 32).

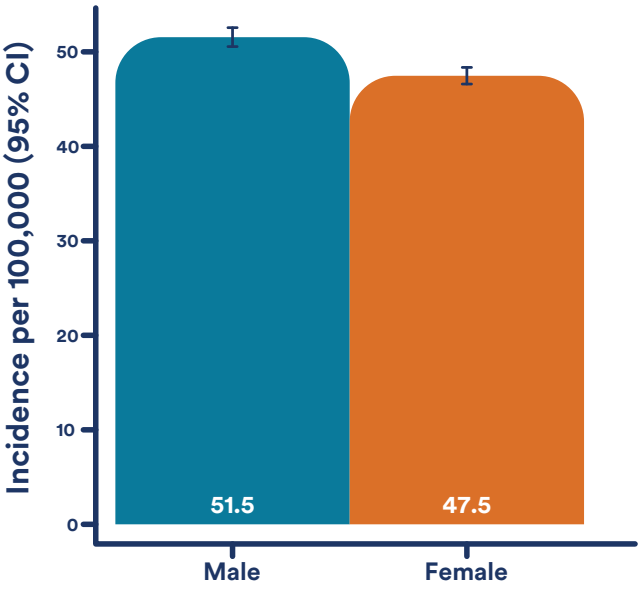
Figure 32: Prostate Cancer Mortality in Washington State
By race and ethnicity, 2018–2022



Source: SEER Mortality, 2018-2022. Age-standardized to US Population, 2000
* rate differs from that in Whites

58 National Cancer Institute. (2024). State Cancer Profiles: Prostate cancer mortality, Washington vs. United States (2016–2020). Surveillance Research Program, SEER*Stat Database: Mortality – All COD, Aggregated With State, Total U.S. (1969–2020)

Figure 33: Invasive Lung Cancer Incidence in Washington By sex, 2017–2021



Source: NPCR/SEER, 2017-2021. Age-standardized to US Population, 2000

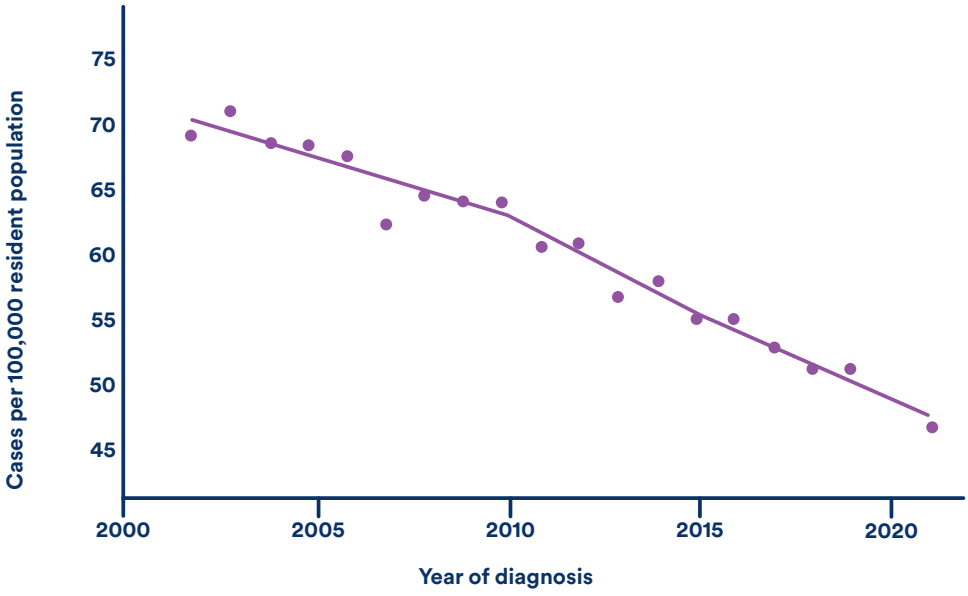
Lung Cancer

Approximately 4,513 new cases of lung cancer are diagnosed in Washington each year. The age-adjusted incidence rate of lung cancer in Washington (48.5 per 100,000, 95% CI 47.6–49.4) is lower than the incidence rate for the U.S. (54.6 per 100,000, 95% CI 54.4–54.8).[59]

Disparities in Lung Cancer Incidence by Sex. The incidence rate of lung cancer among males (51.5, 95% CI 50.6-52.6) is significantly higher than that for females (47.5, 95% CI 46.6-48.4) (Figure 33).

Lung Cancer Incidence Trends in Washington. Overall, lung cancer incidence rates in Washington have been declining from 2002–2021, with a pronounced, significant drop of -2.5% (95% CI -4.2%- -2.1%) annually since 2010 (Figure 34).

Figure 34: Trends in Lung Cancer Incidence, 2002–2021. Washington

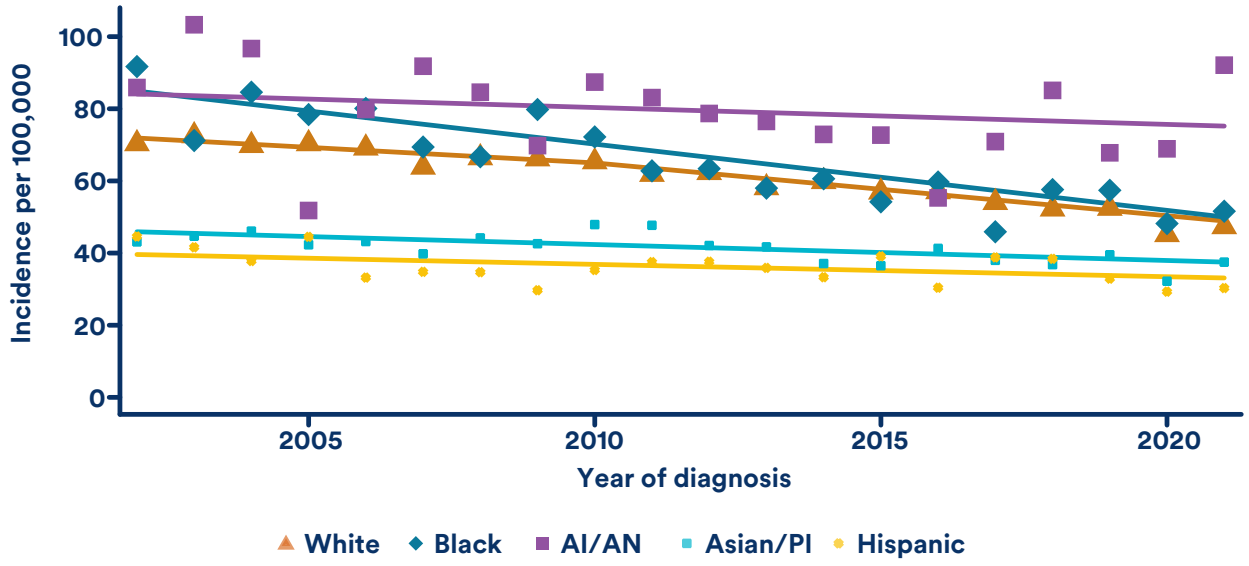


Source: Incidence data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Based on figure created by statecancerprofiles.cancer.gov on 12/27/24.

59 National Cancer Institute. State Cancer Profiles: Lung Cancer Incidence, Washington vs. United States (2017–2021). Bethesda, MD: Surveillance Research Program, National Cancer Institute.

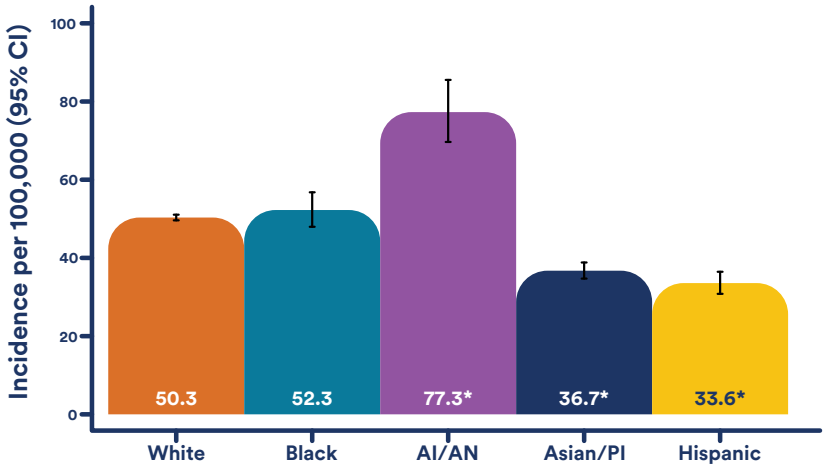
Disparities in Lung Cancer Incidence by Race and Ethnicity. In examining trends in lung cancer incidence rates by race and ethnicity, the Black population (-2.7%, -3.6%- -1.9%) in Washington stands out as the group with a consistent decline in lung cancer incidence from 2002–2021 (Figure 35).

Figure 35: Invasive Lung Cancer Incidence, Washington, 2002–2021



In recent years (2017–2021), the AI/AN population in Washington (77.3, 95% CI 69.7-85.5) experienced the highest lung cancer incidence rate of any group (Figure 36). In fact, the lung cancer incidence rate for AI/AN people was 2.3 times higher than the rate among the Hispanic population (33.6, 95% CI 30.8-36.5).

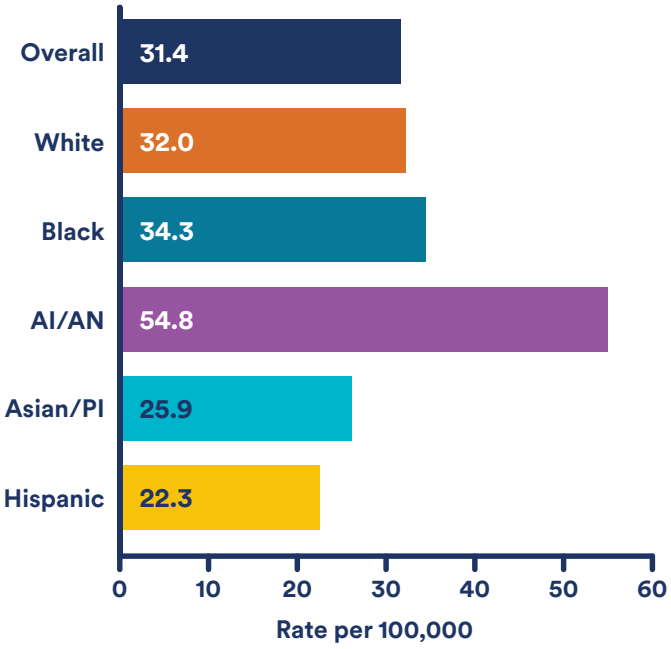
Figure 36: Invasive Lung Cancer Incidence in Washington, by race and ethnicity, 2017–2021



Source: NPCR/SEER, 2017-2021. Age-standardized to US Population, 2000
* rate differs from that in Whites

Patterns of Late-Stage Lung Cancer Incidence. Almost 65% of incident lung cancer cases are diagnosed at a late stage. Defined by SEER/NPCR as cases determined to be regional or distant stage at diagnosis, late-stage lung cancer incidence has the potential to be reduced over time by increasing lung cancer screening.

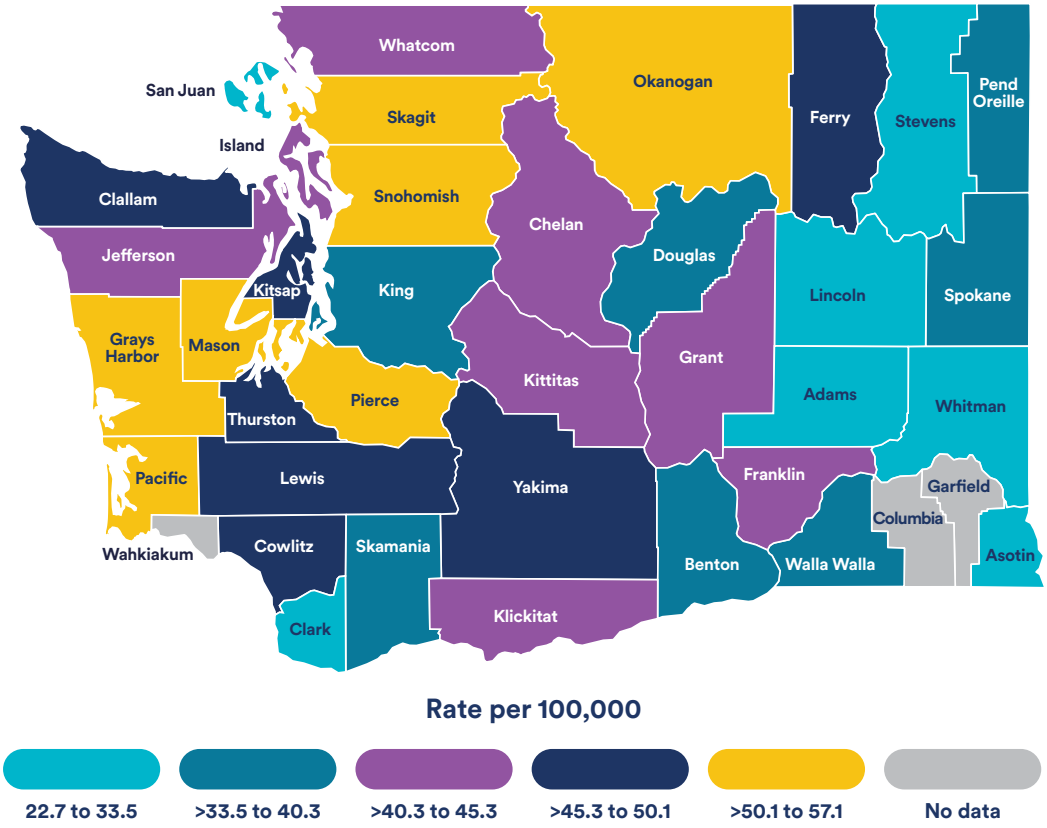
Figure 37: Incidence Rates of Late-Stage Lung Cancer, by race and ethnicity, 2017–2021



The rate of late-stage lung cancer in Washington (31.4, 95% CI 30.9-32.0) is significantly lower than the rate in the U.S. (34.3, 95% CI 34.2-34.4). However, considerable variation exists by race and ethnicity (Figure 37). Specifically, the AI/AN population in Washington has a rate of late-stage lung cancer of 54.8 (95% CI 48.4-61.7) that significantly exceeds the overall rate in Washington. Conversely, the Asian/PI (25.9, 95% CI 24.2-27.7) and Hispanic (22.3, 95% CI 20.1-24.6) populations have the lowest incidence rates of late-stage lung cancer.

Source: SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Based on the 2023 submission.

Figure 38: Incidence of Late-Stage Lung Cancer, 2017–2021

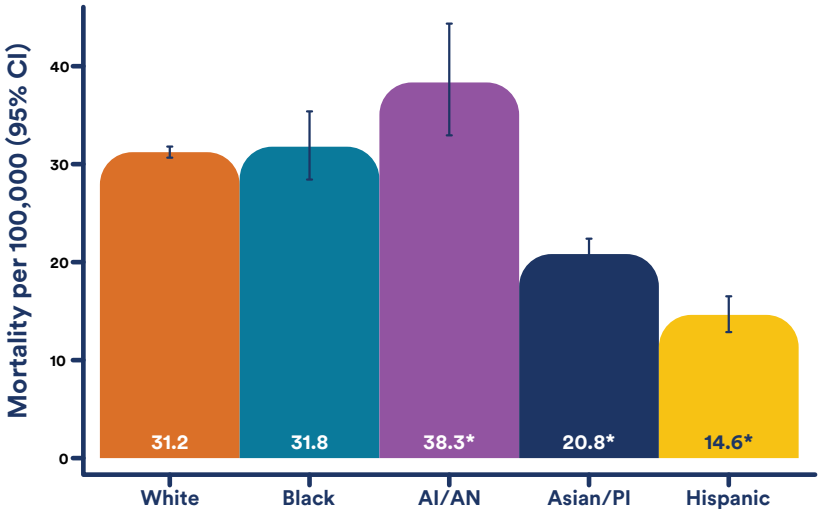


Source: SEER*Stat Database - United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Based on the 2023 submission.

Several counties in Washington have incidence rates of late-stage lung cancer that significantly exceed the statewide rate (Washington state late stage lung cancer mortality rate = 34.2 per 100,000), including Mason, Grays Harbor, Okanogan, Pierce, Skagit, Snohomish, Clallam and Thurston counties. Counties with significantly lower rates of late-stage lung cancer include Spokane, King, Clark, Asotin and Whitman (Figure 38).

Lung Cancer Mortality. Lung cancer is the most common cause of cancer death in Washington, with 2,765 people dying from lung cancer each year. The age-adjusted lung cancer mortality rate in Washington for 2018–2022 was 29.7 (95% CI 29.4-30.0). Substantial racial and ethnic disparities in lung cancer mortality exist, with the AI/AN (38.3, 95% CI 32.9-44.3) and Black (31.8, 95% CI 28.4-35.4) populations experiencing significantly higher lung cancer mortality rates than Asian/PI (20.8, 95% CI 19.3-22.4) or Hispanic (14.6, 95% CI 12.9-16.5) populations (Figure 39).

Figure 39: Lung Cancer Mortality in Washington, by race and ethnicity, 2018–2022

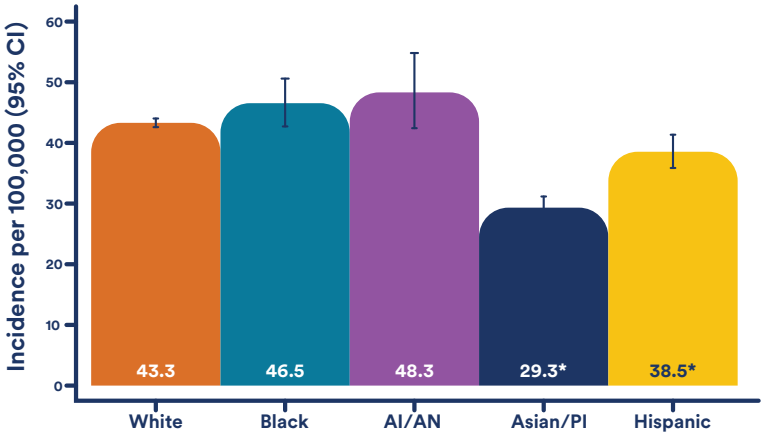


Source: SEER Mortality, 2018-2022. Age-standardized to US Population, 2000
*rate differs from that in Whites

Hematologic Malignancies

As a group, hematologic malignancies make up the fourth most common type of cancer in Washington, with an average of 3,729 cases diagnosed annually. The age-adjusted incidence rate of hematologic malignancies in Washington for 2017–2021 was 42.6 (95% CI: 42.0–43.2). Hematologic malignancies, often called blood cancers, are cancers that begin in blood-forming tissue, such as the bone marrow, or in the cells of the immune system. Examples of hematologic cancer are leukemia, lymphoma and multiple myeloma.

Figure 40: Invasive Hematologic Cancer Incidence in Washington By race and ethnicity, 2017–2021

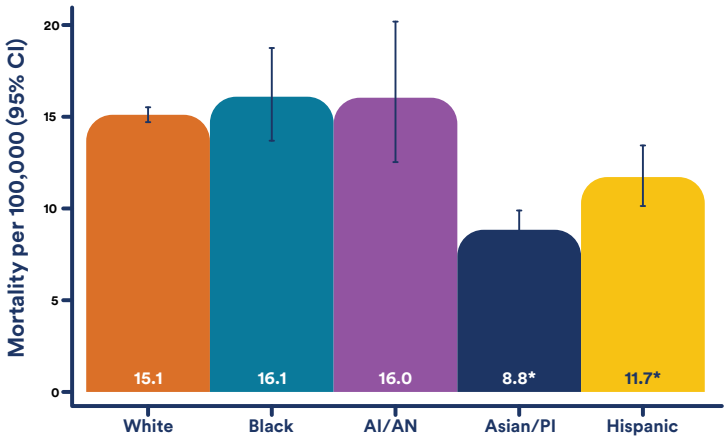


Source: NPCR/SEER, 2017-2021. Age-standardized to US Population, 2000
*rate differs from that in Whites

Disparities in Hematologic Malignancies Incidence by Race and Ethnicity. AI/AN (48.3, 95% CI 42.4-54.8) people in Washington have the highest incidence rate of hematologic malignancies of all populations. Conversely, Asian/Pacific Islander (29.3, 95% CI 27.6-31.2) people have a significantly lower incidence rate of hematologic malignancies than all other groups (Figure 40).

Hematologic Malignancies Mortality. On average, 1,291 people in Washington die from hematologic malignancies annually. The age-adjusted mortality rate of hematologic malignancies in Washington for 2018–2022 was 29.8 (95% CI: 29.3–30.3). Black (16.1, 95% CI 13.7-18.7) and AI/AN (16.0, 95% CI 12.5–20.2) people in Washington have the highest mortality rates of hematologic malignancies. (Figure 41) In contrast, Asian/PI (8.8, 95% CI 7.9-9.9) and Hispanic (11.7, 95% CI 10.1-13.4) people have significantly lower hematologic malignancies mortality rates.

Figure 41: Hematologic Malignancies Mortality in Washington By race and ethnicity, 2018–2022



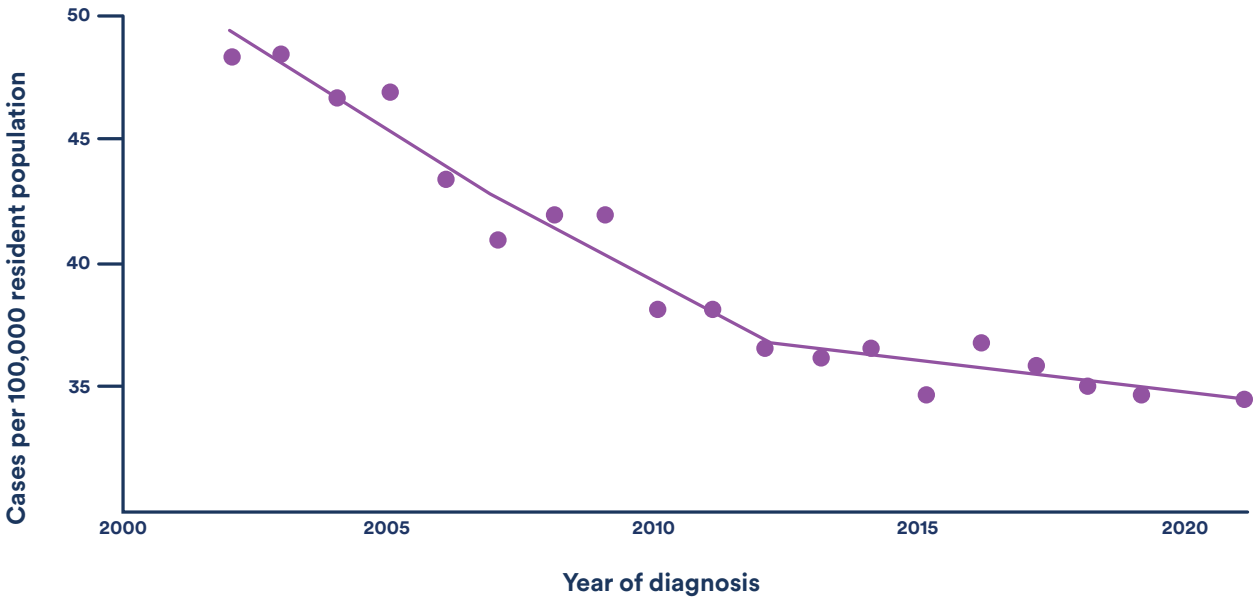
Source: SEER Mortality, 2018-2022. Age-standardized to US Population, 2000
*rate differs from that in Whites

Colorectal Cancer

An average of 2,964 new cases of colorectal cancer are diagnosed each year in Washington. The age-adjusted incidence rate of colorectal cancer in Washington for 2017–2021 was 34.2 (95% CI: 33.7–34.8).

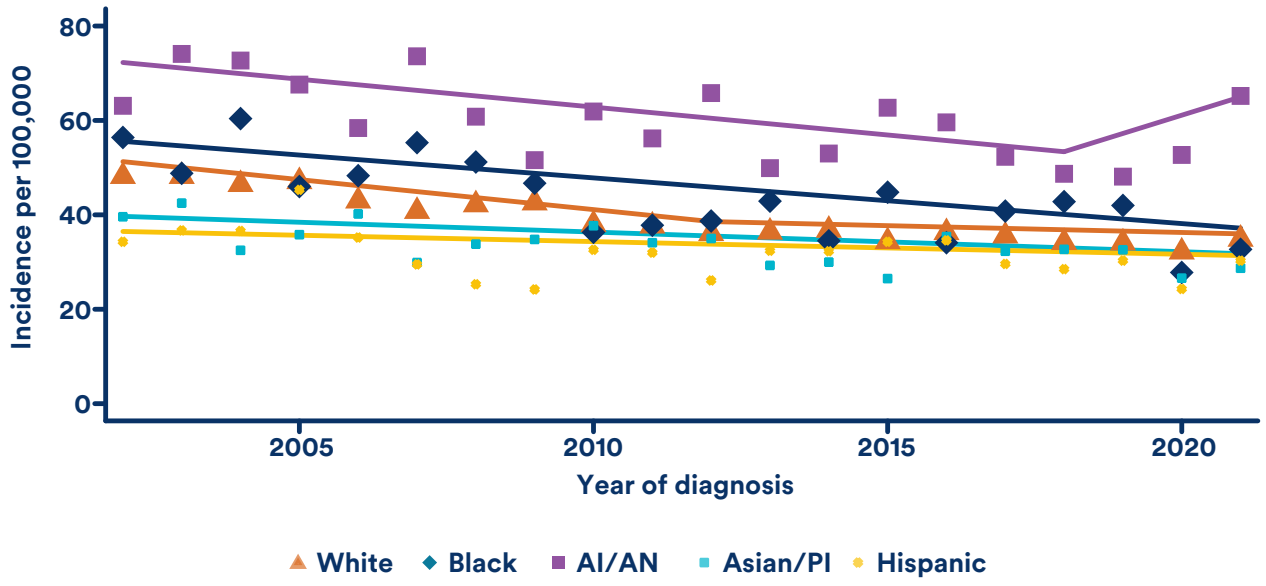
Colorectal Cancer Incidence Trends in Washington. Following a decline of -2.9% (95% CI -3.7%--2.5%) per year between 2002–2012, colorectal cancer incidence rates in Washington remained stable (-0.7%, 95% CI -1.3%-0.3%) between 2012–2021 (Figure 42). In contrast, the incidence of colorectal cancer in the U.S. continued to decline by -1.1% (95% CI -1.3%- -1.8%) 2011–2021.

Figure 42: Incidence Rates of Late-Stage Colorectal Cancer



Source: Incidence data provided by the National Program of Cancer Registries SEER*Stat Database - U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Based on figure created by statecancerprofiles.cancer.gov on 12/27/24.

Figure 43: Invasive Colorectal Cancer Incidence, Washington, 2002–2021

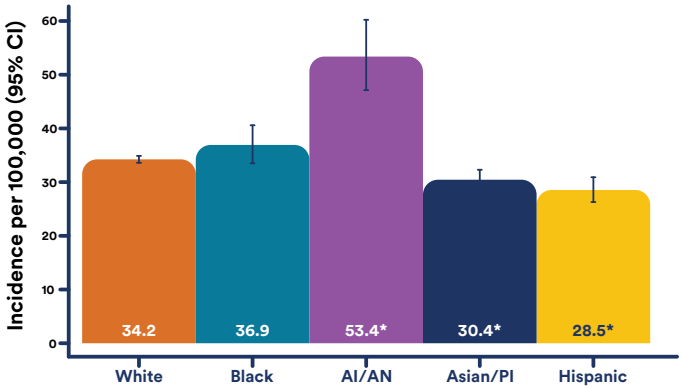


Source: State Cancer Profiles. Regression lines calculated using the Joinpoint Regression Program (Version 5.1). Age-standardized to US Population, 2000

Disparities in Colorectal Cancer Incidence by Race and Ethnicity. Black (-2%, 95% CI -2.2%- -1.8%), White (-0.9%, 95% CI -1.4%- -0.5%) and Hispanic (-0.8%, 95% CI -1.2%- -0.4%) populations in Washington experienced significant annual declines in the colorectal cancer incidence rate (Figure 43). However, the incidence rate of colorectal cancer among the AI/AN population neither increased nor decreased between 2002–2021.

In recent years, the AI/AN (53.4, 95% CI 47.1-60.2) incidence rate of colorectal cancer has far exceeded that of any other group. In contrast, the Hispanic (28.5, 95% CI 26.3-30.9) population experienced the lowest rate of colorectal cancer (Figure 44).

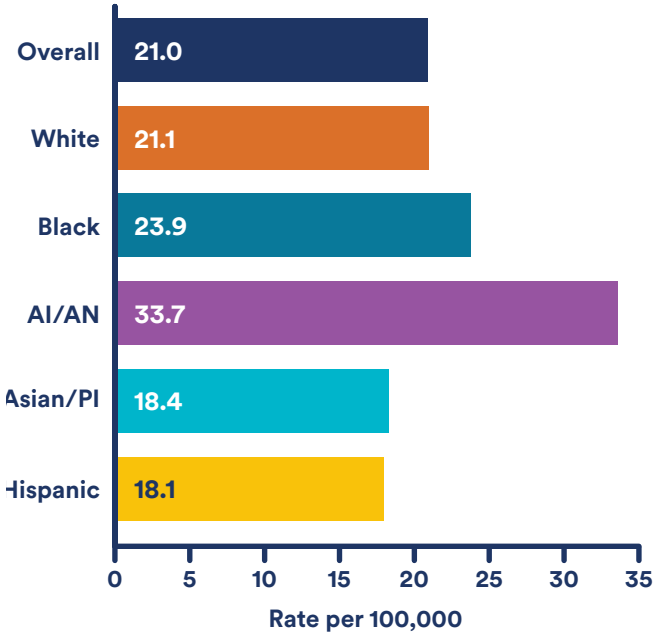
Figure 44: Colorectal Cancer Incidence in Washington, by race and ethnicity, 2018–2022



Source: NPCR/SEER, 2017-2021. Age-standardized to US Population, 2000
*rate differs from that in Whites

Patterns of Late-Stage Colorectal Cancer Incidence. More than 60% (n=1,814) of colorectal cancer cases in Washington are diagnosed at regional or distant stage. The incidence rate and proportion of late-stage colorectal cancer does not differ between Washington and the U.S. The incidence rate and proportion of late-stage colorectal cancer does not differ between Washington (21.0, 95% CI 20.5-21.4) and the U.S. (21.8, 95% CI 21.8-21.9). The AI/AN (33.7, 95% CI 28.8-39.2) population in Washington has the highest rate of late-stage colorectal cancer of any group, whereas the Hispanic (18.1, 95% CI 16.3-20.0) population has the lowest rate (Figure 45).

Figure 45: Incidence Rates of Late-Stage Colorectal Cancer, by race and ethnicity, 2017–2021

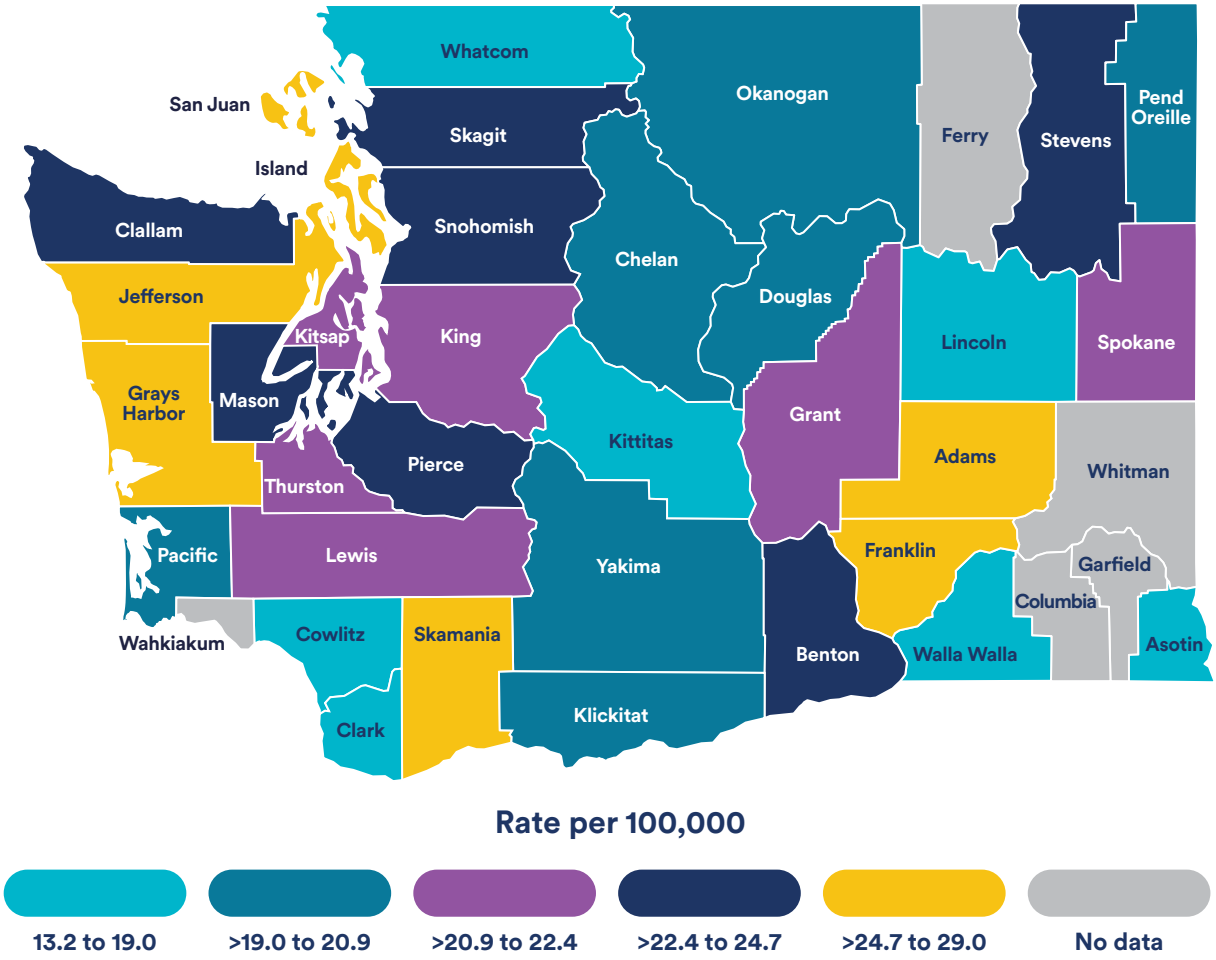


Source: Source: Incidence data provided by the National Program of Cancer Registries SEER*Stat Database. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

> **"[We are seeing individuals who are] either late-stage diagnosed or are having trouble navigating the system.** Generally, they're late-stage diagnosed because they've seen doctors routinely, [been] sent to different specialists and are just not receiving the diagnosis until much later. They are just told, 'Oh, there's nothing wrong with you.' And then, two, three months later, 'Oh, you have cancer.' I'm actually seeing it across all socioeconomic populations."
> — Community Partner (Western Washington)

Considerable geographic variation in the incidence of late-stage colorectal cancer exists by county in Washington (Figure 46).

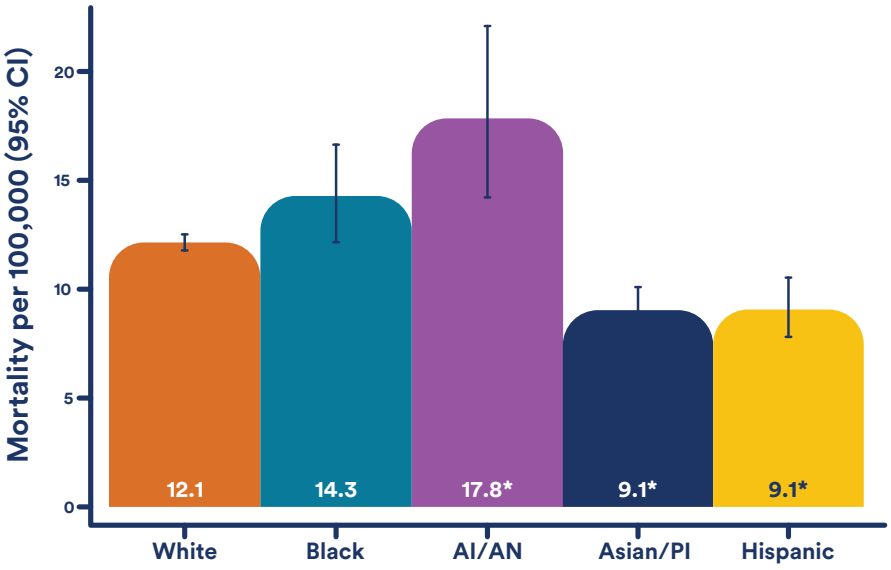
Figure 46: Incidence of Late-Stage Colorectal Cancer, 2017–2021



Source: Incidence data provided by the National Program of Cancer Registries SEER*Stat Database. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Colorectal Cancer Mortality. Colorectal cancer remains the fifth most common cause of cancer death in Washington, with an average of 1,065 deaths per year. The age-adjusted mortality rate of colorectal cancer in Washington for 2018–2022 was 11.9 (95% CI 11.6-12.2). The AI/AN (17.8, 95% CI 14.2-22.1) and Black (14.3, 95% CI 12.2-16.6) populations in Washington experience significantly higher mortality rates of colorectal cancer than the Hispanic (9.1, 95% CI 7.8-10.5) and Asian/PI (9.1, 95% CI 8.1-10.1) populations (Figure 47).

Figure 47: Colorectal Cancer Mortality in Washington, by race and ethnicity, 2018–2022

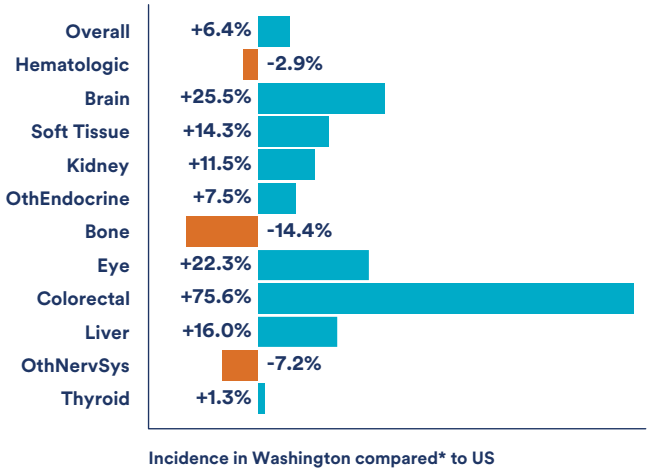


Source: NPCR/SEER Mortality, 2018-2022. Age-standardized to US Population, 2000
*rate differs from that in Whites

Cancer Burden Across the Lifespan

Different patterns of cancer exist for different age groups. Exploring cancer incidence and mortality across the lifespan informs efforts to prevent, treat and promote the well-being of cancer survivors at every age.

Figure 48: Invasive Cancer Incidence in Washington Compared* to U.S. Age 0–14, 2017–2021



Source: NPCR/SEER, 2017-2021. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

Children, Ages 0–14

Among children ages 0 to 14, hematologic cancers are the most common type of cancer diagnosed in Washington (6.4 per 100,000), followed by cancers of the brain (3.7 per 100,000). Cancer mortality for this age group does not differ between children in Washington (1.8 per 100,000) and children in the U.S. (1.9 per 100,000).

Adolescents and Young Adults, Ages 15–39

The incidence rate of testicular cancer, melanoma, colorectal and oral cancer among youth ages 15–39 in Washington is higher than the incidence rate for U.S. youth of the same age group.

Sites with higher incidence:

- Testicular (12.5 per 100,000 in WA vs. 11.0 per 100,000 in the U.S.)
- Melanoma (7.2 per 100,000 in WA vs. 5.8 per 100,000 in the U.S.)
- Colorectal (6.0 per 100,000 in WA vs. 5.0 per 100,000 in the U.S.)
- Oral (1.6 per 100,000 in WA vs. 1.3 per 100,000 in the U.S.)

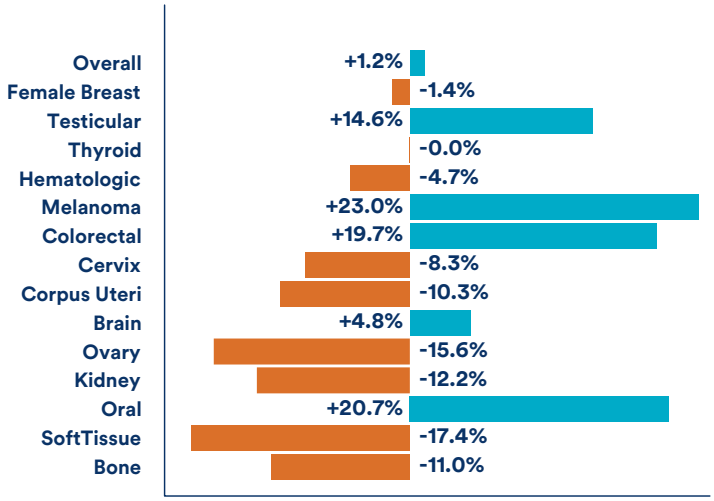
Figure 49: Cancer Mortality in Washington Compared* to U.S. Age 0–14, 2018–2022

Source: SEER Mortality, 2018-2022. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

Conversely, the incidence rate of ovarian, kidney and soft tissues cancers among youth ages 15-39 in Washington is lower than that of U.S. youth of the same age group.

- Ovary (2.4 per 100,000 in WA vs. 2.8 per 100,000 in the U.S.)
- Kidney (2.1 per 100,000 in WA vs. 2.4 per 100,000 in the U.S.)
- Soft Tissue (1.3 per 100,000 in WA vs. 1.6 per 100,000 in the U.S.)

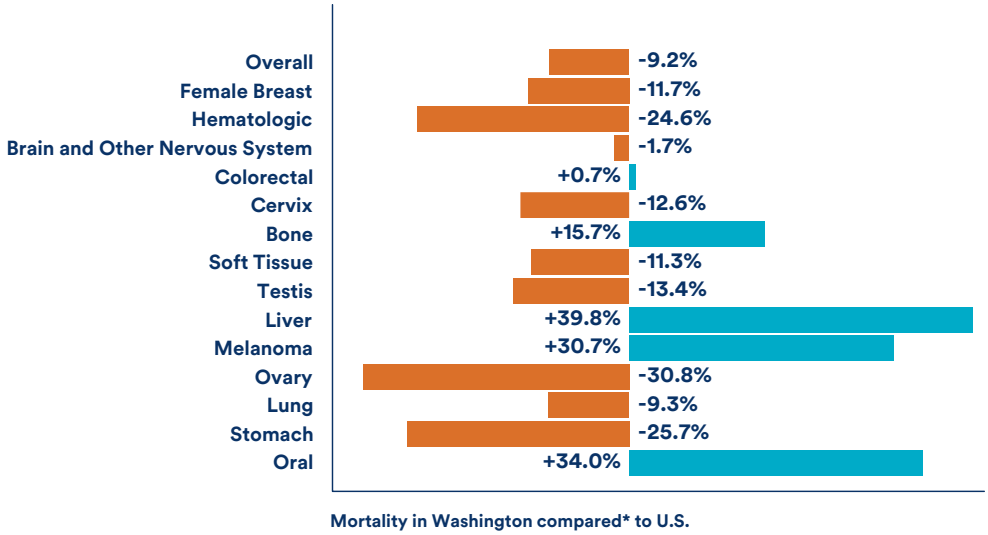
Figure 50: Invasive Cancer Incidence in Washington Compared* to U.S. Age 15–39, 2017–2021



Source: NPCR/SEER, 2017-2021. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

Cancer mortality among youth ages 15–39 in Washington is lower than the mortality rate for U.S. youth in the same age group (7.4 per 100,000 vs. 8.2 per 100,000). The mortality rate of liver cancer (0.3 per 100,000) among youth ages 15–39 in Washington is higher than the liver mortality rate for U.S. youth of the same age group (0.2 per 100,000). Conversely, the mortality rate for hematologic cancer (0.9 per 100,000) among youth in this age group in Washington is lower than for the U.S. (1.2 per 100,000).

Figure 51: Cancer Mortality in Washington Compared* to U.S. Age 15–39, 2018–2022



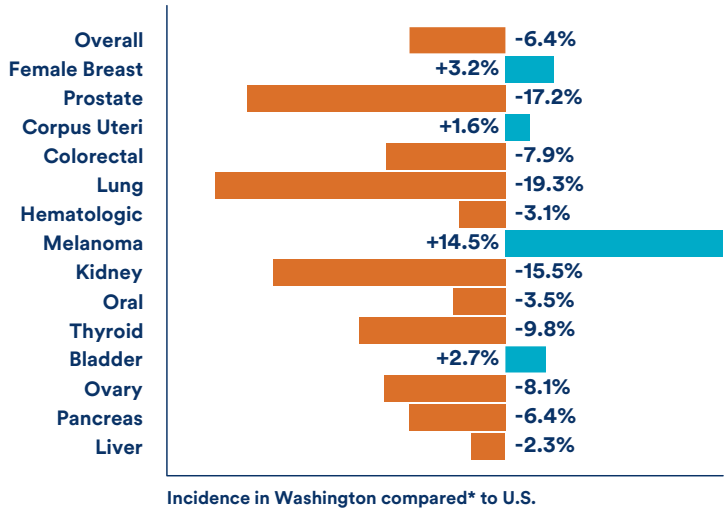
Source: SEER Mortality, 2018-2022. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

Middle Age Adults, Ages 40–64

The overall incidence rate of cancer among individuals ages 40 to 64 in Washington is lower than that of U.S. adults in the same age group (591.8 per 100,000 vs. 632.1 per 100,000) (Figure 54). This is largely driven by lower incidence rates of the following cancer types:

- Prostate (133.8 per 100,000 in WA vs. 161.7 per 100,000 in the U.S.)
- Colorectal (50.3 per 100,000 in WA vs. 54.7 per 100,000 in the U.S.)
- Lung (48.7 per 100,000 in WA vs. 60.3 per 100,000 in the U.S.)
- Hematologic (47.6 per 100,000 in WA vs. 49.1 per 100,000 in the U.S.)
- Kidney (24.1 per 100,000 in WA vs. 28.5 per 100,000 in the U.S.)
- Thyroid (19.5 per 100,000 in WA vs. 21.6 per 100,000 in the U.S.)
- Ovary (15.6 per 100,000 in WA vs. 16.9 per 100,000 in the U.S.)
- Pancreas (14.6 per 100,000 in WA vs. 15.6 per 100,000 in the U.S.)

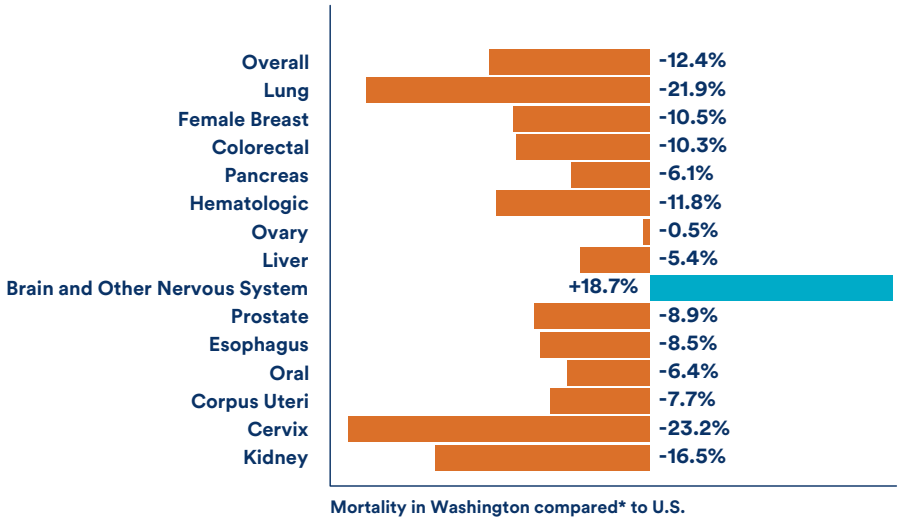
Figure 52: Invasive Cancer Incidence in Washington Compared* to U.S. Age 40–64, 2017–2021



Source: NPCR/SEER, 2017-2021. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

The overall cancer mortality rate in this age group is 12% lower for residents of Washington than for those in the U.S. (127.6 per 100,000 vs. 145.6 per 100,000) (Figure 55). However, the mortality rate for cancer of the brain among adults 40 to 64 in Washington is higher than for adults in this same age range in the U.S. (7.1 per 100,000 vs. 6.0 per 100,000).

Figure 53: Cancer Mortality in Washington Compared* to U.S. Age 40–64, 2018–2022



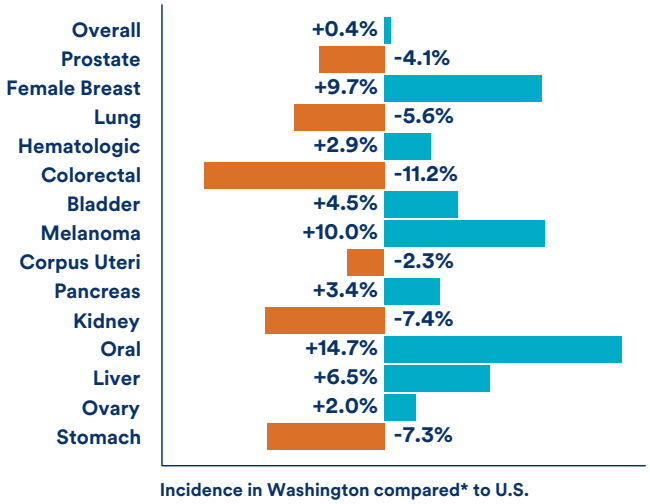
Source: SEER Mortality, 2018-2022. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

Senior Adults, Ages 65+

The risk of cancer increases substantially with age, leading to the highest cancer incidence rates seen among senior adults ages 65 and older. Within this age group, Washington adults have higher incidence rates for the following cancers:

- Female breast (472.5 per 100,000 vs. 430.6 per 100,000)
- Hematologic (187.5 per 100,000 vs. 182.2 per 100,000)
- Bladder (115.3 per 100,000 vs. 110.2 per 100,000)
- Melanoma (100.2 per 100,000 vs. 91.1 per 100,000)
- Pancreas (74.1 per 100,000 vs. 71.7 per 100,000)
- Oral (52.4 per 100,000 vs. 45.7 per 100,000)
- Liver (43.8 per 100,000 vs. 41.1 per 100,000)

Figure 54: Invasive Cancer Incidence in Washington Compared* to U.S. Age 65+, 2017–2021



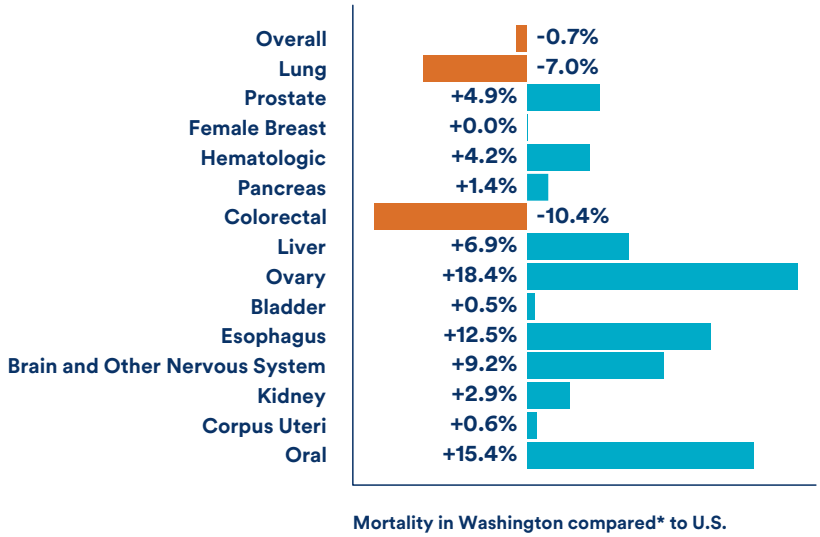
Source: NPCR/SEER, 2017-2021. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

Conversely, Washington adults ages 65 and older have lower incidence rates than in the U.S. overall for the following cancers:

- Prostate (588.6 per 100,000 vs. 613.4 per 100,000)
- Lung (280.5 per 100,000 vs. 297.1 per 100,000)
- Colorectal (134.7 per 100,000 vs. 151.6 per 100,000)
- Kidney (62.7 per 100,000 vs. 67.7 per 100,000)
- Stomach (26.9 per 100,000 vs. 29.0 per 100,000)

The overall cancer mortality rate among adults ages 65 and older living in Washington does not differ substantially from the rate of adults in this age group in the U.S. For senior adults ages 65 years and older

Figure 55: Cancer mortality in Washington Compared* to U.S. Age 65+, 2018–2022



Source: SEER Mortality, 2018-2022. Crude rates
Proportional Comparison = 100((Rate in WA / Rate in U.S.)-1)

in Washington, the mortality rates for lung (176.9 per 100,000 vs. 190.3 per 100,000) and colorectal (58.3 per 100,000 vs. 65.1 per 100,000) cancers are lower than those in the U.S. for the same age group.

However, Washington adults 65 years and older have higher cancer mortality rates than those in the U.S. for the following cancer types:

- Prostate (124.5 per 100,000 vs. 118.6 per 100,000)
- Hematologic (86.3 per 100,000 vs. 82.8 per 100,000)
- Liver (38.0 per 100,000 vs. 35.6 per 100,000)
- Ovary (35.5 per 100,000 vs. 30.0 per 100,000)
- Esophagus (22.1 per 100,000 vs. 19.6 per 100,000)
- Brain (19.9 per 100,000 vs. 18.2 per 100,000)
- Oral (14.8 per 100,000 vs. 12.9 per 100,000)

The Cost of Cancer

The financial consequences of cancer care are significant for both individuals and families. In the United States, the cost of cancer care is expected to reach more than $240 billion annually by 2030. Cancer patients paid $5.6 billion out of pocket for cancer treatments in 2018.[60]

- Female breast cancer has the highest treatment cost of any cancer. It accounted for 14% of costs ($29.8 billion) in 2020.[61]
- Colorectal cancer has the second highest treatment cost, accounting for 11.6% of costs ($24.3 billion) in 2020.[62]

In Washington between 2017 and 2019, the average cost of care for breast, colorectal and lung cancer across the spectrum of cancer care (from initial treatment to post-treatment surveillance to end-of-life care) was $90,464, with an average treatment episode length of 179 days.[63]

The costs of cancer do not impact all patients equally. "After a cancer diagnosis, approximately one-half of individuals face personal economic burdens associated with the disease and its treatment (financial toxicity) that disproportionally affect those with fewer resources."[64]

Several factors contribute to the cost of cancer. They include lack of preventive services, limited insurance coverage or lack of insurance, treatment plans and medications, emergency department visits and more. Other indirect cancer-related costs, such as appointment-related transportation and lodging, childcare, lost income due to missed work and caregiving, may further exacerbate the financial burden experienced by patients and their families.

> **"Financial toxicity has to be at the top of [the list of health-related priorities for communities].** I think we have a lot of people who lose their job because they can't go back [during treatment], so there's no real federal protection for a cancer patient beyond FMLA. And, what does that give you? It gives you 90 days, and what cancer is resolved in 90 days? Very few of them. So, many people can lose their job just by trying to save their life."
> —Health Care Staff Member (Washington)

60 Cancer Action Network. *The Costs of Cancer: 2020 Edition.* American Cancer Society 2020.
61 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). "Health and Economic Benefits of Breast Cancer Interventions." U.S. Centers for Disease Control and Prevention, Department of Health and Human Services 2024.
62 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). "Health and Economic Benefits of Colorectal Cancer Interventions." U.S. Centers for Disease Control and Prevention, Department of Health and Human Services 2024.
63 Hutchinson Institute for Cancer Outcomes Research (HICOR). *Community Cancer Care in Washington State: Quality and Cost Report 2023*, Version 4. Fred Hutch Cancer Center 2023.
64 American Cancer Society. *Cancer Facts and Figures 2024.* American Cancer Society 2024.

Community Health Needs Identified

To complement quantitative data, 93 individuals from clinics, public health agencies, Native tribes and community organizations participated in interviews and listening sessions, providing valuable insights. Additionally, the Fred Hutch Patient and Family Advisory Council shared firsthand experiences of navigating cancer care. Primary and secondary data collection revealed six key community health needs across Washington. These community health needs are intertwined, and several issues have persisted from previous community health assessments.

A. Access to Care

Access to high-quality, affordable and comprehensive care is a key contributor to physical and mental health.

Access to Care — Top Issues Identified
• Lack of providers • Rurality and the difficulty of accessing services • Lack of health insurance and suboptimal health insurance plans • Lack of health education (in general and specifically about cancer) • Transportation barriers to accessing care • Complexity of the health care system and difficulties navigating it. Insufficient and inadequate continuity of care and coordination across systems and providers. • Unequal access to digital health services and overreliance on telehealth

For interview and focus group participants, the lack of available providers — preventive, primary and specialty care, pharmacy, screening and diagnostic services — in close proximity to patients is a critical issue. Some interviewees indicated that this has "gotten worse post-COVID, with providers leaving the field and smaller health centers closing, especially in rural areas." They added that "aging rural communities face unique challenges due to slow population growth [and] minimal return of younger generations."

Other prominent issues that were brought up included "low utilization numbers [and] difficulty recruiting specialty care providers"; hospitals closing down or merging; and concentration of a lot of resources in urban centers, primarily King County. In some cases, community members are unaware that some of these services also exist locally and believe they need to travel to metro areas to get some basic cancer screening services.

> **"Health services are not evenly distributed within the whole state.** They're pretty much [only in] Seattle. Or we have Spokane. But when you are away from those big centers, I don't know that people have enough health resources that they can go to and have the proper care."
> — Community Partner (Puget Sound Region)

Lack of Health Insurance and Suboptimal Health Insurance Plans

Insurance coverage allows individuals to access free or low-cost preventive care and reduce the cost of unexpected medical expenses. The overall uninsured rate in Washington has decreased since the implementation of the Affordable Care Act (ACA) in 2010, from 14.2% to 6.3% in 2023. The uninsured rate in the U.S. in 2024 was 8.7%. In spite of this decrease, however, lack of medical insurance and being underinsured remain a significant barrier. Many people still don't have a primary care provider who can offer preventive care or follow up with them after screening results. This could be due to un/underinsurance, lack of providers in rural areas or decreasing numbers of primary care providers, among other issues.

> **"Patients may be unable to maintain their health due to a lack of insurance coverage.** They may prioritize certain medical needs over preventative services, giving patients a feeling of not being able to get healthy."
> — Community Partner

> **"For folks who are uninsured, they often don't get access to care until symptoms have become emergent.** And so, that, then, puts them into the ER, or an urgent care, where maybe they can stabilize those symptoms, but they're not really looking at, often, getting to the roots of underlying disease."
> — Community Partner (Northwest and North Puget Sound Regions)

Several interviewees clarified that "health insurance is not the same as access to actual health care." They reported high premium costs, lack of providers who accept certain insurance plans and long waitlists for critical follow-up care (such as after a cancer diagnosis). The cost of health care, and cancer care in particular, is still very high for many, even with health insurance. Additionally, there are other financial barriers associated with a cancer diagnosis, such as the loss of jobs as a consequence of treatment.

> **"[There are] incredibly high copayments for cancer medications;** not having coverage or having inadequate coverage, which a lot of seniors seem to have coverage but not enough when they get a cancer diagnosis."
> — Community Partner (Washington)

> **"The uncertainty of insurance coverage for multiple opinions and lack of education for insurance coverag**e often worsens the stress for newly diagnosed patients. The paperwork associated with insurance and treatment requirements [is overwhelming]."
> — Health Care Staff Member

> **"Limitations that are put in place by Medicare and Medicaid themselves are sometimes really hamstringing the ability that we have to provide assistance to patients,** so internally the legal team has kind of interpreted laws or regulations from CMS [Centers for Medicare & Medicaid Services] that articulate the level of support we can provide to patients, and that has drastically reduced in the recent years. The regulations are so far behind the cost of living and the requirements that we put on patients to be here."
> — Health Care Staff Member

Certain cultural groups experience these issues more acutely than others.

> **"[We see] less access to health care or [individuals who] haven't felt safe accessing it long-term for LGBTQ [people].** Lack of steady employment has often meant lack of insurance, lack of access to health care."
> — Community Partner (South-Central Region)

> **"[We see this] particularly among Latino communities.** They tend to struggle with being able to find access to honestly a lot of different things because of the fact that they never have access or rarely have access to the best medical health insurance or sick days."
> — Community Partner (North and South Puget Sound Regions)

Participants also shared that there is still a high need for support navigating financial assistance options.

> **"They went to an ER visit and came out, and they're like, 'Oh. Well, you have cancer. So, follow up with your provider.'** But if you don't have a provider to follow up with, you're left in the unknown. So, it's like, 'Where do I go from here?' I feel like there needs to be more resources available within the hospital and letting them know what their options are and where they need to go to seek additional information or additional resources."
> — Community Partner (North-Central and South-Central Regions)

> **"And there's limited outreach in terms of explaining to patients what their financial assistance options are** — a lot of patients will take a longer time scheduling their follow-up or their imaging because they're just concerned about paying because a lot of undocumented patients can't receive the federal aid that other patients can receive. So, really calling patients and helping them understand the resources that are available to them, and then also directing them back to the clinic for follow-up —'cause a lot of patients, especially with the language barrier, aren't as comfortable reaching out."
> — Community Partner (Western Washington)

> **"I feel like there's this gap between, there's things that exist, but that actual connection of really helping people be able to access that without a lot of added stress continues to be a challenge.** I mean, I can't tell you how many times people come back to us with paperwork, with bills, with something that they shouldn't have received."
> — Community Partner (Western Washington)

Transportation Barriers to Accessing Care

For individuals with cancer who need to travel regularly for treatment, lack of reliable, affordable and consistent transportation may be an obstacle to accessing care. In fact, transportation was one of the main barriers to care that interview and focus group participants mentioned. In the words of one participant, "Even though that's not a health issue, it can exacerbate a health issue. You might not access health care because of transportation."

> **"Many don't have private transportation.** Reliable public transportation is nonexistent. We have People for People, but it has limitations."
> — Community Partner (North and South-Central Regions)

Common issues that interviewees listed regarding transportation as a barrier to care include cost, not having a caretaker to drive them and travel distance, particularly in rural areas. An estimated 10% of the population in Washington live in a non-metro area; however, 30 out of 39 counties are considered rural.[65, 66]

> **"I would really like somehow to be able to take the worry of people when they look at a cancer diagnosis,** walk out of that office and have to drive 35 miles to home. And now they're going to be going back on a continual basis for some kind of cancer treatment. Now they also have to worry about gas. They also have to worry about somebody to drive them."
> — Community Partner (Southeast Region)

65 Economic Research Service. "Rural Classifications – What is Rural?" U.S. Department of Agriculture.
66 Office of Financial Management (OFM). Washington Data and Research: "Population density and land area criteria used for rural area assistance and other programs." Washington State 2024.

> **"A lot of people who are out in the boonies, they're not getting EMS care very quickly.** They're not able to get to town if they don't have transportation because no one can get out and get them because the bus system doesn't go that way."
> — Community Partner (Northeast Region)

Interviewees spoke about issues such as not owning a car, lack of public transportation and hesitation to use it when in treatment.

> **"Transportation difficulties for patients who are immunocompromised and unable to drive to doctor appointments.** Transportation for rural communities that require ferries — getting patients to and from their appointments safely."
> — Community Partner (Washington State)

Complexity of the Health Care System

Many interviewees reported that the process of accessing cancer and health care was overly complex, multifaceted and difficult to navigate.

> **"There's a local level response, there's a country level, state, federal. [...]** Everyone is shooting from all cylinders, but a more coordinated approach is probably what we need."
> — Community Partner (North Puget Sound Region)

> **"The rarity of a diagnosis while making educated decisions without education and trying to be your own advocate.** The urgency of deciding on therapies. 'Where do I get treated?' and 'What type of treatment is best?' and if standard care or a clinical trial would be best. Trying to figure out where would be the best place for care can be difficult, and often patients may have to consider moving out of state to get the best possible outcome. It can take months to see an oncologist and begin treatment because providers are frequently unavailable."
> — Cancer Survivor (Washington State)

Some respondents highlighted poorly informative web pages and inconsistent distribution of information, while others reported difficulty navigating bureaucracy. A common theme in these discussions was the desire for simple, clear language to explain concepts related to cancer.

> **"Expecting a patient to be able to navigate a fractured health care system is almost impossible and creates a lot more additional stress.** It's a systems-level barrier of a fractured service delivery that patients can't manage on their own."
> — Community Partner (Washington)

> **"Resources like Cancer Centers, DSHS [Department of Social and Health Services] and other state resources don't have a good enough resource page online.** There are a lot of resources and a lot of people who want to help our communities. Volunteers who will support individuals getting access to care. But we don't have a good system in place to connect the pieces."
> — Community Partner (North and South-Central Regions)

AI/AN people face health care systems that are often complex, chronically under-resourced, and poorly coordinated. Under its trust responsibility, the federal government must make medical, dental, and mental health services available to citizens of federally recognized AI/AN tribes. This obligation is carried out in three main ways:

- **Indian Health Service (IHS)** is a federal agency that directly provides care in many reservation and village settings.
- **Tribally operated health programs** are clinics and hospitals that tribes run themselves under self-determination contracts or compacts with IHS (Public Law 93-638).
- **Urban Indian Health Program (UIHP)** are nonprofit organizations funded by IHS that deliver culturally appropriate care to AI/AN people living in urban areas.

All three components remain severely underfunded compared with the broader U.S. health care system, contributing to ongoing health disparities for AI/AN communities.

> **"Even though I grew up in the IHS [Indian Health Service] system, now I'm learning all the intricacies of how it works**, purchase-referred care and how tribal sovereignty fits into all of that, too, and how the IHS system then communicates, and where is that warm handoff for a patient into other health care systems, such as Fred Hutch. Those intentional barriers and policies that have been put in place to make these systems not work. They really set us up for failure from the get-go."
> — Tribal Community Partner

> **"It can be hard enough to get an appointment with a specialist that services an IHS clinic because the wait times are really long,** and people don't always know how to navigate referrals and getting in for treatment on their own. [...] People still struggle with how to navigate to get here for care and how to pay for it, and I think a lot of people don't even see it as an option because it's too far. Or they're scared to get screenings because a lot of our people are dying from cancer, so they don't even wanna talk about it because it seems really, really scary."
> — Tribal Community Partner

Further complications arise when tribal members live within a clinic's service area, but are not from that community. Individuals in that position are only able to visit their local clinic for emergency situations.

> **"I've lived that struggle before.** When I lived in Wenatchee, I needed to have a follow-up for my cancer. And I was trying to figure out: Where can I go to get the X-rays and the labs and all the follow-ups for my cancer. I had to travel all the way to Yakima. So, it's not like these clients can just go wherever they want. It's a real hardship."
> — Tribal Community Partner

> **"[There are many] Natives who are not living in an area where they can access services.** I spent 36 years in Alaska, and I could go to any clinic, and I could see any doctor. And I could go to the hospitals, and I could access their pharmacy. I never had to worry about it. And to come here and see that that's a worry, it kind of shocks me. I don't understand it."
> — Tribal Community Partner

Unequal Access to Digital Health Services

Technology is now an essential component of accessing and managing health care. Access to telehealth services is particularly necessary in areas with limited medical resources. Yet disparities exist related to the digitalization of health care.

> **"We rely too much on technology,** and we are forgetting about that face-to-face type of approach."
> — Community Partner (Northwest and Puget Sound Regions)

> **"Telehealth is a good offering, but it can increase health disparities for people who aren't tech savvy or don't have reliable internet.** Hard to ask for a family member to help with setting up a telehealth call when it's a personal health matter."
> — Community Partner (Northeast and Southeast Regions)

These disparities may be associated with the cost of internet services, the lack of broadband infrastructure in some areas, difficulty navigating digital systems, online materials not being available in languages other than English and more. For example, while Washington is one the best-connected states in the country, there still are more than 316,000 businesses and residents with no or deficient access to reliable broadband service.[67] The rates of people statewide who are subscribed to broadband services are much lower for specific populations, including:

- Individuals 60+ years: 74%
- Individuals receiving Medicaid or other government assistance: 75%
- Individuals who speak English "not well": 74%
- Individuals who speak English "not at all": 62%
- Individuals with a disability: 71%
- American Indian and Alaska Natives: 70%

> **"If you're not computer literate, phone technology literate or speak English, it's really difficult for people to access services."**
> — Community Partner (Rural Areas)

> **"Telehealth offers some relief but [is] still inaccessible for certain low-income, refugee and immigrant groups."**
> — Community Partner (Northeast and Southeast Regions)

67 Washington State Department of Commerce. BE*AD (Broadband Equity, Access and Deployment Program) Initial Proposal,* Volume II. Washington State 2023.

Community Assets and Resources

Some of the community resources that contribute to ensuring access to high-quality, affordable and comprehensive health care include:

- **Community and youth political proactiveness** and efforts toward policy changes, including the Apple Health expansion to ensure that all low-income immigrants and refugees can receive affordable health coverage, and a federal waiver that would allow Medicaid to pay for traditional Indigenous healing practices. Champions include the Washington Immigrant Solidarity Network (WAISN) and the Washington's American Indian Health Commission.
- **Local collaboration** between health departments, health care providers, Accountable Communities of Health (ACHs), community-based organizations, faith-based organizations, networks and coalitions to coordinate cancer care and prevention efforts. One community partner (Northeast Region) noted, "Our biggest positive attribute that we have is the fact that we have community partners that are willing to come to the table."
- **Transportation services** offered through communities and agencies. According to a community partner (South Puget Sound Region), organizations "are doing a tremendous amount of work in supporting transportation for folks: handing out gas cards, providing subsidies, bus tickets, train tickets and also transporting folks themselves." Partners include Dial-A-Ride, the Northeast Tri County Health District's Cancer Care Fuel Card Program, Angel Flights and more.
- **Indigenous peoples**, who are "aware of what their gaps and barriers are and really working to bridge those gaps with the resources they can access. Certain tribes have invested money in creating roles for patient navigation. Communities are aware of cancer risk and are taking action in a lot of ways. They're integrating prevention with culture and making their education materials culturally specific to their specific tribe" (Tribal Health Care Provider, Washington).
- **Community clinics and Federally Qualified Health Centers** (community-based health care organizations providing primary care and support services to patients regardless of immigration status, insurance coverage or ability to pay). Interview participants praised Connect Casino Road and Lahai Health, Sea Mar Community Health Centers, Yakima Valley Farm Workers Clinic, Tri-Cities Community Health, Grace Clinic, International Community Health Center, Community Health Plan of Washington and others.
- **Training of health care providers,** including training non-cancer-focused providers to better serve cancer patients and survivors.

B. Culturally and Linguistically Sensitive Care

Participants in interviews and focus groups strongly agreed that discrimination affects all other social determinants of health and the delivery of care.

Culturally and Linguistically Sensitive Care — Top Issues Identified
• Mistrust in health care rooted in historical trauma, colonialism and unequal treatment • Fear and stigma around cancer and cancer care • Language isolation, including lack of in-language and culturally sensitive care and resources (as opposed to simply translating materials)

One participant said, "If we don't address the intergenerational trauma experiences, we're going to continue to perpetuate the disparities that exist within our communities."

> **"A lot of it is due to the history and the political identity of Indigenous people and how we've just arrived to where we are.** A lot of it's economic. Being forced on reservations, the breakup of the family unit, the lack of jobs, resources. Colonization. It's environmental. A lot of the reasons why many Indigenous communities face SDOH kind of challenges are in the systems that they find themselves in. It was colonization. It is intentional."
> — Health Care Organization Staff Member

Mistrust in health care remains an issue among minoritized communities, those who identify as LGBTQIA+, people who are poor and those who live in rural areas. The lack of trust in health care and clinical research is founded in both the historical legacy and the current experiences of undertreatment, mistreatment and discrimination. Many interviewees referred to a lack of trust toward health care systems and providers.

> **"[There is a lot of] distrust and fear around participating in Western medical care systems.** I think folks often experience discrimination when they're being seen by non-Native doctors."
> — Community Partner (Washington)

> **"It makes me question: Is this how it is in clinics that are not serving Natives?** I wanna know if there are any comparisons between clinics that service non-Natives versus Natives as far as how this process takes place. Are they experiencing the same disparities? Or is this something that Natives are seeing more? And if so, why is that, and how can we change it?"
> — Community Partner (South-Central Region)

> **"I'm still seeing Black women and men that are treated differently...**having delayed appointments, having to wait, not given the full scope of information. Why are you missing it, doctors?"
> — Community Partner (North and South Puget Sound Regions)

Assessment participants also feel that ageism is an issue. Many older adults report not feeling welcomed or being treated respectfully in health care settings.

> **"My doctor doesn't listen to me. My doctor discounts me because I'm old.** When I talk about an issue, the doctor says, 'Well, that's just because you're getting on in years.' The doctor talks to me in ways that I don't understand."
> — Community Member

Appropriate Care Delivery

Culturally and linguistically sensitive care can affect every stage of the health care process. There was extensive discussion among assessment participants about cultural differences that may impact access to and quality of cancer care. They indicated that most health care providers do not provide services that are linguistically and culturally attuned with the communities they serve. Moreover, some participants expressed a fear of not being understood by providers.

> **"Many people struggle to find a primary care physician (PCP) who can explain things clearly.** [There is also] difficulty in discussing family history of cancer due to cultural barriers."
> — Community Partner (North and South-Central Regions)

> **"People are always worried about going to the doctors** because they don't know if there's somebody that's gonna speak the language or understand the culture."
> — Community Partner (North Puget Sound Region)

Participants shared how "there's more of an impact depending on the community and demographic and culture that you participate in and identify with." For example, most clinics and facilities don't offer services or appointments outside of traditional working hours, which can present a barrier to patients with demanding schedules or family obligations.

> **"If they really want to have a lucid conversation with a doctor, it needs to take place in these little windows during their day,** and providers aren't aware of that... There's no consideration beyond actually having the appointment to the quality of what's going to happen during that appointment."
> — Community Partner (Northeast Region)

> **"We don't have appointments for people who can't leave work.** We don't have evening appointments. We don't have childcare, and so when we had COVID restrictions on caregivers or children in the building, it drastically reduced access."
> — Health Care Staff Member

When it comes to addressing language barriers, sometimes simply providing translated materials isn't enough. In order to be effective, translated resources must also be culturally appropriate and specific to the patient's needs. Even clinics and facilities that can offer general materials in multiple languages may still lack multilinguistic resources related to specific diagnoses or care needs. One participant brought up alternative means of communication that may increase accessibility and how "some communities may find pictures and graphics easier to understand and navigate than words."

> **"We have a lot of people in our community that are not even Spanish speakers, they speak a dialect,** and so many clinics and hospitals in the area don't have interpreters specifically for their dialects."
> — Community Partner (Washington)

> **"[We need to start] making sure that there is language translation and interpretation,** making sure that even prescription bottles [are] in your primary language."
> — Community Partner (Northeast Region)

Participants also noted that in some areas and for some communities, traditional and rural ideals encourage self-reliance and ruggedness, often at the expense of adequate or timely care.

> **"Conservative ideals and not wanting to give or take handouts...**They have this idea of self-resilience or self-reliance."
> — Community Partner (Northeast and Southeast Regions)

> **"They're farmers. They're like, 'Rub some dirt on it. Get back to work.'** They're not necessarily seeing the doctor and doing their preventative care regularly."
> — Community Partner (Northeast Region)

> **"[There is a] mentality of 'We can power through, and we don't go to the doctor until we are on our deathbed.'** It's just like this ruggedness is [something] I think an older population really clings to."
> — Community Partner (South Central Region)

In general, many participants feel that the health care system does a poor job of making people feel welcome.

> **"The health care system doesn't really lend itself to people feeling welcome.** It's not a space that was made for them in those clinical settings. How do we get people to see themselves here or recognize themselves in these different clinical spaces, or are we making room for that culture to be practiced so that they feel like they're gonna be treated in a good way?"
> — Health Care Staff Member

Fear, Taboos and Stigma

Many interviewees (especially those who represent historically marginalized groups) report having fear, taboos and stigma surrounding cancer and health care. This is due in part to the inherent scariness of a life-threatening disease like cancer, but can also be attributed largely to the troubled historical relationship between the medical community and Indigenous, Black and Brown communities.

> **"Something I've noticed in a lot of the events that we've done is the fear of talking, even saying the word cancer** — if I talk about it, I'm gonna bring it upon myself, or if I don't know about it, it doesn't exist."
> — Health Care Staff Member

This includes fears around preventive screening, which can often lead to diseases being addressed before they become lethal. This is particularly worrying, especially given that cost is also a deterrent for many people who might benefit from screening.

> **"[There is a lot of] concern about genetic screening, especially among minority communities** that have good reason not to trust the U.S. government."
> — Community Partner (Eastern Washington Region)

> **"Not wanting to get screened because of the fear of knowing whether or not they have something,** and then fear of how they're gonna cover for those services."
> — Community Member

Care Navigation Barriers

Availability of and access to culturally attuned prevention, education and screening was another priority need identified in the previous Fred Hutch CHNA. Patients, families and communities continue to face care navigation barriers due to the complexity of the health care system. Confusing costs and benefits, unavailable in-language services and resources, and difficult-to-understand medical information are some of the factors that prevent people from accessing care. Patient and cultural navigators and community health workers play an increasingly key role in eliminating health disparities related to access to care and addressing the deep-rooted mistrust of the health care system among minority groups and marginalized populations due to historical trauma, mistreatment and discrimination.

> **"Health system navigation is challenging due to cultural differences,** especially in understanding prescriptions, appointment follow-ups and family-centric health care needs."
> — Community Partner (Northeast and Southeast Regions)

> **"People who don't speak English have little knowledge of their diagnosis, their treatment plan.** They oftentimes will say, 'So, what is your diagnosis?' 'I have cancer.' 'What kind of cancer?' 'It's in my breast.' And they have no clue what stage or even what type of cancer. And then, we'll say, 'What kind of treatment?' 'I don't know. I just go.' And so, we're trying to work with populations and helping them understand their diagnosis, their treatment, their next steps and what questions to ask."
> — Community Partner (Western Washington Region)

Community Assets and Resources

Interview participants listed a number of valuable people, entities and resources in their communities. These examples continue to guide Fred Hutch and the Consortium in becoming trusted entities that provide culturally and linguistically sensitive care:

- **Cultural practices and cultural knowledge keepers and elders.** One Tribal community partner noted, "Our culture is a protective factor." Activities such as Paddle for the Battle — an intertribal event to address cancer through healing with prayer, stories, songs and a canoe journey — and "other cultural practices that integrate a cancer lens and engage the community are huge strengths" (Tribal community partner, Washington).
- **A strong network of community-based organizations** (CBOs) offering support in culturally sensitive ways, focused on serving specific populations and honoring the increasing diversity of communities. "CBOs play an essential role in direct support for underserved communities, often through innovative approaches" (Community Partner, Eastern Washington).
- **Community health educators, community health workers,** community engagement specialists and promotoras, who are "trusted, community-centered resources who bridge gaps in cultural understanding and health literacy." Community partners from around the state noted that these individuals "are going down to the most vulnerable areas [of our communities]," and "are part of a community [such as] Slavic, Marshallese, Afghan and are a great way to connect with people and provide spaces that are culturally relevant and in languages that they speak."

- **The Office of Community Outreach and Engagement (OCOE)** at Fred Hutch, whose mission is to improve health outcomes for all populations through cancer research that addresses and reduces cancer health disparities. "OCOE [staff] travel to smaller towns where educational resources are even more scarce. In the past, OCOE has conducted home workshops which were effective due to the more intimate, personal format" (Community Partner, Northeast Region).
- **həli?il** (A Lushootseed word meaning "to become well/heal") at Fred Hutch is a program focused on identifying barriers to lung cancer screening in Indigenous communities and partnering with tribal and community leaders.

C. Social Determinants of Health

Interview participants identified the prevalence of combined social and economic needs as one of the most significant health issues impacting communities. As described throughout the CHA, the unfulfillment of basic needs is associated with poor health and health care use. These social and economic needs are generally interwoven.

> **"They just kind of all bleed together and they support each other in a bad way,** I guess is one way to say it. I mean, if we had better housing, if we had better employment, some of these other issues would disappear. But we don't, so they all kind of exist and co-mingle together."
> — Community Partner (Northeast Region)

Social Determinants of Health — Top Issues Identified
• Unavailability and high cost of childcare
• Houselessness and lack of affordable housing
• Unequal access to traditional foods, nutritional resources and places to stay physically active
• Climate and environmental impacts on health
• Social isolation among LGBTQIA+ seniors and individuals living in rural areas

Lack of Affordable Housing

Interview and listening session participants highlighted the lack of affordable housing as a health-related social need that also represents a prevalent gap across communities.

> **"Housing, childcare. I think a really important nuance is that the west side has a high cost of living,** but their salaries are much higher than the east side. On the east side, 33 to 36% of that is housing. On the west side, it's around 23%. Eastern Washington residents are really taking a burden on cost of living because our salaries are not commensurate with the cost of living in the state."
> — Community Partner (Northeast and Southeast Regions)

> **"Many of the other health disparities that LGBT seniors face, particularly BIPOC trans elders, are exacerbated by the high cost of housing or a lack of safe housing access** in addition to the social isolation, which means that folks are less likely to seek treatment, less likely to have ways to get to medical appointments and doctors' appointments, less likely to have folks who can help ensure that they're eating nutritious meals and taking proper care of themselves, not even touching on the mental health impact that isolation can have on an older adult population."
> — Community Partner (North Puget Sound Region)

Interviewees also pointed out housing needs for, and the unaffordability of, temporary relocation for long-term patients who travel from rural areas for treatment.

> **"We're [limited by] the distance to find good cancer care.** And when you are able to find it, the distance to travel and then also the burden that our urban counterparts don't have of having to stay overnight multiple nights in a hotel to access that care. And so, there's that element of just access to resources."
> — Public Health Officer

Food Insecurity

Food insecurity was also on the list of barriers to care, according to CHA interview participants. They highlighted the importance of eating healthy, nutritious foods during the entire cancer experience continuum and the inability of many, including older adults, to access and cook nutritious meals.

> **"What I think is contributing to the disparity? It's lifestyle.** I just know that we've had a lot of grief, loss and trauma. Trauma is linked to inflammation, and inflammation is linked to almost every health disparity that we face. And then you link that with the diet and the lack of exercise, and that leads to a lot of health disparities."
> — Tribal Community Partner

> **"High consumption of fast food due to convenience.** Lack of exercise, closely linked to screen time."
> — Community Partner (North and South-Central Regions)

Unaffordability, pollution and the lack of nearby grocery stores or farmer's markets decrease people's ability to access healthy foods. Interviewees also noted a perceived increase in the use of food banks in the last couple of years.

> **"Access to healthy food.** It's shocking to me that we are an agricultural belt, yet people have food insecurity and not a lot of access to fresh fruits and vegetables."
> — Community Partner (Central and East Regions)

> **"Marginalized communities lack the resources to get the nutrition that they need.** Many people still live in food deserts."
> — Community Partner (North Puget Sound Region)

> **"Environmental exposure [is an issue], so a lot of people might not be able to have access to their traditional foods** because they've been polluted."
> — Community Partner

Climate and Environmental Impacts on Health

A number of interviewees and focus group participants cited environmental justice and climate change issues as impacting their health. They detailed concerns related to lead poisoning, inability to filter water and even worries about specific geographical sites.

> **"[There is] a lot of conversation around some of the most powerful political and elected officials in the community** basically corralling their power to cover up the prevalence of problems and how that relates to cancer. In the Airway Heights (between the airport and Airway Heights and Fairchild Airforce Base), it feels like we're just grasping the generational impact for years to come of PFAS [also known as "forever chemicals"] and the groundwater basically being poisoned."
> — Community Partner (Northeast Region)

> **"Hanford Site in central Washington has been a major concern,** just how that's impacted health and how that might have an impact on other social determinants of health for Native people."
> — Tribal Community Partner

> **"We have huge environmental impacts on our health.** A lot of the people I speak with can't minimize the environmental impacts on themselves and their families. It's impossible for them to go to a grocery store and choose the organic [produce] and then go home and wash those versus what they can pick up at a food bank. These issues are probably nationwide, and it would be so nice if somebody would start addressing these issues that I think are just very systemic. Our soil is contaminated."
> — Community Partner (South-Central Region)

Social Isolation

Interviewees and listening session participants find it critical for organizations and health care institutions to facilitate opportunities for patients and caregivers to connect with people who have similar lived experiences.

> **"Oftentimes, LGBT seniors go back into the closet as they age.** This is particularly prevalent in skilled nursing facilities or memory care situations where folks don't know that their caregivers will continue to treat them well or provide them with adequate care. It's particularly dangerous for trans folks who in being trans can't go back into the closet in the same way without actually fully giving up their identities. And so, they're put in even more uncomfortable and potentially dangerous or violent situation[s] based on that."
> — Community Partner (North and South Puget Sound Regions)

> **"Not having community or family support has a significant impact on what happens to patients when they get care.** Patients who do not have the support system don't have the same conversations with their providers and don't always know to ask questions or advocate for themselves."
> — Cancer Survivor (Washington)

Community Assets and Resources

Interview participants cited available resources that contribute to addressing the communities' needs related to social determinants of health. These include:

- **Local community-based, faith-based and mutual-aid organizations** that enhance the quality of life of community members and provide assistance with needs. "EMS volunteers, fire departments, schools [...] even if they're not directly health-related, they're very willing to partner with us" (Community Partner, North Puget Sound Regions).
- **Fellow community members,** who were named as one of the most crucial strengths and resources to best support health and well-being. Their connections, partnerships and peer support make it possible for organizations to engage with and offer resources directly to communities. One community partner (North Puget Sound Region) remarked, "I really think human contact will always be above everything." Interviewees also highlighted the sense of community, "knowing that everyone is your neighbor and having that passion behind wanting to help the community" (Community Partner, Northeast Region).
- **Sense of resilience** and finding ways to overcome social determinants of health challenges. One community partner (Northwest Region) noted, "[People] are so incredibly resilient [...] but even resilience in itself can be a burden." Another community partner (North and South Puget Sound Regions) alluded to the ability of specific groups or communities to draw on historical resilience to meet modern needs: "The LGBT senior community as a whole is incredibly resilient but they're not resilient by choice: history and circumstance, discrimination, the HIV/AIDS epidemic, all those things have [been] forced upon them."
- **Specific housing providers,** such as the Edward Thomas House at Harborview Medical Center (a recuperative care program for people who are unhoused and do not require hospital level care but are too sick to return to a shelter or the streets); Fresh Start Housing (which provides clean and sober, communal and low-barrier housing); and Pomeroy Assist Garfield County Humanitarian Association (which provides emergency housing).
- **Nutrition providers and services,** including farmer's markets, food banks, free lunches, Meals on Wheels providers and other resources offering healthy food choices.
- **Cities, parks and recreation departments and outdoor spaces** that offer accessible and safe options for physical activity. As examples, one community partner (North Puget Sound Region) cited "[t]hings like the senior lunches, exercise programs within Parks and Recreation. They offer different levels of exertion and target different age groups and people that are coming back from chronic disease so that they can have healthier lifestyles."

D. Preventive Care

Interviewees expressed a lack of awareness about cancer, its risk factors and the importance of family history in assessing cancer risk. For some community members, discussions about cancer, including early detection and prevention, remain taboo.

> **"[There is] limited outreach and education around cancer screening,** particularly among BIPOC communities who may face stigma around discussing health history."
> — Community Partner (Eastern Washington Region)

Preventive Care — Top Issues Identified
• Limited outreach and education around cancer screening
• Persisting disparities in incidence, late-stage diagnosis and mortality rates
• High rates of late-stage cancer diagnoses
• Unawareness of available resources

Rural or underrepresented areas, in particular, often have insufficient patient education resources regarding cancer screenings and risk factors.

> **"[We] especially [need] cancer prevention specific to people who live on reservations, people who are Indigenous.** What does prevention specifically look like for that community?"
> — Community Partner (Washington)

> **"BCCHP [Breast, Cervical and Colon Health Program] [...] took a step back as well** because of the fact that they removed the funding for colorectal cancer screening."
> — Community Partner (Washington)

Refugees and immigrants face severe disparities in cancer screening. Many of them also experience elevated risks from infection-attributable cancers linked to their country or region of origin.[68] In addition, many fear deportation or other challenges based on their immigration status, which prevents them from seeking health care.

68 Walker, PF et al. "Cancer Screening in Refugees and Immigrants: A Global Perspective." *Am J Trop Med Hyg* 2022.

> **"[These populations have a high degree of] unfamiliarity with U.S. health care processes,** compounded by language limitations and different cultural norms around health and family care."
> — Community Partner (Northeast and Southeast Regions)

> **"There is a great amount of refugees coming over [...who] were not informed** of or did not have the health care or already came from [...] hardship. It just made it more stress[ful] on them, too, so that also is a factor."
> — Community Partner (South-Central Region)

> **"Recognizing all the traumas people experience throughout their journey to the U.S. as refugees and immigrants [is important].** We can do a much better job of how we communicate about and provide access to mental health. It needs to be incorporated into every aspect of health conversations."
> — Public Health Officer (Northeast Region)

An additional issue related to immigrants and refugees mentioned by at least one of the interview participants was about their potential contribution to the health care workforce:

> **"[One of the most pressing health issues facing the communities is] retaining and recruiting workforce.** And for refugee and immigrant health care providers, getting that recertification in the United States so that they can provide the services that they did in their home countries."
> — Community Partner (Northeast Region)

Limited Outreach and Education Around Cancer Screening

As noted in previous sections, understanding patterns and disparities (whether related to geography, sex, race or ethnicity) in cancer incidence, late-stage diagnosis and mortality rates may help inform decision-making about cancer education, prevention and screening. The following is a list of cancers that affect some populations disproportionately:

Female Breast Cancer

- Approximately 30% of all female breast cancer diagnoses in the state are late-stage female breast cancer.
- Asian/PI and Hispanic populations showed increasing female breast cancer incidence.
- AI/AN people had the highest rate of late-stage female breast cancer and female breast cancer mortality rate.
- Chelan, Skagit and Snohomish counties experienced late-stage female breast cancer incidence rates exceeding the Washington rate.

Prostate Cancer

- Late-stage prostate cancer represents 26.7% of all prostate cancer diagnoses in Washington.
- Black and White populations showed statistically significant increases in the incidence of prostate cancer.
- Black people had the highest risk of late-stage disease and mortality rate.
- San Juan, Clallam, Whatcom and King counties have significantly higher incidence rates of late-stage prostate cancer than Washington as a whole.

Lung Cancer

- Almost 65% of lung cancer cases are diagnosed at a late stage.
- The incidence rate of lung cancer among males is significantly higher.
- AI/AN peoples experienced the highest lung cancer incidence rate and late-stage lung cancer.
- AI/AN and Black populations experienced significantly higher lung cancer mortality rates than other populations.
- Mason, Grays Harbor, Okanogan, Pierce, Skagit, Snohomish, Clallam and Thurston counties have incidence rates of late-stage lung cancer that significantly exceed the statewide rate.

Hematologic Malignancies

- AI/AN peoples have the highest hematologic malignancy mortality rates in Washington.

Colorectal Cancer

- More than 60% of colorectal cancer cases in Washington are diagnosed at late stage.
- Colorectal cancer incidence rates in Washington remained stable, while they continued to decline in the U.S.
- The AI/AN population by far exceeded the incidence rate of colorectal cancer of any other group. They also had the highest rate of late-stage colorectal cancer.
- The AI/AN and Black populations experienced significantly higher mortality rates.
- Counties with the highest incidence of late-stage colorectal cancer include Adams, Pend Oreille, Franklin, Lincoln and Skamania.

Unawareness of Resources and How to Access Them

Even when care is available, some interviewees reported a lack of understanding and awareness of accessible resources.

> **"Having access to resources is different than utilizing them.** And I think that there is a huge internal barrier when it comes to utilizing resources. And having the resources is not enough."
> — Community Partner

Community Assets and Resources

Interview participants highlighted some available resources and current initiatives to make cancer prevention, education and screening more accessible and widespread. These include:

- **Mobile clinics,** such as the Fred Hutch Mammography Van and the Department of Health Care-a-Van mobile health unit. One Tribal community partner reported, "We're bringing the mammogram vans into the powwow grounds on a regular basis." Another community partner (South Puget Sound Region) noted, "[Mobile clinics] are able to reach folks that might not otherwise be reached, and they're able to connect those folks with screenings for cancer, blood pressure, diabetes, etc."
- **Screening and prevention efforts tailored to specific communities,** including community health events and culturally specific prevention materials. "We are working with specific tribal partners on metaphor and storytelling as an accessible way to talk about cancer and kind of indigenizing that process," said one Tribal community partner. Another community partner (North and South Puget Sound Regions), cited Project SASSY (Seattle Area Smoking and Screening StudY), a collaboration between Fred Hutch and Seattle's LGBTQ+ Center: "Project SASSY is an excellent example of making an intentional effort to connect with the LGBT community around smoking cessation and cancer screenings and prevention."
- **Efforts by health care institutions to increase awareness** about cancer prevention and care. This also includes a movement in health care settings to consider care of the whole person by adding support staff to assist patients who need more than physical treatment.
- **Community-based organizations** providing screening and diagnostic services, classes and support groups. Some of them include Cancer Lifeline, Native Women's Wellness Program, Cancer Action Network and more.
- **Efforts by schools** that focus on the health and well-being of youth populations. For example, the Sunnyside School District hired a nurse to work with migrant children. The nurse conducts dental and health assessments for newly arrived migrant children.
- **Structural and system changes** such as moving to an electronic health record, which "has helped capture some of the gaps in provider education. The automated system does the reminders and reduces handoff error; you don't have to rely on the human to be infallible" (Community Partner, Southeast Region).

E. Health Care Unaffordability and Cost of Living

Assessment participants repeatedly mentioned issues related to affordability of cancer care, including the cost of lodging, hospital bills, transportation and lack of financial aid. One participant remarked, "You have to be out on the streets to qualify for assistance. You don't make a lot, but you make too much to qualify."

Unaffordability and Cost of Living — Top Issues Identified
• Unaffordability and perception of unaffordability of cancer care
• Cost of living

> **"Paying for visits is a big concern and then navigating any sort of financial assistance program.** We have pretty good navigators and translators, but it's still a really daunting process."
> — Community Partner (Puget Sound Region)

> **"After we were treated, the bills started coming.** I just cannot keep up with the payments."
> — Cancer Survivor (Washington)

Additionally, the cost or perceived cost of treatment may force people to delay or not receive care. One community member noted, "In some cases, [people feel it's] better not to know because they may not have the resources to do anything if they are screened and something is abnormal."

> **"'Well, I can't afford cancer treatment. So, I'm not going to pursue it.'** We hear that. No matter what, they were just gonna be faced with massive bills, and they didn't wanna put their family through that. So, we've heard people say, 'I'd rather die than leave my family in debt.'"
> — Community Partner (Puget Sound Region)

> **"A lot of them will avoid going to a clinic or a doctor, even just for a checkup**, because they don't want to find out if they have an illness, because they're afraid of treatment and if they're gonna be able to afford it."
> — Community Partner (North Sound Region)

Health care unaffordability falls under the larger umbrella of the increasing cost of living in the state. People from every corner of the state shared how "wages haven't kept up nearly as much with cost of living and inflation." By some metrics, Washington's economy is expanding (for example, the unemployment rate has improved by almost one percentage point, from 3.8% in October 2023 to 4.6% in November 2024); however, the cost of groceries, gas, housing and health care has remained high for many. One-third of families in the state earn less than $74,999 per year. As seen on p. 26, the Self-Sufficiency Standard for the lowest geographic area in the state (Franklin County) is $72,015.

> **"When someone is having to make a decision on whether or not they can pay for a prescription or keep their lights on**, oftentimes they'll spend the money on trying to keep the lights on."
> — Community Partner (North Puget Sound Region)

> **"[It's difficult for] lower economic populations to reach those treatment centers. [There is also] the cost of it.** When you look at how [regions were] supported by the lumber industry and how things have changed; the fishing industry and how that has changed. And [now it's] a large retirement area. So, the economic levels of those individuals is a little different. One of the issues that we've run into is people choosing to go through their treatment versus paying their rent, so to speak."
> — Community Partner (Peninsula/Coastal Region)

Community Assets and Resources

Below are a few available resources referenced by interview participants that work to address the unaffordability of cancer care:

- **Fred Hutch Financial Assistance and Financial Counseling** helps patients navigate financial difficulties and alleviate some of their financial stress. However, many patients are unaware that these resources are available to them.
- **One-time financial assistance.** There are a number of charitable organizations that provide aid to cancer patients. For example:
  - Cancer Lifeline's Patient Financial Assistance Fund offers financial aid to qualifying low-income patients in western Washington. However, this fund has its limitations. One cancer survivor said, "Cancer Lifeline offers $250 to $300 once, and that's great for tomorrow, but that doesn't ensure that the $3,000 I'm due to owe for rent gets paid."
  - Lazarex Cancer Foundation, which helps patients with costs to participate in clinical trials.
  - Tri-Cities Cancer Center Foundation, which helps cover patient needs like hotel vouchers and medication co-pay.
  - CancerCare, a national nonprofit agency that offers support, information and financial assistance.
  - The Leukemia & Lymphoma Society, which offers financial aid to patients with significant financial need who have leukemia, non-Hodgkin lymphoma, Hodgkin lymphoma or multiple myeloma.

F. Mental Health

Mental health was once again identified as one of the most pressing health issues facing communities, according to interview participants. The National Alliance on Mental Illness (NAMI) reports that one in five U.S. adults experience mental illness each year.[69] Over 27% of people aged 18 or older in Washington had any mental illness between 2021 and 2022.[70]

A cancer diagnosis and treatment can be emotionally overwhelming for patients and their families and caregivers. The fear of illness and the financial burden of cancer can have a significant impact on the mental health of a person and their loved ones. One-third of patients with cancer present a mental health condition during all phases of the disease, depending on the stage and type of cancer.[71]

Mental Health — Top Issues Identified
• Lack of mental health care access • Issues related to cancer and emotional, socioeconomic consequences • Substance use disorders

> **"The fear of talking, even saying the word cancer.** If I talk about it, I'm gonna bring it upon myself, or if I don't know about it, it doesn't exist."
> — Indigenous Health Care Provider (Washington)

> **"It's rising, it's concerning. For physical [health issues], it is easier to find support for my clients.** But people in my culture and community, we grow up thinking that [...] for us to go with a psychologist or counselor means that you're crazy. It is a taboo."
> — Community Partner (Northeast Region)

> **"[The] baseline of stress across the board that is impacting people at every level of their health.** It's hard to get to a place of thinking about cancer prevention when your mental health is not great."
> — Community Partner (Northeast and Southeast Regions)

69 National Alliance on Mental Illness (NAMI). "Mental Health in Washington." NAMI 2021.
70 Substance Abuse and Mental Health Services Administration (SAMHSA). 2021–2022 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). U.S. Department of Health and Human Services 2022.
71 Caruso, R & Breitbart, W. "Mental health care in oncology. Contemporary perspective on the psychosocial burden of cancer and evidence-based interventions." *Epidemiology and Psychiatric Sciences* 2020.

Interview participants noted a high demand for mental health services post-COVID across the state. Meanwhile, there is a shortage of mental health providers in 39 designated geographic areas,[72] covering 36 of the 39 Washington counties.[73, 74] In 2023, there was one mental health provider per 200 people in Washington. The mental health provider ratio is worst in Garfield County (one provider per 2,360 people) and Douglas County (1,580 people) and best in Lewis (1:160) and King, Whatcom and Pierce counties (1:170).[75]

> **"Mental health care is limited. We only have so many mental health workers and facilities,** and then we have so many people needing services in a proactive way. It has nothing to do with an individual system or network. It's region-spread."
> — Community Partner (South-central Region)

Community Assets and Resources

Interview participants noted the following resources supporting emotional and mental health in our communities:

- **Patients and their social circles,** including caregivers, faith-based communities and cultural networks, are essential sources of support. "I want to call it affinity groups: their families, extended families, cultural families that are not related to them," said one Washington-based health care provider. "These are groups that rally to support people to get them to appointments that help them with emotional resilience, that pay for their rent when they can't."
- **Local mental health providers,** who provide much-needed support to cancer patients and their families. Interview participants referenced providers such as Asian Counseling and Referral Service, Lourdes Counseling Center, Palouse River Counseling and Mariposa House.
- **Campaigns and materials** focusing on mental health and tailored to specific populations (such as youth, Tribal peoples, cancer patients and rural communities). One community partner from the Southeast region highlighted the WSU Extension's Preventing Farmer Suicide Campaign: "If you're trying to tap into the farming community, because cancer rates among farmers are pretty high, that would be an interesting model to look at of how they utilized a CBO that is trusted to get messaging out to the farmers."

72 Health care shortage areas, determined by the Health Resources and Services Administration (HRSA), include health professional shortage areas (HPSAs), which are geographic areas; subgroups of the populations or specific facilities lacking professionals in primary care, mental health or dental care; and medically underserved areas and populations (MUAs and MUPs), which are geographic areas or populations that lack access to primary care services only. Geographic areas can be single or multiple counties, parts of cities or other divisions, depending on the state.

73 Cox, E. "States with the biggest mental health care deserts." ADHDAdvisor.org NA.

74 Health Resources & Services Administration (HRSA). HPSA Find Tool, data.HRSA.gov. U.S. Department of Health and Human Services.

75 County Health Rankings & Roadmaps. *Access to Care: Mental Health Providers: Washington.* University of Wisconsin Population Health Institute 2024.

Impact of the Previous Community Benefit Implementation Plan

Between 2022 and 2024, Fred Hutch allocated over $147 million — nearly 7.13 percent of its operational costs — toward community benefit initiatives. A significant portion of this funding was directed toward expanding access to high-quality clinical services for individuals unable to afford care, including subsidized care and essential services provided at a financial loss to the organization. Additionally, Fred Hutch made investments to support publicly accessible research, community health improvement programs and services aimed at reducing cancer burdens in underserved populations, and educational opportunities for health care professionals.

The 2022 Community Health Needs Assessment identified key health need priority areas: reducing health disparities; providing culturally attuned prevention, education and screening; and ensuring access to affordable and comprehensive care. These priorities were shaped by the overarching goal of delivering equitable care to all communities and individuals. To effectively and authentically implement these initiatives, Fred Hutch undertook a process of strengthening internal infrastructure and fostering relationships with community partners.

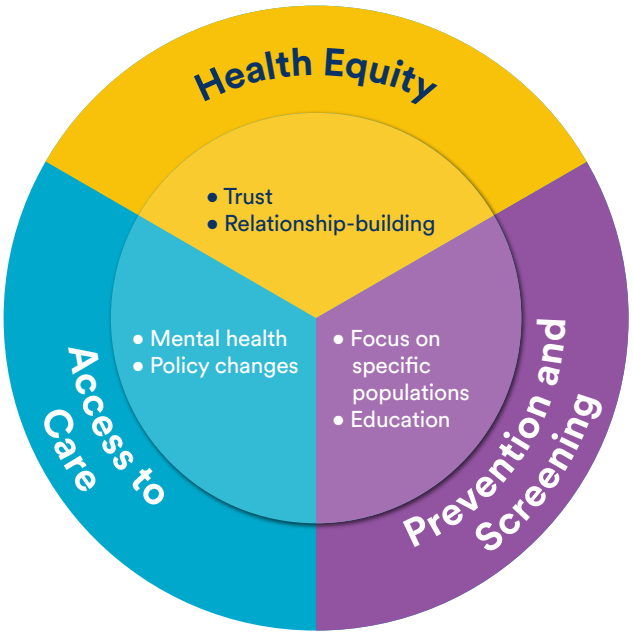
Below is a summary of the identified priorities from the 2022 CHNA, along with the actions we have taken and their impacts to date.

All priorities and goals were created and published in 2022.

Priority 1: Addressing Disparities in Cancer Care and Outcomes

Achieving health equity is at the center of the Implementation Plan priority areas. Trust and relationship-building are essential to becoming an anti-racist organization and advancing equitable change.

Figure 56: 2022–2025 Community Benefit Implementation Plan Priority Areas



Goal 1.1: Improve language access and culturally relevant resources to better serve community members who speak a language other than English or who prefer visual communication.

- OCOE conducted in-depth assessments and audits of current health education materials, including interviews and focus groups with diverse community-based organizations and partners. The findings from this process were then used to help inform the development of new materials.

- OCOE community health educators created an online, internal community education resource library, including a system to track material updates.
- OCOE implemented quarterly cancer-specific trainings for community health education staff to equip them with knowledge and tools to share with community partners.
- OCOE and the Patient Experience Department are working to develop single-page cancer prevention materials for community members and patients. These materials will be translated into multiple languages and made available both online and in print.
- OCOE assisted Patient Navigation in obtaining an American Cancer Society grant in 2022 that added a second Patient Navigator for patients who prefer Spanish. That position has since been made permanent.

Goal 1.2: Build cultural responsiveness, internal capacity and organizational infrastructure to increase accessibility and provide high-quality treatment to patients of all backgrounds.

- Staff are now required to complete training on how to ensure, fair, non-discriminatory, and accessible treatment for all.
- Fred Hutch participated in the National Comprehensive Cancer Network Health Equity Report Card Pilot Project. The Report Card scores improved across all categories (Community Engagement, Accessibility, Bias and Quality of Care) between 2022 and 2024.
- Fred Hutch increased representation of BIPOC staff in decision-making positions. Four years ago, none of Fred Hutch's executive leadership identified as BIPOC. While leadership remains overwhelmingly racially and ethnically homogenous, Fred Hutch made marked strides in our efforts to diversify, with 19% self-identifying as BIPOC and 57% as women leaders. Overall BIPOC employee representation remains steady from previous years at 39%.

Goal 1.3: Sustainably improve access to clinical trials for underrepresented minority (URM) patients.

- Fred Hutch convened a Patient Needs & Outcomes Committee to provide recommendations on accessibility and patient-centeredness in patient care, research and clinical trials. The Committee developed specific recommendations and next steps aimed at creating a more robust clinical trials infrastructure to promote broad participation and representation.

Goal 1.4: Strengthen the capacity of community-based organizations who are rooted in and trusted by our communities.

- From 2022 to 2024, Community Benefit and OCOE teams distributed over $400,000 in community grant funding to 42 community organizations on behalf of Fred Hutch and the Consortium.

Goal 1.5: Enhance the ability to analyze data at a granular level to better understand the burden of cancer, including implementing greater Fred Hutch patient segmentation by race and ethnicity.

- All Fred Hutch clinic sites operationalized and implemented collection of patient and ethnicity data, with a 93% capture rate.

- Fred Hutch created a new campaign, titled We Ask Because We Care, to inform patients about the importance of collecting patient demographic information in order to ultimately better meet their individual needs

Goal 1.6: Improve knowledge of concordant cancer care among health care and allied health providers and students while building programs that address workforce development in underrepresented populations.

- Fred Hutch increased the number of faculty who self-identify as BIPOC from 34% in FY23 to 36% in FY24 through inclusive outreach and support strategies, while ensuring all faculty opportunities remain open to all individuals and are based on merit and qualifications.
- Fred Hutch sustained ongoing partnerships with numerous workforce development organizations and local colleges, such as Shoreline Community College, CareerWork$, and Heritage University, to reach and support students and individuals from underserved, rural, and lower-resource backgrounds

Priority 2: Providing Culturally Attuned Prevention, Education and Screening

Data from the 2022 CHNA highlighted the importance of lifestyle and behavior changes, education and screening in reducing the risk for some cancers. Yet communities of color often face increased risk and likelihood of cancer, as well as worse health outcomes, due to unequal access to resources.

Goal 2.1: Provide education about healthy behaviors, recommended screening, treatment options and available resources to members of our community.

- From 2022 to 2024, Fred Hutch staff participated in over 300 community events and health fairs across the state to promote cancer prevention, screening and vaccine education. Fred Hutch staff built partnerships with a variety of community-based organizations.

Goal 2.2: Collaborate with community-based organizations, tribal nations and government agencies to reduce the rate of non-ceremonial tobacco use in our communities and increase lung cancer screening.

- The Indigenous Cancer Health Equity Initiative and həliʔil Program collaborated with tribal nations, governments and organizations.

Goal 2.3: Increase the number of medically underserved members from priority populations (Black/African American, Asian, Indigenous populations and low-income) who are receiving recommended female breast cancer screening.

- From 2022 to 2024, Fred Hutch provided 14,418 mammograms via our Fred Hutch Mammography Van, providing screening to rural and underserved communities that might not otherwise have access.
- The Mobile Mammogram team conducted targeted outreach and scheduling assistance for Black/African American women who are overdue for mammograms.

Goal 2.4: Increase awareness about prostate cancer disparities and screenings among Black and African American men through community-based research and advocacy.

- OCOE faculty assisted in the development of the Black & African-descent Collaborative for Prostate Cancer ACtion (BACPAC) virtual research community and annual prostate cancer symposium, focusing on Black and African-descent men, their families and caregivers.

Priority 3: Delivering Access to Affordable and Attainable Comprehensive Care, Including Mental Health Care

Socioeconomic factors have a significant impact on health and contribute to disparities. As such, in order to be effective, health care must be affordable, timely, close to home and linguistically and culturally sensitive. Barriers such as transportation, cost and provider availability affect access to care. Addressing cancer risk and treatment requires coordinated efforts at policy, systems, environmental (PSE), grassroots and family levels. Community Health Needs Assessment (CHNA) interviewees emphasized the importance of policy and system changes while also supporting community-based organizations in their efforts to improve care access. Mental health, a top priority identified in the CHNA, is deeply impacted by the emotional toll of a cancer diagnosis and treatment. Goals aimed at improving mental health for patients, families and communities are included in this priority area.

Goal 3.1: Prioritize public health education and advance policies seeking to reduce barriers to care.

- Fred Hutch Government & Community Relations team works with state, federal and local policymakers to provide education and advance policies to increase access to prevention, screening, high-quality cancer care and clinical trials through over 30 policymaker education sessions annually.

Goal 3.2: Improve socioeconomic factors that prevent patients from accessing care and keep them from attaining their full health potential.

- Fred Hutch developed and implemented a social determinants of health screening tool called the Supportive Care Questionnaire, which all new patients receive in MyChart or in the clinic to assess their needs beyond cancer care. To date, food access has been a top need identified, so plans to develop a food pantry for patients are underway.

Goal 3.3: Enhance access to mental health care for cancer patients, families and the community.

- Fred Hutch developed and formalized partnerships with community-based mental health providers, updated our mental health resource list for patients and launched a suicidal ideation assessment for patients.

Acknowledgments

Victoria García Tamayo from Contacto Consulting, LLC, provided support with data collection, data analysis and the writing of this report. Contacto Consulting brings together people and organizations to foster thriving communities and belonging. Contacto is committed to elevating different voices, especially those that are not often heard in public spaces. 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.

Fred Hutch Cancer Center and the Consortium would like to thank all of the individuals and organizations who graciously offered their advice, expertise and assistance in the preparation of this Community Health Assessment. We recognize that our efforts to monitor the cancer burden in our catchment area, to complete this assessment and to address the health needs of our community are greatly strengthened by their support and participation.

We are especially grateful to all of the community constituents, the Fred Hutch Patient and Family Advisory Council and Fred Hutch staff who shared their thoughtful, insightful perspectives about the health challenges and opportunities in our communities. We would like to thank all the individuals who offered their time, assistance and expertise in preparing this report, including OCOE leaders, faculty and staff, and Marketing and Communications staff. Additional thanks go to state and county health departments for maintaining the data we needed.

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Appendix

Appendix A: Interview and Listening Session Questions

Interview Questions

Hi <NAME>,

Thank you for taking the time to talk with me/us about the health of the communities your organization serves. As I mentioned in my email, we conduct a community health assessment every three years. This is both a requirement of being a nonprofit and an important step in incorporating community voices in our work. Your insights will help us develop strategies to increase community benefit and improve health outcomes across Washington.

A major component of the assessment is to conduct interviews with key community partners to better understand the needs and strengths of the communities and how Fred Hutch can be involved in addressing the issues or building on those resources. Our conversation is completely confidential. Please feel free to be honest and speak your truth. All information provided by interview participants will be combined and reported together. We won't associate your name with anything you say.

Can you please provide verbal consent to continue with the interview?

I'd also like to get your permission to record this call for accuracy and transcription purposes only. None of the interview materials, including the recording, will be shared outside of the assessment team.

Do I have your permission to continue? [If no, probe for concerns and assure the participant that we are only recording interviews because responses are very valuable to reporting accurate findings].

Do you have any questions before we start?

Organizational Background

1. How long have you been with your organization and what is your role?
2. What is the mission of your organization?
    - Probe: Who does your organization serve?
    - Probe: In which counties do you work?

Community Needs and Strengths

3. What do you feel are the most pressing health issues facing the communities you serve?
4. What do you think creates these issues?
    - Prompt: For example, economic factors, societal/social factors, environmental factors, health behaviors, misinformation, barriers to accessing care)
5. What are the main gaps or concerns that the communities you serve face specific to cancer prevention and care?

6. Do you consider that these issues are being addressed in any way, and if so, how?
7. What are the main strengths and resources in the communities you serve that support health and well-being?
    - Probe: Are there specific organizations, leaders, coalitions, initiatives, policies?
8. What resources are needed in the community?
    - Probe: How can Fred Hutch be involved in addressing the issues or building on those strengths and resources that you identified?

Outreach and Engagement

9. What outreach strategies have been successful in helping you connect with the communities you serve and provide services?
    - Prompt: For example, social media (Facebook, Instagram, Snapchat, Twitter, etc.), community events, one-on-one, group gatherings, etc.
10. What outreach strategies or resources does your organization need to better connect with communities?
    - Probe: How can Fred Hutch help with that?
11. How do you think the Consortium partners (Fred Hutch, University of Washington and Seattle Children's Hospital) are perceived in the communities you serve?
    - Probe: Are they seen as accessible? Welcoming? Trustworthy?

Those are all my questions for you. Is there anything else you would like to share with me?

Thank you so much for your time today! <Turn off recording.>

Appendix B: Interview & Listening Session Participant Organizations

Action Health Partners

Amend Health

Angel Flight West

Asian Counseling Referral Service

Astria Health

Better Health Together

Cancer Pathways

Cancer Survivorship Provider Network (CSPN)

Center for MultiCultural Health

CHAS Health

Chinese Information Service Center (CISC)

Cierra Sisters

City of Toppenish Community Safety Network

Coordinated Care

C-Suite Center for Hope

El Centro de la Raza

Elevate Health

Feast World Kitchen

Fred Hutch Cancer Center Government & Community Relations

Fred Hutch Cancer Center Office of Community Outreach and Engagement

Fred Hutch Cancer Center Patient Navigation

Fred Hutch Cancer Center Social Work

Fred Hutch Cancer Center həliʔil program

Garfield County Hospital District

GenPride

Innovia Foundation

Inspire Development Centers

Institute of Translational Health Sciences

Kadlec Regional Medical Center

Kadlec Tri-Cities Cancer Center

Kathleen Sutton Fund

Latino Educational Training Institute

Leukemia Lymphoma Society

Lincoln County Health Department

North Sound Accountable Community of Health

Northeast Tri County Health

Pacific Northwest Prostate Cancer for Patient Advocates Committee

Pacific Northwest University of Health Sciences

Providence Community Wellness and Health Training

Quileute Tribal Health

Rural Resources Community Action (RRCA)

Sea Mar Community Health Centers

Southeast Washington Alliance for Health

South Puget Intertribal Planning Agency (SPIPA)

Spokane Regional Health District

Sunnyside School District

The Lighthouse Advocacy, Prevention, and Education Center

Us TOO in Seattle

UW Medicine Primary Care Clinics

Washington State Department of Health

Washington State Department of Health Breast, Cervical and Colon Health Program (BCCHP)

Washington State University

Wellness House

Whitman County Public Health

Yakima Valley Community Foundation

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