

2022–2025 Community Benefit Implementation Plan



Fred Hutch
Cancer Center

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Fred Hutch is an independent, nonprofit organization that also serves as the cancer program for UW Medicine. This unique relationship allows for enhanced care coordination with one of the world’s leading integrated health systems.

UW Medicine

Introduction

As of April 2022, we have evolved our structure and partnerships to create the Fred Hutchinson Cancer Center as a means of deepening Seattle Cancer Care Alliance’s commitment to delivering the highest quality, most advanced cancer care. Fred Hutchinson Cancer Center is a unified adult cancer care and research center bringing together Seattle Cancer Care Alliance and Fred Hutchinson Cancer Research Center into a single, independent, nonprofit organization that is also a clinically integrated part of UW Medicine and UW Medicine’s cancer program. This Implementation Plan aims to meet the community health needs identified through the [2022 Seattle Cancer Care Alliance Community Health Needs Assessment](#) (also called CHNA) developed prior to the creation of the Fred Hutchinson Cancer Center.

Our community

For the purposes of this Implementation Plan, we have kept the definition of community used in the CHNA.¹ The data gathered through the CHNA are used as a basis for this report. We define our community as everyone in King, Pierce and Snohomish counties, where 78% of Fred Hutch patients reside. The total population in our community is 3.98 million people. Covering 6,309 square miles, King, Pierce and Snohomish are situated within the original lands of the Coast Salish peoples, the first people of the Salish Sea.



¹ The Fred Hutch catchment area expands to all of Washington. During these transitional years as a new entity, we will work to expand the community benefit impacts to other communities as appropriate.

Demographic profile of our community

The adult population in the Fred Hutch community is comprised of 14% of people 65 and older and 62% who are between 18 and 64 years old. Females comprise exactly half the population in the Fred Hutch community.

In terms of race and ethnicity, there is growing demographic diversity in the region. Those who identify as Asian account for 12.4% of the three-county area. Hispanics/Latinos represent 10.6%; people who identify as two or more races are 7.1%; Blacks/African Americans account for 5.6%; and people of other races are 3.8% of the population. Native Hawaiian and Pacific Islanders (NHPI) and American Indian and Alaska Natives (AIAN) are 0.8 and 1.1%, respectively. People who identify as white account for 63.7%. The population of children under age 18 is now 53% people of color. The region is also rich in linguistic diversity; about one in five individuals live in a household that speaks a language other than English.

Although our community area generally performs better than other regions in terms of health indicators, health inequities do exist, and not all communities experience consistently good health. Historic systems of racist policies and practices have shaped and continue to limit access to resources and opportunities for Black, Indigenous and other communities of color. In the Fred Hutch community:

- While the median household income in 2019 was estimated at \$95,850, Black/African American and Hispanic/Latino households averaged \$34,600 and \$22,705 below the Fred Hutch community average, respectively.
- While almost 40% of people in King County have a college degree, less than 20% of Pierce County residents do.
- Forty percent of white adults have a bachelor's degree or higher compared to 9% of Native Hawaiian and Pacific Islander, 20% of American Indian and Alaska Native, 23% of Hispanic/Latino, and 24% of Black adults.
- Almost half (49.2%) of renters and 29% of mortgage holders are considered cost-burdened, which means those who pay more than 30% of their income for housing.
- Significant racial disparities have been documented for most cancers. Compared to other racial/ethnic groups in our service area, American Indians and Alaska Natives (AIAN) have a disproportionate burden of both lung and colorectal cancer incidence and mortality while Blacks/African Americans have a higher mortality rate of both breast and prostate cancers.

2022–2025 Community health priorities

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

Our Community Benefit priorities are informed by the Community Health Needs Assessment (CHNA), which we conduct every three years. In June 2022, the Fred Hutchinson Cancer Center Board of Directors adopted the 2022 CHNA, which focused on the social and economic factors that impact the health of our communities with the goals of achieving health equity, illustrating the continuing inequities facing our community, and providing context for the health priorities identified through the report.

Through the primary and secondary data collection, seven areas rose to the top as significant community health needs:

- Access to affordable and attainable comprehensive care
- Culturally attuned prevention, education and screening
- Environmental health and climate change
- Health equity
- Mental health support for patients, families and community
- Policy and systems change while increasing capacity of community-based organizations and community clinics
- Trust and relationship-building

See the 2022 [Seattle Cancer Care Alliance CHNA](#) for more information.

Community Benefit Implementation Plan process

After we completed the CHNA, we facilitated a prioritization exercise with Fred Hutch leaders and staff representing a range of functions across the organization, both clinical and administrative, including departments engaged in conducting Community Benefit activities on a day-to-day basis. (See Appendix A for participating Fred Hutch groups). This group reviewed qualitative and quantitative data from the CHNA and discussed the identified themes, which outlined cancer-related health needs and assets in our community. Finally, we reached consensus on which health issues were priorities for Fred Hutch.

Criteria for prioritization* included severity of need, magnitude/scale of the need, presence of clear disparities or inequities, existing attention and resources dedicated to the issue, potential for partnering and collaborating with local organizations, and opportunity for Fred Hutch to make a meaningful contribution.



Carmen Marquez-Mendez, a community health educator in the Office of Community Outreach & Engagement, speaks with an attendee of the 2022 Health and Wellness Festival at Rainier Beach Community Center.
Photo by Connor O'Shaughnessy.

Prioritization criteria

Severity of need	How serious the health need is (such as its potential to cause death or disability) and how poorly it performs compared to the relevant benchmark.
Scale of the need	The number of people affected by the health need.
Clear disparities or inequities	<ul style="list-style-type: none"> • Disparity: The quantity that separates a group from a reference point on a particular measure of health (HP2010) (i.e., Is there a difference in lung cancer mortality rates between population groups?). • Inequity: A difference in the distribution or allocation of a resource (such as education, access to screenings, fresh food) between groups (i.e., Is the disparity in lung cancer mortality rates due to differences in social, economic, environmental or healthcare resources?).
Maximizing Fred Hutch assets	The potential for Fred Hutch to make a meaningful contribution to addressing the need because of its expertise, existing strategies, and/or unique resources.
Existing resources dedicated to the issue	Current efforts in the local community that already address the health need.
Potential for partnering and collaborating with organizations	Existing organizations Fred Hutch could work with to address the particular community health need.

*Adapted from the prioritization tool used by Kaiser Permanente Washington for its [2019 Community Implementation Strategy Report](#)

We also administered a survey among Fred Hutch staff, former and current patients, family and friends of patients treated at Fred Hutch as well as community members. The survey was administered online and only in English. The goal of the survey was to help us prioritize the identified areas based on Fred Hutch’s ability to address the needs. The survey was completed by 38 people. (See Appendix B for survey questions).

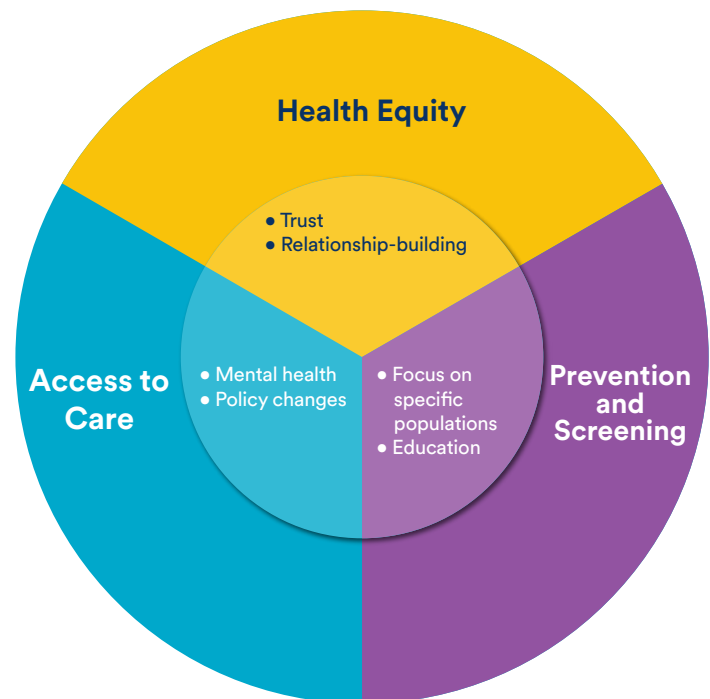
Health needs that Fred Hutch plans to address

The community health needs identified during the CHNA are intertwined. Further, several of these community health needs have persisted from previous community health assessments and have been exacerbated by the COVID-19 pandemic.

The prioritization exercise narrowed these health priorities based on Fred Hutch’s ability to use our existing resources to address the needs and contribute to meaningful health improvement. The survey corroborated these priority areas.

Fred Hutch has combined most of the needs identified through the CHNA into three priority areas:

- Advancing health equity
- Providing culturally attuned prevention, education and screening
- Delivering access to affordable and attainable comprehensive care, including mental health care



We will continue to strengthen our trust and relationship-building within Fred Hutch and with community partners. Our commitment to health equity and becoming an antiracist organization encompasses supporting policy and systems change while increasing capacity of local tribal and community-based organizations and community clinics.

Priority 1: Advancing health equity

Achieving health equity is at the center of all the Implementation Plan priority areas. Trust and relationship-building are essential to becoming an anti-racist organization and advancing equitable change. Our communities are increasingly diverse, and the lack of trust in health care remains an issue among Black, Indigenous and people of color (BIPOC), those who identify as LGBTQ+, people who are poor, and those from rural communities. Mistrust in health care is founded in both the historical legacy and the current experiences of racism, undertreatment, and mistreatment. Increasing diverse access to clinical trials is an ongoing challenge.

The top issues identified within this priority are:

- BIPOC representation in staffing, decision-making and advisory groups
- Prevention and treatment care inequities
- Data disaggregation
- Acceptance and inclusion of traditional medicine
- Root causes of mistrust
- Medical biases and indifference
- Accessibility to BIPOC communities
- Partnerships with trusted clinics, organizations and tribes
- Specific concerns by population: racism, deportation, refugee status, tribal sovereignty, Asian hate, anti-Blackness, Islamophobia

Vision: We will address our organization’s entrenched social inequities associated with race, ethnicity, language, cultural norms and education to move to a system where every person has the opportunity to attain their full health potential.

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

1.1.1: By July 2025, audit the availability of specific community education materials for priority populations.

1.1.2: By July 2025, based on audit results, develop, enhance, or translate education materials based on community partner needs.

1.1.3: By July 2025, establish a system to review community education materials to ensure they are culturally relevant.

1.1.4: By July 2025, explore opportunities to use, adapt and/or distribute among Fred Hutch community audiences existing in-language and culturally based health education materials developed by federally qualified health centers (FQHCs) and other community partners.

Goal 1.2: Build cultural responsiveness and internal capacity in equity, diversity, inclusion and anti-racism so that every patient who identifies as Black, Indigenous or another person of color receives support according to their preferences.

1.2.1: By July 2025, increase the offering of diversity, equity, inclusion, belonging and bias awareness education to Fred Hutch providers and research staff.

1.2.2: By July 2025, participate in the National Comprehensive Cancer Network (NCCN) Health Equity Report Card Pilot Project and improve report card score from initial evaluation.

1.2.3: By July 2025, increase representation of Black, Indigenous and other people of color in committees, advisory groups, and overall decision-making.

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

1.3.1: By July 2025, implement at least three of the recommendations presented by the Task Force on Inclusion & Equity in Research in June 2022 to ensure diverse populations in clinical research.

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

1.4.1: Annually, provide at least \$100,000 of unrestricted grants to community-based organizations to provide cancer and social determinants of health-related awareness, prevention and care services.

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.

1.5.1: By July 2025, improve collection of race and ethnicity data of new patients for five specific teams; reach 95% capture rate of new patient and ethnicity data.

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

1.6.1: Annually, provide opportunities to at least 75 apprentices, undergraduate and graduate students, residents, and fellows to train at Fred Hutch.

1.6.2: By July 2025, implement training for cultivating recruitment and retention of BIPOC staff.

1.6.3: Annually, provide curriculum development and class support to the CareerWork\$ program to support low-income young adults advance their careers in healthcare.

Resources Fred Hutch plans to commit

- Clinical Research, Education and Practice
- Community Benefit
- Diversity, Equity & Inclusion Council (DEIC)
- Fred Hutch’s Pathways Undergraduate Researchers
- Health Equity Advisory Group
- Human Resources
- Marketing
- Nursing Education
- Office of Community Outreach and Engagement (OCOE)
- Office of Diversity, Equity and Inclusion
- Operations Leadership
- Patient Education
- Resource Center

Potential partners

- Community-based organizations
- FQHCs including International Community Health Services, Neighborcare Health, Sea Mar Community Health Centers, Seattle Indian Health Board
- South Puget Intertribal Planning Agency (SPIPA) and local tribes
- Colleges and universities including Seattle Pacific University, Seattle University, University of Washington, South Seattle College, Highline Community College
- Puget Sound Oncology Nursing Society, Seattle Nursing Research Consortium
- King County Hospitals for a Healthier Community

Priority 2: Providing culturally attuned prevention, education and screening

Data from the 2022 CHNA once again 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 inequitable access to resources and environmental factors. Further, disparities in incidence and/or mortality exist by race, ethnicity and place. Compared to other racial/ethnic groups in our service area, American Indians and Alaska Natives (AIAN) have a disproportionate burden of both lung and colorectal cancer incidence and mortality while Blacks/African Americans have a higher mortality rate of both breast and prostate cancers.

Priority 2: Providing culturally attuned prevention, education and screening



Research Technician Sarah Masunaga works in the Preclinical Modeling Lab at the Fred Hutchinson Cancer Center.
Photo by Robert Hood.

Black, Indigenous, people of color and other community members who have been historically disenfranchised from the health care system are eager to learn and take ownership of their health. Hospitals and health care providers, including Fred Hutch, must respond by providing free, in-language, culturally attuned and easy-to-understand screenings, information and resources. For example, assessment participants emphasized the need for education, support and services after a positive screening.

The top issues identified within this priority are:

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

Vision: We will promote knowledge of healthy lifestyles and regular cancer screenings to decrease the prevalence and severity of cancer with a focus on marginalized and BIPOC communities.

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

2.1.1: Every year, participate in at least 10 community health events reaching priority populations by race (Black/African American, Hispanic/Latino, Asian, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander people), place (geographic areas with higher cancer incidence), age (i.e., youth), and gender and sexual orientation (i.e., males, LGBTQ+)

2.1.2: By July 2025, educate and train Federally Qualified Health Centers (FQHC) about cancer prevention and screening.

2.1.3: By July 2025, explore partnering with community-based organizations to provide youth focused cancer prevention education sessions.

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.

2.2.1: By July 2025, explore ways to provide tobacco counseling opportunities and nicotine replacement therapy to community members.

2.2.2: By July 2025, complete the grant proposal and, if approved, the implementation of supporting network sites with lung cancer screening and a process for handling positive findings.

2.2.3: By July 2025, increase awareness about screening for tobacco use and tobacco cessation among medical and support service providers in the community.

2.2.4: By 2025, expand lung cancer screening access to outlying communities by reaching them where they are.

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 breast cancer screening.

2.3.1: Every year, deliver at least 3,500 mammography screenings in at least seven different community settings via the Mammogram Van.

2.3.2: Every year, partner with at least one community organization and support their established community events to provide breast cancer screenings to Black and African American women.

2.3.3: By July 2025, explore ways to partner with UW Medicine to increase mammography screening for Black women within the system.

2.3.4. Manage at least two outreach campaigns per year to outside referring providers for due/overdue patients.

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

2.4.1. By July 2025, develop a knowledge-to-action campaign to increase awareness about prostate cancer screening, diagnosis and outcomes that centers the lived experiences of Black and African American men.

2.4.2. By July 2025, host a prostate cancer equity symposium to bring together experts, community partners and community members to discuss the latest breakthroughs in the prevention, detection and treatment of prostate cancer.

Resources Fred Hutch plans to commit

- Community health educators
- Fred Hutch Affiliate Network sites
- Genetics and Prevention programs
- Imaging and Procedures Department
- Living Tobacco-Free Services
- Mammogram Van
- Nurse Navigation
- Office of Community Outreach and Engagement (OCOE)
- Patient navigators
- Strategic Network, Outreach & Education
- Tobacco cessation counselors
- Department of Urology researchers and staff

Potential partners

- APICAT
- Center for Multicultural Health
- Cierra Sisters
- Gay City
- International Community Health Services
- NeighborCare Health
- Neighborhood House
- Public Health - Seattle & King County Access and Outreach
- Sea Mar Community Health Centers
- Seattle Indian Health Board
- Seattle King County Clinic
- Seattle Metropolitan Urban League
- Somali Health Board
- South Puget Sound Intertribal Planning Agency
- UW Population Health on the Breast Cancer Equity Initiative
- UW Primary Care
- Western WA Medical Group
- Black & African-Descent Collaborative for Prostate Cancer Action (BACPAC)
- Communities of Color Coalition



James Lilly, a community outreach specialist with the Fred Hutch-based Seattle Vaccine Trials Unit, speaks with an attendee of the 2022 Health and Wellness Festival at Rainier Beach Community Center.

Photo by Connor O'Shaughnessy.

Priority 3: Delivering access to affordable and attainable comprehensive care

Access to health care must be affordable, timely, close to home and culturally sensitive. Socioeconomic factors contribute to the health and wellbeing of our communities and are the major drivers of health inequities. For example, transportation, the cost of care and provider availability close to where people live impact how likely they are to access medical care. Health services and information must be linguistically and culturally attuned to the patients, families and communities accessing care.

Cancer risk reduction and treatment should be a coordinated approach at the policy, systems and environmental (PSE) levels as well as the grassroots and family level. CHNA informants called for changes in policies and systems while at the same time supporting organizations who work directly with communities. Strategies related to PSE change and support of community-based organizations impact access to care and are included in this priority area.

A cancer diagnosis and treatment can be emotionally overwhelming. Emotional stress, uncertainty and physical pain can all take a toll on mental health. Mental health was one of the top identified needs in the CHNA. Access to high-quality health care is a key contributor to physical and mental health. Consequently, goals related to mental health for patients, families and community are also included into this priority area.

The top issues identified within this priority are:

- Financial support
- Location (issues of gentrification, rural access, non-geographically-based insurance policies)
- Digital literacy and in-person services
- Reduction of inequities and availability of wraparound services related to affordable housing, food security, childcare and transportation
- Unrestricted funding support for all cancer prevention and treatments
- Infrastructure support, capacity building and sustainability of community clinics and community-based organizations
- Support for emotional and socioeconomic consequences of cancer
- COVID-19 pandemic and socioeconomic consequences
- Alcohol and drug abuse
- Building emotional stamina

Vision: We will improve access to high-quality cancer care along the cancer care continuum and to wraparound services that bolster health.

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

3.1.1: Attend at least 20 meetings annually with policymakers to provide education about state and federal opportunities to increase access to prevention, screenings and high-quality cancer care.

3.1.2: By Q1 of each calendar year, select one community benefit priority area as a Commission on Cancer (CoC) Barrier to Care accreditation and identify barriers as a focus for the upcoming year. By Q4 of each calendar year, share with the CoC committee a report that includes priority area selected, barrier identified, resources used to address the barrier, metrics related to outcomes of reducing the chosen barrier and plans for the future.

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

3.2.1: By July 2025, pilot a Social Determinants of Health (SDoH) Patient Screening tool to assess patients' social barriers and refer them to community resources. Include barriers such as: housing instability, food insecurity, transportation, financial assistance and interpersonal safety.

3.2.2: By July 2025, audit the current database of community resources available for patient and family referrals and identify additional resources that address SDoH domains.

3.2.3: Annually, provide at least \$300,000 in assistance to patients and families who have non-medical financial needs for transportation, lodging, food security and other.

3.2.4: By July 2025, explore partnership opportunities between departments and clinics within Fred Hutch to better support patients for whom transportation is a barrier to accessing health care (including patients on Medicare).

3.2.5: By July 2025, continue to integrate a population-based navigation model into our service structure to serve more patients experiencing socio-economic barriers, as well as those who need help navigating through Fred Hutch or require community resources.

3.2.6: By July 2025, explore a food security intervention for patients and families who screen positive for food insecurity.

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

3.3.1: By July 2025, deepen relationships with community-based mental health providers to create easy and focused referral destinations when patients end their active oncology treatment.

3.3.2: By July 2025, implement and sustain an institution-wide suicidal ideation assessment.

Resources Fred Hutch plans to commit

- Community Benefit
- Family Assistance Fund
- Government and Community Relations
- Medical Nutrition Therapy
- Patient Navigation
- Social Work
- Supportive Care
- Supportive Resources

Potential partners

- Commission on Cancer
- King County Hospitals for a Healthier Community
- Members of Congress
- Public Health – Seattle & King County (PHSKC)
- Washington Health Care Authority
- Washington State Department of Health
- Washington State Legislators



Fred Hutch's Katherine Briant listens to a workshop attendee during the OCOE's Community Grant Writing Workshop, January 13, 2020, at the Fred Hutchinson Cancer Research Center in Seattle, Washington.

Photo by Robert Hood.

Health needs Fred Hutch does not intend to address

This report does not include a complete inventory of everything Fred Hutch does to support the health of our communities, including our commitment to climate health equity. While we are not directly addressing environmental health and climate change within this Community Benefit Implementation Plan, we know that physical health goes hand in hand with a healthy environment. Fred Hutch is committed to environmental sustainability. Energy conservation, recycling and composting, water conservation and sustainable transportation are embedded in everything we do. We aim to support environmental policies, systems and research that promote sustainable and climate-resilient operations at Fred Hutch facilities and mitigate the overall impacts of climate change. We plan to engage in existing and upcoming climate resilience healthcare analyses and strategic frameworks intended to mitigate our contributions to climate change and secure business resilience in the face of climate change, in alignment with the U.S. Department of Health and Human Services' initiative to halve U.S. carbon emissions by 2030.

Evaluation of impact

At Fred Hutch, we are committed to continuously understanding the impact of our community benefit efforts. We track the impact of our many initiatives on an ongoing basis. We will monitor and evaluate the goals listed in this Implementation Plan to document the impact of our actions in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of people reached/served, collaborations and partnerships, the number of educational opportunities conducted, the number of screening events offered, the number of grants made and dollars spent, among others. In addition, Fred Hutch tracks outcomes, including health outcomes, as appropriate and depending on available resources.

Appendix A

Health Needs Prioritization Exercise/Survey: Fred Hutch Group Participants

- Clinical Operations
- Genetic Counseling
- Imaging
- Interpreter Services
- Medical Nutrition Therapy
- Nurse Navigation
- Nursing Education
- Office of Community Outreach & Engagement
- Patient Access
- Patient and Family Education
- Patient Engagement & Equity
- Patient Navigation
- Prevention Program
- Quality Safety and Value
- Rehabilitation Therapies
- Social Work
- Strategic Outreach and Medical Education
- Supportive Care Services
- Survivorship
- Tobacco Cessation

Appendix B

Health Needs Prioritization Survey

(Conducted prior to the creation of the Fred Hutchinson Cancer Center)

Every three years, SCCA conducts a community health needs assessment (CHNA) and Implementation Plan. The CHNA helps us identify issues that impact health in the community. The implementation plan describes how we will address the needs identified in the CHNA and how we plan to meet the community health needs identified in the CHNA and list any needs identified in the CHNA that are not being addressed and the reasons for not addressing them.

This process will guide our efforts to work with our partners to improve cancer-related population health outcomes.

We would like to hear from you! This survey will help us prioritize the areas where SCCA has the greatest ability to address community health needs.

1. What is your relationship to SCCA?
 - Former or current patient
 - Family or friend of patient treated at Fred Hutch
2. In which county do you live?
 - King County
 - Pierce County
 - Snohomish County
 - Other county in Washington state
3. Share the race/ethnicity(ies) with which you identify.
 - American Indian or Alaska Native
 - Asian
 - Black or African American
 - Hispanic or Latino
 - Multi-Racial
 - Native Hawaiian or Pacific Islander
 - White
 - Prefer not to answer
 - Other (please specify):
4. Seven health needs emerged from the CHNA. Which three do you consider the highest need in our community?
 - Access to affordable and attainable comprehensive care
 - Culturally attuned prevention, education, and screening
 - Environmental health and climate change
 - Health equity
 - Mental health for patients, families and community
 - Policy and system changes while increasing capacity of community clinics and organizations
 - Trust and relationship-building
5. Are there any other health needs not included in the previous question that you consider high priorities in our community?

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6. Please rank the seven health needs that emerged from the CHNA from 1 to 7 based on where you think SCCA’s involvement can most contribute to meaningful health improvement (with 1 where SCCA is most able to have an impact and 7 where SCCA is least able to have an impact.)

Access to affordable and attainable comprehensive care	Culturally attuned prevention, education and screening	Environmental health and climate change	Health equity	Mental health for patients, families and community	Policy and system changes while increasing capacity of community clinics and organizations	Trust and relationship-building
Priority 1 (Fred Hutch most able to impact)						
Priority 2						
Priority 3						
Priority 4						
Priority 5						
Priority 6						
Priority 7 (Fred Hutch least able to impact)						

7. Please share any comments or suggestions about the identified health needs, the prioritization of these areas or how SCCA can contribute to meaningful health improvement. (Please do not include any personal health information in your response.)

8. Please share any efforts, policies, partnerships or local organizations that are working toward addressing any of the community health priority areas identified above.



Fred Hutch
Cancer Center