



CANCER CONSORTIUM

FRED HUTCH • UNIVERSITY OF WASHINGTON • SEATTLE CHILDREN'S

2021-2022

CONVERSATIONS

ACROSS WASHINGTON

Listening sessions with
community-based organizations
and healthcare organizations

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*Front cover photo: Allium field in Yakima Valley.
Photo by Gloria Coronado.*

EXECUTIVE SUMMARY

The Fred Hutch/University of Washington/Seattle Children's Cancer Consortium's (Cancer Consortium) Office of Community Outreach & Engagement (OCOGE) regularly conducts catchment area needs assessments to identify and track the cancer burden and cancer inequities that exist by geographic region and race/ethnicity in Washington State. Needs assessment findings inform the Cancer Consortium strategies and OCOGE priority areas for outreach, engagement, and research. The information gathered during these conversations across Washington is one piece of a comprehensive statewide needs assessment currently underway by the OCOGE. The overall goal of the interview and focus group conversations highlighted in this report was to learn more about how organizations throughout the state are addressing health concerns and how the Cancer Consortium could better meet the needs of Washingtonians.

Conversations across Washington included interviews and focus groups with individuals from 23 community-based organizations and healthcare organizations from across the state between October 2021 and April 2022. Participating organizations provide services including primary care, diagnostic, and inpatient treatment. Several community-based organizations provide resources to address social determinants of health, such as transportation, education and trainings, food insecurity, housing instability, and health care access.

Community outreach practices varied across organizations and region. Many spoke to the importance of having dedicated, bilingual staff that mirror communities served, the role of community informed outreach practices, the need for both traditional and non-traditional partnerships, and how a range of outreach media can support client engagement. Numerous barriers included the existence of limited funding to support outreach, healthcare systems engendering mistrust, disruptions of services largely due to the COVID-19 pandemic, and vast catchment areas that exceed staff capacity. Challenges specific to rural areas included limited knowledge about best practices for effectively reaching clients, lack of linguistically accessible services aligned with client need and availability, and proximity of available services relative to where clients live.

There is a strong spirit of collaboration and creative problem-solving in addressing needs. Especially in rural regions, the existence of these partnerships, trust, and resilience were noted as community strengths. When the conversation turned to community challenges, the list of challenges was lengthy. It included limited and costly housing, communities with limited healthy food options, disparate broadband coverage, and limited access to healthcare services due to high cost, lack of transportation, and understaffed or no local services. Findings associated with culturally relevant and service accessibility challenges included the lack of inclusive communication

capabilities, which resulted in individuals not seeking care, inadequate care being provided, and inequities among Black, Indigenous, and People of Color (BIPOC) communities.

All participants expressed an interest in future collaborations with the Cancer Consortium. Participants serving both rural and urban regions highlighted the need for educational resources and proven health education practices. Rural participants would like to leverage the Cancer Consortium's data capabilities to inform decision-making, gain access to best practices for raising awareness around cancer screenings, and tap into existing marketing and messaging operations to expand reach. Urban participants spoke about amplifying their impact through a collaboration with the Cancer Consortium to conduct education and address disparities in the communities.

The Cancer Consortium's catchment area grew from 13 counties in western Washington to include the entire state of Washington as of January 2022. The OCOE has been increasing outreach and engagement efforts across the state. Opening the OCOE

Spokane office has been a tremendous help in developing a stronger network of partners in eastern Washington. As this report highlights, communities across the state are facing challenges accessing healthcare services, and organizations are interested in collaborating with the Cancer Consortium to tackle these challenges. OCOE staff in Spokane have been networking and identifying opportunities to support existing efforts focused on health access and health equity. Over the past several months, they have been meeting with area organizations to discuss the creation of a mobile screening unit program. Recently, twelve Spokane area organizations attended a meeting to discuss the creation of a community action board that would help guide the work of the OCOE Spokane office. These are only a few examples of how this report is helping the OCOE prioritize outreach, engagement, and research across the state. We hope this report will be just as helpful to others within and outside of the Cancer Consortium in identifying how they may be able to contribute to a healthier Washington.



*Farm and field in Arlington, WA.
Photo by Dillon van Rensburg.*

SUMMARY OF KEY FINDINGS

Topic	Key Findings
Client outreach and engagement facilitators	<p><i>Shared themes for both rural and urban regions included:</i></p> <ul style="list-style-type: none"> • The use of dedicated, bilingual staff (such as navigators, care coordinators, and community health workers) that mirror the communities served and support outreach operations. • Community-informed outreach was cited as a critical element that can result in gaining trust from the community via trusted messengers who provide high-quality and culturally relevant information. • The role of traditional and non-traditional community partnerships was evident in the patient referral process, development of easy-to-read outreach materials, and blended resources to meet client needs across a continuum. • Using a range of media such as Facebook, newspapers, flyers, email were common practices used to reach clients.
Client outreach and engagement barriers	<ul style="list-style-type: none"> • Lack of funding to support outreach operations, healthcare systems engendering mistrust, service disruption, and vast catchment areas were cited as barriers to effective outreach. There is an association between underfunded organizations and limited outreach staff. • Lack of knowledge around best practices for conducting outreach and providing services in rural regions. • Rural-related challenges included limited knowledge about best practices for effectively reaching clients, lack of linguistically accessible services aligned with client need and availability, and proximity of available services relative to where clients live.
How clients learn about available services	<p><i>Shared themes across both rural and urban regions included:</i></p> <ul style="list-style-type: none"> • A primary care provider was the most cited starting place for individuals seeking information about cancer and/or cancer-related behaviors. • The internet, organizational websites and social media were also noted as common resources for gaining information. • Participants highlighted a long list of community-based and healthcare organizations that they were familiar with as potential resources for individuals to seek information.

Topic	Key Findings
Community strengths	<p><i>Shared themes across both rural and urban regions included:</i></p> <ul style="list-style-type: none"> • Descriptions for community strengths included “close-knit,” “contained,” “safe,” and “bedroom community feel region”. • Genuine care, compassion, and desire to help each other were noted as values held among residents, practitioners, and community-based organizations. • Partnerships are dynamic in nature and work to supplement services and collectively meet resident needs. <p><i>Rural-specific themes included:</i></p> <ul style="list-style-type: none"> • Being in a rural area was considered both a strength and challenge—where strong partnerships, cohesion, trust, and resilience are the result of scarcity of resources and feelings of isolation.
Community challenges	<ul style="list-style-type: none"> • Physical environment-related challenges included the housing crisis, living in food deserts, disparate broadband access, and limited access to needed (social and health) resources. • Factors serving as barriers to accessing healthcare services included transportation, income, understaffing, availability of accessible and culturally relevant services, and communication barriers. • Mental health, substance use disorder, and homelessness were commonly noted as important health issues impacting communities.
COVID-19 impact	<ul style="list-style-type: none"> • An “all hands approach” to address COVID was used to mitigate risk: service/program disruptions, halting community outreach/education operations, and launching vaccine clinics at the height of the pandemic were common. • Operational shifts were made to address emergent needs, inefficiencies, and access barriers. • Telehealth was a tool for connecting with clients. However, inequitable access to broadband connection and telephones were notable barriers. • Participants relied on partnerships and federal funding to address emergent needs.

Topic	Key Findings
Future partnership opportunities	<ul style="list-style-type: none">• All participants expressed interest in future partnership.• Sharing educational and effective health education practices was cited as a need across both region types.• Urban participants are seeking to partner to amplify impact and reach through their physicians, medical students, and residents; access to translated materials and multi-lingual staff.• Rural participants would like to partner to leverage the Consortium’s data capabilities, gain access to best practices for raising cancer screening awareness, tap into marketing resources and explore collaboration around transportation and access challenges.



Golden hour at a farm on the Palouse near Colfax, WA. Photo by Dan Lewis

BACKGROUND

The Cancer Consortium builds upon the complementary strengths and resources of three partner institutions: Fred Hutchinson Cancer Center, University of Washington (UW), and Seattle Children's. The three institutions work together to address the full spectrum of cancer research, clinical care, and programs in Washington State (WA) to reduce the burden of cancer. The Cancer Consortium's Office of Community Outreach and Engagement (OCOE) focuses on improving health outcomes for everyone by using authentic engagement, a community-based research approach, and education driven by community need to address cancer health disparities.

OCOE faculty, staff, and community health educators (CHE) located in Seattle, Spokane, and Sunnyside work directly with community leaders, organizations, and researchers to support ongoing efforts and initiate new projects to increase knowledge and awareness of cancer risk factors, screening services, treatment options, and survivorship care across the state. The OCOE regularly conducts catchment area needs assessments to track cancer burden and cancer inequities that exist. The needs assessment findings inform the OCOE priority areas for outreach, engagement, and research.

In 2017-2018, the OCOE and a steering committee of representatives from the three Consortium partner institutions conducted

the first comprehensive needs assessment of the catchment area. At the time, the catchment area consisted of 13 counties around the Puget Sound, west of the Cascade Mountains, south of the Canadian border, and north of Lewis County. The resulting [OCOE Community Health Assessment: A Report to the Community](#) was released in 2019.

On January 1, 2022, the Cancer Consortium catchment area [increased from 13 counties to all 39 counties](#) in Washington. The subsequent needs assessment in 2021-2022 included the entire state of WA. In addition to gathering state data on the cancer burden and gathering quantitative survey data from 2,000 WA residents (results to be published in 2023), the OCOE collected qualitative data through interviews and focus groups with 23 community-based organizations and healthcare organizations from across the state. This report provides a summary of the qualitative data gathered during these conversations, including how organizations are conducting outreach and engagement, community strengths and challenges, and the potential for future collaborations.

INTRODUCTION

The overall goal of these interview and focus group conversations was two-fold:

- 1) To learn more about the characteristics of communities throughout the state and how organizations are addressing health concerns in different communities.
- 2) To learn how the Cancer Consortium could better meet the needs of Washingtonians.

We spoke with representatives from organizations that have missions directly related to cancer, as well as cancer-related behaviors, such as physical activity, nutrition, tobacco, sun exposure, and vaccinations. We also spoke with organizations that focus on addressing social determinants of health, such as food insecurity, housing instability,

racism/discrimination, transportation, healthcare access, or education, etc. in their region, given the importance of these factors to cancer. We asked questions such as: What health outreach and education activities are currently being conducted? What are the barriers and facilitators to cancer-related outreach and care? Where are the opportunities for the Cancer Consortium to form partnerships with community-based organizations to collaborate on addressing community needs? The information we collected is helping us create new partnerships to support existing programming and collaborate on new initiatives where gaps were identified, such as a much-needed mobile screening unit in eastern Washington.



Cherries hanging on a branch before harvest in late spring at Yakima Valley. Photo by Trong Nguyen

DATA COLLECTION & ANALYSIS

OCOE staff identified potential key community contacts and organizations across the state who provide health and social services to rural and urban populations. Initial contact was made with Washington State Health Care Authority's Accountable Communities of Health (ACH), regional organizations playing a key role between the health care delivery systems and local communities, with a goal of promoting health equity and addressing social determinant of health. These ACH contacts are well connected in their regions and were able to refer staff to local leaders and community organizations addressing health needs in the area. Recruitment continued using a snowball method as interviewees also provided contact information for additional organizations addressing health needs in the county. Referred organizations were contacted and invited to participate in an interview.

OCOE staff sent an initial email invitation to all identified organizations. OCOE Community Health Educators (CHEs) followed up via email with everyone who responded with interest in participating in an interview. CHEs then scheduled and conducted the interviews via Zoom. Each interview was recorded. The interview guide included 14 questions. In two instances, the interviews turned into focus groups due to the number of individuals the interviewee invited to participate on the call. Interview and focus group duration averaged 43 minutes and 52 minutes, respectively.

Upon the completion of the audio-recorded interviews and focus groups, an external party was used to transcribe the audio files. All transcripts were thoroughly reviewed and cleaned up by members of the OCOE research team. Transcripts were then transferred to the research consultant for analysis. A preliminary round of manual, "big bucket" coding was completed, using a subset of transcripts to get a sense of the data and launch the development of a codebook. Findings from this round of coding resulted in an updated codebook that was used to support the second round of coding conducted in Atlas ti®. The Code Distribution Report in Atlas ti® helped to highlight the frequency of codes across and within the transcripts, with codes placed in ranking order. The report tool served as a resource for identifying potential associations between codes. In instances where associations were highlighted in the report, respective transcripts were examined to gain an understanding of context that could explain the nature of such associations. Qualitative coding is an iterative process and requires several rounds of review before formal analysis is completed and interpretations can be put forth. Coded data was grouped into themes using an inductive thematic analysis approach. Additional memos were also developed during the coding process to help capture "aha moments," themes, and potential relationships in real time.

Cross-case analysis was then used to identify commonalities and differences between

participant responses by region type. All participants were categorized as either rural, urban, or a mix of both regions based upon self-report of counties served. The U.S. Census Bureau defines rural areas of the United States as those that are not considered urban, with a population of less than 50,000, and density of less than a thousand people per square mile (U.S. Census Bureau, 2020). Disparities across rural vs. urban areas were highlighted in the 2019 [OCOE Community Health Assessment: A](#)

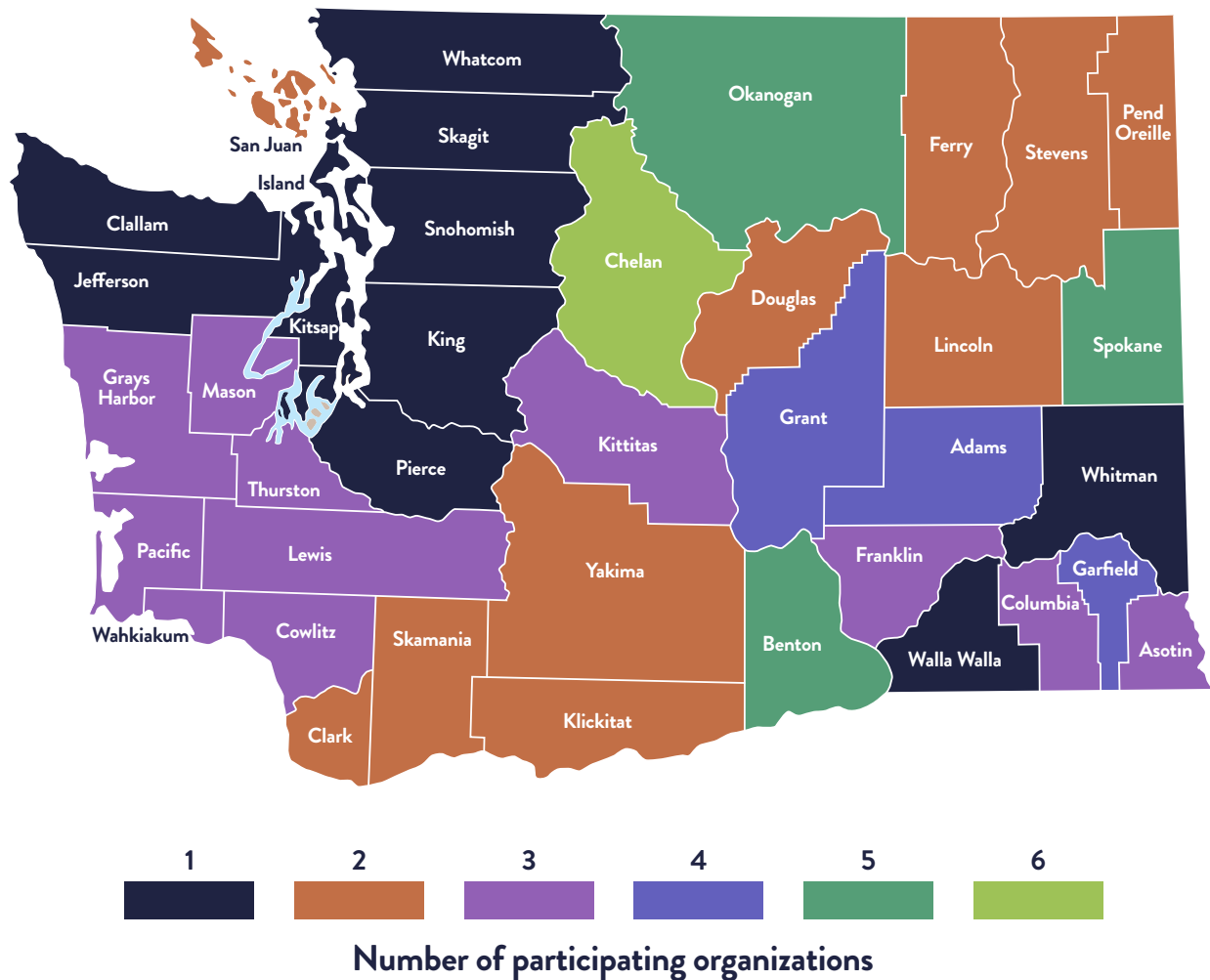
[Report to the Community](#). Rural populations, when compared to more urban and suburban populations, had relatively higher overall rates of cancer incidence and mortality and lower rates of adherence to screening mammography, Pap test, and colorectal cancer screenings. Categorizing participants by rural, urban, or mix of both regions is an attempt to elucidate regional barriers contributing to these disparities.



View of Mt. Adams from Best Western Grapevine, Sunnyside, WA. Photo by Katherine Briant.

RESULTS

Interviews and focus groups were conducted by OCOE CHEs from October 2021 through April 2022. A total of 19 interviews and two focus groups were completed that included participants from 23 organizations. One organization provides services throughout the Northwest, while the remaining 22 organizations provide services to 27 counties across the state. In an effort to better understand the new larger geographic catchment area, recruitment of organizations outside the original 13-county catchment area and counties with more rural populations were prioritized for this needs assessment.



Participating organizations provide a range of services including primary care, diagnostic, and inpatient treatment. In addition, there were several community-based organizations whose primary role was to convene partners to address shared challenges and serve high-risk populations. Organization type and region where they provide services are listed in Table I. Nearly 70% of organizations provide some type of cancer outreach and/or outreach

services. Colon, cervical, and breast cancer are the most common types of cancer being addressed. Outreach activities included health fairs, health education, and campaigns. Of those who provided demographic data on the populations they serve, six organizations stated that 55-74% of the population they serve are Black, Indigenous and People of Color (BIPOC) individuals.

TABLE I. PARTICIPANT PROFILE BREAKDOWN

Organization Type	Region type where services provided		
	Rural	Urban	Rural & Urban
Accountable Communities of Health (ACH)	2	0	1
Community-Based Organization (CBO)	5	3	1
Clinic	5	3	0
Local Health Department (LHD)	2	0	0
Higher Education	0	1	0
Totals	14	7	2

A. CLIENT OUTREACH AND ENGAGEMENT FACILITATORS

Participants were asked to share their experiences with facilitators related to client outreach practices. Themes found in the data are noted in Figure 1. Responses highlighted that despite the differences between rural and urban regions, the facilitators that enable client outreach are largely the same. There were a range of common themes that spoke to the importance of having dedicated, bilingual staff that mirror communities served; the role of community-informed outreach practices, the need for both traditional and non-traditional partnerships, and how a range of outreach media can support client engagement.

Figure 1. Client Outreach and Engagement Factors: Themes

Shared themes included the following:

- The use of dedicated, **bilingual staff that mirror the communities** served to support outreach operations such as navigators, care coordinators, and community health workers.
- **Community-informed outreach** was cited as a critical way to gain trust from the community, using trusted messengers who provide quality, culturally relevant information.
- The role of **traditional and non-traditional community partnerships** was evident in the patient referral process, development of easy-to-read outreach materials, and blended resources to meet client needs across a continuum.
- **Using a range of media** such as Facebook, newspapers, flyers, email were common practices used to reach clients.

Golden hour at the farm on the Palouse of eastern Washington near Colfax, WA. Photo by Dan Lewis

Organizations noted internal capacity to support outreach efforts as an important factor in their ability to effectively reach clients. Dedicated staff with the primary role of client outreach are needed to ensure these operations are ongoing, conducted both in the organizational setting and out in the community, and focused toward reaching individuals who have historically had less access to services. The demographic makeup of these staff and their communication capabilities play an important role in the degree to which communities see themselves represented and build trust. For example, having bilingual staff onboard minimizes communication barriers and enhances health literacy. Commonly used staff included navigators, care coordinators, and community health workers. An example of a participant response supporting these findings included:

“We’ve tried to [get] community health workers in each of those various parts of the county that [more] closely reflect the patient populations... they have begun serving dual roles where they educate in clinic but also outside of clinic walls at health fairs.”

Another facilitator included utilizing community outreach as a mechanism for

aligning efforts with real-time needs. This involved having face-to-face time in the community, seeking out community leaders, and learning about needs faced by residents. In addition, this work entailed working in partnership with community to develop culturally relevant, accessible, and quality interventions. Over time, trust can be built

with community, resulting in opportunities to leverage community members’ social capital and knowledge to convey important health education messages. Examples of participant responses included:

“

Through listening, we are putting programs in place that are the programs that the community needs, not the programs that we consider that they need.

”

“We organized a [vaccination] event in a Mexican store on a Sunday. We talked to the owner to ask about the possibility to have a vaccination event, what day is best, what day [do] they have more people in there, [and] if they thought it was a good idea to have [this] event in their place. We had the event and had double [the number of expected] people [attend because] we were able to establish a relationship and sit with them on planning, highlight what [they] need, and prepare marketing materials that were reflective of the tribe.”

“Through listening, we are putting programs in place that are the programs that the community needs, not the programs that we consider that they need. So, I think that for us that’s the most important... to bring the community voice into programs.”

Partnerships that include both traditional and non-traditional organizations were noted as another important outreach factor by participants. These relationships provide opportunities to tap into resources across organizations, expand reach exponentially, and aid in client need being met across a continuum. In addition, participants spoke to how they collaborated with other entities to support the patient referral process and collectively develop educational collateral. In building these networks, it is important to think about entities that have a direct touch or involvement with clients that your organization is seeking to connect with. Examples of organizations to consider for partnership included business groups, community coalitions, community centers, and groups. Noted below is participant response supporting these findings:

“So, it takes all of those different partners... working in different communities and different areas in the healthcare field to be able to provide those services to the families and our housing sites.”

Lastly, the use of different media served as tools to facilitate client outreach operations. Traditional media such as TV, radio and newspaper were cited as common practices. Social media, particularly Facebook and Instagram, also played a significant role in communicating with clients, disseminating important messages, and clients learning about available resources.



Tractor plowing fields in Eastern Washington state. Photo by Edmund Lowe Photography

B. CLIENT OUTREACH AND ENGAGEMENT BARRIERS

In addition to sharing client outreach factors, participants highlighted numerous barriers. Respective themes are documented in Figure 2. There were several common themes that included limited funding to support outreach, client mistrust of healthcare, disruptions of services largely due to the COVID-19 pandemic, and vast catchment areas that exceed staff capacity.

Organizations with limited funding dedicated to supporting outreach operations resulted in minimal and/or no outreach efforts. Funding for outreach was typically used for staffing costs, purchasing of outreach materials (brochures and other handouts), and community event-related expenses. The absence of this funding highlighted an association between underfunded organizations and limited staffing. In these instances, participants experienced challenges with prioritizing outreach functions without causing clinical disruptions. Examples of participant responses included the following:

“We lack the fiscal resources needed to reach people.”

“So when you are funded at 40 percent of need, I think when you are trying to pull somebody out for different cancer trainings or clinical trainings, they will have to leave the clinic. And it’s hard because we don’t have a navigator in every clinic where cancer is their job.”

Figure 2. Client Outreach and Engagement Barriers: Themes

- Lack of funding to support outreach operations, healthcare systems engendering mistrust, service disruption, and vast catchment areas were cited as universal barriers impacting outreach. There is an association between underfunded organizations and limited outreach staff.
- Lack of knowledge around best practices for conducting outreach and providing services in rural regions.
- Rural-related challenges included limited knowledge about best practices for effectively reaching clients, lack of linguistically accessible services aligned with client need and availability, and proximity of available services relative to where clients live.

Sorting and processing cherries manually,
Yakima Valley. Photo by Trong Nguyen

The COVID-19 pandemic brought about both increased feelings of mistrust of healthcare among clients and service disruption. This mistrust was evident among marginalized communities and aided in some clients being reluctant to engage in services, even when outreach was geared toward them. Participants recognized the role that the system has played in creating mistrust over time and there is an opportunity to take ownership to address this critical challenge. Examples of service disruptions included complete shutdown of services, limitations in providing face-to-face time out in the community, and reduced hours to routinely meet client needs, which resulted in missed opportunities to engage and effectively connect with clients. Participants shared:

“The pandemic impacted the community’s trust of medicine especially in marginalized communities.”

“We earned that mistrust, and we need to undo that.”

“It’s actually [about] seeing people out and about. We used to have wellness dinners...and have an activity or share a message about cancer screening. We were able to share information and maybe show some educational materials like what the lumps in breasts would feel like.”

“

Each corner of the county is unique, so we can’t adopt a one-size-fits-all strategy and don’t have the resources to tailor everything that we do to [meet] the needs of each of the populations in our county.

”

Vast geographic service areas were also stated as another barrier contributing to reaching clients and defined as “distance to and from services” and “region size.” There was mention of a lack of awareness around the bi-directional challenges that distance can create in both accessing clients and clients seeking out services. These challenges often result in large amounts of time and financial resources being spent on travel. Participants also spoke to covering large areas across the state that are

sparsely populated and comprised of a mix of individuals within and outside of community areas. As one participant shared:

“I think one [barrier] is just the geographic distance that we cover. So, we have a really big

area that is sparsely populated. There are a few communities but there are a lot [of] people that live in a community and live out kind of just off the hills and in the mountains and in the forest.”

Assessment findings highlighted several rural-related barriers that make it difficult to reach clients such as the perceptions about attitudes and behaviors held by rural residents, lack of linguistically accessible services aligned with client need and availability, proximity of available services relative to where clients live, limited transportation, disparate broadband access, and limited practitioner knowledge of best practices for engaging individuals living in rural settings.

Existing service offerings are largely limited to clients who speak English, despite the growing populations of immigrants, migrants, refugees, and clients in need of diverse language options. Participants shared challenges with the lack of bilingual providers, interpreter services, and translated materials. Furthermore, the availability of services is not conducive to client availability. There is a need to provide the same service across multiple days each week, ensuring that there are morning, afternoon, and evening hours available.

Transportation was noted as a common challenge for individuals living in rural regions, where public transportation systems are limited and services are not conveniently located within proximity to where clients reside, making travel necessary. These challenges are particularly difficult to mitigate within subsets of the population, including those living with disabilities and the elderly.

Working with individuals who have disparate access to broadband services across the rural region also presented another outreach barrier for participants, who can't rely on telehealth or organizational websites to engage clients.

Lastly, participants shared challenges with the identification of best practices for outreach and providing services in rural areas—whether that means tailoring services and bringing them to clients or creating pathways to ease access to services elsewhere. This knowledge gap and the range of rural-related related barriers of

proximity of services, transportation, client behaviors/preference, and disparate broadband access presents bi-directional challenges. Service providers' capabilities to reach clients and clients' capacity to tap into services are reduced, making it difficult for practitioners to use traditional and "one-size-fits-all" outreach approaches, especially in the absence of adequate fiscal and/or human resources. Examples of supporting evidence included:

"Layering [service awareness among this population] on top of the broadband challenges and transportation challenges, you end up with a population that's very fragmented. There's a pretty big difference in approaches of what's going to reach those people versus the people that you might be able to reach through the more traditional methods."

"Each corner of the county is unique, so we can't adopt a one-size-fits-all strategy and don't have the resources to tailor everything that we do to [meet] the needs of each of the populations in our county."

C. HOW CLIENTS LEARN ABOUT AVAILABLE SERVICES

Participants drew upon personal experiences and knowledge when asked to share insights on where people in their communities look for information regarding cancer and cancer-related behaviors. Common themes captured in the data are documented in Figure 3. Primary care providers, the internet, organizational websites, community-based and healthcare organizations were cited as the most frequently sought out resources for information.

Figure 3. Common Themes: Where Individuals Seek Information about Cancer and/or Cancer-Related Behaviors

- A **primary care provider was the most cited starting place** for individuals seeking information about cancer and/or cancer-related behaviors.
- The **internet**, especially organizational websites and social media were also noted as **common resources** for information.
- Participants highlighted a long list of **community-based and healthcare organizations** that they were familiar with as potential resources for individuals to seek information.

Banks Lake, WA. Photo by Real Window Creative.

Established relationships with primary care providers are a frequent starting place for community members seeking information. Primary care providers can be seen as trusted sources who can build knowledge where gaps may exist and act as a conduit for making connections to services to meet the range of client needs. An example of this finding included:

“I would say they would start with their primary care provider. I know for me...I lost my husband in 2017 and we used an oncologist at Confluence Health who later connected with a specialist at Swedish Hospital. So, I just think those healthcare connections that are already established by these facilities – whether they be in Seattle or Spokane – a local person would probably just start with their local provider because the trust is there...and then follow the recommendation if they need to be seen elsewhere.”

The internet, social media and organizational websites served as another place where people may seek out information related to cancer and cancer-related behaviors. These electronic sources are often used by organizations to push out information and are largely helpful in communities where there are limited media outlets such as radio or a local news station. As one participant shared:

“Facebook is a huge resource in our rural area. We don’t have local news on television that serves our specific area, and newspapers are just weekly publications. A lot of the kind of word-on-the-street type information is pushed out through Facebook.”

In addition to primary care providers and electronic resources, individuals seek out information through known resources that can include community-based and healthcare

organizations.

Like primary care providers, these entities can serve as guides in getting people access to needed services and answer questions that individuals may have.

For both rural and urban regions, there

are a range of service providers that individuals may seek out to gain respective information. Entities like Confluence Health and Family Health Center have footprints in both regions.

In rural regions, gaining information through traditional methods such as newspapers, local radio, and brochures are common practice. Word of mouth is also a “go-to” practice in rural regions largely due to the close-knit nature of these communities, where residents have built relationships.

“

Facebook is a huge resource in our rural area. We don’t have local news on television that serves our specific area, and newspapers are just weekly publications.

”

D. COMMUNITY PROFILE: STRENGTHS

Participants were asked to provide insight into community strengths. Captured themes are documented in Figure 4.

Figure 4. Community Profile Strengths: Themes

Universal themes across both region types:

- Descriptions for community strengths included “**close-knit,**” “**contained,**” “**safe,**” and “**bedroom community feel region.**”
- **Genuine care, compassion, and desire to help each other** were noted as values held among residents, practitioners, and community-based organizations.
- **Partnerships were dynamic** in nature and work to supplement services and collectively meet resident needs.

Rural-specific themes included:

- Being in a rural area was considered both a strength and challenge—where **strong partnerships, cohesion, trust, and resilience are the result of scarcity** of resources and feelings of isolation.

Historic flour mill, Oakesdale, WA. Photo by Steve Smith.

In addition, communities were comprised of individuals that held values of shared accountability and care for their peers. Everyone generally knows each other, and there is a desire to reach out to one another to check in and lend a hand when needs present. As one participant shared:

“We live in a close-knit community, and we do know everybody. I mean, that’s the good news about living in a small community. So, when somebody is in trouble, or needs things, I can call up my community partners.”

Lastly, dynamic partnerships play an integral role in meeting community needs. There is a strong emphasis on collaboration, convening and creative problem-solving in addressing needs. Especially in rural regions, the existence of these partnerships, cohesion, trust, and resilience, are born from the scarcity of fiscal and human resources and long-held feelings of isolation among community members and practitioners alike.

E. COMMUNITY PROFILE: CHALLENGES

Structural and social determinants of health were identified as primary factors influencing community challenges. Figure 5 documents the notable shared themes of community challenges for urban and rural settings.

Figure 5. Community Challenges: Themes

- **Physical environment**-related challenges included the housing crisis, living in food deserts, disparate broadband access, and limited access to needed (social and health) resources.
- Factors serving as **barriers to accessing healthcare** services included transportation, income, understaffing, availability of accessible and culturally relevant services, and communication barriers.
- **Mental health, substance use disorder, and homelessness** were commonly noted as important health issues impacting communities.

Old rusted abandoned mailbox by the side of a dirt unpaved farm road in the Palouse. Photo by melissam

Challenges related to the physical environment included inflated housing costs and short supply, individuals residing in communities with limited health food options, disparate broadband coverage, and limited access to resources (both social and health) needed to lead a healthy life. Noted barriers impacting community members' ability to access healthcare services included transportation, low income status among segments of the population, system staffing, and service availability.

Transportation was a common challenge participants highlighted. Needed services are not conveniently located within proximity to where clients reside, making travel necessary. In addition, transportation challenges often resulted in missed appointments, underutilization of available resources, and inability to access healthy food choices. Costs associated with transportation is also a factor impacting access. An example of a participant response supporting this finding included:

“Part of the challenge in being rural is having access to resources, including access to food. Even though we are in an agricultural area, not everybody has access to foods and markets that are nearby. In some cases, people are driving 40 miles to get healthcare.

In order to get access to healthcare, then you have to have access to transportation, and then you have to be able to afford the gas to get there and the time away from work.”

Low income was cited as a community challenge experienced by segments of the population that is confounded by limited employment options or low-paying jobs. These individuals are often faced with the difficult decision to prioritize and balance social and health needs, resulting in poorer health outcomes. Furthermore, data has shown notable variances in life expectancy between

communities with high and low incomes, despite the geographic distance between them. As one participant shared:

“We have a fairly substantial low-income population, and most of those people work in agriculture or service industry. There’s a fairly substantial gap between different parts of the community, based on income. Interestingly, if you look at the life expectancy by census tract, between highest and lowest, there’s about a 13-year difference in life expectancy. And the census

tract with the greatest life expectancy and the one with the lowest are about 2.5 miles apart.”

Findings associated with culturally relevant and service accessibility challenges included the lack of inclusive communication

capabilities and the proximity of services relative to where individuals reside. Limited availability of needed medical services and service providers was a common challenge shared by participants that proved to be more significant in rural areas of the state, where service options were deemed limited even prior to the pandemic. The lack of culturally relevant services resulted in individuals not seeking care, inadequate care being provided, and inequities among BIPOC communities.

Collectively, the stated structural and social determinants of health contributed

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Interestingly, if you look at the life expectancy by census tract, between highest and lowest, there’s about a 13-year difference in life expectancy.

99

to high rates of mental health, substance use disorder, and homelessness within and across communities—where individuals may experience one or more of these conditions at any given time. As one participant shared:

“We have, unfortunately, a large homeless population – as does every city, I’m sure, across

the United States. However, we have a large population of social determinants with folks, where they’re homeless [and] our shelters are inundated with folks. So, I think that we just don’t have enough resources within mental health.”



*Wind turbines seen from Steptoe Butte State Park.
Photo by Roman Khomlyak*

F. COVID-19 IMPACT UPON SERVICES

The COVID-19 pandemic had a profound impact upon participant services and staffing alike. Themes are captured in Figure 6. At the height of the pandemic, efforts were shifted from traditional, preventative operations and geared toward addressing COVID-19 cases. Several participants talked about how they used an “all-hands-on-deck” approach to ensure that emergent needs were being addressed. Launching vaccination clinics and halting community outreach, face-to-face visits, and non-emergent care were common practices that resulted in elevating only emergent cases, delaying of routine cancer screenings, and an increase in undetected cancers. Examples of participant responses supporting these findings included:

“It’s hard to promote colonoscopies or screenings because — in the very beginning — we didn’t want people out seeing anybody, and they weren’t accepting people unless it was an emergency or if the doctor had a reason that “this person has to get a colonoscopy.” But otherwise if it was just a regular screening or a mammogram — unless it was something [like] they definitely had a lump — places weren’t accepting people back in the summer of 2020.”

“A lot of the advances we have made with our community health workers and case management to do a lot of that work has really been devoted towards COVID. I haven’t looked at our cancer screening rates in a while, but I would guarantee you that we’re behind, because we’re not investing as many resources in those activities.”

Figure 6. COVID-19 Impact: Themes

- An “all-hands-on-deck” approach to address COVID was used to mitigate risk: service/program disruptions, halting community outreach/education operations, and launching vaccine clinics at the height of the pandemic was common.
- Operational shifts were made to address emergent needs, inefficiencies, and access barriers.
- Telehealth was a tool for connecting with clients. However, inequitable access to broadband connection and telephones were notable barriers.
- Participants relied on partnerships and federal funding to address emergent needs.

North Cascade Mountains. Photo by Edmund Lowe Photography.

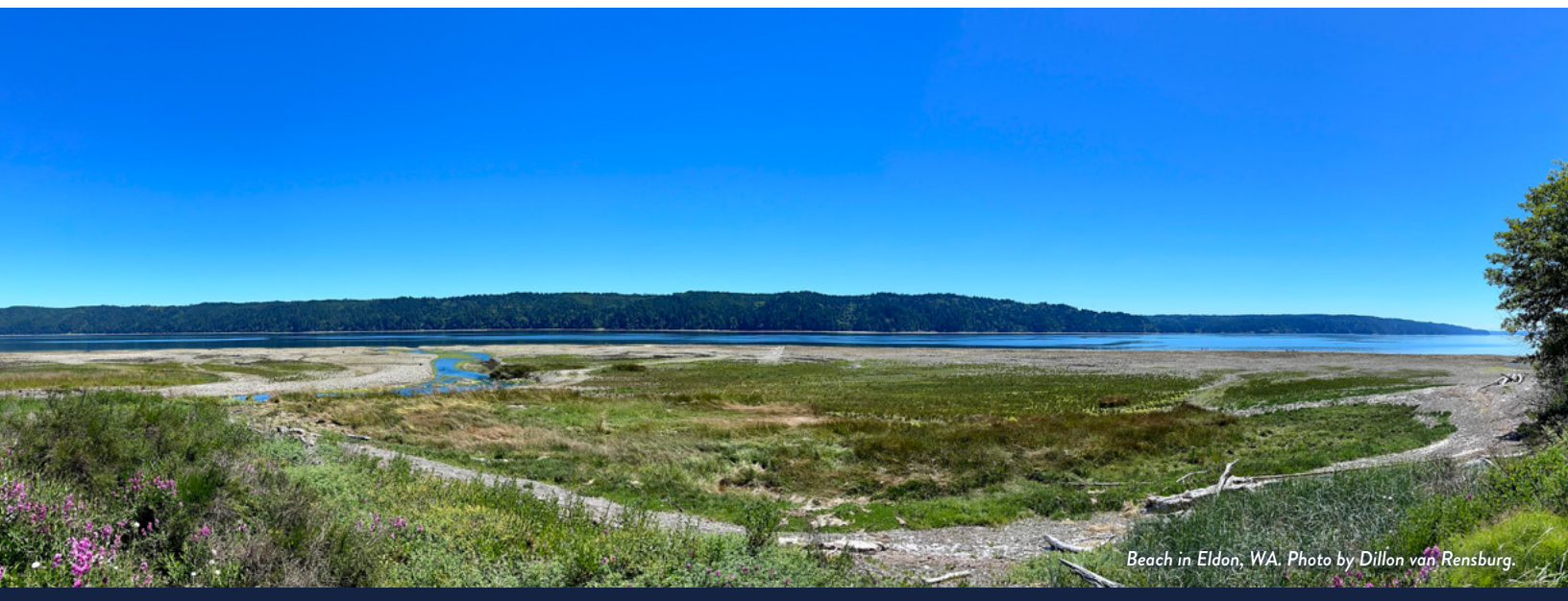
Participants drew upon creative problem-solving to address operational inefficiencies and access barriers so that patients could be seen safely at a time when there was much uncertainty. Examples of these shifts included the changing of hours to align with patient availability and conducting outreach and visits virtually or via phone. While telehealth was launched across many practices during the pandemic and worked to expand overall access, participants expressed challenges reaching all clients due to inequitable broadband and telephone access. As one participant shared below:

“Because of COVID and the high risk to both the clients and my staff, the state actually put a halt on face-to-face visits. We had over 200 clients on our lead org list that had no access to a phone. They did not have a cellphone. They didn’t have a landline. And they didn’t have internet.”

There was a reliance on partnerships and federal funding to address emergent needs

resulting from the pandemic. Organizations banded together to leverage resources, expand access to resources, and develop a plan for action. The role of existing and effective partnerships was evident in being able to respond to needs in a timely fashion. An example of a participant response supporting this finding included:

“We live in a very fortunate community, and we’ve all worked very well together. We’ve worked with the hospital. The hospital took on additional burden for the COVID-19 testing and vaccinations. And we’ve all tried to help when we can. Public health took on the education and contact tracing and things like that and regulations and guidelines in the community. But it’s been a community effort and all of the healthcare components just work excellent together.”



Beach in Eldon, WA. Photo by Dillon van Rensburg.

G. FUTURE PARTNERSHIP OPPORTUNITIES

All participants expressed an interest in working together with the Fred Hutch/UW/Seattle Children’s Cancer Consortium in some capacity in the future. Due to the interest across all organization types and similarities in needs, categorizing findings by organization type did not yield any patterns. Table II highlights participant needs and tangible opportunities to advance efforts. Findings elevated the need for sharing educational resources and proven health education practices for participants serving both rural and urban regions. Rural participants would like to leverage the Cancer Consortium’s data capabilities to inform decision-making, gain access to best practices for raising awareness around cancer screenings, and tap into existing marketing and messaging operations to expand reach. In addition, there was some discussion around collaborating across entities to address transportation and healthcare access at the systems level. An example of a participant response highlighting findings included:

“I think, from our perspective, one thing that would be helpful is helping identify both quantitative and qualitative metrics that we can use to measure the success of these outreach

programs and the success of the impacts in the convergence between health outcomes and affordable housing and access to safe and affordable housing.”

Urban participants spoke to having access to staff but would like to amplify impact through partnership with the Cancer Consortium. There are opportunities to utilize their physicians, medical students, and residents in the field to conduct education and address disparities. In addition, there is a role for partnership in developing and disseminating translated health education materials. Lastly, a need for additional access to multilingual staff to meet the range of clients’ communication needs was identified as an important need.

TABLE II. FUTURE PARTNERSHIP OPPORTUNITIES BY REGION TYPE

Rural	Urban
<ul style="list-style-type: none"> • Sharing educational resources and effective health education practices • FH sharing data capabilities to build knowledge to support clinical decision-making and operations • Sharing best practices for raising cancer screening awareness • Marketing and messaging • Collaborating around addressing transportation and access issues 	<ul style="list-style-type: none"> • Utilizing participant physicians to conduct educational presentations • Partnering to get medical students and residents engaged in efforts to eliminate disparities • Translated materials • Expanding access to multilingual staff



Vantage Bridge over Columbia River. Photo by Dillon van Rensburg.

REFLECTIONS

Findings in this report are solely representative of participant perceptions and limited in scope concerning community perceptions. It's unclear if community residents are truly aware of the community-based organizations and healthcare entities noted as resources for providing information about cancer and cancer-related behaviors. There's an opportunity to conduct community/consumer focus groups to address this gap. The practice implication here is to address any knowledge gaps around available services, increase utilization, and improve health outcomes.

Only two participants expressed sentiments around

the association between the lack of inclusive practices to adequately meet needs of the BIPOC community and historical lack of diversity within communities. While these responses did not present across more participants, it is an interesting finding worth exploring from the community/consumer lens to gather lived experience and understand implications for health outcomes, etc. Noted below is a supporting participant response:

"We have an increasing number of Afghan refugees, which presents a cultural issue. We've

been lacking diversity for so long that, for some people, I think there's a lack of cultural curiosity. I don't think we can ever become culturally competent, but I think there's that curiosity about learning about other cultures and trying to figure out how we can help them in that context. So I think that's a big component."

A review of participating organizations' profiles presents an opportunity to assess current Cancer Consortium partnerships to elevate

gaps and determine priorities for statewide outreach and engagement efforts. This approach could be used as a starting place to support the development of a heat map to better understand service

availability and potential coverage gaps. Adding statewide incidence and mortality cancer data and screening rates to such a heat map could also help the Cancer Consortium prioritize geographic areas across the state with a higher cancer burden.

One of the recurring themes around challenges facing participating organizations is the lack of information on best practices for outreach and providing services in rural areas. This is something the OCOE is well-positioned to address. Recently the OCOE Spokane

“**I don't think we can ever become culturally competent, but I think there's that curiosity about learning about other cultures and trying to figure out how we can help them in that context.**”

CHEs invited several local organizations to discuss how to start a mobile screening unit – something that does not currently exist in eastern Washington.

Potential collaboration opportunities discussed during the interviews included leveraging the Cancer Consortium’s data capabilities to inform decision-making and gain access to best practices for raising awareness around cancer screenings, and tapping into existing marketing and messaging operations to expand reach. This work has already started with a recent exploratory meeting to gauge interest of Spokane-area organizations in creating a

community advisory board that would help guide the work of the OCOE Spokane office and create a space for sharing of data and best practices.

The information shared during these interviews and focus groups is helping the OCOE develop and prioritize outreach, engagement, and research in our catchment area. The hope is that this report will also benefit community organizations and healthcare organizations across Washington to spark conversations and strategies on overcoming shared barriers and supporting all Washington residents in obtaining equitable and quality healthcare.



*Allium field in Yakima Valley.
Photo by Gloria Coronado.*

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"El Sarape" – Toppenish Mural celebrating the farmworker, painted by Daniel DeSiga. Photo by India Ornelas.

CANCER CONSORTIUM

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