2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Clallam County, Washington

Sponsored by

OLYMPIC MEDICAL CENTER

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Clallam County, the service area of Olympic Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Olympic Medical Center by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

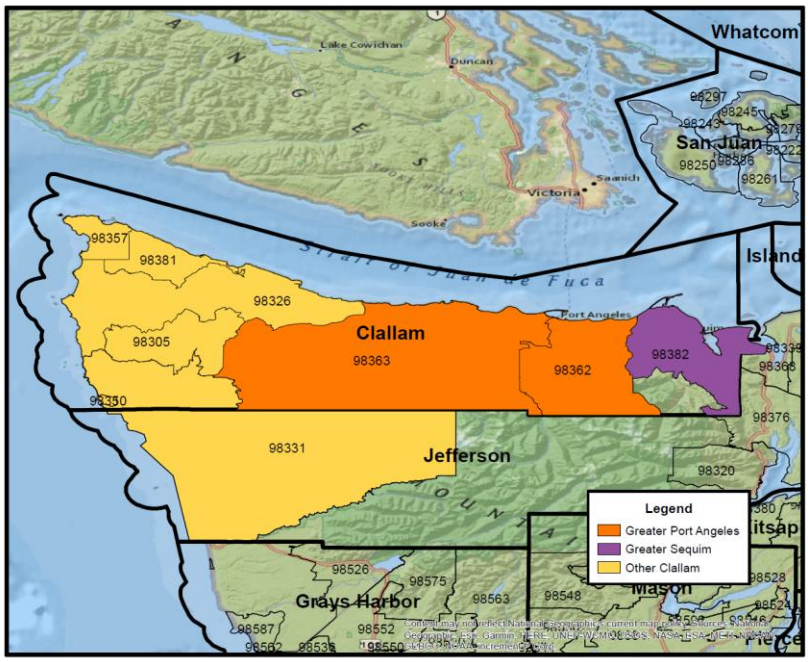
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Olympic Medical Center and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Clallam County” in this report) is defined as each of the residential ZIP Codes comprising Clallam County, Washington (one of which also extends into neighboring Jefferson County). This community definition, determined based on the ZIP Codes of residence of recent patients of Olympic Medical Center, is illustrated in the following map.

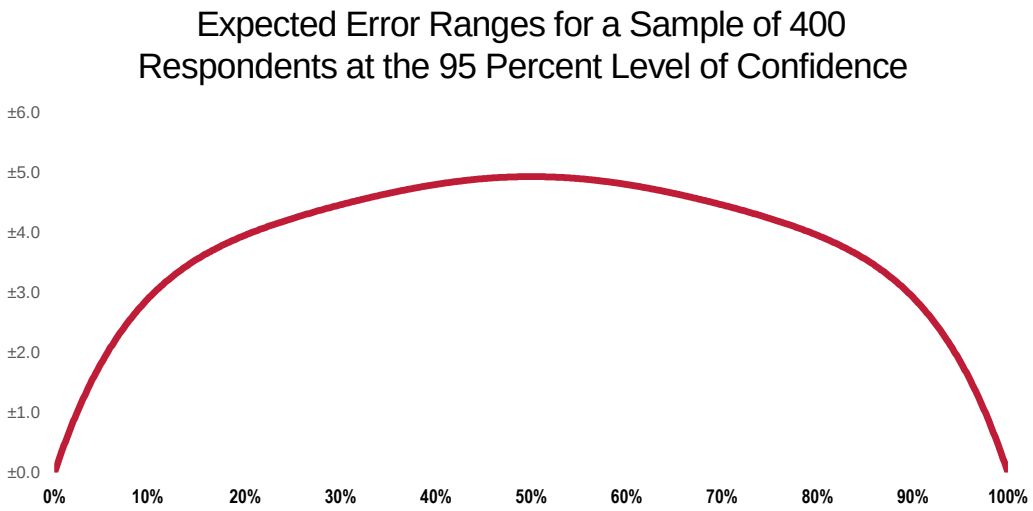


Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of 400 individuals age 18 and older in Clallam County, including 200 in the Greater Port Angeles area, 150 in the Greater Sequim area, and 50 in the remaining areas of Clallam County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Clallam County as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is ±4.9% at the 95 percent confidence level.



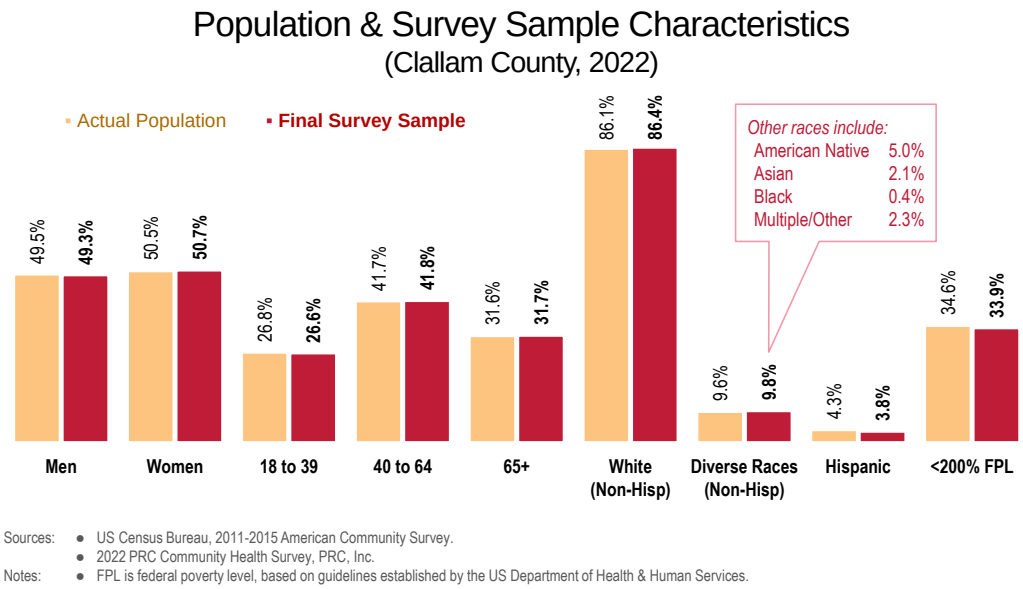
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% ± 2.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% (50% ± 4.9%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Clallam County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2022 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. "White" reflects non-Hispanic White respondents; "Communities of Color" includes Hispanics and non-White race groups.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Olympic Medical Center; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 41 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	9
Other Health Providers	12
Social Services Providers	6
Other Community Leaders	14

Final participation included representatives of the organizations outlined below.

- Caregivers HomeCare Team
- Castell Insurance
- Clallam County Board of Health
- Clallam County YMCA
- Clallam Fire District No. 3
- Clallam Mosaic
- Clallam Transit
- Dungeness Valley Health & Wellness Clinic
- First Step Family Support Center
- Gellor Insurance, Inc.
- Habitat for Humanity
- League of Woman Voters
- Lower Elwha Tribe
- Medical Staff Executive Committee
- North Olympic Healthcare Network
- Olympic Medical Center
- Olympic Medical Home Health
- Olympic Medical Physicians
- Olympic Medical Physicians Medical Specialties
- Olympic Medical Physicians Primary Care
- Olympic Medical Physicians Surgical Specialties
- Olympic Medical Physicians Walk-in Clinics
- Olympic Peninsula Community Clinic
- Olympic Peninsula Healthy Community Coalition
- Peninsula Behavioral Health
- Port Angeles Fire District
- Port Angeles Food Bank
- Port Angeles Regional Chamber of Commerce
- Port of Port Angeles
- Sequim Dungeness Valley Chamber of Commerce
- Sequim Food Bank
- Shipley Center
- St. Andrew's Place Assisted Living Community
- United Way of Clallam County

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Clallam County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Washington Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Olympic Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Olympic Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Olympic Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	29
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	108
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	15
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	16
Part V Section B Line 3h The process for consulting with persons representing the community's interests	9
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	113

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access (esp. Other Clallam County) ▪ Inconvenient Office Hours (esp. Greater Port Angeles) ▪ Routine Medical Care (Adults) ▪ Emergency Room Utilization (esp. Other Clallam County) ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death (All Cancers) ▪ Lung Cancer Deaths
DIABETES	▪ Diabetes Prevalence
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Prevalence ▪ High Blood Pressure (esp. Greater Sequim)
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths ▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crashes
MENTAL HEALTH	▪ Suicide Deaths ▪ Diagnosed Depression (esp. Greater Port Angeles) ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Access to Recreation/Fitness Facilities ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
POTENTIALLY DISABLING CONDITIONS	▪ Disability Prevalence
SUBSTANCE ABUSE	▪ Key Informants: Substance abuse ranked as a top concern.

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Abuse
3. Nutrition, Physical Activity & Weight
4. Access to Healthcare Services
5. Disability & Chronic Pain
6. Diabetes
7. Heart Disease & Stroke
8. Injury & Violence
9. Cancer
10. Infant Health & Family Planning

Hospital Implementation Strategy

Olympic Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Clallam County results are shown in the larger, gray column.

The columns to the left of the Clallam County column provide comparisons among the three county subareas, identifying differences for each as “better than” (), “worse than” (), or “similar to” () the combined opposing areas.

The columns to the right of the Clallam County column provide comparisons between county data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether Clallam County compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)				0.8	3.8	4.3	
Population in Poverty (Percent)				14.5	10.8	13.4	8.0
Children in Poverty (Percent)				23.2	13.6	18.5	8.0
No High School Diploma (Age 25+, Percent)				7.5	8.7	12.0	
Housing Exceeds 30% of Income				29.9	31.7	30.9	
					better	similar	worse

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	3.4	7.9		6.9	11.4	8.7	7.9
% Difficulty Accessing Primary Care in Past Year (Composite)	36.7	31.5	49.7	36.1		35.0	
% Cost Prevented PC Visit in Past Year	5.7	2.6	6.4	4.6	8.9		

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
% Difficulty Getting PC Appointment in Past Year	19.2	20.4	32.9	21.1			
% Inconvenient Hrs Prevented PC Visit in Past Year	12.4	5.8	7.1	9.3			
% Difficulty Finding PCP in Past Year	17.8	19.6	28.6	19.6			
% Transportation Hindered PC Visit in Past Year	3.0	3.0	2.6	3.0			
% Language/Culture Prevented PC Care in Past Year	0.0	0.0	0.0	0.0			
% Difficulty Getting Child's Primary Care in Past Year				2.6		8.0	
Primary Care Doctors per 100,000				132.2	115.2	102.3	
% Have a Particular PCP for Medical Care	74.6	81.7	80.0	77.9	70.2		
% [With PCP] Travel >15 Miles for PCP Visit	22.7	13.6	17.3	18.6			
% Have Had Routine Checkup in Past Year	53.9	56.5	51.8	54.7	77.3	70.5	
% Child Has Had Checkup in Past Year				81.6		77.4	

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
% Two or More ER Visits in Past Year	8.3	6.2	20.1	8.8		10.1	
% Rate Local Health Care "Fair/Poor"	22.7	19.2	31.8	22.3		8.0	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

			worse
better	similar		

CANCER	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
Cancer (Age-Adjusted Death Rate)				159.0	145.2	149.4	122.7
Cancer Incidence Rate (All Sites)				512.2	442.4	448.6	
Female Breast Cancer Incidence Rate				129.1	133.5	126.8	
Prostate Cancer Incidence Rate				108.9	98.1	106.2	
Lung Cancer Incidence Rate				62.4	52.7	57.3	
Colorectal Cancer Incidence Rate				40.1	35.1	38.0	

CANCER (continued)	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
% Cancer	12.4	11.6	3.3	11.2	11.6	10.0	
Mammogram in Past 2 Years (% Women 50-74)				65.8	70.0	74.8	
					better	similar	worse

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

DIABETES	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
% Diabetes/High Blood Sugar	11.1	15.3	8.7	12.4	8.6	13.8	
					better	similar	worse

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

HEART DISEASE & STROKE	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
Coronary Heart Disease (Age-Adjusted Death Rate)				78.4	77.5	91.5	127.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	11.7	8.5	3.3	9.6	5.5	6.1	
Stroke (Age-Adjusted Death Rate)				38.2	35.3	37.6	33.4
% Stroke	3.8	7.6	0.0	4.9	2.8	4.3	
% Told Have High Blood Pressure	36.7	47.3	23.4	39.4	30.3	36.9	27.7
% Told Have High Cholesterol	26.9	22.5	17.5	24.2		32.7	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
Infant Death Rate				5.8	4.3	5.8	5.0
Births to Adolescents Age 15 to 19 (Rate per 1,000)				23.2	16.3	20.9	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
Unintentional Injury (Age-Adjusted Death Rate)				59.6	44.5	50.4	43.2
Motor Vehicle Crashes (Age-Adjusted Death Rate)				12.8	8.0	11.5	10.1
Violent Crime Rate				277.8	297.1	416.0	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

MENTAL HEALTH	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
% Diagnosed Depression	27.7	17.8	17.9	22.8	23.4	20.6	
Suicide (Age-Adjusted Death Rate)				25.7	15.8	13.8	12.8
Mental Health Providers per 100,000				193.1	211.4	124.9	
% Unable to Get Mental Health Svcs in Past Yr	5.2	1.8	4.5	3.8		7.8	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
Population With Low Food Access (Percent)				38.2	23.1	22.2	
Fast Food (Restaurants per 100,000)				56.0	75.6	82.2	
Recreation/Fitness Facilities per 100,000				11.2	13.9	12.2	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

ORAL HEALTH	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
% [Age 18+] Dental Visit in Past Year	60.2	76.2	72.1	67.7	69.3	62.0	45.0
Dentists per 100,000				42.8	43.3	33.1	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
Disability Prevalence (%)				20.0	12.7	12.6	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
COVID-19 (Age-Adjusted Death Rate)				182.4	168.5	299.7	
Lung Disease (Age-Adjusted Death Rate)				37.5	34.6	39.1	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

					better	similar	worse

SEXUAL HEALTH	DISPARITY AMONG SUBAREAS: Greater Port Angeles	Greater Sequim	Other Clallam County	Clallam County	CLALLAM COUNTY vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
HIV Prevalence Rate				112.9	215.2	372.8	
Chlamydia Incidence Rate				251.7	465.2	539.9	
Gonorrhea Incidence Rate				26.5	151.3	179.1	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

					better	similar	worse

SUBSTANCE ABUSE	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
% Binge Drinker	17.3	12.6	24.4	16.2	15.4	24.5	
% Used a Prescription Opioid in Past Year	8.6	12.8	6.8	10.0		12.9	
% Personally Impacted by Substance Abuse	38.9	28.8	36.6	34.9		35.8	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

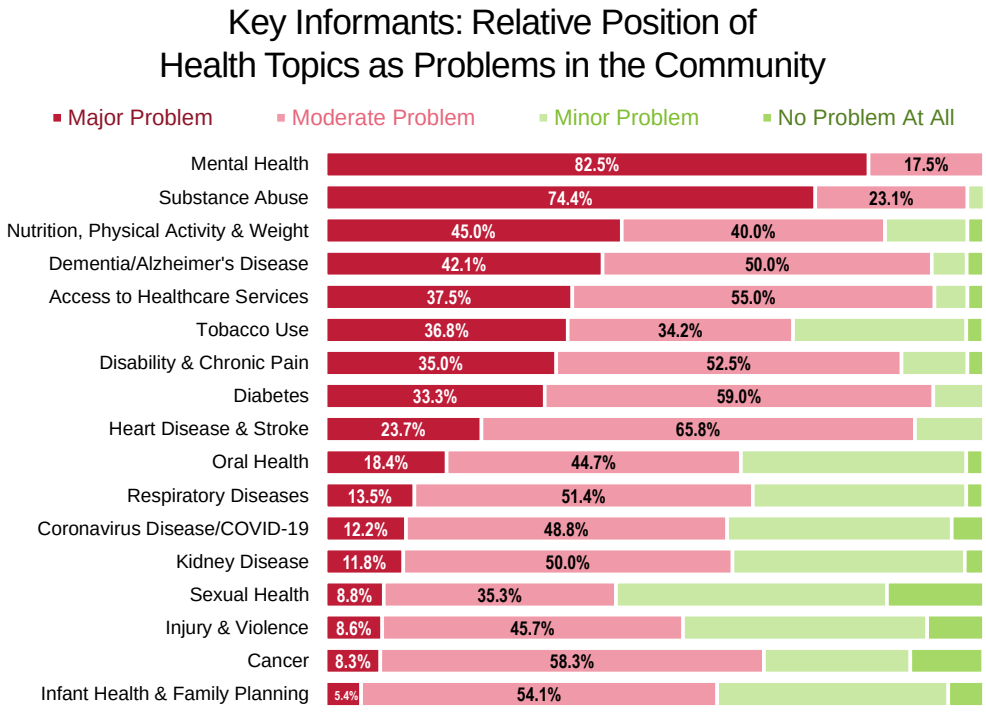
TOBACCO USE	DISPARITY AMONG SUBAREAS			Clallam County	CLALLAM COUNTY vs. BENCHMARKS		
	Greater Port Angeles	Greater Sequim	Other Clallam County		vs. WA	vs. US	vs. HP2030
% Current Smoker	10.8	3.3	16.7	8.6	11.5	17.4	5.0
% Currently Use Vaping Products	4.1	1.1	11.9	3.8	5.2	8.9	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Clallam County, the focus of this Community Health Needs Assessment, encompasses 1,738.68 square miles and houses a total population of 75,392 residents, according to latest census estimates.

Total Population
(Estimated Population, 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Clallam County	75,392	1,738.68	43
Washington	7,404,107	66,453.36	111
United States	324,697,795	3,532,068.58	92

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

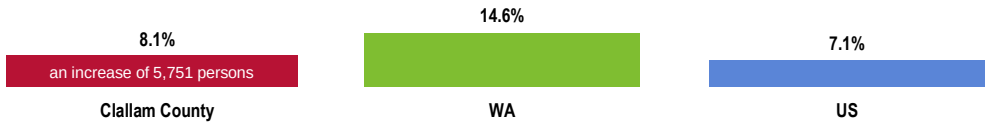
Population Change 2010-2020

A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2010 and 2020 US Censuses, the population of Clallam County increased by 5,751 persons, or 8.1%.

BENCHMARK ► Represents a lower population increase than was found across Washington.

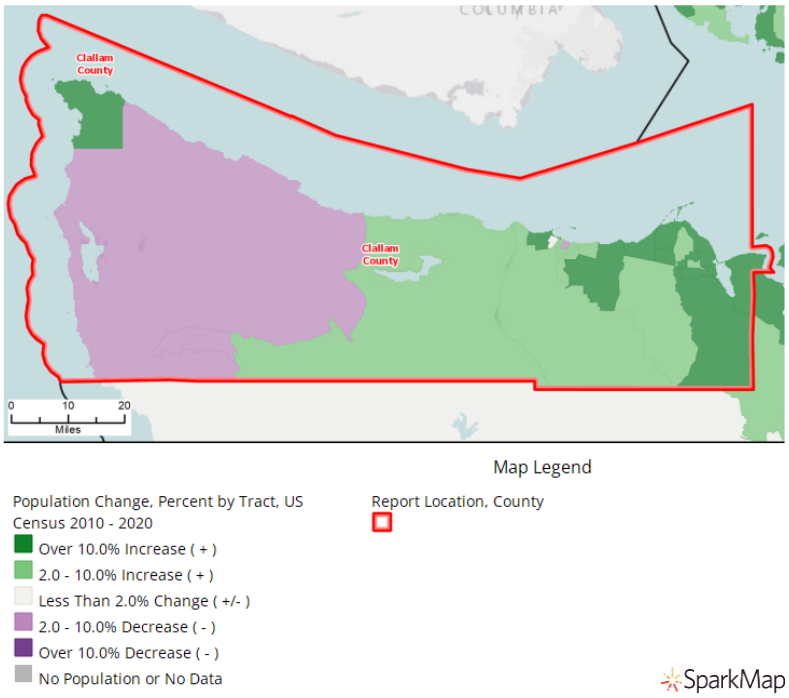
Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

This map shows the areas of greatest increase or decrease in population between 2010 and 2020.

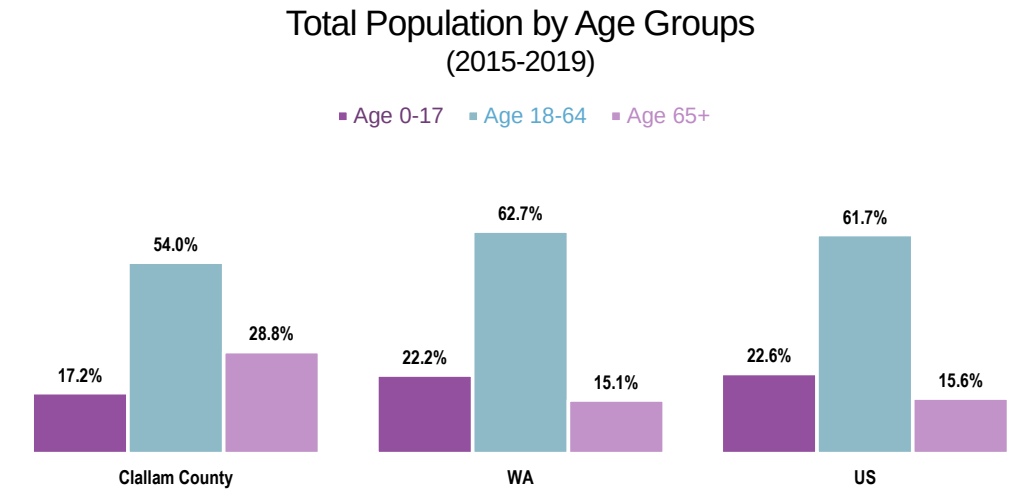


Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In Clallam County, 17.2% of the population are children age 0-17; another 54.0% are age 18 to 64, while 28.8% are age 65 and older.

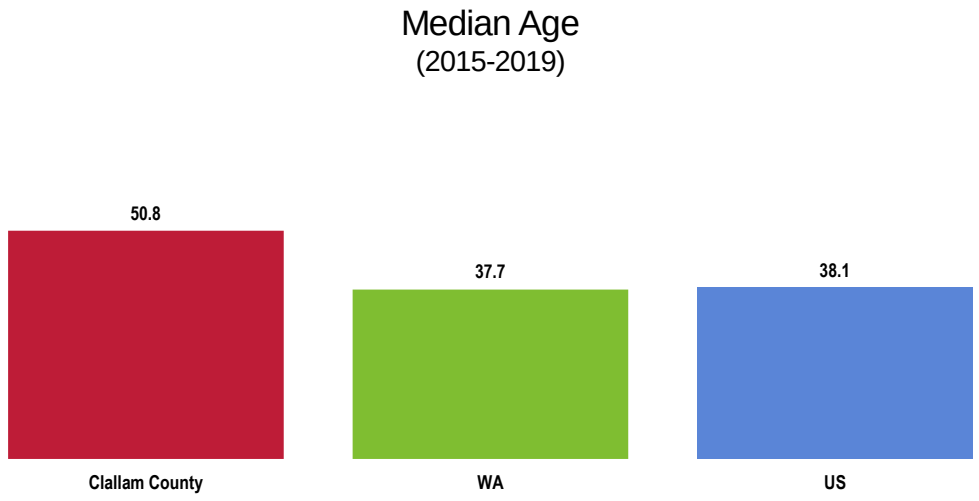
BENCHMARK ► The age distribution of Clallam County skews much older than that of the state and nation.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Median Age

Clallam County is much "older" than the state and the nation in that the median age is considerably higher.



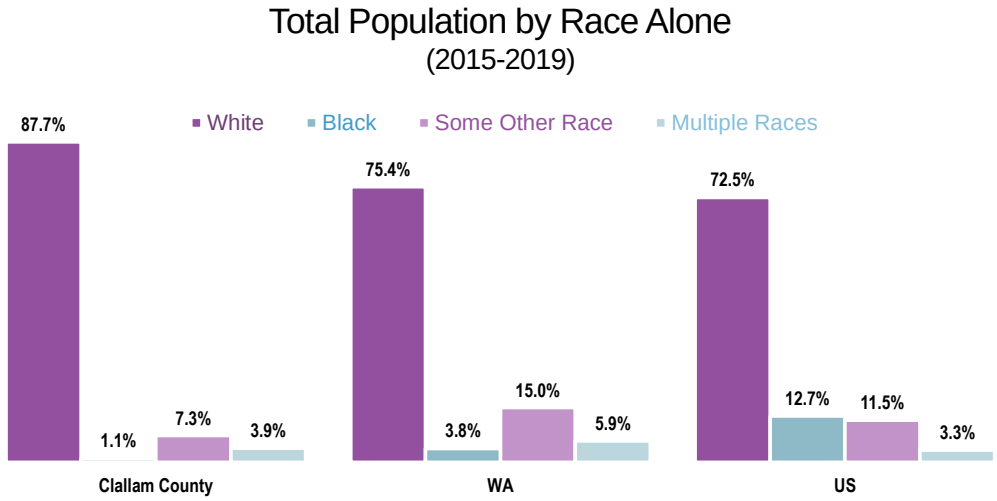
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 87.7% of residents of Clallam County are White and 1.1% are Black.

BENCHMARK ► Less diverse than Washington and the US.



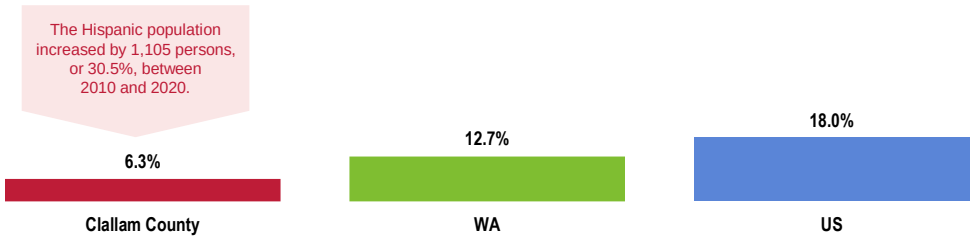
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Ethnicity

A total of 6.3% of Clallam County residents are Hispanic or Latino.

BENCHMARK ► Much lower than the Washington and US proportions.

Hispanic Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

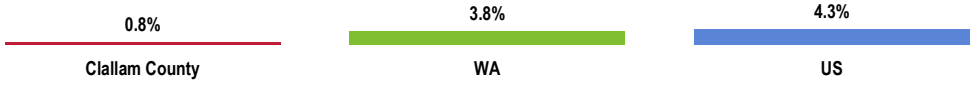
Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

A total of 0.8% of Clallam County population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► Favorably lower than the state and national findings.

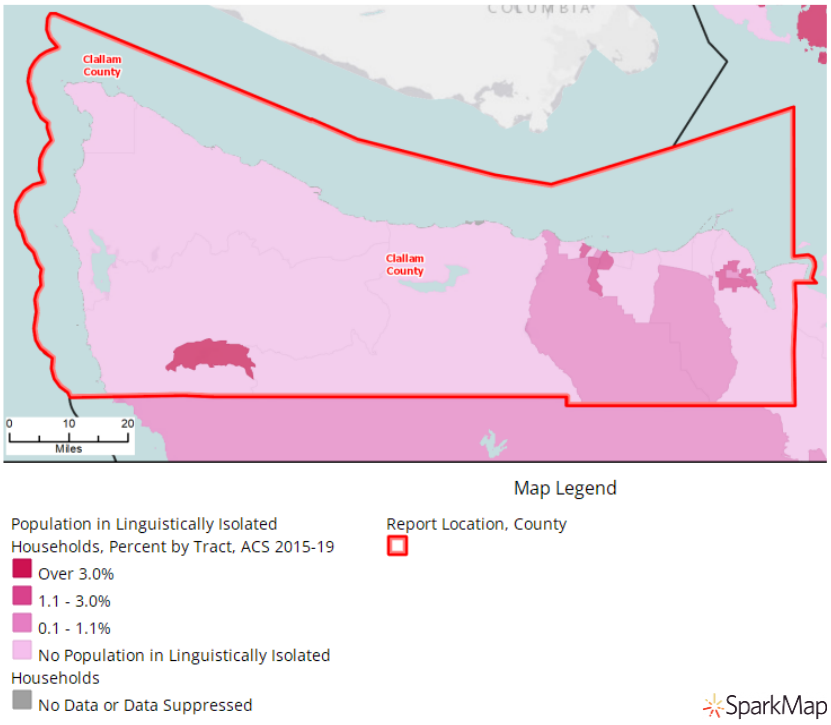
Linguistically Isolated Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."

Note the following map illustrating linguistic isolation throughout Clallam County.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Poverty

The latest census estimate shows 14.5% of Clallam County total population living below the federal poverty level.

BENCHMARK ► Higher than the state finding. Fails to satisfy the Healthy People 2030 objective.

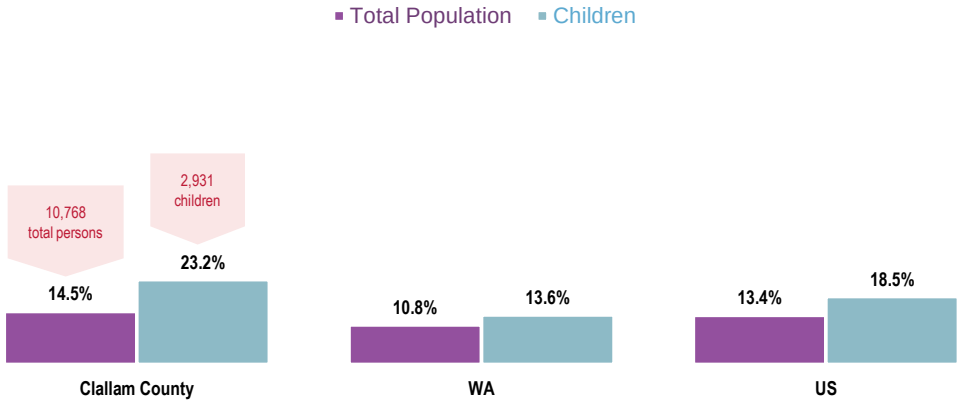
Among just children (ages 0 to 17), this percentage in Clallam County is 23.2% (representing an estimated 2,931 children).

BENCHMARK ► Higher than the state and national findings. Fails to satisfy the Healthy People 2030 objective.

Population in Poverty

(Populations Living Below the Poverty Level; 2015-2019)

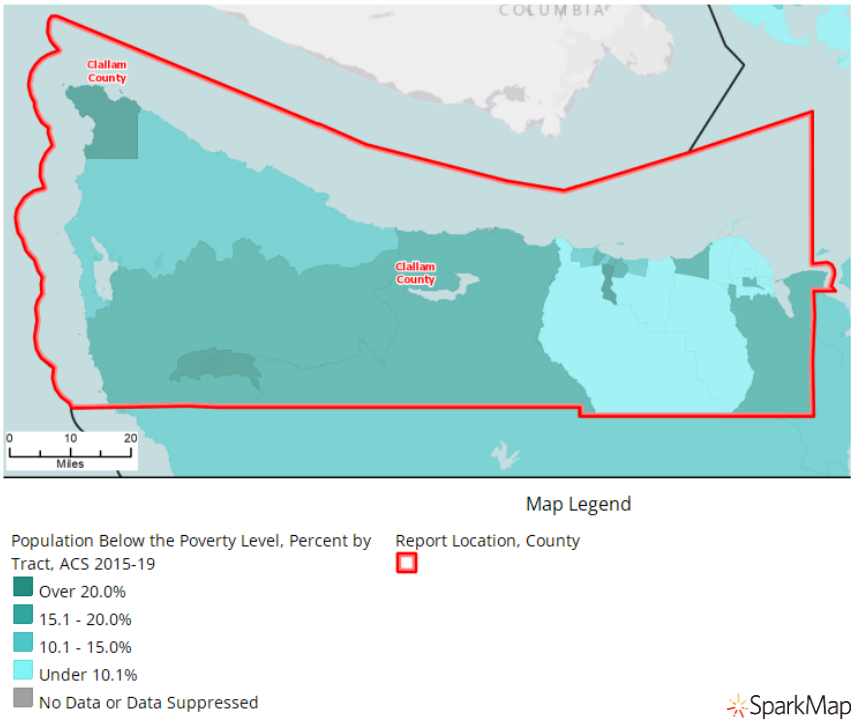
Healthy People 2030 = 8.0% or Lower

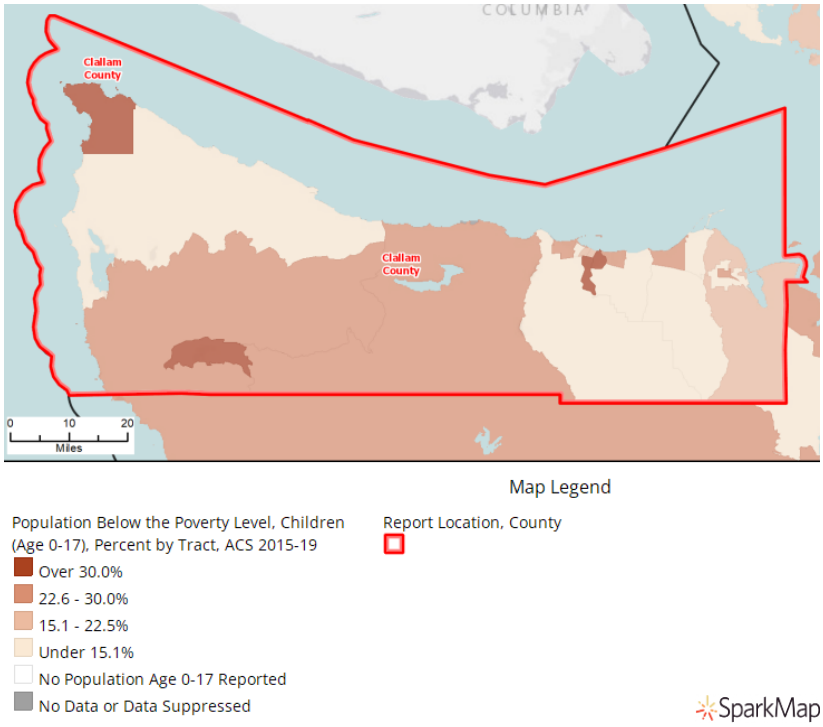


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

The following maps highlight concentrations of persons living below the federal poverty level.





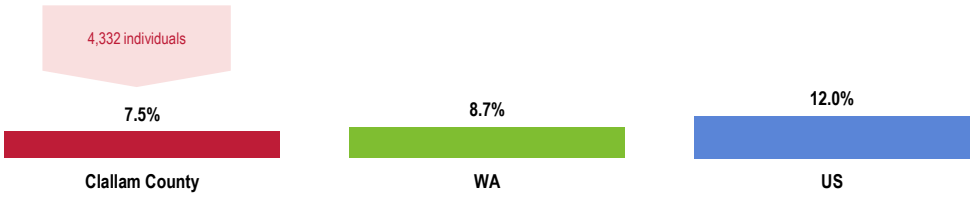
Education

Among the Clallam County population age 25 and older, an estimated 7.5% (over 4,300 people) do not have a high school education.

BENCHMARK ► Favorably lower than the Washington and US proportions.

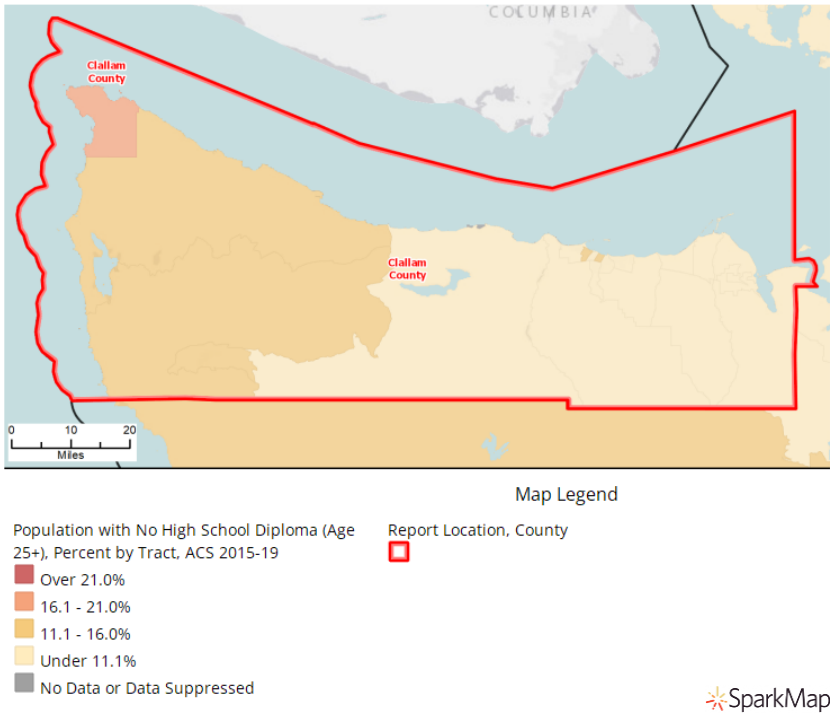
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

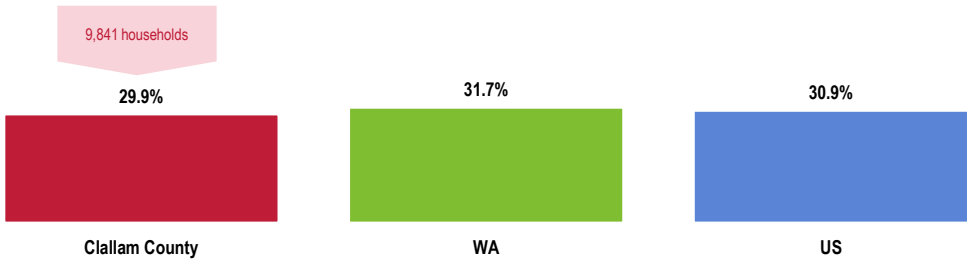


Housing

Housing Cost Burden

29.9% of Clallam County residents (representing 9,841 households) report spending 30% or more of their total household income on housing.

Housing Costs Exceed 30% of Household Income
(2015-2019)



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the households where housing costs exceed 30% of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.

Food Access

Low Food Access

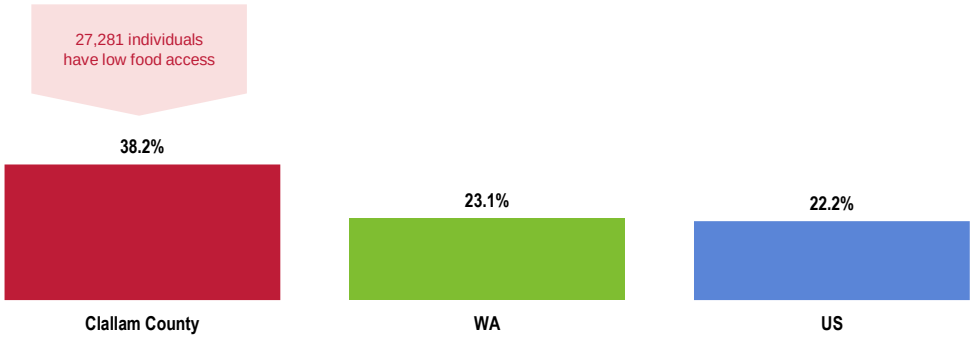
Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.

US Department of Agriculture data show that 38.2% of Clallam County population (representing over 27,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

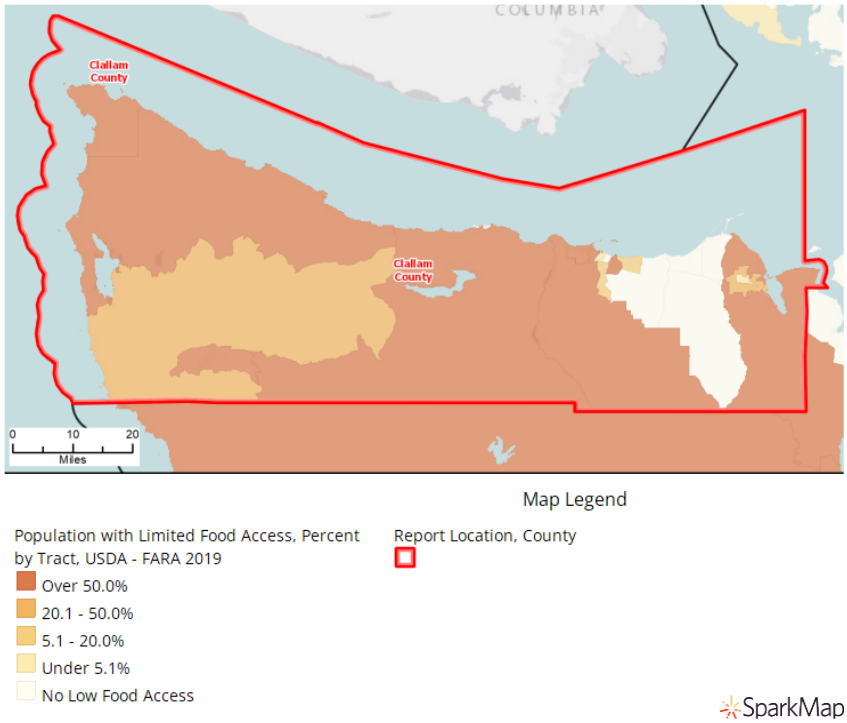
BENCHMARK ► Much higher than the Washington and US findings.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



HEALTH STATUS

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Depression

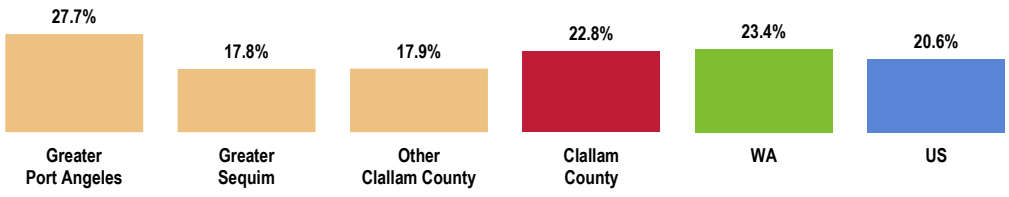
Diagnosed Depression

A total of 22.8% of Clallam County adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

DISPARITY ► Diagnosed depression is much higher in the Greater Port Angeles area. Reported more often among women and young adults.

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

Have Been Diagnosed With a Depressive Disorder



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 308]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

Here, "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

In addition, Communities of Color includes all Hispanic and non-White race respondents.

Have Been Diagnosed With a Depressive Disorder
(Clallam County, 2022)

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 308]

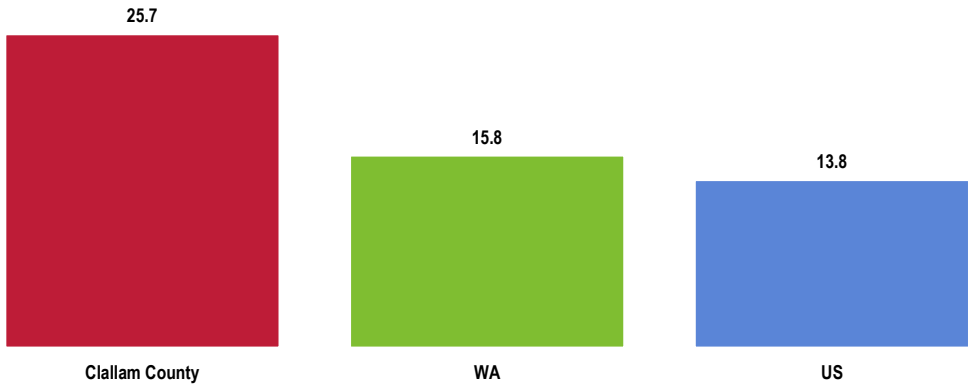
Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Suicide

In Clallam County, there were 25.7 suicides per 100,000 population (2016-2020 annual average age-adjusted rate).

BENCHMARK ► Much higher than the Washington rate, and nearly double the national suicide rate. Fails to satisfy the Healthy People 2030 objective.

Suicide: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

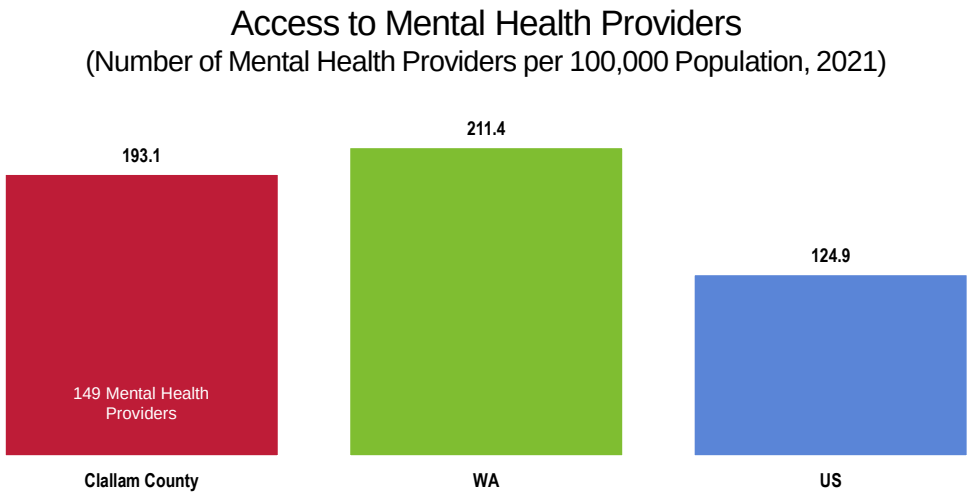
Mental Health Treatment

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in Clallam County and residents in Clallam County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In Clallam County in 2021, there were 193.1 mental health providers for every 100,000 population.

BENCHMARK ► Higher than the US finding.



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

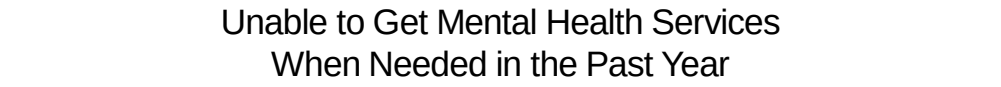
Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

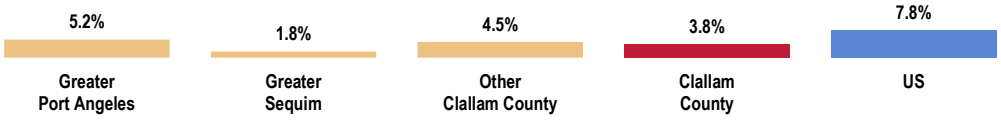
Difficulty Accessing Mental Health Services

A total of 3.8% of Clallam County adults report a time in the past year when they needed mental health services but were not able to get them.

BENCHMARK ► Favorably lower than the national percentage.

DISPARITY ► Difficulty accessing mental health services decreases with age (negative correlation). Appears to be higher in communities of color.

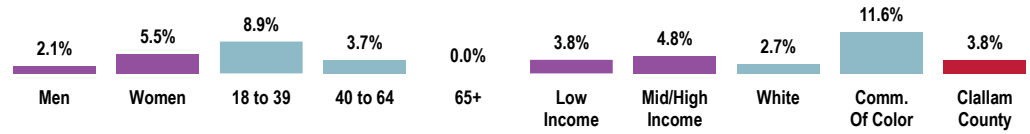




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 309]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(Clallam County, 2022)

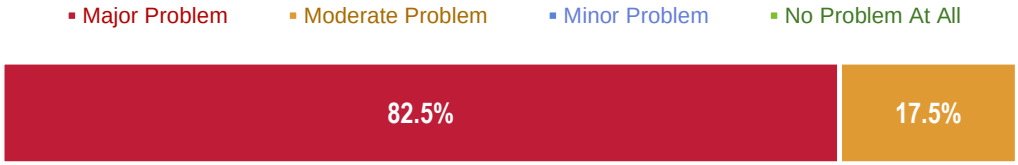


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

Most key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.

Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2022)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> In the last 3 years we have experienced a significant rise in the need for our services for behavior/mental health problems. Again, the absence of mental health resources especially for those without insurance/funds to pay for private care end up falling on local Law enforcement and Fire/EMS services to fill the gap. Neither discipline is intended to provide these services and they are not trained or staffed to deal with mental health calls. This is becoming and ever-increasing problem that is and will impact these agencies' ability to deliver service within their mission. Many of the patients cross over to the substance abuse category as well as they self-medicate. – Other Health Provider
>
> Depression, Isolation, Suicidal thoughts and actions, drug induced fog, anger management issues, a falling away from the churches as sources of hope. Lack of hope, friends, and exercise. Secondary effects of being mentally ill involve being able to keep a job, housing, and food security. – Community Leader

> The ability to provide appropriate care for individuals with co-diagnoses of IDD. In addition, insufficient providers of mental health providers to neurotypical individuals and long wait times for entry to care. – Social Services Provider
>
> People are not getting the help they need, and the support infrastructure is not there. The general public needs to be educated that this problem affects all of us, not just those with the mental health issue. – Community Leader
>
> System doesn't work. PBH not addressing mental health crisis management, not enough mental health providers. – Social Services Provider
>
> Exacerbation of condition as a result of drug/alcohol abuse. Lack of community treatment options. Lack of inpatient treatment options. Lack of adequately trained personnel to care for patients with mental health. Lack of continuity of care for mental health patients. Lack of standardization for the care of patients with mental health. Lack of psychiatry services on the Peninsula. Lack of "crisis stabilization" centers on the peninsula. – Other Health Provider
>
> In many communities, jails are the biggest mental health facilities and that is probably true here too. Wages are too low to attract and keep staff. OMC no longer has a psych unit. It needs to have one for acute care needs; patients are needlessly cared for in other counties instead of here. At the primary care level, acceptance of mental health problems as OK to get help with is a major problem. The stigma is severe, also getting help is a struggle when you are not coping; it is an oxymoron to think challenged people can reach out for needed help. – Community Leader
>
> Mental Health needs have soared since the beginning of the pandemic. We are seeing increased anxiety, depression, and difficulty managing stress overall. Lack of available and affordable housing exacerbates this. Further the expansion of BH into primary care to get "upstream" has largely served to exacerbate an already substantive workforce shortage issue. The reality is the majority of people being caught "upstream" would not have ended up in the community behavioral health system. – Other Health Provider
>
> Stigma, not enough psychiatrists or behavioral health specialists, difficulty for cross-organizational communication/collaboration (need digital HIPAA compliant communication tool that is EMR-agnostic), enough that many patients who need their services refuse to go there – Community Leader

Access to Care/Services

> Not enough therapists to see patients and lack of inpatient facility for mental health. Widespread substance use contributes to worse mental health. Housing prices are too high so there is more housing insecurity. – Physician
>
> Long wait times for the uninsured or underinsured and the inadequate number of providers. – Other Health Provider
>
> Significant gaps in the care system. No good site for mental illness. – Other Health Provider
>
> Access to effective care. – Community Leader
>
> We have no gerontological psych, care options on the Peninsula at all, and those in crisis are put on long wait lists. – Community Leader
>
> Difficulty accessing services, barriers to entry, no right door, community mental health center places quotas on numbers of patients, no access to autism or eating disorder treatment. – Physician
>
> There is limited access to mental health resources and long waits for youth services. – Social Services Provider
>
> Access to care. – Physician
>
> Lack of resources. – Physician
>
> Access to care. – Other Health Provider

Lack of Providers

> Access to mental health practitioners. People with immediate needs are unable to get help due to shortage of professionals. – Community Leader
>
> There are not enough providers or any providers that take Medicaid. I've heard there are waitlists or a voicemail saying there is no wait list and no openings. – Community Leader
>
> Lack of providers. – Community Leader
>
> Paucity of providers historically for inpatient, ER and ambulatory setting. – Physician

Denial/Stigma

> There is a stigma associated with mental health. They are inadequate for our community. There are too few providers of mental health services. – Other Health Provider
>
> Admitting to needing help. – Community Leader
>
> Destigmatize mental health for me is the greatest need. – Social Services Provider

Diagnosis/Treatment

> Major depression and anxiety are interfering with medical are. Lack of access to newer treatments such as ketamine infusion and TMS needed for severe illness. – Physician

Follow-Up/Support

> Same as every community many are not able to follow through with treatment plans due to emotional or financial resources. – Physician

Homelessness

> Homelessness! There is not supportive housing temporary or long-term in Sequim. The only facility that was here and operated by Serenity House was torn down to build the new Civic Center on Cedar St & Sequim Ave, with no thought plan or funding of how to replace what was being removed to make way for the new building. – Community Leader

Teen/Young Adult Rates

> I am particularly concerned about youth mental health and the ability for families to access support for the increase in socio-emotional problems that children are experiencing. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Washington and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Heart Disease & Stroke Deaths

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Coronary Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

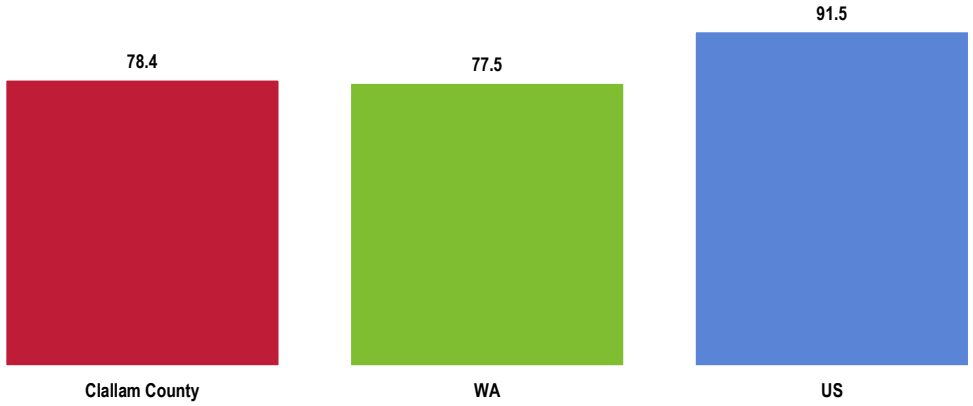
Between 2016 and 2020, there was an annual average age-adjusted coronary heart disease mortality rate of 78.4 deaths per 100,000 population in Clallam County.

BENCHMARK ► Favorably lower than the national rate. Satisfies the Healthy People 2030 objective.

Coronary Heart Disease: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 90.9 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

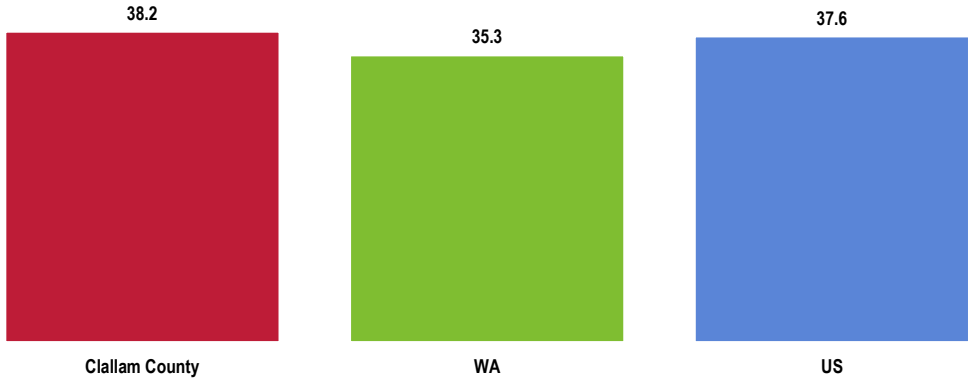
Stroke Deaths

Between 2016 and 2020, there was an annual average age-adjusted stroke mortality rate of 38.2 deaths per 100,000 population in Clallam County.

Stroke: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

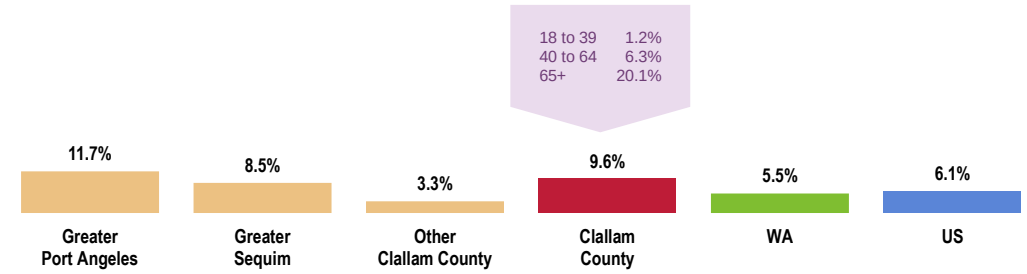
Prevalence of Heart Disease

A total of 9.6% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

BENCHMARK ► Higher than the Washington and US prevalence.

DISPARITY ► Lowest in the Other Clallam County area. Prevalence of heart disease strongly correlates with age in Clallam County.

Prevalence of Heart Disease



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

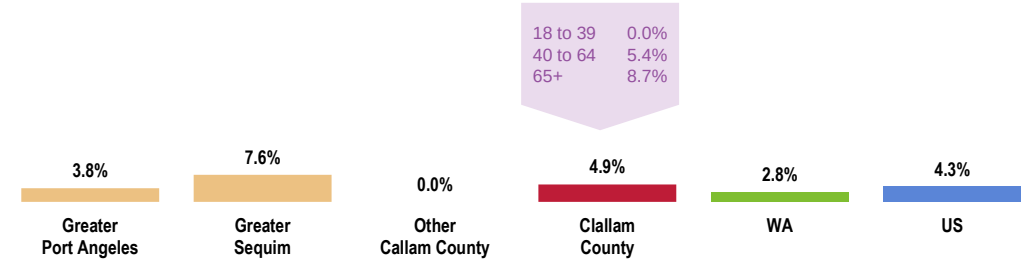
Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

A total of 4.9% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

DISPARITY ► Lowest in other the Other Clallam County area. Prevalence of stroke increases significantly with age.

Prevalence of Stroke



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 303]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

A total of 39.4% of Clallam County adults have been told by a health professional at some point that their blood pressure was high.

BENCHMARK ► Higher than the state finding. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Significantly higher in the Greater Sequim area (not shown).

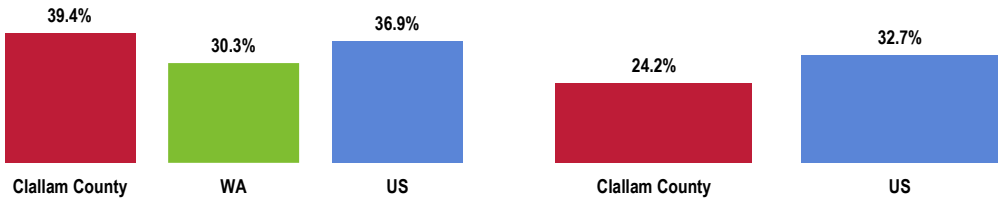
A total of 24.2% of adults have been told by a health professional that their cholesterol level was high.

BENCHMARK ► Favorably lower than the national finding.

Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower

Prevalence of High Blood Cholesterol

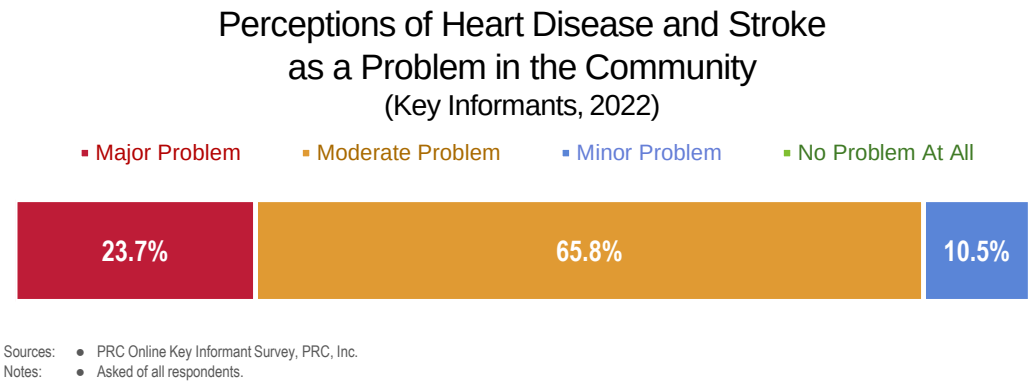


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 304-305]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Key Informant Input: Heart Disease & Stroke

Nearly two in three key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> It's a major problem in all communities. – Physician
>
> There are many 9-1-1 responses for these issues. – Other Health Provider

Access to Care/Services

> It seems that most treatments, especially surgical, are done in either Kitsap, Pierce or King County. Specialists are also not local but frequently only in the area for a day or two per month. – Community Leader
>
> Because of the severity of heart disease and stroke, and the life-threatening nature of these conditions, it is essential to have a Level 3 Trauma Center (OMC) in our community. – Other Health Provider

Lack of Providers

> Such a vital demographic and chronic illness reality. Recent very difficult and unfortunate erosion in cardiac providers. At a time when that program should be growing, not shrinking. – Physician
>
> Same answer, gerontological specialists for elders with this disease. Elders require specialty knowledge. – Community Leader

Awareness/Education

> There is no chronic disease language as part of the public health arm in the county. – Community Leader

CANCER

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

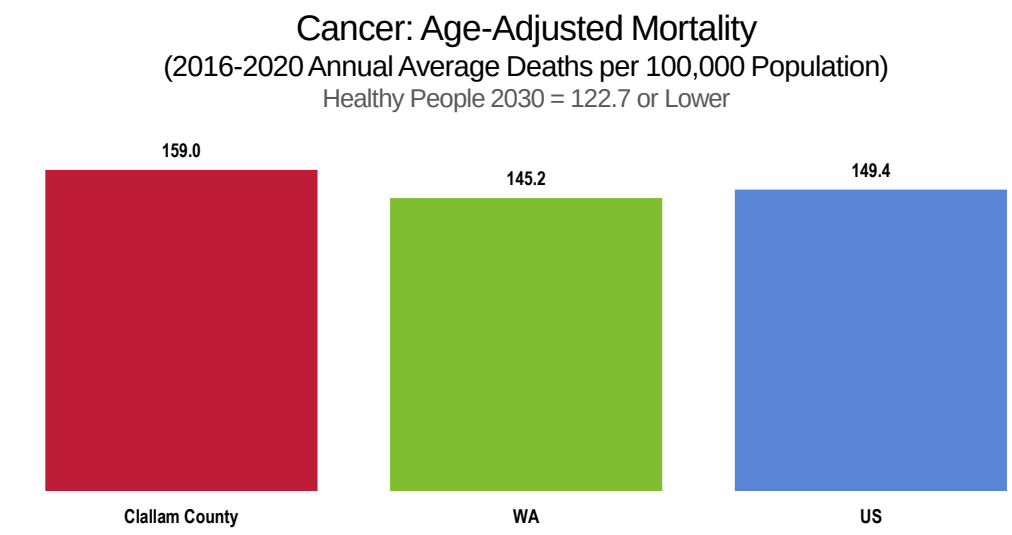
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2016 and 2020, there was an annual average age-adjusted cancer mortality rate of 159.0 deaths per 100,000 population in Clallam County.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

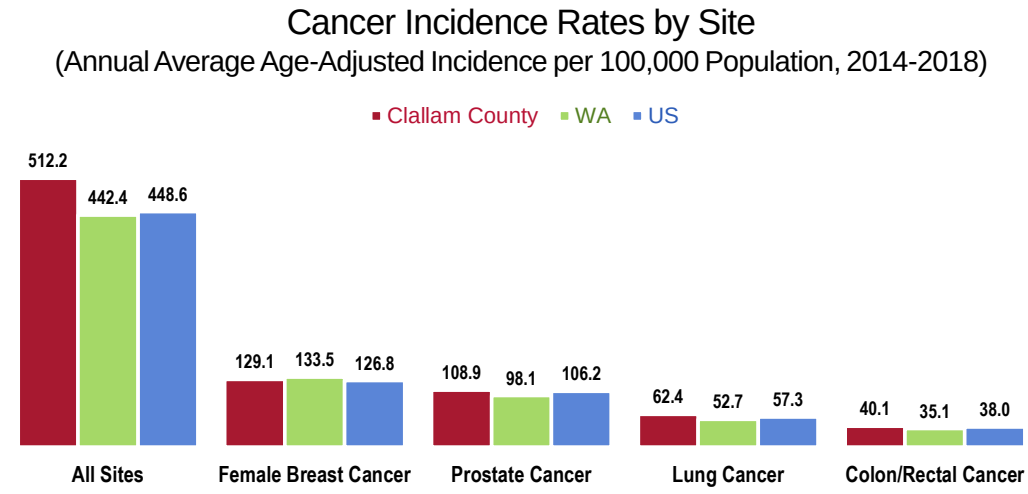
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

The highest cancer incidence rates by site are for female breast cancer and prostate cancer.

Lung Cancer ► Higher than the Washington rate.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

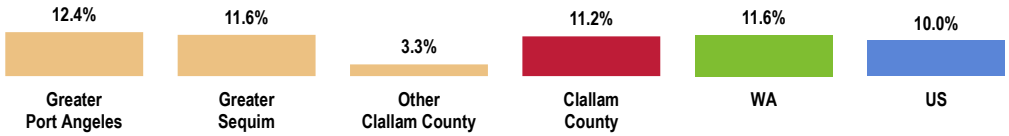
Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

A total of 11.2% of surveyed Clallam County adults report having ever been diagnosed with cancer.

DISPARITY ► Particularly low in the Other Clallam County area. Cancer prevalence increases with age and is higher among White residents.

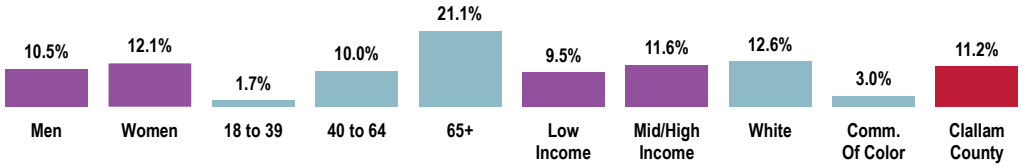
Prevalence of Cancer



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 307]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(Clallam County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 307]

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

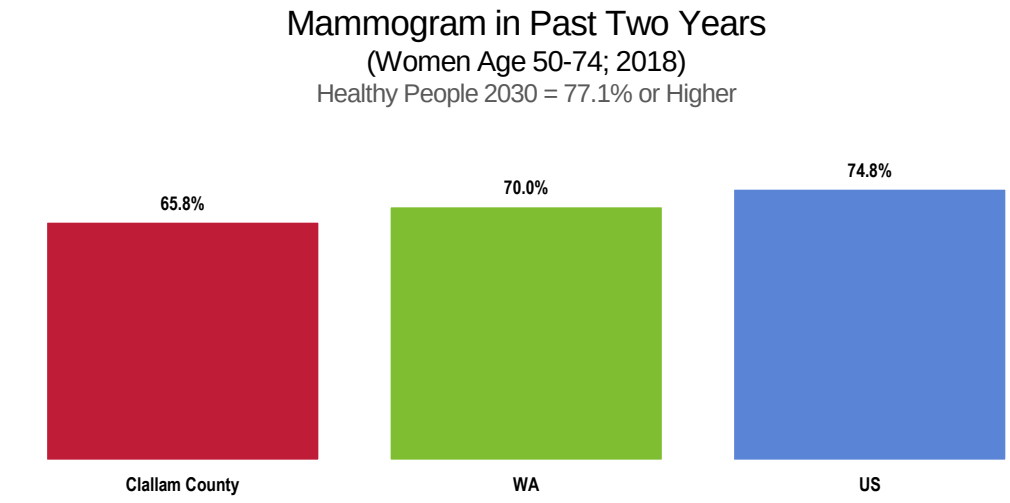
FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among women age 50-74, 65.8% have had a mammogram within the past 2 years.

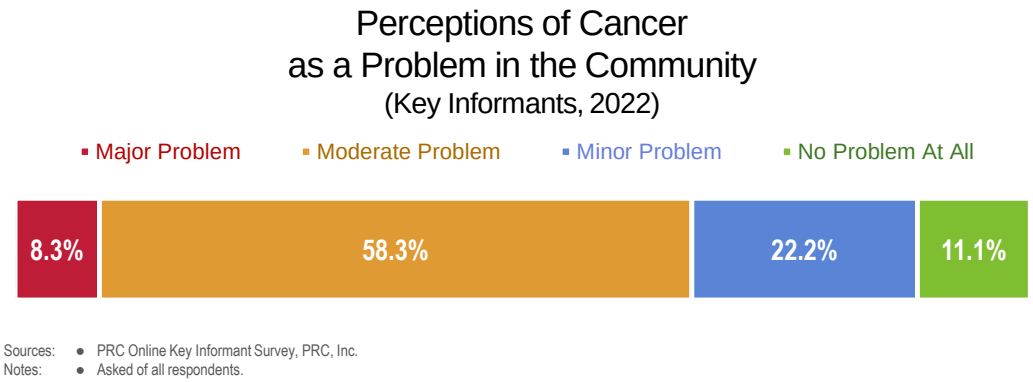


Sources:
- Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Both my son-in-law and daughter recently had cancer. For testing and care they had to go off of the Olympic Peninsula. Throat cancer, Seattle and thyroid cancer, Tacoma. – Community Leader
>
> Because of the severity of cancer and the frequency of challenging treatments, those with cancer in our community are in dire need of care and it is essential to have OMCC. – Other Health Provider

Contributing Factors

> Geography, turnover in staff, I perceive hospital administration doesn't have a handle on this. – Social Services Provider

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

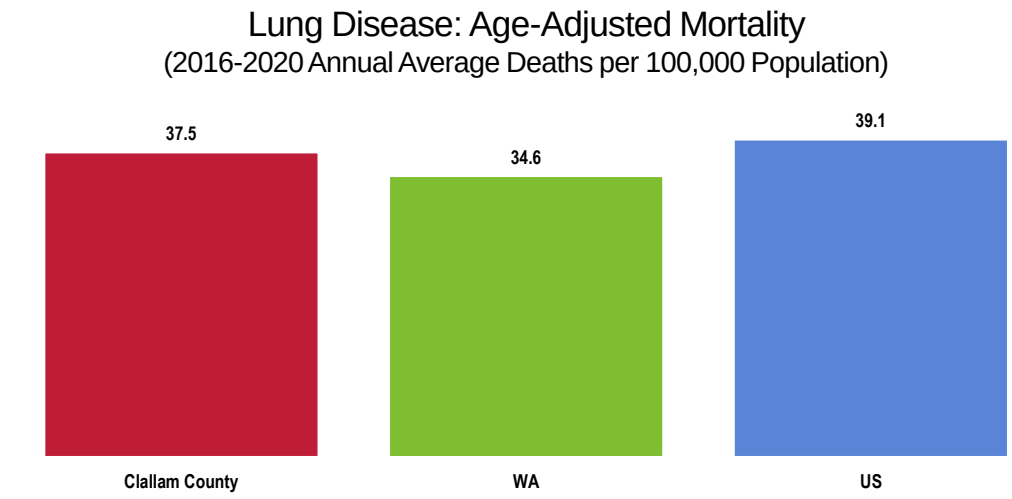
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Lung Disease Deaths

Between 2016 and 2020, the county reported an annual average age-adjusted lung disease mortality rate of 37.5 deaths per 100,000 population.

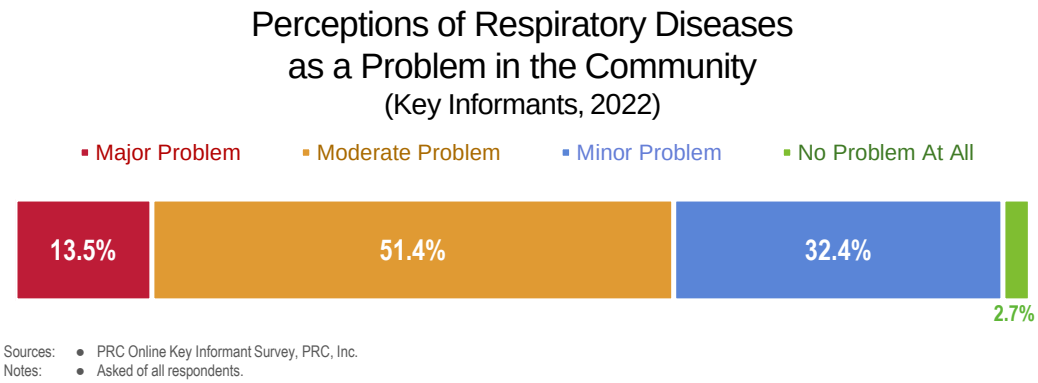


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- This indicator is relevant because lung disease is a leading cause of death in the United States.

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of resources locally. – Community Leader

Prevalence/Incidence

> Prevalence of disease in my population, including the homeless. – Social Services Provider

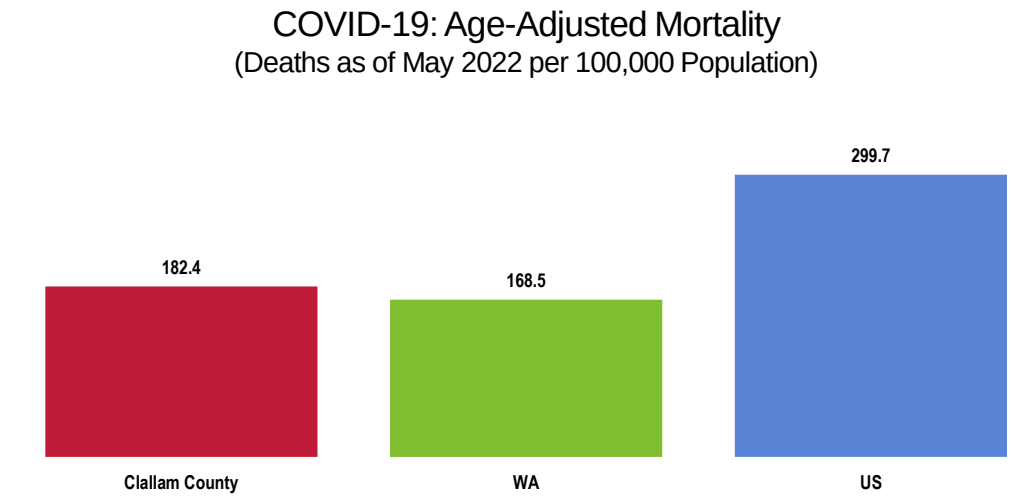
Lack of Providers

> Not enough long doctors. With COVID, the lung doctor was pulled from clinical practice to help at the hospital, leaving patients without less access to care. It is unlikely that COVID will go away and its complications will affect the respiratory system. – Community Leader

Coronavirus Disease/COVID-19 Deaths

As of May 2022, Clallam County reported an age-adjusted COVID-19 mortality rate of 182.4 deaths per 100,000 population.

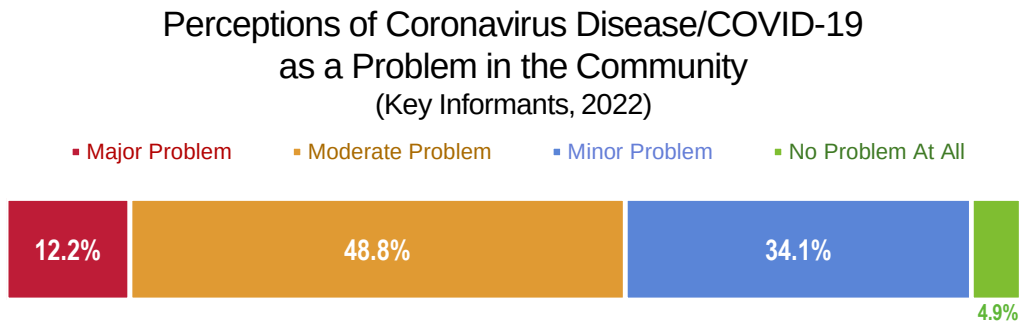
BENCHMARK ► Much lower than the national finding.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2022.

Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a "moderate problem" in the community.



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Lack of Adherence to Safety Measures

> Community members do not always follow policy and procedures concerning COVID-19. Requirements on gloves, handwashing, social distancing and vaccinations. – Other Health Provider
>
> The case numbers continue to rise, and residents are not taking it seriously. – Other Health Provider
>
> Noncompliance with advised precautions. – Physician

Not Enough People are Getting Vaccinated

> Many in the community remain unvaccinated and the numbers continue to surge and cause challenges. – Other Health Provider

Contributing Factors

> So many sick and so many reluctant to be immunized. Weird ways that people think about public health in our community. Reluctance to believe in science and attitudes and actions that are potentially violent and anti-public health. – Social Services Provider

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

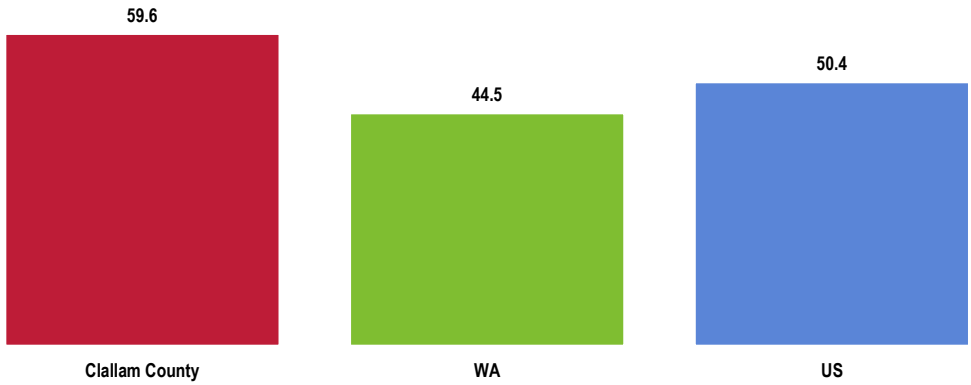
Between 2016 and 2020, there was an annual average age-adjusted unintentional injury mortality rate of 59.6 deaths per 100,000 population in Clallam County.

BENCHMARK ► Higher than the Washington and US findings. Fails to satisfy the Healthy People 2030 objective.

Unintentional Injuries: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Motor Vehicle Crash Deaths

Between 2016 and 2020, there was an annual average age-adjusted motor vehicle crash mortality rate of 12.8 deaths per 100,000 population in Clallam County.

BENCHMARK ► Higher than the state rate in particular. Fails to satisfy the Healthy People 2030 objective.

Motor Vehicle Crashes: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.1 or Lower

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- This indicator is relevant because motor vehicle crash deaths are preventable, and they are a cause of premature death.

Violent Crime

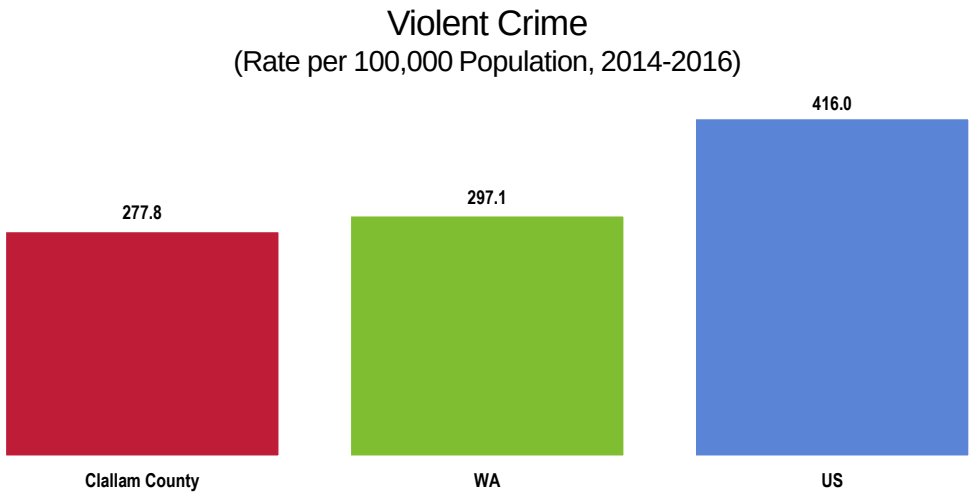
Violent Crime Rates

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Between 2014 and 2016, the county reported 277.8 violent crimes per 100,000 population.

BENCHMARK ► Well below the national rate.

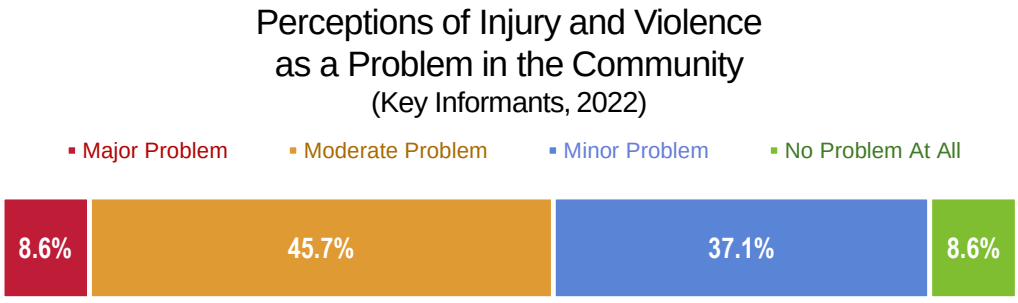


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Impact on Quality of Life

> A cause of generational trauma, poor medical advice compliance, and substance abuse. – Physician

Law Enforcement

> Lack of law enforcement and ability to enforce law. – Community Leader

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

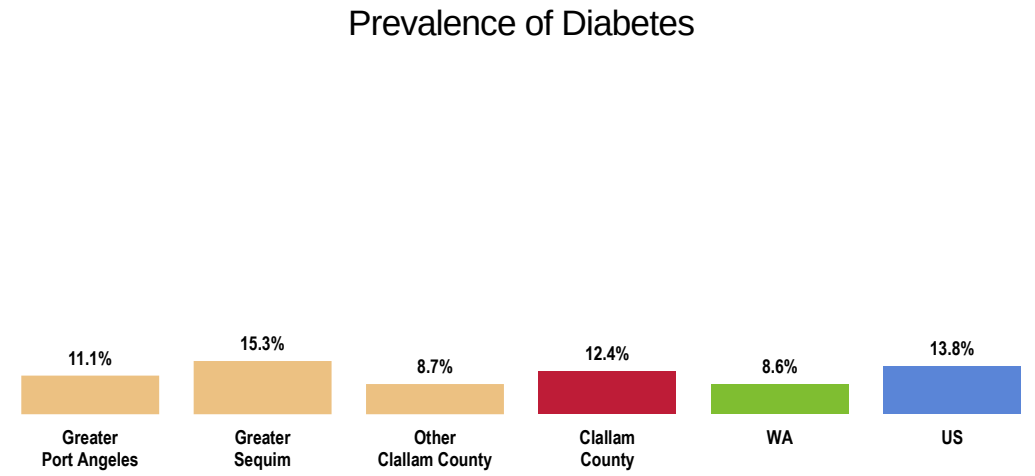
– Healthy People 2030 (https://health.gov/healthypeople)

Prevalence of Diabetes

A total of 12.4% of Clallam County adults report having been diagnosed with diabetes.

BENCHMARK ► Unfavorably higher than the state finding.

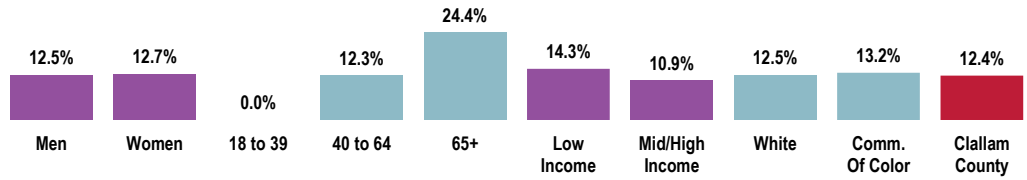
DISPARITY ► Diabetes prevalence increases with age among survey respondents.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 306]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(Clallam County, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

A high percentage of key informants taking part in an online survey characterized *Diabetes* as a "moderate problem" in the community.

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2022)

Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Lack of insurance coverage for nutritionist visits, not a "walking or biking friendly" community, healthy foods more expensive and less "convenient" and lack of insurance coverage for continuous glucose meters. – Community Leader
>
> Absolute lack of healthy information available for lifestyle change, in addition, environment is not conducive to healthy changes, i.e. restaurants offering healthier choices, worksites giving activity breaks, etc. – Other Health Provider
>
> Education and cost of living very high. – Physician
>
> Access to specific diabetes clinic, nutritionist, support groups. More education on nutrition starting in the elementary schools and continuing through middle school and high school. – Community Leader
>
> Affording healthy food. Access to Libre devices for close monitoring. – Physician

Access to Affordable Healthy Food

> Access to healthy foods and beneficial physical activity. – Community Leader
>
> Diets are bad and access to healthy foods and healthy cooking is needed in some places. – Social Services Provider
>
> Affordable access to diabetic friendly foods and support. – Social Services Provider

Access to Care/Services

> Adjunct services, especially dietary consultation. – Social Services Provider

Co-Occurrences

> Diabetes continues to grow in our region and our nation. People with mental health challenges are also more likely to be at risk of obesity and diabetes as are those who are low income. – Other Health Provider

Prevalence/Incidence

> Increasing numbers. – Other Health Provider

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

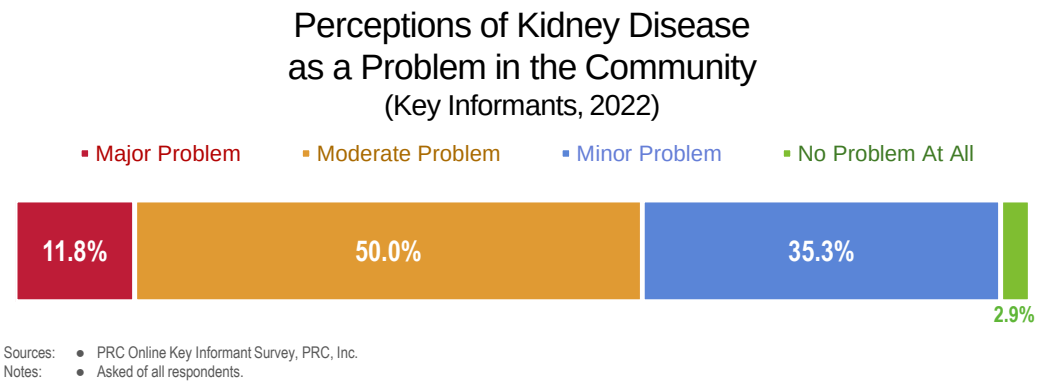
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Key Informant Input: Kidney Disease

Half of key informants taking part in an online survey characterized *Kidney Disease* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Wait lists for dialysis and other treatments seem very long. – Community Leader

Lack of Providers

> One nephrologist from Virginia Mason is the only source I know. All others have to be referred out of area. – Other Health Provider

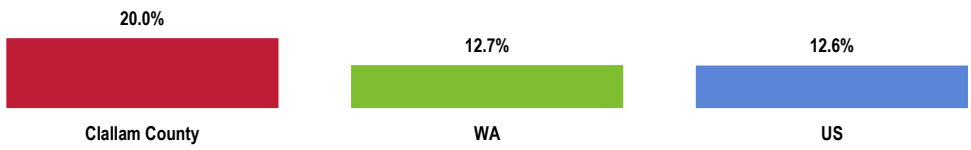
POTENTIALLY DISABLING CONDITIONS

Population With Any Disability

Of the non-institutionalized Clallam County population, a total of 20.0% of adults report having any kind of disability.

BENCHMARK ► Much higher than the Washington and US percentages.

Population With Any Disability
(Total Civilian Non-Institutionalized Population; 2015-2019)



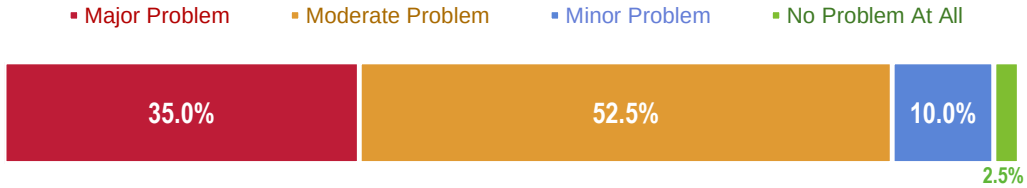
Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.

Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a "moderate problem" in the community.

Perceptions of Disability & Chronic Pain
as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

> Those with chronic pain, including one member of my immediate family, have found that it is nearly impossible to find effective pain management in Clallam County. Providers are so reluctant to prescribe medication that it seems the "pendulum has swung too far" with regard to prescriptions of pain management medications. – Other Health Provider
>
> One of the highest opioid prescribing in the state in the past. Lack of services. This has improved dramatically in the last few years but still significant. Should be helped by the MAT in Sequim. – Physician
>
> No chronic pain clinics locally. – Social Services Provider
>
> No chronic pain clinics in our area, people must travel across the water. – Community Leader

Contributing Factors

> We appear to have a large cohort of individuals who are disabled and or struggle with chronic pain. This was highlighted several years ago when we really started looking closely at opioid prescribing habits. Clallam County was through the roof. There has been a lot of headway made in terms of opioid prescribing. However, those with Medicare due to disability often cannot access the care they need due to limited provider access, copays, etc. – Other Health Provider
>
> Because of the number of patients I see that struggle with chronic pain, their focus on medications/drugs/procedures to "fix" them, the prevalent feeling that getting disability is fairly easy to do and is "hitting the jackpot", and the negative effect they have on a person's ability to be a productive member of society. – Community Leader
>
> Providers are not willing to take these clients. Many do not have great health insurance. I do not feel that they are treated with respect and understanding. – Other Health Provider
>
> Poor access to primary care and need for universal system of paying for health insurance both contribute to excess disability and pain. – Community Leader

Diagnosis/Treatment

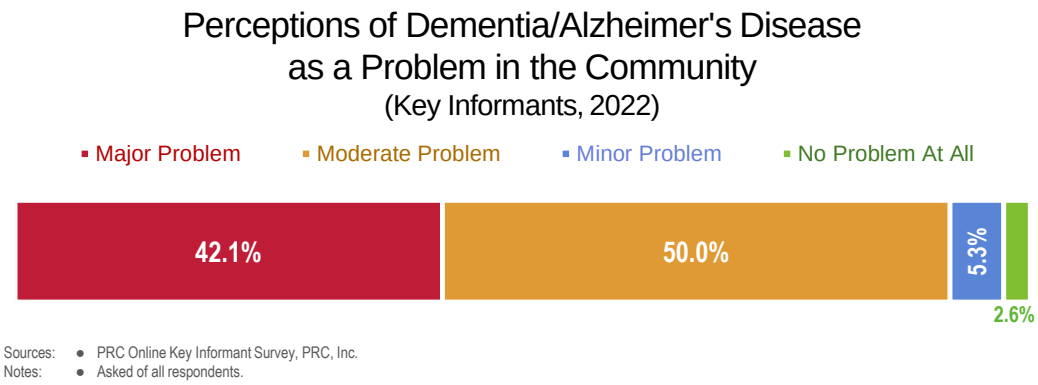
> Many providers from previous years gave pain medications inappropriately causing unrealistic expectations with the current population. – Physician
>
> Local providers have little to no training to work effectively with individuals with IDD. The type of care needed for someone who is neurodiverse requires significant time expenditure to truly root out medical issues and concerns and requires the co-engagement of family and care providers. Some providers err on the side of relying completely on care provider/family input without actually listening to the needs of the actual client. Some providers err in the opposite direction - not putting any value on the input from care providers/family members but relying exclusively on individual patients who may articulate false or confusing information. – Social Services Provider

Work Related

> Community of forestry and fishery professionals at high risk for injury and need for CPM. Resources for pain management are limited, CPM clinics, interventional procedures. – Physician

Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementia/ Alzheimer's Disease* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> We have read that it affects 50% of the population 85 and over, to one degree or another. It is incurable. There are very little preventative steps that are publicly mentioned or available. It can affect people as young as in their 50s. It robs the person of who they are and is a long slow death and fading away. We have had panel discussions about this at our senior center, Shipley Center. Government started some initiatives on this and we appreciate that, but need an update on what is being done. – Community Leader
>
> Every vector in this regard is going the wrong direction: incidence and percent of population over age 80 is the most rapidly growing cohort. Clallam County has a shortage of medical providers; (I have lived here for 5 years and have only had PAs and NPs as my primary physician;) specialty care appointments are a very long wait everywhere. There are only one or two Adult Family Homes in the County and the infrastructure to get them created is lacking. People move here to retire and have no family support compared to other areas and thus need more care because family is not around. – Community Leader
>
> Not a problem per-say, but per-capita for a community of our size the amount of people here with this diagnosis is a lot. There are many facilities (assisted living/dementia care/nursing homes) that offer care, the problem is housing for the care providers. There is NO affordable housing for our workforce that supports these businesses to live in, rental, home ownership, etc. – Community Leader
>
> We have a large older population of patients; many families are very stretched by trying to care for their family who has dementia. There are limited memory care options and caregiver options available locally. We do not have sufficient specialists to help with diagnosis and management (only 1 neurologist) – Physician
>
> Our organization sees a lot of people who are suffering from dementia/Alzheimer's disease. Anecdotally it appears the number of people we are seeing is rising. There are continual instances of these people having no local support network which leads to local emergency services filling the gap for non-emergency needs and navigation through the social services web. – Other Health Provider

Access to Care/Services

> There are not enough gerontological specialists (is there more than one?) in the area to help patients and their families navigate the disease, and there are not enough facilities specializing in dementia care with an option for low income or impoverished patients. – Community Leader
>
> No geropsychiatry facilities. – Physician
>
> Lack of placement options, takes up existing hospital beds. – Social Services Provider
>
> Large numbers of patients with dementia unable to remain in their homes, and no smooth transition to care facilities. End up poorly cared for in acute care beds that should be used for other purposes. – Physician
>
> There are insufficient memory care facilities in the local community. The care provided by local supported nursing facilities and senior living homes has had poor reports from family members of those within the facilities, especially for patients who experience dementia. – Social Services Provider

Aging Population

> Growing baby boomer population and need for more neurology and gyro psych care and consultative support to all other providers, particularly primary care. – Physician
>
> Sequim is a large retirement community. The caregiver for patients with dementia is often also elderly and frail. They can't provide the care required and in home resources are limited and expensive. – Physician

Diagnosis/Treatment

> Difficult to treat, renders many patients unable to care for themselves. – Other Health Provider

BIRTHS

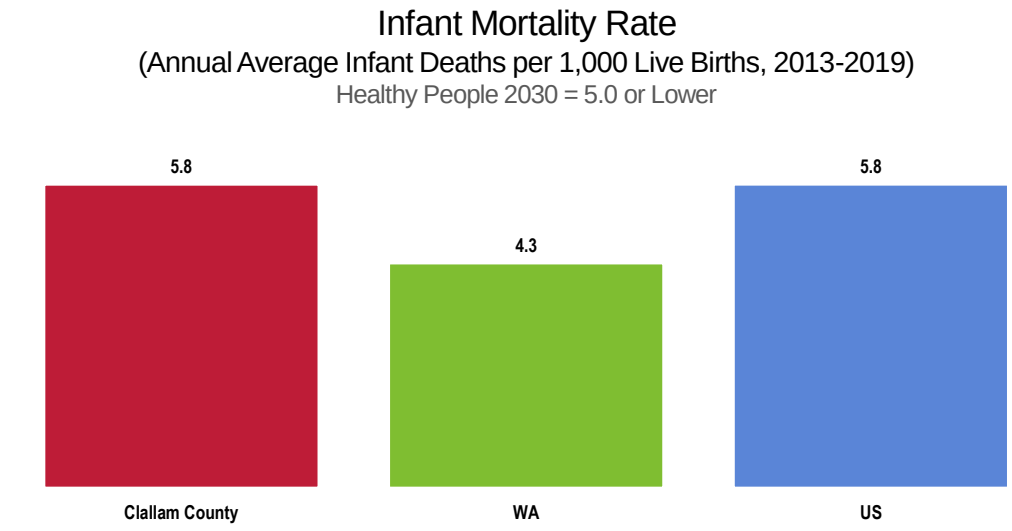
BIRTH OUTCOMES & RISKS

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2013 and 2019, there was an annual average of 5.8 infant deaths per 1,000 live births.

BENCHMARK ► Worse than the statewide infant mortality rate.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

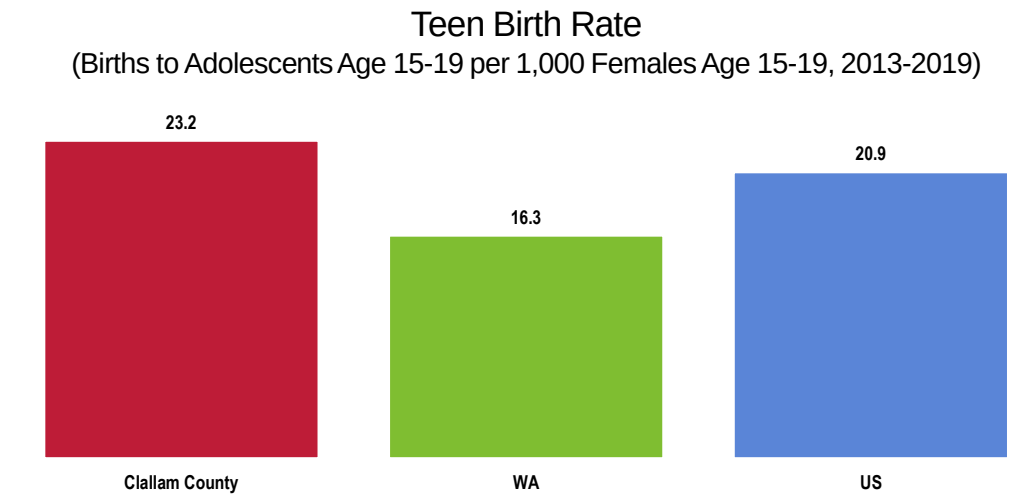
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2013 and 2019, there were 23.2 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in Clallam County.

BENCHMARK ► Well above the Washington rate.

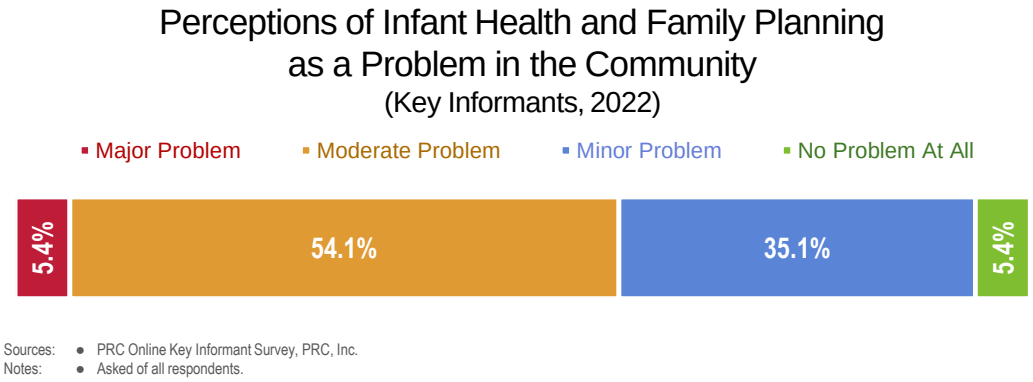


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a "moderate problem" in the community.



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> I have heard that infant mortality rates are very high. And that there is a need to incentivize the seeing of doctors for pre-natal care so that mothers will go. – Community Leader
>
> The Robert Wood Johnson foundation's County Health Assessment for counties across the state shows our infant mortality ratings with only two other counties higher than us. Also, lack of access to care precludes early prenatal visits. – Other Health Provider

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

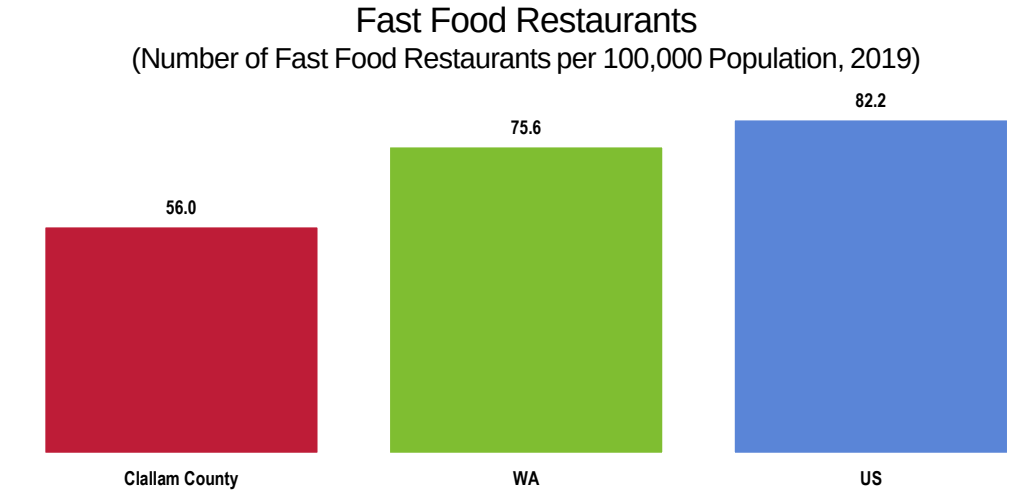
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Fast Food Restaurants

As of 2019, there were 56.0 fast food restaurants per 100,000 residents in Clallam County.

BENCHMARK ► Lower than both the state and national findings.



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

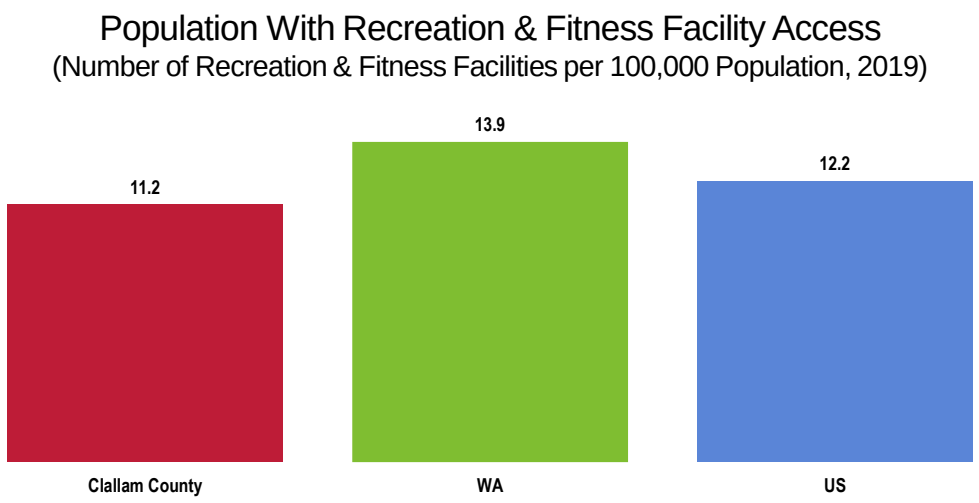
Access to Physical Activity

In 2019, there were 11.2 recreation/fitness facilities for every 100,000 population in Clallam County.

BENCHMARK ▶ Lower than the state finding.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

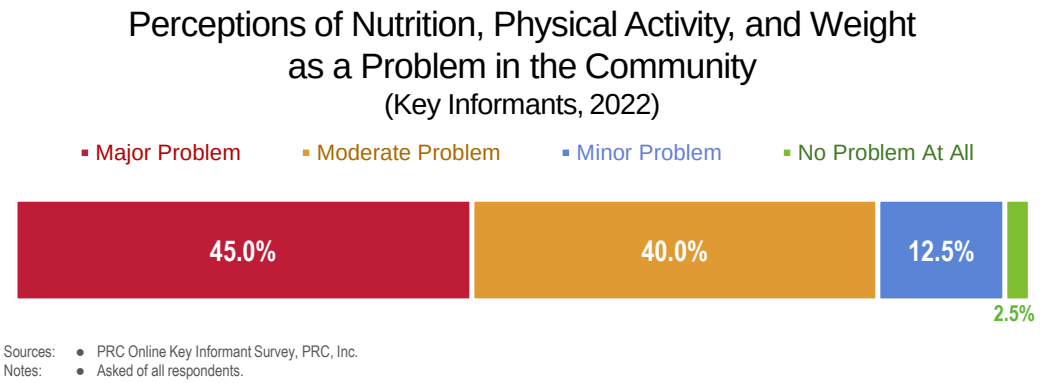


Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Key Informant Input:
Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Limited availability and staffing OMC dietary. – Physician
>
> Clallam County is in need of more wellness programs, and it is essential that our providers embrace lifestyle medicine to prevent chronic disease. We need to go from treating ill patients to supporting wellness. – Other Health Provider
>
> Insufficient options for people who experience IDD. Barriers to service include environmental (lack of ramps), social (stigmatizing individuals who are not neurotypical), physical (various levels of ability) and economic (many with IDD are at or below poverty levels of income). – Social Services Provider
>
> Not enough resources. – Community Leader

Contributing Factors

> Access and affordability of healthy calories. Need for pool exercise, but not affordable. – Physician
>
> We have a lot of low-income individuals who have a lack of education about nutrition. The foodbanks receive cakes and cookies oh my! Then they pass these on to those in poverty exacerbating their health issues. We are an area that encourages outdoor activities but if you have transportation issues your options are limited. Obesity continues to be a primary health issue throughout the nation. Dietary consultation is difficult to come by in our county. – Other Health Provider
>
> Healthy food is more expensive and less convenient than unhealthy food, stress levels high (leads to weight gain, poor eating choices, less exercise), rural area that isn't "bike" or "walk" friendly for daily activities (going to school, work, grocery store, etc.), insurance doesn't cover treatment (nutritionist, medications, surgery, etc.) for a diagnosis of obesity – Community Leader
>
> Depression, access to nutritious food and finances. – Social Services Provider

Access to Affordable Healthy Food

> Affordable access to healthy, nutritious foods is the greatest challenge. – Social Services Provider
>
> For some, access to healthy food choices. – Other Health Provider

Lifestyles

> People eat poorly as there is a plethora of bad food options available and not many good ones. People do not get out to exercise as much as they could in a hugely nature-oriented area. – Community Leader
>
> On the surface it seems our community is growing in unhealthy ways. – Other Health Provider

Access for Medicare/Medicaid Patients

> Need a program that can be accessed by Medicaid and Medicare patients. – Social Services Provider

Due to Covid-19

> COVID. – Community Leader

Lack of Providers

> I do not know of a single weight lost specialist, mental health support provider or nutritionist who is available for people with chronic obesity. – Community Leader

Obesity

> Obesity is not recognized as a problem in the community. It seems to be considered "acceptable" to be morbidly obese. – Physician

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol Use

Binge Drinking

- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

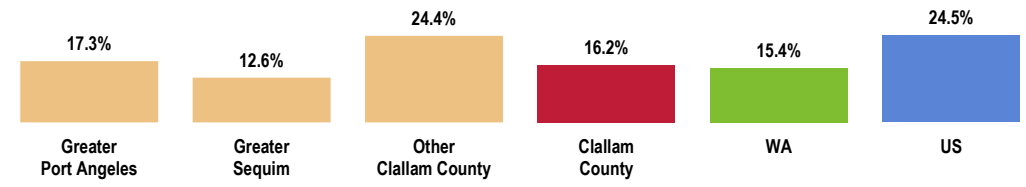
A total of 16.2% of area adults are binge drinkers.

BENCHMARK ► Significantly lower than the national percentage.

DISPARITY ► Binge drinking decreases with age and increases with income.

Binge Drinkers

Healthy People 2030 = 25.4% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 313]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Binge drinking reflects the number of persons aged 18 years and over who drank 5 or more drinks on a single occasion (for men) or 4 or more drinks on a single occasion (for women) during the past 30 days.

Binge Drinkers
(Clallam County, 2022)
Healthy People 2030 = 25.4% or Lower

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 313]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov [Objective SA-15]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

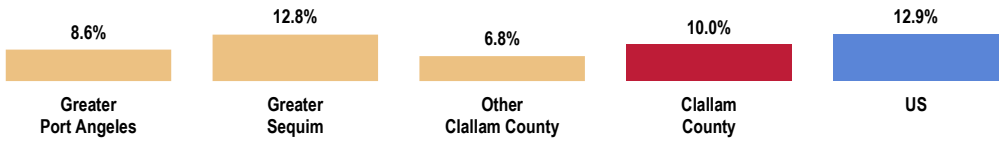
Notes:
- Asked of all respondents.
- Binge drinking reflects the number of persons aged 18 years and over who drank 5 or more drinks on a single occasion (for men) or 4 or more drinks on a single occasion (for women) during the past 30 days.

Use of Prescription Opioids

A total of 10.0% of Clallam County residents report using a prescription opioid drug in the past year.

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

Used a Prescription Opioid in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 314]
- 2020 PRC National Health Survey, PRC, Inc.

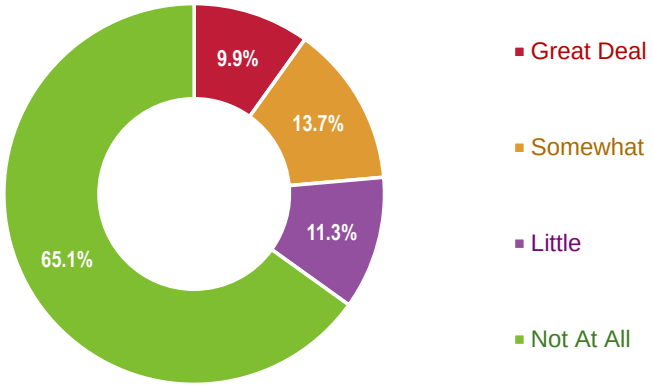
Notes:
- Asked of all respondents.

Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

Most Clallam County residents' lives have <u>not</u> been negatively affected by substance abuse (either their own or someone else's).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)
(Clallam County, 2022)

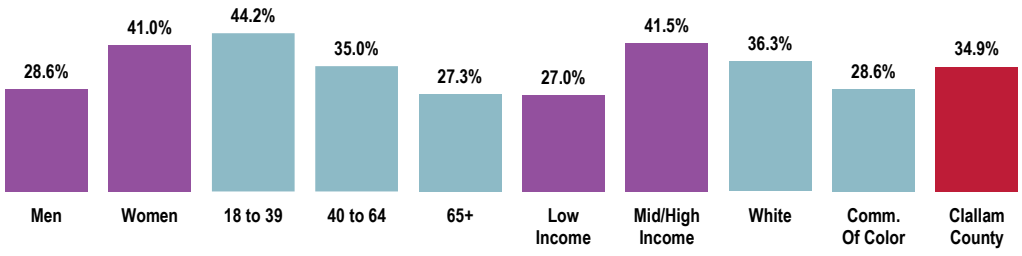


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 315]
Notes: ● Asked of all respondents.

However, 34.9% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

DISPARITY ► Lowest in the Greater Sequim area (not shown). The personal impact from substance abuse appears to decrease with age; women and mid-to-high-income residents <u>more</u> often report that their life has been negatively affected by substance abuse.

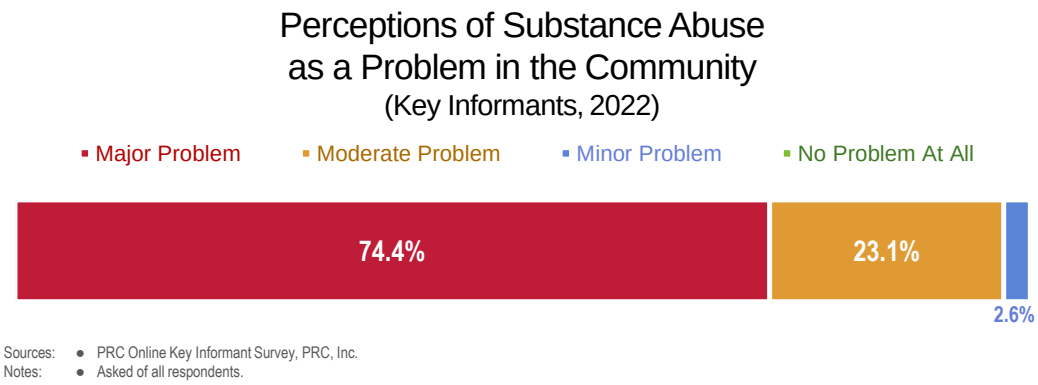
Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(Clallam County, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 315]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

Nearly three in four key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Multiple Factors

> Clallam County is in need of more substance abuse treatment for those with disorders. The homelessness and lack of affordable housing exacerbate the problem. The ED needs to be more compassionate in its treatment of substance abuse and mental health patients; trauma informed care training and implementation is needed. – Other Health Provider
>
> Stigma, difficulty working, time consuming treatment programs into life, barriers to effective/efficient communication between treatment providers due to things like CFR42part 2 or digital communication difficulties. – Community Leader
>
> We have had a strong focus on the opioid epidemic due to the high risk of death... largely associate with fentanyl. That said, we see even more individuals with alcohol and methamphetamine problems. SUD issues plague our community resulting in increased crime and diminished quality of life. We have seen reduced numbers of individuals seeking treatment since the Blake decision. – Other Health Provider
>
> Need inpatient detox facility. Patients recognizing their need for treatment. Too many marijuana shops. – Physician
>
> Community opinion, though the MAT clinic in Sequim will be a great addition to the local options. – Community Leader
>
> Stigma, transportation and risk of loss of employment. – Physician
>
> Lack of an effective system to guide patients in obtaining treatment, is labor intensive. Involves a lot of hand holding. The legal system is lacking, need an easier path to involuntary commitment, hopefully mental health court will help when in place. – Social Services Provider
>
> The greatest barrier is patients truly wanting treatment and following through. Related to this is the ease of access to illicit substances. The second greatest is for there to be access to services for patients with medical/mental health complexity. – Other Health Provider

Access to Care/Services

> Lack of resources. – Physician
>
> Lack of treatment programs. Hurdles for physicians and other providers to be able to prescribe medically assisted treatments. – Physician
>
> There is no inpatient YOUTH substance abuse treatment center on the Olympic Peninsula. Adult inpatient is lacking too. Meaning families must travel to the other side to visit family members that are seeking inpatient substance abuse. Difficult on families due to extra travel time and expense (gas) - and on the family member seeking treatment as it limits time with family and friends during recovery. – Community Leader
>
> This is about to have some help with the opening of the Healing Center. – Community Leader
>
> Not enough available space for people to enter into programs. – Social Services Provider
>
> Access to immediate treatment. – Other Health Provider

Denial/Stigma

> Stigma. – Physician
>
> The stigma associated with treatment for the disorder. – Other Health Provider
>
> The stigma associated with substance use disorder. Incentives related to treating SUD. – Community Leader

Diagnosis/Treatment

> The addicted community isn't always seeking treatment. – Community Leader
>
> It is my perception that those who wish to have SA treatment can access it. I see that problem being that there is no mechanism to compel people who have obviously severe and destructive SA problems to get treatment. – Other Health Provider
>
> Willingness of addicts to seek help. – Community Leader

Awareness/Education

> Lack of knowledge of what services are available. – Other Health Provider

Follow-Up/Support

> Patients unable to follow through with resources available. – Physician

Government/Policy

> Lack of ability to leverage help due to protective laws. – Community Leader

Homelessness

> If the person is homeless, depressed, doesn't have enough to eat, just getting to appointments or treatment can be daunting. If they have mental health issues, they may not WANT help and be stuck in their addiction. I hope the new MAT clinic will help without too much collateral damage to the community, homeless encampments in the area, etc. – Community Leader

Most Problematic Substances

Key informants (who rated this as a "major problem") identified **alcohol** as causing the most problems in the community, followed by **heroin/other opioids** and **methamphetamine/other amphetamines**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a "Major Problem")	
ALCOHOL	41.7%
HEROIN OR OTHER OPIOIDS	37.5%
METHAMPHETAMINE OR OTHER AMPHETAMINES	20.8%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

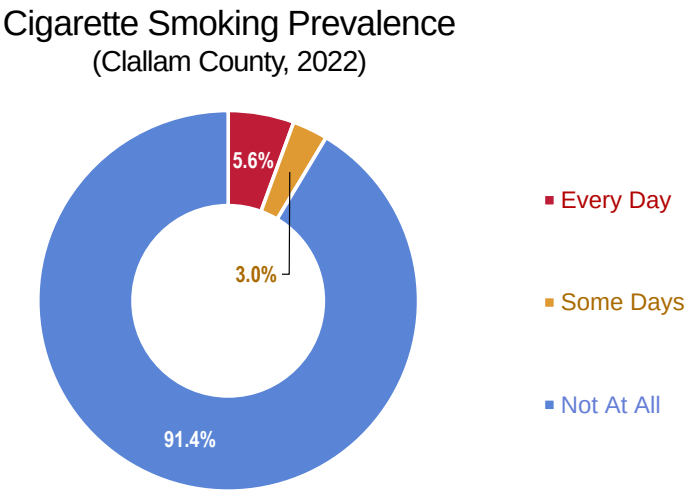
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 8.6% of Clallam County adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).

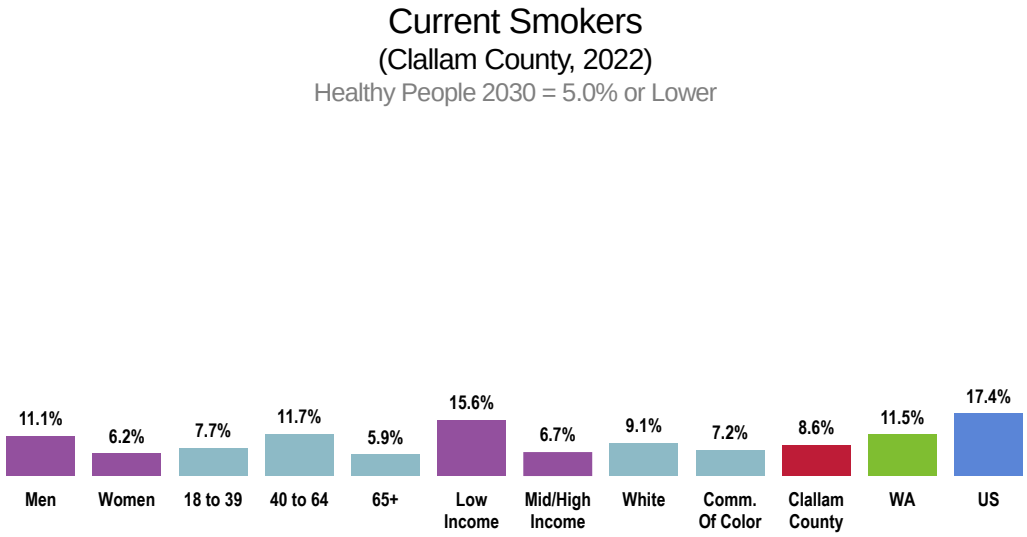


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in Clallam County.

BENCHMARK ► Lower than both the state and national percentages. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Particularly low in the Greater Sequim area (not shown).



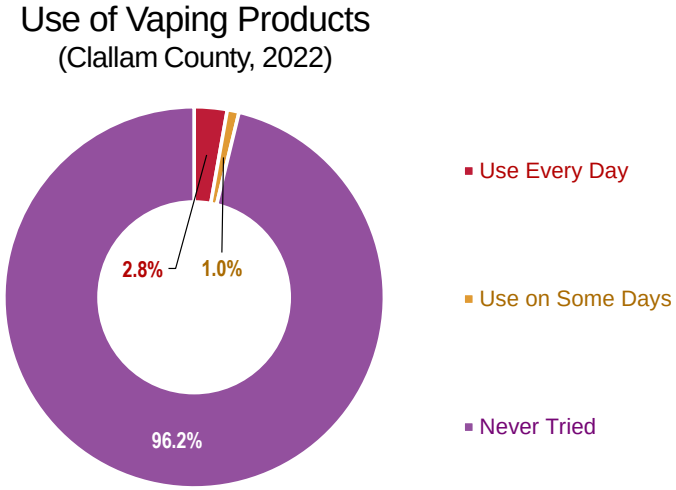
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 311]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Other Tobacco Use

Use of Vaping Products

Most Clallam County adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 312]

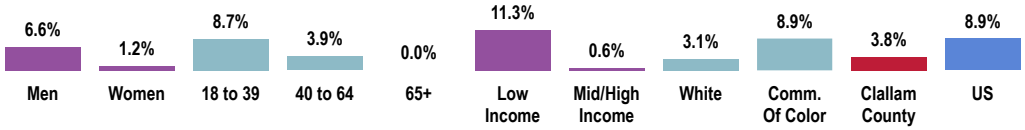
Notes:
- Asked of all respondents.

However, 3.8% currently use vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ► Much lower than the national finding.

DISPARITY ► Lowest in the Greater Sequim area (not shown). Use of vaping products decreases with age and is higher among men and lower-income residents.

Currently Use Vaping Products
(Clallam County, 2022)



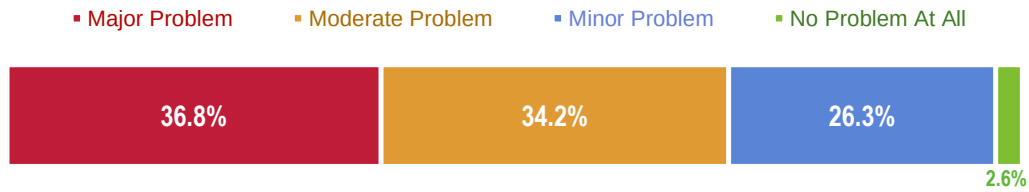
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 312]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "major problem" in the community, followed closely by "moderate problem" responses.

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

> Never been a good local shared, cohesive program. Sort of embarrassing actually. – Physician
>
> Tobacco cessation programs are needed. – Other Health Provider
>
> I do not know of any dedicated tobacco cessation programs. – Community Leader

Prevalence/Incidence

> It is a problem in every community. – Physician
>
> Read in the last county assessment that we were rated high for tobacco use. – Community Leader
>
> Incidence of disease. – Social Services Provider

Impact on Quality of Life

> Smoking leads to respiratory, heart disease, cancers, worsens wound healing, osteoporosis, it is a risk factor for so many diseases. – Physician
>
> Smoking is one of the greatest contributors to poor health throughout the lifespan. Cardiac disease and lung disease are greatly exacerbated by smoking. Tobacco use drives a significant portion of healthcare costs. Further it promotes litter. People who would never actively litter often feel it's fine to drop, stamp out and walk away from cigarette butts. Secondhand smoke poses a risk to all those around the smoker as well. – Other Health Provider

Co-Occurrences

> Causes cancer. – Community Leader
>
> Relation to CVD, lung disease and cancer. – Physician

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

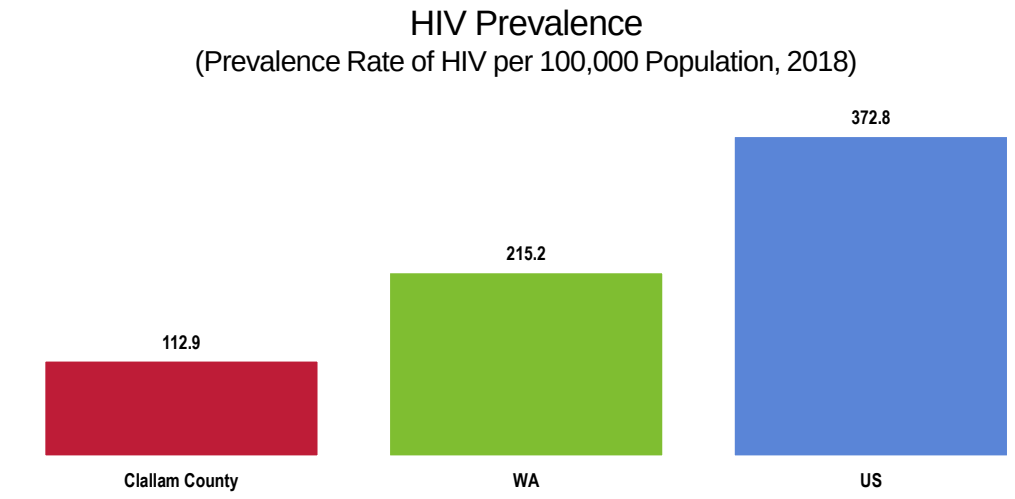
– Healthy People 2030 (https://health.gov/healthypeople)

HIV

HIV Prevalence

In 2018, there was a prevalence of 112.9 HIV cases per 100,000 population in Clallam County.

BENCHMARK ► Much lower than both the state and national rates.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

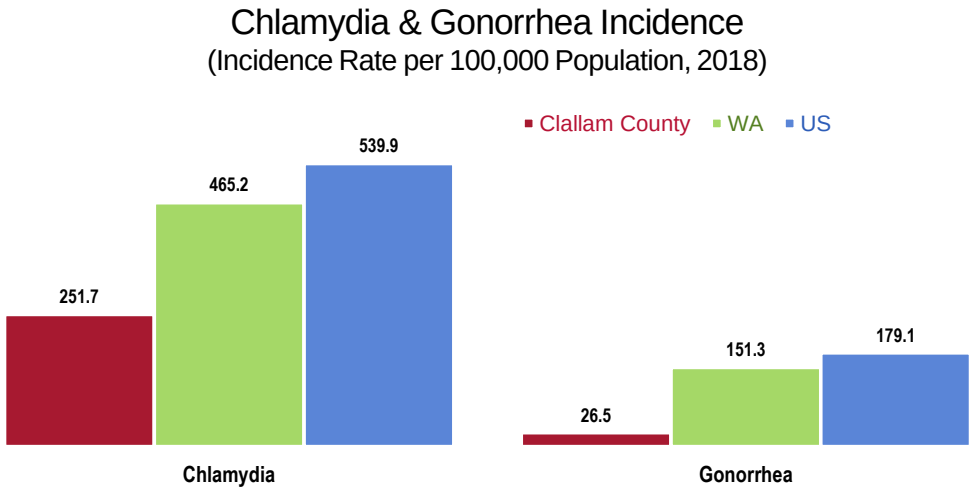
Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in Clallam County was 251.7 cases per 100,000 population.

The Clallam County gonorrhea incidence rate in 2018 was 26.5 cases per 100,000 population.

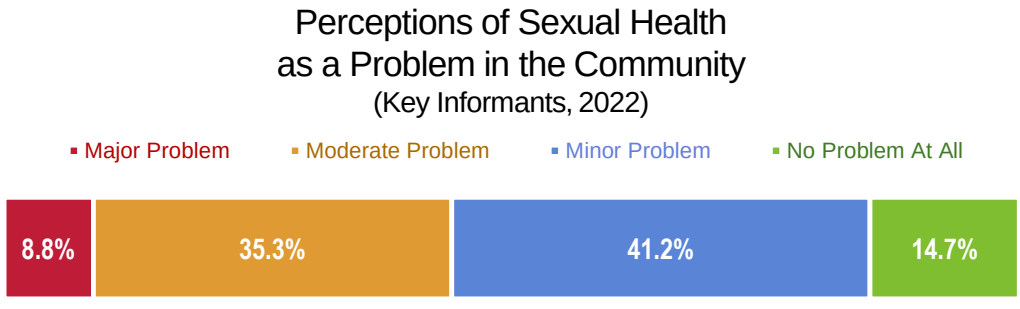
BENCHMARK ► Both chlamydia and gonorrhea rates in Clallam County are lower than the state and national rates.



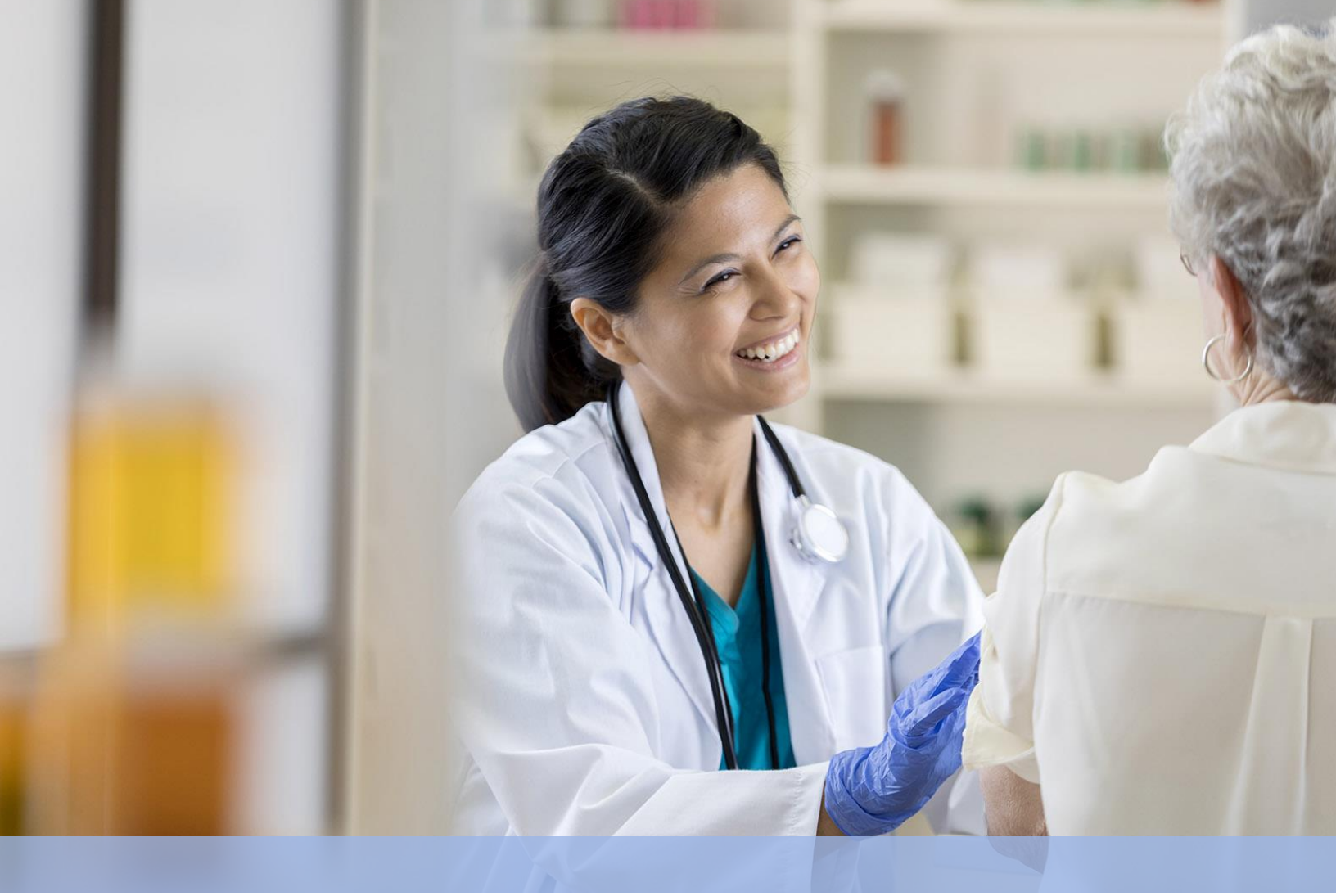
Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

A plurality of key informants taking part in an online survey characterized *Sexual Health* as a "minor problem" in the community.



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.



ACCESS TO HEALTH CARE

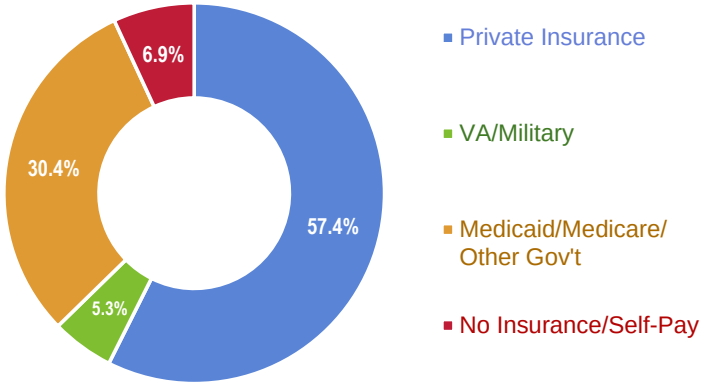
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 57.4% of Clallam County adults age 18 to 64 report having health care coverage through private insurance. Another 35.7% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults Age 18-64; Clallam County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

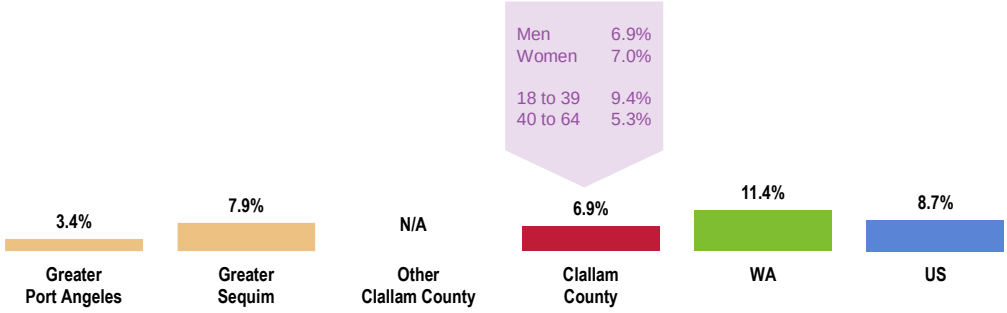
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 6.9% report having no insurance for health care expenses.

BENCHMARK ► Favorably below the Washington finding.

DISPARITY ► Significantly lower in Greater Port Angeles (insufficient data for Other Clallam County).

Lack of Health Care Insurance Coverage
(Adults Age 18-64; Clallam County, 2022)
Healthy People 2030 = 7.9% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

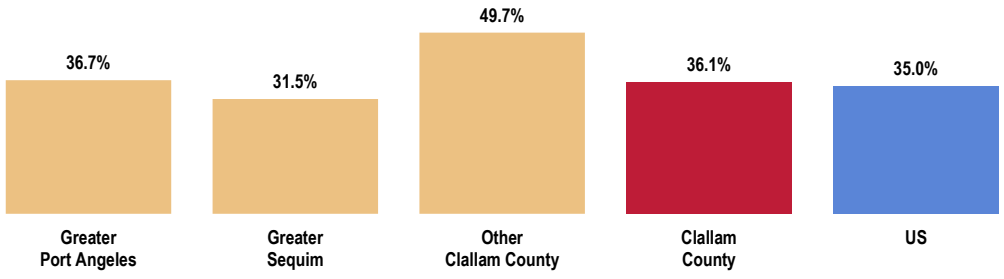
Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 36.1% of Clallam County adults report some type of difficulty or delay in obtaining health care services in the past year.

DISPARITY ► Significantly higher in the Other Clallam County area.

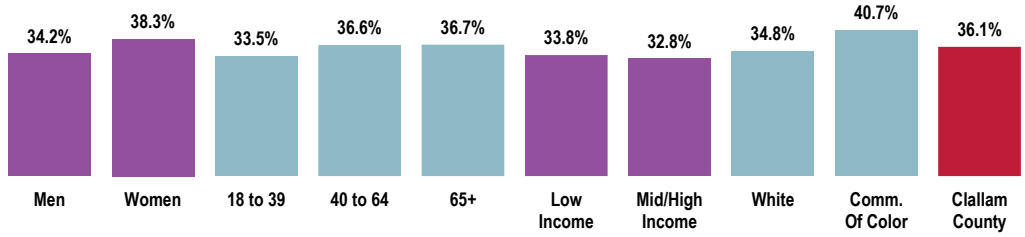
Experienced Difficulties or Delays of Some Kind in Receiving Needed Primary Health Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing primary health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Primary Health Care in the Past Year
(Clallam County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing primary health care in the past 12 months.

Barriers to Health Care Access

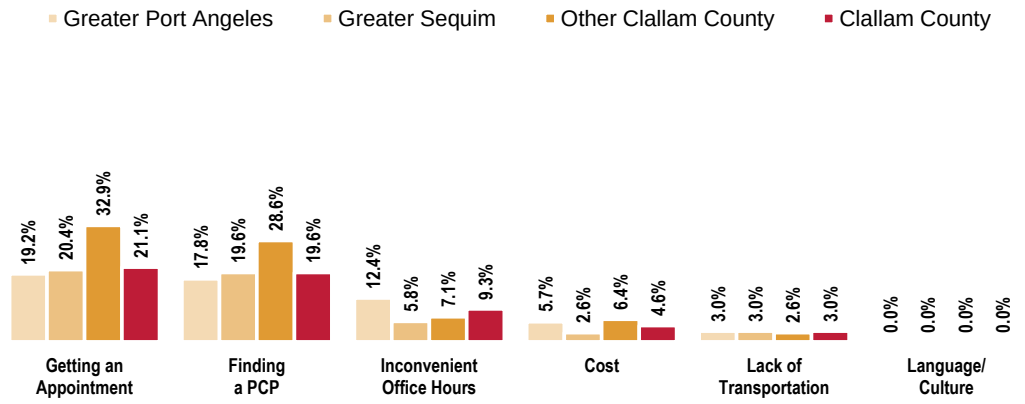
Of the tested barriers, appointment availability and difficulty finding a primary care provider impacted the greatest shares of Clallam County adults.

DISPARITY ► Residents of the Greater Port Angeles area more often reported inconvenient primary care hours as a barrier to care. Appointment availability and finding a primary care provider appear to have greater impact in the Other Clallam County area.

To better understand health care access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Primary Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 6-11]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- National data reflects the prevalence of barriers preventing medical care but does not specify primary care.

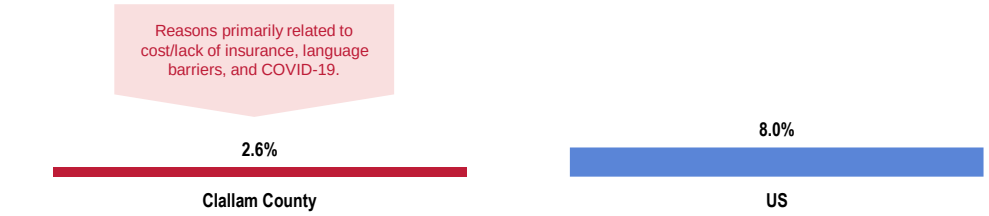
Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 2.6% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

BENCHMARK ► Well below the national percentage.

Had Trouble Obtaining Primary Medical Care for Child in the Past Year
(Parents of Children 0-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants, 2022)

Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Lack of Providers

> There aren't enough providers. There aren't enough providers that will take Medicaid. It's difficult to be connected to the services that are identified as necessary. Transportation to services is an issue as well. – Community Leader
>
> Lack of doctors taking new patients. Limited housing availability, affordable or otherwise has made bringing physicians, nurses, other health care specialist to our community a huge challenge. Also, our poor school facilities, not being able to pass a bond at the 60% super majority to build new 21st century facilities for today's learning. In addition, broadband access issues across Clallam County are another issue impact tele-doctors and other web-based health care opportunities. – Community Leader
>
> A few vital subspecialties have not been reliable or sustainable over time. Neurology and mental health, more recently cardiology. These are core to care in our community. – Physician
>
> Instability of pool of primary care providers. – Social Services Provider
>
> Uninsured or underinsured families and the limited number or primary and specialty physicians. – Other Health Provider
>
> Obtaining primary care for uninsured patients. Access to specialty care for patients who cannot travel to bigger cities, transportation, connectivity to specialist electronically due to minimal sophistication of patients. – Physician
>
> Need to be more stable primary care providers in our community. Also, we don't have enough caregivers available to provide caregiving services to the elderly in our community--many qualify for assistance with housework, shopping, cooking & personal care, but there aren't people to fill the positions. – Other Health Provider
>
> Not enough providers, specialty care access worse than primary care access, but both are an issue. – Community Leader
>
> It is hard getting appointments and finding providers that are taking patients. – Social Services Provider
>
> Lack of specialty care such as cardiology. Available specialist but a long wait for appointments like neurology. Patients may not have transportation to appointment in the area or to specialists outside of the area. – Physician
>
> Many people are on wait lists trying to get a primary doctor and the change-over in doctors is frequent in the area. – Social Services Provider
>
> Accessing primary care is very challenging in Clallam County. Primary care providers have limited panels and many are closed. Often providers are booked out and it is difficult to get an appointment. When issues are strictly limited during a visit that has taken a long time to obtain, this can be frustrating for the patient. – Other Health Provider

Access to Care/Services

> Difficulty accessing timely and appropriate mental health services. – Physician
>
> While OMC does a good job at the level of specialization it has, travel to specialty centers is difficult, involving ferry trips and/or long drives. Once we get there, we are surrounded by religious hospitals and specialty providers no matter what direction we travel. OMC has approval to establish a hospice but, until it does, CMS data shows that vastly more home health patients die in its home health agency than in any other agency in Washington. These are hospice patients without hospice. Local loyalties to an inadequate volunteer hospice are further damaging to local patient access to that needed service. Furthermore, the hospital is required by law to provide abortion services equivalent in complexity to its obstetrics services. Yet it does not provide this important aspect of primary care. Mental health care access is woefully inadequate. – Community Leader

Co-Occurrences

> Health care for individuals who have co-occurring intellectual & developmental disabilities (IDD) is a major issue across all aspects of care. Providers are not sufficiently trained to work with individuals with IDD and are reluctant to take these individuals into their care case load. The extent of time needed to care for individuals with IDD is often counter to expectations for time spent with patients, exacerbating the problem. – Social Services Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

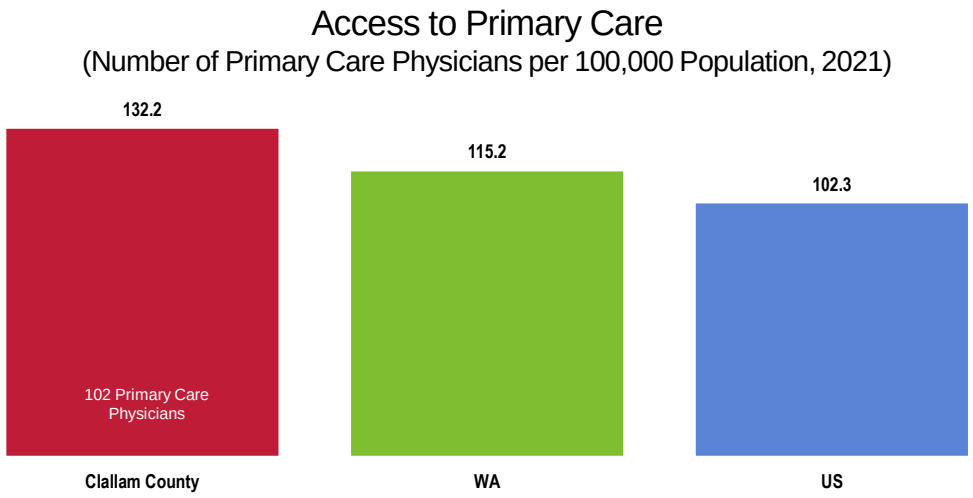
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

In 2021, there were 102 primary care physicians in Clallam County, translating to a rate of 132.2 primary care physicians per 100,000 population.

BENCHMARK ► Much better than the national ratio.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

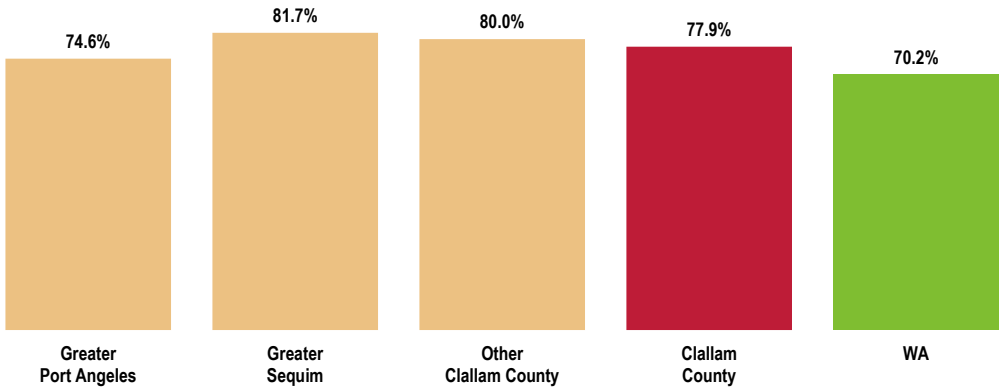
Primary Care Provider Relationships

A total of 77.9% of Clallam County adults report having a particular primary care provider (PCP) that they consider to be their own personal doctor or healthcare provider.

BENCHMARK ► Favorably higher than the state finding.

DISPARITY ► Likelihood of having a particular primary care provider improves with age.

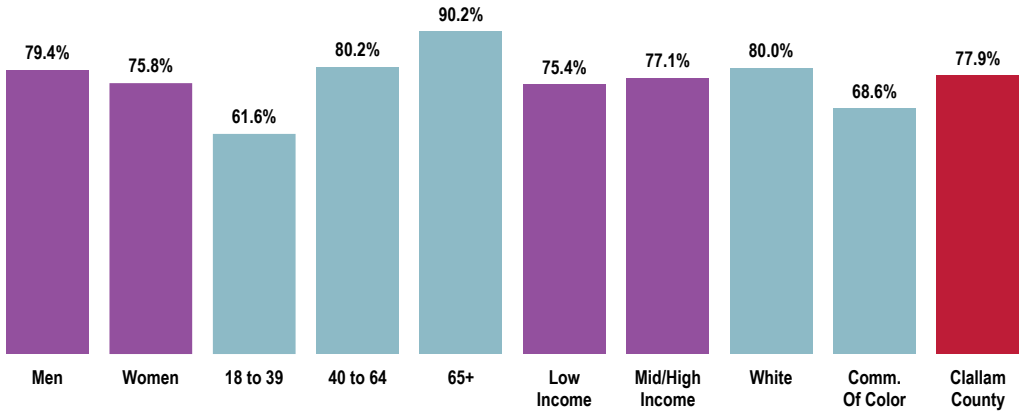
Have a Particular Primary Care Provider



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 14]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.

Notes:
- Asked of all respondents.
- In this case, "primary care" includes medical care from a family practice, general practice, or internal medicine physician, a physician assistant, or a nurse practitioner.

Have a Particular Primary Care Provider
(Clallam County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 14]

Notes:
- Asked of all respondents.
- In this case, "primary care" includes medical care from a family practice, general practice, or internal medicine physician, a physician assistant, or a nurse practitioner.

Utilization of Primary Care Services

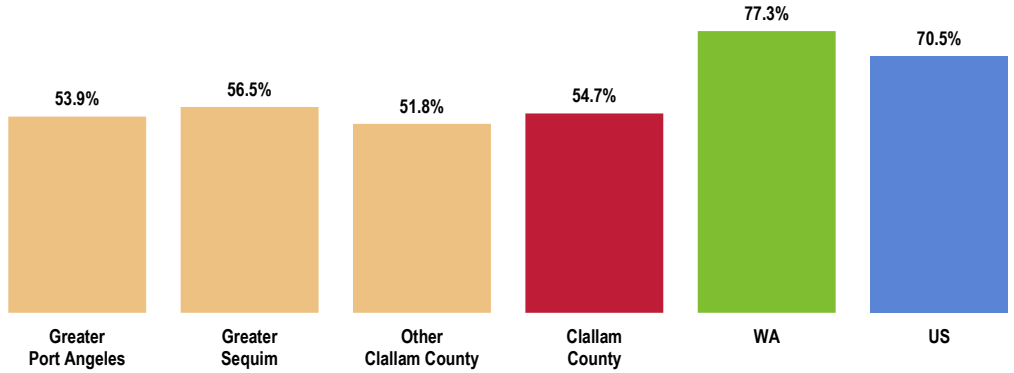
Adults

Over half of adults (54.7%) visited a physician for a routine checkup in the past year.

BENCHMARK ► Much lower than the Washington and US findings.

DISPARITY ► Primary care utilization increases with age among survey respondents.

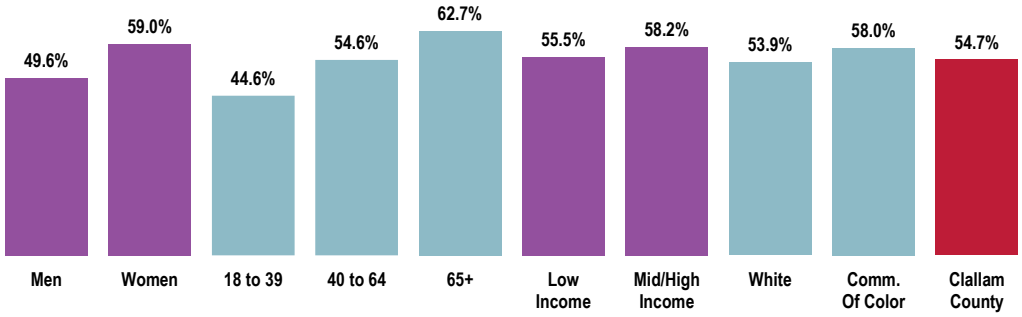
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Clallam County, 2022)

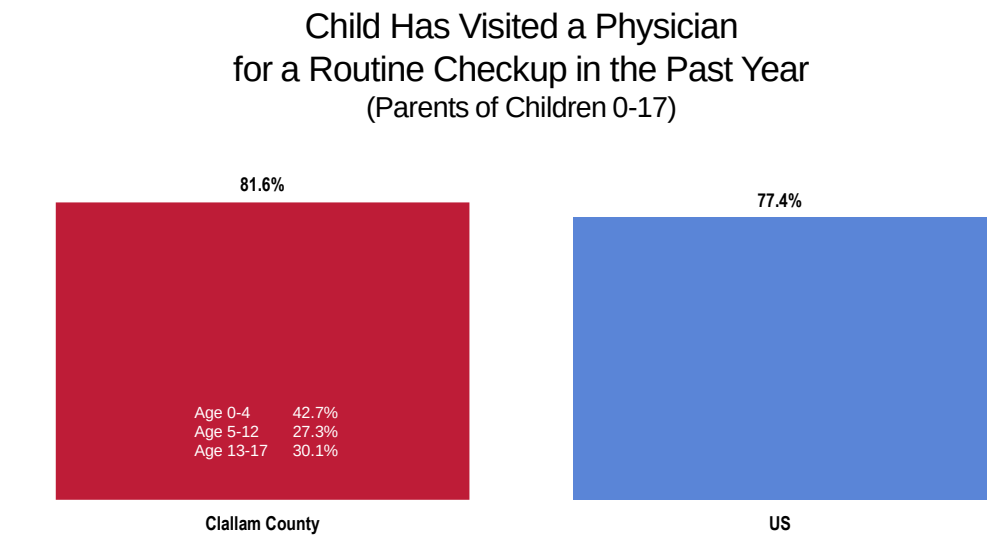


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 22]

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 81.6% report that their child has had a routine checkup in the past year.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.

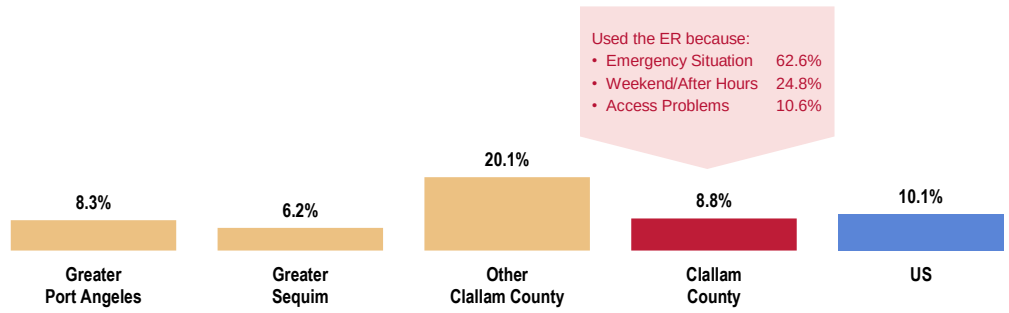
Notes:
- Asked of all respondents with children 0 to 17 in the household.

EMERGENCY ROOM UTILIZATION

A total of 8.8% of Clallam County adults have gone to a hospital emergency room more than once in the past year about their own health.

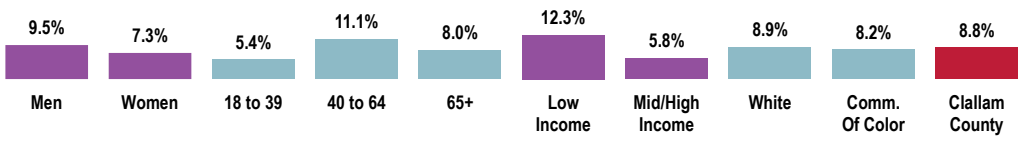
DISPARITY ► Emergency room utilization is considerably higher in the Other Clallam County area.

Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 23-24]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Clallam County, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

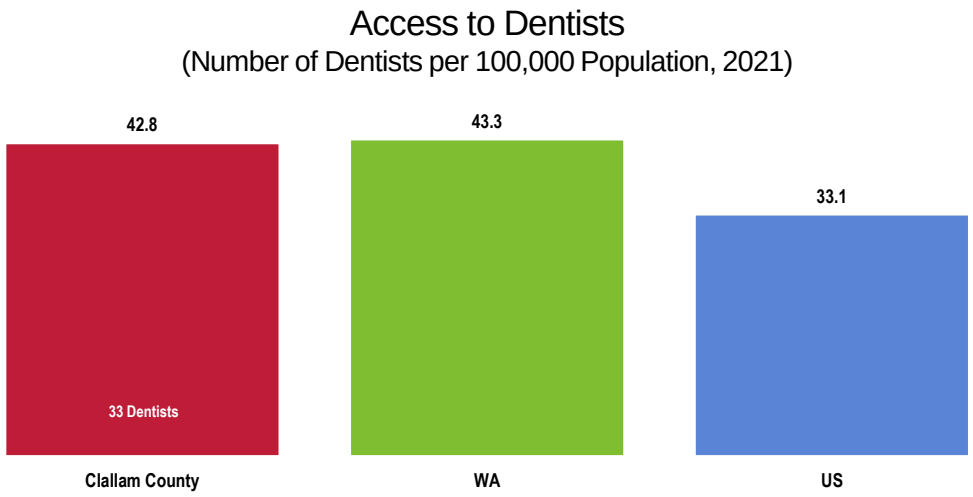
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Providers

In 2021, the county had 42.8 dental providers per 100,000 population.

BENCHMARK ► Higher than the national ratio.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists - qualified as having a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Dental Care

Adults

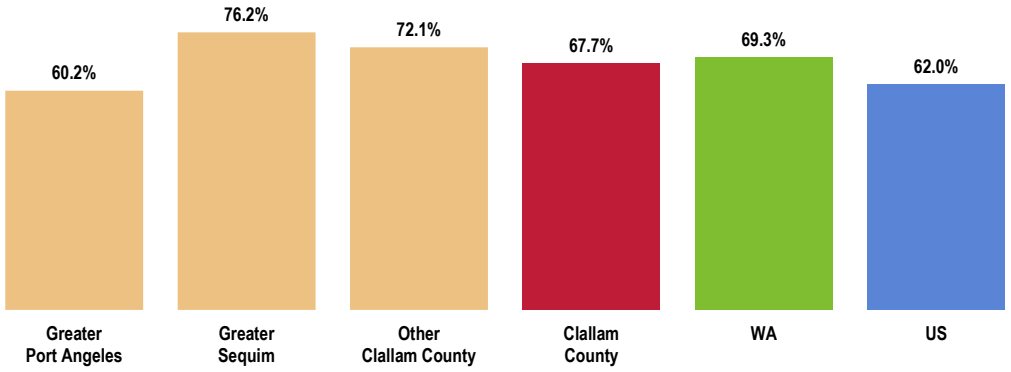
Two in three Clallam County adults (67.7%) have visited a dentist or dental clinic (for any reason) in the past year.

BENCHMARK ► Higher than the national finding. Satisfies the Healthy People 2030 objective.

DISPARITY ► Lowest in the Greater Port Angeles area.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

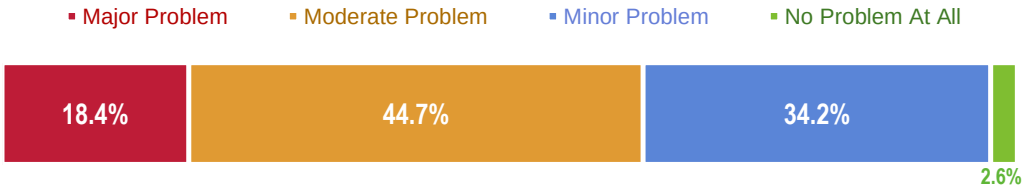
Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Income/Poverty

> Low-income patients have an impossible time accessing. – Social Services Provider
>
> No fluoride. Very few dentists for low-income folks. Almost all dentistry is self-pay. – Physician

Access for Medicare/Medicaid Patients

> Oral health is essential to wellness. For our Medicaid population, we are beginning to offer more services. There is more treatment needed. – Other Health Provider

Diagnosis/Treatment

> Dental care for individuals with IDD can be extremely complex and local providers do not have the expertise to deal with these concerns. Also, many in the IDD community require sedation dentistry which is not always available from local providers. Finally, many local dentists are reluctant to take on patients with limited verbal abilities and require support from family/caregivers. Providers who accept Medicare is also a limitation. – Social Services Provider

Impact on Quality of Life

> Gum disease and poor dental health can lead to other illness in the body. Many do not have insurance and cannot afford regular cleanings and screenings for oral health. – Other Health Provider

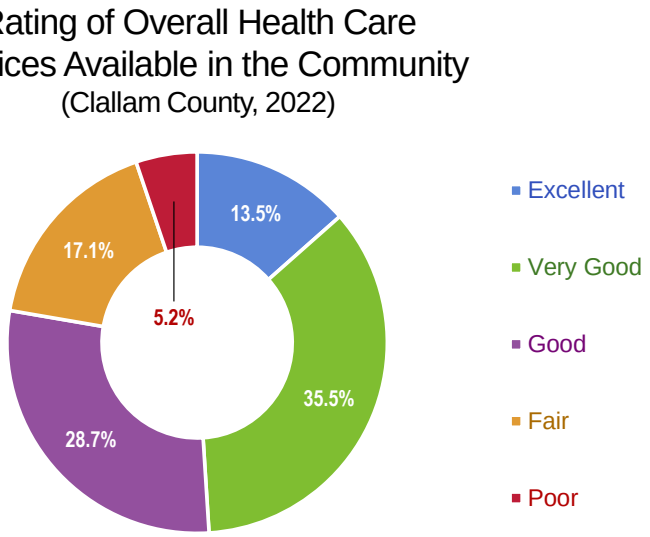
Lack of Providers

> Lack of oral surgeons and pediatric dentists. Many of the local dentist will not accept Apple Health or only take a limited number of patients a year. Foster parents must drive to Kitsap/Bremerton area to take the children in their care to the dentist. – Community Leader

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

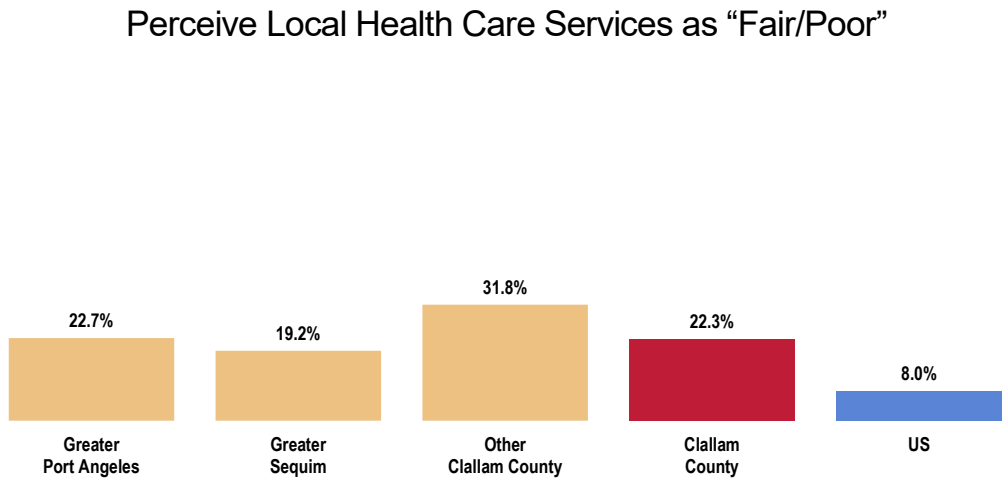
Nearly half of Clallam County adults rate the overall health care services available in their community as "excellent" or "very good."



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

However, 22.3% of residents characterize local health care services as "fair" or "poor."

BENCHMARK ► Nearly three times the national finding.

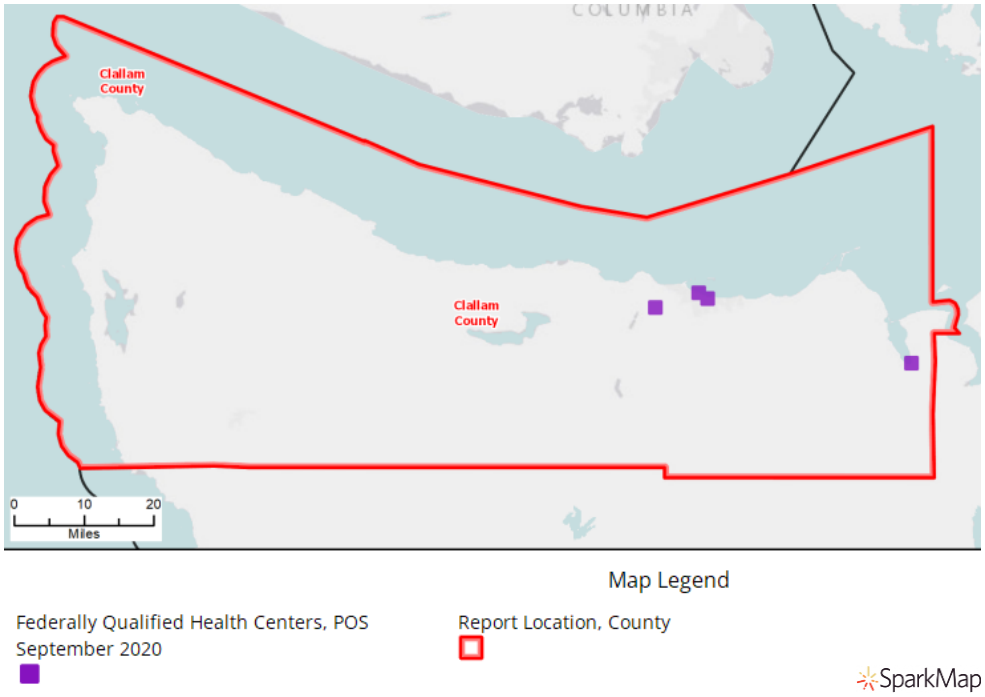


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within Clallam County as of September 2020.



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Assured Hospice Care
- Department of Health
- Doctor's Offices
- Dungeness Valley Health and Wellness Clinic
- Emergency Services
- Hospice of Clallam County
- Jamestown
- Jamestown Family Health Clinic
- Jamestown Healing Center
- North Olympic Health Network
- Olympic Medical Center
- Olympic Medical Physicians
- Olympic Peninsula Community Clinic
- Olympic Peninsula Healthy Community Coalition
- Paratransit Services
- Peninsula Behavioral Health
- SeaMar
- Sequim Free Clinic
- VIMO Clinic

Cancer

- Kathleen Sutton Fund
- Olympic Medical Cancer Center
- Olympic Medical Center
- Operation Uplift

Coronavirus Disease/COVID-19

- Clallam County Public Health Department
- County Media Information
- First Step
- Jamestown Family Health Clinic
- North Olympic Health Network
- Olympic Medical Center
- Olympic Medical Physicians
- Pharmacies
- Public Health Department

Dementia/Alzheimer's Disease

- Adult Protective Services
- Alzheimer's Association
- Area on Aging
- Catholic Community Services Volunteers
- Department of Children, Youth, and Families
- Department of Health
- Discovery Memory Care
- Doctor's Offices
- Dungeness Court
- Healthcare Leaders
- Highland Court
- Home Instead
- Laurel Place
- Memory Care Center
- Olympic Agency on Aging
- Olympic Medical Center
- Sequim Health & Rehabilitation
- Sherwood Assisted Living
- Sherwood Manor
- Skilled Nursing Facilities
- Tim's Place

Diabetes

- Country Aire (natural food store)
- Department of Health
- Doctor's Offices
- First Step
- Food Bank
- Jamestown Family Health Clinic
- North Olympic Health Network
- Olympic Medical Center
- Olympic Medical Physicians
- Olympic Peninsula Healthy Community Coalition
- Sequim Food Bank
- Sequim Free Clinic
- Shipley Center
- Sunny Farms (natural food store)
- Swedish Diabetes Education
- Tribal Programs
- WIC

Disability & Chronic Pain

- Area on Aging
- Department of Children, Youth, and Families
- Department of Social and Health Services
- Doctor's Offices
- Inspire Medical Clinic
- Jamestown Family Health Clinic
- Jamestown Healing Center
- Jamestown Primary Care
- Massage and Acupuncture
- Medication-Assisted Treatment Programs
- Mosaic
- North Olympic Healthcare Network
- Olympic Medical Center
- Peninsula Behavioral Health
- Social Security

Heart Disease & Stroke

- Doctor's Offices
- Olympic Medical Center
- Olympic Medical Physicians
- YMCA

Infant Health & Family Planning

- North Olympic Health Network

Injury & Violence

- City Council

Kidney Disease

- Doctor's Offices
- Olympic Medical Center

Mental Health

- Behavioral Health Organizations
- Counselors
- Court Diversion Programs
- Discovery Memory Care
- Doctor's Offices
- First Step
- Hospitals
- Housing Solutions Committee
- Jamestown
- Jamestown Family Health Clinic
- Law Enforcement
- Medication-Assisted Treatment Clinic at Sequim
- Mental Health Services
- New Growth
- New Growth Behavioral Health
- New Growth Counseling
- North Olympic Health Network
- Olympic Medical Center
- Olympic Medical Physicians
- Olympic Peninsula Community Clinic
- Peninsula Behavioral Health
- Re-Discovery
- Sequim Health & Housing Collaborative
- Serenity House
- Shipley Center
- Support Groups
- Tribal Treatment Centers

Nutrition, Physical Activity, & Weight

- Anytime Fitness
- Common Sense Nutritional Therapy
- Doctor's Offices
- Fitness Centers/Gyms
- Food Bank
- Ideal Protein
- North Olympic Discovery Marathon
- North Olympic Health Network
- Olympic Medical Center
- Olympic Peninsula Healthy Community Coalition
- Parks and Recreation
- Peninsula College
- Port Angeles Food Bank
- School System
- Sequim Food Bank
- Shore Aquatic Center
- Stormking
- Swimming Pools
- YMCA

Oral Health

- 111 Dental
- Advanta Dental
- Dentist's Offices
- Dungeness Dental
- Insurance
- Jamestown
- Jamestown Family Health Clinic
- North Olympic Health Network
- Olympic Peninsula Community Clinic
- SeaMar

- Sequim Family Dentistry
- Smile Mobile
- Tribal Programs

Respiratory Disease

- Jamestown
- North Olympic Health Network
- Olympic Medical Center
- Olympic Peninsula Community Clinic

Sexual Health

- Clallam County Health and Human Services
- Doctor's Offices
- First Step
- Planned Parenthood
- School System

Substance Abuse

- AA/NA
- BAART
- Cedar Grove
- Detox Centers
- Doctor's Offices
- Four Directions Counseling and Recovery Center
- Hospitals
- Inpatient Programs
- Jamestown
- Jamestown Family Health Clinic
- Jamestown Healing Center
- Jamestown MAT Clinic
- Jamestown Primary Care
- Jamestown S'Klallam Clinic
- Klallam Counseling Services
- Medication-Assisted Treatment Clinic at Sequim
- Medication-Assisted Treatment Programs
- Mental Health Services
- North Olympic Health Network
- Olympic Community Action Programs
- Olympic Medical Center
- Olympic Medical Physicians
- Olympic Peninsula Community Clinic
- Olympic Peninsula Health Services
- Olympic Personal Growth
- Peninsula Behavioral Health
- Re-Discovery
- Reflections Counseling
- Sequim Free Clinic
- Serenity House
- Specialty Services II
- Tribal Treatment Centers

Tobacco Use

- Churches
- Clallam County Health and Human Services
- Doctor's Offices
- First Step
- Jamestown
- Olympic Medical Center
- Pharmaceutical Assistance
- Quit Line

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, Olympic Medical Center has been invested in contributing to the improvement of the health of our community, including our most vulnerable populations. We've also provided more than $7.2 million in charity care.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

Olympic Medical Center conducted its last CHNA in 2019and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Olympic Medical Center would focus on developing and/or supporting strategies and initiatives to improve:

- Behavioral Health
- Substance Abuse
- Chronic Disease Management: Heart Disease & Stroke
- Wellness: Nutrition, Physical Activity, and Weight
- Access to Health Services
- Cancer

Strategies for addressing these needs were outlined in Olympic Medical Center's 2019 Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Olympic Medical Center to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Behavioral Health

Strategy 1: Continue, pursue and implement appropriate affiliation options, including via telemedicine, for behavioral health	
Strategy Was Implemented?	Yes
Outcome	Progress Made.

Strategy 2: Continue to ensure patient access to high-quality behavioral health specialist care through provider recruitment and retention	
Strategy Was Implemented?	Yes
Evaluation	Progress Made.

Strategy 3: Partner with Jamestown S'Klallam Tribe to evaluate the feasibility of a 16-bed behavioral health evaluation and treatment facility in Sequim. Increase behavioral health treatment options throughout the community through collaborative work with local partners and expansion of OMC behavioral health services	
Strategy Was Implemented?	Yes
Evaluation	Progress Made.

Priority Area: Substance Abuse

Strategy 1: Assure best practices are followed for use of opioids, reduce reliance on opioids when appropriate, provide effective pain management and expand options to safely address pain, and work together to help prevent overdoses and provide treatment pathways for those with substance use disorders.	
Strategy Was Implemented?	Yes
Evaluation	Progress Made.

Strategy 2: Support Jamestown S'Klallam Tribe's efforts to open outpatient Medication Assisted Treatment center with wrap-around services for Clallam County residents experiencing substance abuse.	
Strategy Was Implemented?	Yes
Evaluation	Complete.

Priority Area: Diabetes, Heart Disease and Stroke

Strategy 1: Leverage evidence-based best practices for areas of high risk in health care: manage chronic conditions such as diabetes and heart failure, and ensure timely interventions for conditions such as stroke.	
Strategy Was Implemented?	No
Evaluation	COVID-19 pandemic and national emergency response required significant resources and no major movement on this strategy occurred.

Strategy 2: Expand OMC's wellness initiative by assessing expertise at OMC and locally; studying the science of lifestyle medicine, researching best practices, evaluating external speakers and programs, and identifying staff and provider wellness champions. Enhance OMC's support of diabetes and heart disease prevention and education, the YMCA partnership, 5-2-1-0 and other current programs with the goal of preventing or reversing chronic disease.	
Strategy Was Implemented?	Partially
Evaluation	Implemented education with staff, but due to COVID pandemic this strategy was unable to be fully realized in the community. Will look at this again after recovery from pandemic.

Strategy 3: Continue, pursue and implement appropriate affiliation options, including via telemedicine, for cardiology, neurology and endocrinology	
Strategy Was Implemented?	No
Evaluation	Need to re-evaluate upon recovery from pandemic.

Strategy 4: Work collaboratively with North Olympic Healthcare Network, Jamestown Family Health Clinic and other organizations to secure primary care access for community members without a current medical home in OMC's service area.	
Strategy Was Implemented?	Yes.
Evaluation	Progress Made.

Priority Area: Nutrition, Physical Activity and Weight

Strategy 1: Expand OMC's wellness initiative by assessing expertise at OMC and locally; studying the science of lifestyle medicine, researching best practices, evaluating external speakers and programs, and identifying staff and provider wellness champions. Enhance OMC's support of diabetes and heart disease prevention and education, the YMCA partnership, 5-2-1-0 and other current programs with the goal of preventing or reversing chronic disease.	
Strategy Was Implemented?	Partially
Evaluation	Implemented education with staff, but due to COVID pandemic this strategy was unable to be fully realized in the community. Will look at this again after recovery from pandemic.

Priority Area: Access to Health Services

Strategy 1: Develop outreach initiatives to engage our community and elected officials in support of local health care to improve access: • Work to reverse CMS site neutral cuts to off-campus, hospital-based clinic services. • Continue and improve valuable programs to fill the current workforce needs and build the workforce of the future.	
Strategy Was Implemented?	Yes.
Evaluation	Reversal of site neutral cuts are pending final CMS OPPS rules; but looks to be complete for rural Sole Community Hospitals, including OMC. Workforce (Progress Made).

Strategy 2: Continue, pursue and implement appropriate affiliation options, including via telemedicine with a focus on needed specialty services.	
Strategy Was Implemented?	No.
Evaluation	Need to re-evaluate upon recovery from pandemic.

Strategy 3: Continue to ensure patient access to high-quality specialist care through the Provider Recruitment and Retention Plan. Recruitment efforts will include hospital medicine, family medicine, cardiology, urology, oncology, psychiatry, gastroenterology, ENT, pain management and other approved specialties, as needed.	
Strategy Was Implemented?	Yes.
Evaluation	Progress Made.

Strategy 4: Work collaboratively with North Olympic Healthcare Network, Jamestown Family Health Clinic and other organizations to secure primary care access for community members without a current medical home in OMC's service area.	
Strategy Was Implemented?	Yes
Evaluation	Progress Made.

Strategy 5: Continue advance care planning services and implement palliative care program with inpatient hospice beds and hospice services by the end of 2020.	
Strategy Was Implemented?	Partially.
Evaluation	Progress Made. Certificate of Need secured for Hospice; however Covid pandemic impacted ability to bring services online.

Strategy 6: Develop and implement strategic goals to be completed by the end of 2020 for the following service lines: Olympic Medical Physicians, Olympic Medical Cancer Center, Olympic Medical Heart Center, diagnostic imaging, nutrition services and Olympic Medical Home Health.	
Strategy Was Implemented?	Yes.
Evaluation	Progress Made.

Priority Area: Cancer

Strategy 1: Continue, pursue and implement appropriate affiliation options, including via telemedicine, with a focus on oncology.	
Strategy Was Implemented?	No.
Evaluation	Need to re-evaluate upon recovery from pandemic.

Strategy 2: Continue to ensure patient access to high-quality oncology specialty care through provider recruitment and retention.	
Strategy Was Implemented?	Yes
Evaluation	Progress Made.

Strategy 3: Develop and implement strategic goals to be completed by the end of 2020 for Olympic Medical Cancer Center.	
Strategy Was Implemented?	Yes
Evaluation	Complete.