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We thank the many community members that gave their time to complete surveys and participate in the community workshops, and all the local agencies who helped to distribute the community survey. We would also like to acknowledge the following individuals and organizations who contributed to this report:

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Bremerton Housing Authority
Grupos de Mamas
Village Green Community Center
Washington State Department of Health

Thank you to Kitsap Public Health District for review, technical support and evaluation of initial drafts and to Tacoma-Pierce County Health Department for their technical assistance and foundational work on the community health needs assessment content and format.
The health of a community is complex. The information in this community health needs assessment (CHNA) comes from many sources, including key health indicators from several data sources and information provided by community members, to better understand the needs of the CHI Franciscan Health Harrison Medical Center service area community.

The Kitsap Public Health District, Assessment and Epidemiology Program prepared this CHNA for the CHI Franciscan Health Harrison Medical Center and was the primary collector and reviewer of the health indicator and demographic data. The Health District participated in the community engagement activities, which included four community workshops, six key informant interviews and a survey of more than 900 residents and community partners, to further identify and prioritize the hospital service area’s health needs. The Health District conducted the analysis of the community engagement data.

This CHNA fulfills Section 9007 of the Affordable Care Act, as well as Washington State CHNA requirements.

Community input

Through the community engagement activities, community residents, coalitions and organizations shared their health needs and concerns about their communities, as well as barriers that affect their communities’ ability to thrive. Common overarching themes from these discussions included:

- The need for health systems to provide accessible, affordable, quality healthcare services;
- The need for health systems to visibly work and educate in the community to promote health and well-being in their patients and communities they serve;
- The need for community members and organizations to be equal partners in decision-making with health systems;
- The need for health systems to visibly engage, and collaborate with the communities and community organizations; and
- The need for health systems to advocate for and participate in making policies, systems and environmental changes that address the social and economic needs of communities they serve.

Other themes related to specific health topics also emerged and can be found throughout this report.
Here are the main findings of this report, based on the health indicator data and main themes that emerged from the community input.

**Description of Community**— The service area is a relatively close-knit community, with increasing racial and ethnic diversity. Almost ¼ of the population is non-White. One quarter of residents live at or below 200% of the federal poverty level, a common eligibility criterion for assistance programs.

**Leading Causes of Death**— Heart disease and cancer are the leading causes of death, similar to WA.

**Chronic Illness**— Asthma and obesity rates are higher among adults compared to the state. The leading causes of hospitalizations (other than pregnancy/childbirth) are diseases of the circulatory system and diseases of the digestive system. There are higher percentages of disabilities among our population compared to the state.

**Access to Care**— Not having a personal doctor is common among adults who are non-White and/or male. More than 3 out of 5 surveyed residents reported having difficulty accessing needed healthcare, mostly commonly due to long wait times for appointments. The entire service area has been designated a mental health shortage area. Community members felt that improving access to primary, specialty, mental and dental care was essential to community health.

**Maternal/Child Health**— The rate of infant death is higher than the Washington State average, and pregnant women in the service area are less likely to receive early and adequate prenatal care and less likely to initiate breastfeeding at birth than the state.

**Violence and Injury Prevention**— Rates of intentional and unintentional injury hospitalizations are statistically lower than the state averages. White, non-Hispanic residents have more than double the rate of suicide deaths compared to non-White residents.

**Behavioral Health**— Adults in the service area report higher rates of depressive disorders compared to Washington State, and women are almost twice as likely as men to report depression. Community members felt that mental health needs caused the biggest problem for the community’s overall health and depression was a major problem for children and youth in the community. Making behavioral healthcare more affordable, accessible and available was a common theme among surveyed residents. Community members saw substance use disorders as being closely related to mental health issues.
Priority health needs
Based on data from this CHNA, the following priority health needs among residents within the CHI Franciscan Health Harrison Medical Center service area emerged. These priorities resulted from applying a prioritization process and criteria to the health indicator data and community engagement themes included in this report. (More detailed information about the criteria and process is in the Supplement sections.)

The priority health needs provide guidance for CHI Franciscan Health planners and decision makers about where best to provide community benefit programs and services to address the most important health needs of the community. Working together, hospitals and health systems, public health, and communities can reduce healthcare costs and improve the health of all people in Kitsap County.

CHI Franciscan Health Harrison Medical Center Service Area Priority Health Needs

- Barriers to access to care for primary, specialty, mental and dental healthcare, especially long wait times for appointments, increasing costs and billing transparency.
- Obesity and poor nutrition.
- Infant mortality and low rates of early and adequate prenatal care and breastfeeding initiation.
- Mental distress and depression among adults, especially women, and youth.
- Substance abuse prevention and treatment among adults and youth.
The Affordable Care Act (ACA, 2010) requires that once every three years a CHNA is conducted by nonprofit hospitals. This report is a collection of data on approximately sixty health indicators that represent the health behaviors, outcomes and status of residents of the CHI Franciscan Health Harrison Medical Center service area in Kitsap County. In addition, this report includes community input from Kitsap County residents gathered at four community workshops, six key informant interviews and a survey of more than 900 community residents and partners. CHI Franciscan Health Harrison Medical Centers are located in Silverdale and Bremerton, cities in Kitsap County, Washington. For the purposes of this assessment, the CHI Franciscan Health Harrison Medical Center service area includes all residents of Kitsap County (See Figure 1).

This CHNA will help guide CHI Franciscan Health Harrison Medical Center in providing high-quality, affordable health care for the members of the community that it serves. Moving forward with a community benefit implementation strategy based on the results of this report will assist in making long-term, sustainable changes and strengthening relationships with other partners working to improve community health.

Summary of needs assessment methodology

This report was completed in accordance with the Affordable Care Act and includes a description of the community served, leading causes of death, levels of chronic illness and other important community health issues and needs. Listed below are eight broad categories of community health needs identified for the CHI Franciscan Health Harrison Medical Center service area.

1) Life Expectancy and Leading Causes of Death
2) Chronic Illnesses
3) Actual Causes of Illnesses
4) Access to Care, Uses of Clinical Preventative Services and Oral Health
5) Maternal and Child Health
6) Preventable Causes of Death
7) Violence and Injury Prevention
8) Behavioral Health
Socioeconomic factors, environment and other factors seemingly unrelated to health may influence the nature of health outcomes. Similarly, relationships between health indicators can affect the degree and/or type of health outcome. For instance, a service area with a high rate of tobacco use among its residents may expect to experience higher rates of cancer and other health effects, and potentially a resulting decrease in live expectancy. Some indicators in this report may affect health outcomes indirectly, and help provide a larger picture of the community's current and future needs.

This CHNA was completed through a multi-stage process designed to integrate findings from a review of available data with the experiences, expertise and opinions of community members and leaders.

Input was gathered from community residents and community stakeholders representing the broad interests of the communities served by hospitals and health systems. Interviews with community residents, organizations and coalitions, and an online survey were used to glean feedback and recommendations. Methodologies and survey and interview questions are further described in the Supplement section at the end of this report.

Approximately 60 indicators were chosen that, together, help understand the health of the community. Demographic data and data on key socioeconomic drivers of health status—including poverty, housing and educational attainment—are provided first. This is followed by the data and analysis of each health indicator and main themes identified through the community engagement methods.

A more detailed description of methods used to collect and analyze data is found in the Supplement section.
Figure 2. Factors that lead to poor health outcomes

Source: Robert Wood Johnson Foundation, 2017 County Health Rankings

Kitsap County was used as a proxy for the hospital service area and Washington State data served as the point of reference and comparison, both represented by grey bars on graphs in this report. Green bars indicate sub-populations within Kitsap County. The graphs have error bars, which visually give an idea of the margin of error or uncertainty in a reported measurement. If the error bars of two different estimates do not overlap, one can most often conclude that the difference is statistically significant and not due to chance.

Data description and limitations

This CHNA presents a robust set of data indicators that enable a broad view of the health needs of the CHI Franciscan Health Harrison Medical Center service area. However, as in all data reports, there are some limitations to these findings:

- Disaggregated data regarding age, race, ethnicity, and gender are not available for all the data indicators, which limits the ability to look at disparities and health inequities within the community.
- Data for the CHI Franciscan Health Harrison Medical Center service area may be limited by the size of the population, requiring the averaging of several years of data. This limits the ability of the report to represent the most current state of health.
- Data are not always collected on an annual basis, and even when they are, the most recent data may not yet be available, resulting in data that can be several years old.
This section reports common themes, issues, and opportunities that came up in the community engagement activities (conversations with community residents, key leaders, organizations and coalitions) and qualitative portions of the community survey. Additional community input related to specific health topics is presented in individual chapters of this report.

About 4 out of 5 residents surveyed felt very or somewhat satisfied with the quality of life in their community. Community residents and other stakeholders agree that the key to a healthy community is to address the basic conditions affecting daily life that promote or hinder individual success, health and well-being.

In order to create and sustain a healthy community, one cannot address the health needs of a community without addressing the availability of resources to meet daily needs (e.g., affordable housing and accessible transportation); access to quality educational, economic, and job opportunities; and access to affordable, quality health care services aimed at prevention first.

Basic needs

Community residents, coalitions and organizations shared with us that the inability to effectively handle life’s stressors is the single biggest problem affecting their communities’ ability to thrive. Mental health needs (such as mental health care, treatment and suicide prevention) and alcohol and other substance abuse were seen as the primary barriers to a healthy community. Safe neighborhoods, good jobs and a healthy economy, access to healthcare, affordable housing, and good schools were seen as keys to ensuring that individuals, families and communities experience good health and well-being.

Community members identified access to safe and affordable housing as a major concern in Kitsap County. Residents said housing cost increases, coupled with limited living wage employment opportunities and lack of public transportation availability, cause more low- and middle-income residents to struggle to manage competing health, family and financial priorities, even when they are employed.

Community leaders and residents alike are concerned that cuts in social service funding will limit services for those struggling to find or maintain housing, as well as limiting emergency shelter and respite shelter capacity.
Community residents identified issues related to **access to affordable, high-quality healthcare**, including a lack of timely access to healthcare due to unavailability of local providers, extreme wait times for appointments, long drives to obtain needed diagnostic or treatment services, and a lack of understanding of billing procedures and insurance coverage. These issues are felt to worsen long-term health problems, increase healthcare costs and increase emergency room and urgent care utilization. As one community leader said, “It’s crucial that individuals and families have access to minimum health benefits...the imminent loss of Harrison Hospital in Bremerton...will further diminish access to health care for many county residents.” Individuals unable or afraid to access healthcare or who are not aware of basic preventive health measures may delay needed preventive and treatment options to the point where their overall health and well-being are permanently affected. Over 60% of Kitsap residents surveyed reported that they or someone they knew had delayed or simply not sought out needed healthcare.

There is also a generalized feeling that healthcare in Kitsap has decreased in quality and variety in recent years, while costs have increased and healthcare billing has become less transparent, leading many who are able, to seek healthcare elsewhere.

**Good jobs and a healthy economy** were identified as key factors that make a healthy community due to their impact on the financial stability of residents, affecting their ability to access and afford healthcare, afford transportation and housing, and promote healthy behaviors and lifestyles for themselves and their families.

Living in a **safe neighborhood** is another key factor in experiencing a healthy community. Surveyed community members feel that crime and violence are two of the biggest problems to their community’s overall health. While crime rates have gone down in many areas over the last two decades, residents still report that mental health and substance abuse issues in their neighborhoods make them feel less safe. Community members and leaders feel that important solutions to creating safer neighborhoods are building community connections and community resources, educating the community not only on problems, but also on how to implement solutions, and improving access to quality mental health care and substance abuse treatment in Kitsap County.
Residents are concerned about what they see as a monopoly in the healthcare community which limits the practice of healthcare providers who now must conform to CHI policies. Many expressed an opinion that healthcare providers and staff in Kitsap County appear less satisfied and more rushed during appointments, at the same time as appointments are becoming less available and providers are moving away from local neighborhoods. Dental treatment availability, especially for Medicaid patients, and mental healthcare availability for those not on Medicaid also seem to be lacking in this community.

Residents felt the most important ways to work on health problems in our communities were to educate the public and our children on preventive medicine and healthy lifestyles through the schools and health fairs, to improve walkability, bikeability and low-cost exercise options locally, and to improve access to healthy, affordable food. Additionally, partnering with residents and community organizations to improve access to and availability of medical, dental, substance abuse and mental healthcare for those who need it was considered vital.

Community members would like hospitals to work collaboratively across all sectors to develop systems to provide holistic, integrated care (physical and behavioral health care services alongside social services) and to broaden preventive care access and preventive education. Community members view hospitals as having major influence in the community and expressed the importance of being proactively involved in policy, systems and environmental change strategies that could best improve the conditions, forces and systems shaping community health.

**Healthcare access and availability**

The community in Kitsap County is spread out in several urban and rural areas, which are often separated by water. Lack of public transportation, long distances by road, traffic congestion through “choke points”, and an area not yet bike- and pedestrian-friendly contribute to decreased access to healthcare facilities. In addition, higher earning potential in nearby large urban centers lures many high-quality healthcare providers away from Kitsap County, which leads to longer wait times for local appointments, further decreasing access to timely care. Opportunities for increasing hospital access and availability include:

- Invest in high-quality physical, mental and dental healthcare professionals. Encourage individuality of providers, as well as patient treatment plans, in order to accommodate the diverse population needs and wants.
What We Heard from the Community—Key Findings

Continued

- Decrease long wait times for an appointment through efficient scheduling and effective staff management. Work to address high utilizers to get them the help they need, through timely care, preventive care and appropriate referral.

- Advocate for improved public transportation and provide transportation to appointments at the healthcare campus, especially for low-income and the elderly.

Healthcare cost and transparency

Community members expressed the importance of the transparency of billing. Lack of understanding of bills, inability to predict cost and inability to determine insurance coverage were expressed concerns of community stakeholders and surveyed residents.

In addition, community members implored healthcare providers to think outside the box to come up with new and innovative ways to reduce healthcare and insurance costs.

Community engagement

Kitsap County is a very connected community, with about 72% of survey respondents reporting feeling connected with their communities. Community members and leaders value the visibility of healthcare providers and facilities within the community, as part of health promotion and prevention activities and meaningful engagement during health system planning efforts. Community members suggested opportunities to build community trust by taking the time to listen to patients and work to embrace a “whole-person” approach by referring to dental, substance use and mental health treatment when appropriate. Other opportunities for community engagement include:

- Hospital staff participation in community education and outreach events (e.g., health fairs and hospital-sponsored events).

- Hospitals hosting events where residents can meet providers and learn about health, preventive medicine and treatment services.

- Health systems partnering with community organizations to offer programs jointly.

- Provide patient-centered, respectful services to all people regardless of age, race, ethnicity, gender, income, language, belief, lifestyle and/or the complexity of the situation. Be respectful of all attitudes toward healthcare and work to educate, not exclude, patients.
2017 Community survey

The following are the results of the community health needs assessment survey. More than 900 community members throughout Kitsap County responded.

- More than half of respondents (54%) reported being very or somewhat satisfied with healthcare in their community.

- Sixty-three percent reported that something has kept them from getting the healthcare they need. The top barrier to getting needed healthcare was long wait times for appointments (37%), followed by the cost (28%) and limits of their health insurance coverage or the health insurance system in general (23%).

### Most important health issues

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you think are the three most important things that make a healthy community? (908 responses)</td>
<td>1. Low crime and violence/ safe neighborhoods</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>2. Good jobs and a healthy economy</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>3. Quality, affordable, accessible healthcare</td>
<td>39%</td>
</tr>
<tr>
<td>What three things cause the biggest problems to your community’s overall health? (908 responses)</td>
<td>1. Mental health needs</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>2. Alcohol and substance abuse</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>3. Poverty</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>4. Housing issues</td>
<td>33%</td>
</tr>
<tr>
<td>What three things cause the biggest problems to children and youth in your community? (891 responses)</td>
<td>1. Drug and alcohol abuse (including tobacco)</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>2. Lack of social opportunities</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>3. Depression</td>
<td>30%</td>
</tr>
</tbody>
</table>
Satisfaction, connectedness and health of the community

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied are you with the quality of life in your community?</td>
<td>Very or Somewhat Satisfied</td>
</tr>
<tr>
<td>(904 responses)</td>
<td>81%</td>
</tr>
<tr>
<td>How satisfied are you with healthcare in your community?</td>
<td>Very or Somewhat Satisfied</td>
</tr>
<tr>
<td>(899 responses)</td>
<td>54%</td>
</tr>
<tr>
<td>How socially connected do you feel in your community?</td>
<td>Very or Somewhat Satisfied</td>
</tr>
<tr>
<td>(905 responses)</td>
<td>72%</td>
</tr>
</tbody>
</table>

Demographics of survey respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25%</td>
</tr>
<tr>
<td>Female</td>
<td>74%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 18 years</td>
<td>0%</td>
</tr>
<tr>
<td>18-29 years</td>
<td>3%</td>
</tr>
<tr>
<td>30-44 years</td>
<td>22%</td>
</tr>
<tr>
<td>45-59 years</td>
<td>30%</td>
</tr>
<tr>
<td>60 years and older</td>
<td>45%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hispanic/Latino</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3%</td>
</tr>
<tr>
<td>No</td>
<td>97%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race (more than one response was possible)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>4%</td>
</tr>
<tr>
<td>Asian</td>
<td>2%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>89%</td>
</tr>
<tr>
<td>Preferred not to answer</td>
<td>5%</td>
</tr>
</tbody>
</table>

While efforts were made to distribute the survey to people of all genders, races/ethnicities and ages, survey participants were disproportionately female, long-term residents (live in Kitsap 10 or more years) and older (45 years and older). Geographically, Kitsap County was reasonably well represented.
Description of Community

DEMOGRAPHIC CHARACTERISTICS

Understanding who lives in a community is the first step toward understanding that community’s health needs. The demographic characteristics of a community are strong predictors of health outcomes and health service needs. For example, communities with large older populations may have different health needs than a younger population. Factors such as lower income and education levels are also strongly linked to worse health outcomes.

Population – Approximately 262,590 people live in the CHI Franciscan Health Harrison Medical Center primary service area: an increase of 72,859 residents or a 38.4% growth since 1990.

Age – Children, teens, and youth represent 23.0% of the population, while 18.9% of the population is 65 or older. Respectively, these numbers are 25.2% and 14.9% statewide, both statistically different.

Race and Ethnicity – A little over three quarters of residents are White, non-Hispanic (77.0%). Hispanic residents are the largest non-White group representing 7.1% of the service area’s total population. Statewide, they account for 12.6%.

Demographics
CHI Franciscan Health
Harrison Medical Center service area,
2016

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>15,695</td>
<td>6.0%</td>
</tr>
<tr>
<td>5-14</td>
<td>30,522</td>
<td>11.6%</td>
</tr>
<tr>
<td>15-24</td>
<td>33,602</td>
<td>12.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>30,780</td>
<td>11.7%</td>
</tr>
<tr>
<td>35-44</td>
<td>28,411</td>
<td>10.8%</td>
</tr>
<tr>
<td>45-54</td>
<td>34,225</td>
<td>13.0%</td>
</tr>
<tr>
<td>55-64</td>
<td>39,818</td>
<td>15.3%</td>
</tr>
<tr>
<td>65-74</td>
<td>30,010</td>
<td>11.4%</td>
</tr>
<tr>
<td>75-84</td>
<td>13,499</td>
<td>5.1%</td>
</tr>
<tr>
<td>85+</td>
<td>6,028</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>132,797</td>
<td>50.6%</td>
</tr>
<tr>
<td>Female</td>
<td>129,793</td>
<td>49.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>18,707</td>
<td>7.1%</td>
</tr>
<tr>
<td>White, non-Hispanic (NH)</td>
<td>202,296</td>
<td>77.0%</td>
</tr>
<tr>
<td>Black, NH</td>
<td>7,209</td>
<td>2.7%</td>
</tr>
<tr>
<td>Asian, NH</td>
<td>13,754</td>
<td>5.3%</td>
</tr>
<tr>
<td>American Indian/Alaska Native, NH</td>
<td>3,621</td>
<td>1.4%</td>
</tr>
<tr>
<td>Pacific Islander, NH</td>
<td>2,521</td>
<td>1.0%</td>
</tr>
<tr>
<td>Multi-Race, NH</td>
<td>14,482</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

SOCIOECONOMIC CHARACTERISTICS

Poverty

- Approximately eleven percent of residents have incomes below the federal poverty level.

- One of every five Black residents and American Indian/Alaska Native residents lives below the Federal Poverty Level. One of every eight Hispanic residents, Native Hawaiian and Pacific Islander residents and residents of two or more races lives below the Federal Poverty Level.

- Twenty-five percent of residents live at or below 200% of the federal poverty level, a common eligibility criterion for assistance programs.

- The rate of poverty varies within the CHI Franciscan Health Harrison Medical Center service area from 2.9% to 27.3% by zip code area (Figure 3).

Housing Affordability

- More than half of renters (51.8%) and more than one-third (34.3%) of home owners with a mortgage in the service area are paying more than 30% of their household income on housing. Spending more than 30% of household income on housing is financially burdensome.

<table>
<thead>
<tr>
<th>People in poverty</th>
<th>Count</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic (NH)</td>
<td>18,738</td>
<td>9.7%</td>
</tr>
<tr>
<td>Black, NH</td>
<td>1,412</td>
<td>24.1%</td>
</tr>
<tr>
<td>AIAN, NH</td>
<td>690</td>
<td>24.6%</td>
</tr>
<tr>
<td>Asian, NH</td>
<td>781</td>
<td>6.5%</td>
</tr>
<tr>
<td>NHOPIL, NH</td>
<td>272</td>
<td>13.7%</td>
</tr>
<tr>
<td>Some other race, NH</td>
<td>808</td>
<td>18.2%</td>
</tr>
<tr>
<td>Two or more races, NH</td>
<td>2,622</td>
<td>15.3%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>2,373</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People below 200% of the poverty level</th>
<th>Count</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renters</td>
<td>15,518</td>
<td>51.8%</td>
</tr>
<tr>
<td>Owners with mortgage</td>
<td>15,981</td>
<td>34.3%</td>
</tr>
<tr>
<td>Owners without mortgage</td>
<td>2,313</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2011-2015
*Percentage of the population living in poverty.
### Immigration

- About six percent of the service area population are immigrants.

### Non-English-Speaking Persons

- The vast majority of the service area residents speak only English at home.
- Among people who speak languages other than English at home, almost thirty percent speak English less than “very well”.

### Immigration and languages

**2011-2015 average**

<table>
<thead>
<tr>
<th>Immigrants</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigrants</td>
<td>16,389</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population 5 years and older</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speak a language other than English at home</td>
<td>18,829</td>
<td>7.8%</td>
</tr>
<tr>
<td>Speak another language and speak English less than “very well”</td>
<td>5,634</td>
<td>29.9%</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2011-2015

### Top 10 countries of origin for immigrants

**2011-2015 average**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country of Origin</th>
<th>Number of Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Philippines</td>
<td>5,159</td>
</tr>
<tr>
<td>2</td>
<td>Mexico</td>
<td>1,494</td>
</tr>
<tr>
<td>3</td>
<td>Canada</td>
<td>1,455</td>
</tr>
<tr>
<td>4</td>
<td>Japan</td>
<td>895</td>
</tr>
<tr>
<td>5</td>
<td>Vietnam</td>
<td>681</td>
</tr>
<tr>
<td>6</td>
<td>United Kingdom</td>
<td>672</td>
</tr>
<tr>
<td>7</td>
<td>Guatemala</td>
<td>640</td>
</tr>
<tr>
<td>8</td>
<td>Germany</td>
<td>586</td>
</tr>
<tr>
<td>9</td>
<td>China</td>
<td>572</td>
</tr>
<tr>
<td>10</td>
<td>Korea</td>
<td>525</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2011-2015

### Top languages spoken other than English

**2011-2015 average**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Foreign Language</th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spanish</td>
<td>6,474</td>
</tr>
<tr>
<td>2</td>
<td>Tagalog</td>
<td>4,912</td>
</tr>
<tr>
<td>3</td>
<td>Japanese</td>
<td>849</td>
</tr>
<tr>
<td>4</td>
<td>German</td>
<td>844</td>
</tr>
<tr>
<td>5</td>
<td>French</td>
<td>784</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2011-2015
Description of Community Continued

Figure 3. Poverty
CHI Franciscan Health Harrison Medical Center service area, 2012-16

High school graduation rate

Graduation rates are important indicators of the current and future health status of students, as academic achievement is impacted by health status.

The four-year graduation rate for students in the CHI Franciscan Health Harrison Medical Center service area for the 2015-16 school year was 81.6%. This is higher than Washington State’s rate of 79.1%.i

Free/reduced price meals

The free and reduced-price meal program in the public school system is a federal program for students whose families meet the definition of being low-income. Students are eligible for free meals if their family’s income is at or below 130% of the federal poverty guidelines. Eligibility for reduced-price meals is between 130% and 185% of federal poverty guidelines. This program assists in ensuring that children get nutritious meals that promote overall health and learning in school.

About one-third (33.7%) of CHI Franciscan Health Harrison Medical Center service area students in kindergarten through 12th grade in public schools during the 2016-17 school year received free or reduced-price meals. This is statistically lower than the Washington State average of 43.3%.ii
Homelessness

Homelessness is an increasing problem due in part to poverty and inequities in housing. Depending on the size of the service area, the percent of total homeless persons served can vary widely. The Homelessness Housing and Assistance Act requires each county in the state to conduct an annual Point in Time count of sheltered and unsheltered homeless persons.

- The most recent Point in Time count took place on January 26, 2017. The Kitsap County count totaled 323 homeless.

- Of the homeless counted in the CHI Franciscan Health Harrison Medical Center service area, the number ranged from a high of 184 in Bremerton to a low of only 1 in Seabeck.

Foster care

- Less than 1% of Kitsap County children ages 17 years and younger received foster care placement services in 2015 (0.75%). Kitsap was statistically higher than the state (0.62%).

- Over half (51.7%) of Kitsap County children under the age of 18 received some type of aid or service through the Washington State Department of Social and Health Services in 2015. This was statistically lower than the state average of 62.9%.

Disability

Disabilities can include impairments in any one or more of five functions: hearing, vision, cognition, ambulation, self-care and independence. Disabilities can prevent a person from living a full, normal life and limit the opportunity to hold a steady job.

- From 2011 to 2015, 15.5% of residents in the CHI Franciscan Health Harrison Medical Center service area had at least one disability, statistically different than Washington State (12.6%).

Assets and Resources include:

- Kitsap Community Resources (KCR) is a community action partnership creating hope and opportunity for low-income residents by promoting self-sufficiency through housing, employment, financial and family resources.

- The Salvation Army provides housing, food, poverty and substance use treatment resources.

- Kitsap Rescue Mission and the Kitsap County Continuum of Care Coalition advocate for and provide services to homeless residents, while Homes for all Leadership Group provides innovative leadership toward ending homelessness.

- The Coffee Oasis youth programs offer friendship, belonging, resources and opportunity to homeless and street-oriented youth ages 13 to 25.

- WorkSource connects people to employment-related resources and assistance.
Leading Causes of Death

Life expectancy, hospitalization and death rates provide important information about the health status of the community. Analyses of causes and disparities among segments of the population can help members of the community identify health needs, prioritize health concerns and develop prevention and intervention activities.

LIFE EXPECTANCY

Life expectancy is a widely-used measure of the overall health of a population. The definition is the average number of years a person at birth can expect to live, given current death rates. Life expectancy can be improved by reducing specific causes of diseases and eliminating health inequities.

- For the CHI Franciscan Health Harrison Medical Center service area, the average life expectancy of a resident born in years 2012 to 2016 is 81 years, one year higher than the state average of 80 years.

- In Kitsap, residents are living longer. The average life expectancy for those born in 2016 is about five years longer than for those born in 1990.

- Patterns in life expectancy data by race in the service area indicate that Native Hawaiian/Pacific Islanders, Blacks and American Indian/Alaska Natives had the shortest life expectancies: 73, 76 and 76 years, respectively. Asians, Hispanics, Multi-Race residents and Whites had the longest life expectancies, at 85, 84, 83 and 81 years, respectively.

- Life expectancy in the CHI Franciscan Health Harrison Medical Center service area varied by geography, ranging from 78.0 to 86.0 years of age (Figure 4). The lowest life expectancies are in the East Bremerton, Port Orchard and downtown Bremerton communities.

Life expectancy
2012-2016 average

LEADING CAUSES OF DEATH

Over the last five years, the main causes of death in the US have remained consistent. The top three (major cardiovascular (CV) diseases, cancer and chronic lower respiratory diseases) account for over 50% of all deaths.\[1\]

- The top three leading causes of death in the CHI Franciscan Health Harrison Medical Center service area were major CV diseases, cancers of all types and Alzheimer’s disease from 2012 to 2016.

- The top ten leading causes of death were the same for the residents of the hospital service area as they were for all Washington State residents.

Leading causes of death in Kitsap
Ranked by number of deaths, 2012-2016 average

<table>
<thead>
<tr>
<th>Causes</th>
<th>Harrison Ranking</th>
<th>WA Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cardiovascular disease</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Chronic lower respiratory disease</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Accidents</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Chronic liver disease and cirrhosis</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Suicide</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Average annual # of deaths due to the top 10 causes</td>
<td>1,650</td>
<td>41,078</td>
</tr>
</tbody>
</table>

LEADING CAUSES OF HOSPITALIZATION

Washington State’s rate of hospitalizations for conditions that can be prevented by early intervention or good outpatient care has historically been lower than the national average.viii

From 2011 to 2015, hospitalizations for diseases of the circulatory system accounted for the majority of the hospitalizations in the CHI Franciscan Health Harrison Medical Center service area, followed by hospitalizations for childbirth and digestive disorders.

The leading causes of hospitalization and their ranking were similar for the hospital service area and the state, but not the same. Hospitalizations for childbirth, conditions originating in the perinatal period and mental illness were less common in the service area than in the state overall. Instead, hospitalizations for diseases of the circulatory and digestive systems, infectious and parasitic diseases and cancer ranked slightly higher in the service area than in the state overall.

The injury and poisoning hospitalization category includes substance use overdose-related hospitalizations. Opioid-related hospitalizations have increased over time in Kitsap County.

Leading causes of hospitalization in Kitsap County

By main category of diagnosis, 2011-2015 average

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Harrison Cases and Rank</th>
<th>WA Cases and Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the circulatory system</td>
<td>14,446 (1)</td>
<td>397,359 (3)</td>
</tr>
<tr>
<td>Complications of pregnancy; childbirth; and the puerperium</td>
<td>11,156 (2)</td>
<td>416,214 (1)</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>10,885 (3)</td>
<td>278,706 (4)</td>
</tr>
<tr>
<td>Certain conditions originating in the perinatal period</td>
<td>10,649 (4)</td>
<td>403,521 (2)</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>8,534 (5)</td>
<td>247,398 (5)</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>8,143 (6)</td>
<td>226,755 (6)</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>7,774 (7)</td>
<td>221,230 (7)</td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>5,888 (8)</td>
<td>155,764 (9)</td>
</tr>
<tr>
<td>Cancer</td>
<td>5,351 (9)</td>
<td>133,367 (10)</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>4,472 (10)</td>
<td>156,742 (8)</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>4,383 (11)</td>
<td>123,213 (11)</td>
</tr>
<tr>
<td>Endocrine; nutritional; and metabolic diseases and immunity disorders</td>
<td>3,180 (12)</td>
<td>89,507 (12)</td>
</tr>
<tr>
<td>Diseases of the nervous system and sense organs</td>
<td>2,062 (13)</td>
<td>65,977 (14)</td>
</tr>
</tbody>
</table>

Half of all American adults have at least one chronic disease or condition. Almost one in three adults have multiple chronic conditions. Just as chronic diseases share many of the same causes, many of the same strategies and interventions can prevent them or lessen their severity. Many chronic diseases are linked to health behaviors, environmental conditions and social and economic factors.

**DIABETES (YOUTH)**

The prevalence of diabetes in youth is self-reported. Public school students are asked if they have ever been told by a doctor or other health professional that they have diabetes. As obesity rates in children continue to increase, type 2 diabetes is becoming more common in youth.

- In the CHI Franciscan Health Harrison Medical Center service area, 3.2% of 10th graders in 2014 reported having diabetes.
- There are no statistical differences between White and non-White youth in the service area.

**Diabetes (10th graders)**

**2014**

![Bar chart showing diabetes prevalence among 10th graders in Harrison, WA State, White-NH, and Non-White categories.](chart.png)

*Source: Healthy Youth Survey, 2014. (Question not asked in 2016.)*
**DIABETES (ADULTS)**

Uncontrolled diabetes can cause kidney disease, blindness, nerve damage, coma, other serious medical conditions and death. Reducing known risk factors (such as tobacco use, weight gain, high blood pressure, poor nutrition and physical inactivity) can prevent type 2 diabetes or delay its onset. The prevalence of diabetes among adults is self-reported data.

- From 2012 to 2016, 9.0% of residents living in the CHI Franciscan Health Harrison Medical Center service area reported having diabetes, approximately the same as the state average.
- There were no statistical differences by gender or race in the service area.

**Diabetes (adults)**

2012-2016 average

- Harrison: 9.0%
- WA State: 8.9%
- White, NH: 8.4%
- Non-White: n<10
- Male: 10.7%
- Female: 7.2%

COLORECTAL CANCER INCIDENCE

Colorectal cancer (occurring in both colon and rectum) affects men and women of all racial and ethnic groups and is most often found in people 50 years or older. In Washington State and throughout the nation, colon cancer is the third leading cause of cancer deaths for both men and women, after lung cancer and breast/prostate cancer.

- From 2010 to 2014, the incidence rate of colorectal cancer in the CHI Franciscan Health Harrison Medical Center service area was 37.4 cases per 100,000.

- There were no statistical differences in colorectal cancer rates by race.


^ Races Combined = Black-NH, AI/AN-NH, Pacific Islander-NH and Multi-Race combined
^^Rate: cases per 100,000 population; rates are age-adjusted to the 2000 US population.

* too few cases to protect confidentiality and/or report reliable rates.
CERVICAL CANCER INCIDENCE

Few women in Washington State get cervical cancer and the most common cause of cervical cancer, human papillomavirus (HPV), can be prevented with vaccination. However, only 39% of 13 to 17-year-olds in the service area have received the recommended HPV series (at least 2 vaccinations).

From 2010 to 2014, the rate of developing cervical cancer for women in the CHI Franciscan Health Harrison Medical Center service area was 7.6 cases per 100,000 women. This rate is similar to the Washington State rate of 6.9 cases per 100,000 women.

Cervical cancer incidence

2010-2014 average


^Rate: cases per 100,000 women; age-adjusted to the 2000 US population

BREAST CANCER INCIDENCE

Breast cancer is the most common cancer that affects women. Screening for breast cancer allows the cancer to be detected earlier, which improves the chances for successful treatment.

- From 2010 to 2014, the female breast cancer incidence rate among residents of the CHI Franciscan Health Harrison Medical Center service area was 164.9 cases per 100,000 women.
- There were no statistical differences by race.

Breast cancer incidence

2010-2014 average


^ Rate: cases per 100,000 population; Harrison and WA State rates are age-adjusted to the 2000 US population; rates for race categories are crude rates.
ASTHMA (ADULTS)

Asthma is a chronic lung disease that inflames and narrows the airways. It has recurring symptoms including wheezing, breathlessness, chest tightening and coughing. Although there is no cure for asthma, it can be managed with medical care.

- From 2012 to 2016, the percent of adults who reported ever being diagnosed with asthma in the Harrison Medical Center service area was 17.5%, statistically worse than Washington State (15.1%).
- Females were statistically more likely to report ever being diagnosed with asthma than males.

**Asthma (adults)**
**2012-2016 average**

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>17.5%</td>
</tr>
<tr>
<td>WA State</td>
<td>15.1%</td>
</tr>
<tr>
<td>White, NH</td>
<td>18.5%</td>
</tr>
<tr>
<td>Non-White</td>
<td>24.5%</td>
</tr>
<tr>
<td>Male</td>
<td>13.8%</td>
</tr>
<tr>
<td>Female</td>
<td>21.2%</td>
</tr>
</tbody>
</table>


ASTHMA (YOUTH)

Asthma is linked to depression, decreased academic achievement and reduced quality of life in children ages 17 years and younger.

- From 2012 to 2016, 12.6% of children in the CHI Franciscan Health Harrison Medical Center service area had ever been diagnosed with asthma.
- There were no statistical differences by gender.

**Asthma (youth)**
**2012-2016 average**

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>12.6%</td>
</tr>
<tr>
<td>WA State</td>
<td>11.1%</td>
</tr>
<tr>
<td>White, NH</td>
<td>21.5%</td>
</tr>
<tr>
<td>Non-White</td>
<td>n&lt;10</td>
</tr>
<tr>
<td>Male</td>
<td>10.0%</td>
</tr>
<tr>
<td>Female</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

HIV INCIDENCE AND PREVALENCE

The Human Immunodeficiency Virus (HIV) attacks the immune system, causing deficiency or damage to the immune system. HIV damages the body’s ability to fight diseases and infections and can lead to Acquired Immunodeficiency Syndrome (AIDS).

- Men having sex with men (MSM) are disproportionately at risk for HIV. Between 2012 and 2016, 88% of new HIV cases with reported risk information for hospital service area residents were MSM. Additionally, people 25 to 34 years of age have the highest number and rate of newly diagnosed HIV cases. Diagnosis rates are also statistically higher among non-Hispanic White people compared to other racial/ethnic groups.

- In 2016, 285 people living in the CHI Franciscan Health Harrison Medical Center service area were living with HIV or AIDS. This equals a rate of 108.4 cases per 100,000 residents in Kitsap County. The state’s rate is 172.7 cases per 100,000 residents.

- From 2012 to 2016, the rate of HIV incidence (newly diagnosed cases) was 3.3 cases per 100,000 residents in Kitsap County and 6.6 cases per 100,000 residents in Washington State. During this time, there were 42 new diagnoses of HIV in Kitsap County.

Eating nutritious foods, becoming more physically active and avoiding tobacco are healthy behaviors that can help prevent many of the diseases and conditions mentioned in the previous section. Even if a person already has a chronic condition such as diabetes or cancer, healthy behaviors can help better manage the illness, avoid complications and prolong life.

**Community Input:** Community stakeholders identified limited physical activity, inaccessibility of affordable nutritious food, and inconsistent clean air and clean, good-tasting drinking water as contributing factors to chronic illness prevention and management. Improved community planning (i.e. bike lanes, sidewalks, clean parks and open green spaces for recreation, as well as inexpensive indoor areas for recreation when raining) and education on healthy lifestyles and nutrition were considered essential to prevent chronic disease.

**OVERWEIGHT AND OBESE ADULTS**

Almost two-thirds of adults in the service area are overweight or obese. Overweight adults are those who have a body mass index (BMI) greater than or equal to 25.0 and less than 30.0, while obese adults have a BMI equal to or greater than 30.0. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer.

- From 2012 to 2016, 32.7% of adults in the CHI Franciscan Health Harrison Medical Center service area were overweight.
- A higher percentage of men reported being overweight than women.

**Overweight (adults)**

**2012-2016 average**

<table>
<thead>
<tr>
<th></th>
<th>2012-2016 average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>32.7%</td>
</tr>
<tr>
<td>WA State</td>
<td>33.6%</td>
</tr>
<tr>
<td>White, NH</td>
<td>32.4%</td>
</tr>
<tr>
<td>Non-White</td>
<td>43.5%</td>
</tr>
<tr>
<td>Male</td>
<td>36.4%</td>
</tr>
<tr>
<td>Female</td>
<td>28.7%</td>
</tr>
</tbody>
</table>

From 2012 to 2016, 28.3% of adults in the CHI Franciscan Health Harrison Medical Center service area were obese. This is statistically higher than the state average.

There were no statistical differences by race or gender.

**Obese (adults)**

**2012-2016 average**

- Harrison: 28.3%
- WA State: 25.1%
- White, NH: 27.2%
- Non-White: 25.4%
- Male: 29.8%
- Female: 26.7%

**Overweight and obese youth**

Obesity contributes to a number of chronic diseases and causes a greater likelihood of premature death. Children and adolescents with BMI values at or above the 95th percentile of the sex-specific BMI growth charts are categorized as obese. Those at or above the 85th percentile, but below the 95th, are considered to be overweight.* Poor diet and physical inactivity are risk factors for youth becoming overweight or obese.

In 2016, 13.4% of 10th graders in the CHI Franciscan Health Harrison Medical Center service area were obese, while 14.0% were overweight.

Non-White 10th graders had a higher percentage of obese, but almost exactly the same percentage of obese and overweight combined (27.3%) as White, non-Hispanic 10th graders (27.4%).

**Overweight and obese (10th graders)**

**2016**

- Harrison:
  - Obese: 13.4%
  - Overweight: 14.0%
- WA State:
  - Obese: 11.7%
  - Overweight: 15.1%
- White, NH:
  - Obese: 12.2%
  - Overweight: 15.2%
- Non-White:
  - Obese: 16.2%
  - Overweight: 11.1%


*Source: Healthy Youth Survey, 2016
PHYSICAL INACTIVITY (ADULTS)

Regular physical activity is one of the main ways to prevent and reduce obesity and many of the health impacts associated with obesity. The percentage of adults 18 years old and older who do not meet the aerobic and muscle strengthening guidelines each week is an indicator of the physical activity or inactivity level of the population.

- In 2013 and 2015, about 3 out of 4 adults in the CHI Franciscan Health Harrison Medical Center service area did not meet both the aerobic and muscle strengthening recommendations for physical activity each week.

- There were no statistical differences by race or gender.

PHYSICAL INACTIVITY (YOUTH)

The Dietary Guidelines for America and the National Association for Sports and Physical Education recommend that children and adolescents participate in at least 60 minutes of physical activity most days of the week, preferably daily. Youth physical activity is based on the percentage of 10th graders who report being physically active on at least five days per week for at least 60 minutes per day.

In the CHI Franciscan Health Harrison Medical Center service area, 51.1% of 10th graders reported that they had not met the physical activity recommendations of 60 minutes of physical activity on at least five days every week.

Source: Healthy Youth Survey, 2016
SUGAR-SWEETENED BEVERAGE CONSUMPTION (YOUTH)

Sugar-sweetened beverages include regular soda, sports drinks and other flavored sweetened drinks. Sugary beverage consumption leads to excess caloric intake and weight gain, increased obesity rates among children and adolescents, and can contribute to increased tooth decay.

In the CHI Franciscan Health Harrison Medical Center service area, 23.8% of 10th grade students reported not drinking a sugar-sweetened beverage in the past seven days.

Sugar-sweetened beverage consumption (10th graders)
Percentage report not drinking any sugary beverages in the past week, 2016

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>White, NH</th>
<th>Non-White</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 percentage</td>
<td>23.8%</td>
<td>23.1%</td>
<td>25.0%</td>
<td>21.4%</td>
</tr>
</tbody>
</table>

Source: Healthy Youth Survey, 2016

FRUIT AND VEGETABLE CONSUMPTION

Eating more fruits and vegetables adds nutrients to diets, reduces the risk for heart disease, stroke, and some cancers, and helps manage body weight when consumed in place of more energy-dense foods.

DAILY FRUIT CONSUMPTION (ADULTS)

In 2013 and 2015, 60.0% of adults in the CHI Franciscan Health Harrison Medical Center service area reported eating at least one serving of fruit each day.

Daily fruit consumption (adults) 2013, 2015

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>White, NH</th>
<th>Non-White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male percentage</td>
<td>55.6%</td>
<td>59.9%</td>
<td>63.8%</td>
<td>64.7%</td>
</tr>
<tr>
<td>Female percentage</td>
<td>60.0%</td>
<td>58.6%</td>
<td>59.9%</td>
<td>63.8%</td>
</tr>
</tbody>
</table>

DAILY VEGETABLE CONSUMPTION (ADULTS)

In 2013 and 2015, 76.9% of adults in the CHI Franciscan Health Harrison Medical Center service area reported eating at least one serving of vegetables each day.

Community Input:

Community leaders identified access to affordable nutritious food as a contributing factor to chronic illness prevention and management.

Community members identified opportunities to educate the public on nutrition and healthy cooking to provide clarity on conflicting information circulated through online social networks. Providing free or low-cost culturally appropriate cooking programs in community settings is very appealing to many community members. Community members also wanted more and better publicized educational materials, and events and classes on obesity, exercise and nutrition.

Low-income individuals and families often depend on public transportation, making grocery shopping challenging. Accessible, affordable transportation was one of the top things surveyed residents wished was more present in their communities.
CIGARETTE SMOKING (ADULTS)

Cigarette smoking is the leading cause of preventable disease and death in the United States. The Centers for Disease Control and Prevention estimates that cigarette smoking kills over 5,000 adults each year in Washington State.\(^i\)

- From 2012 to 2016, the CHI Franciscan Health Harrison Medical Center service area had about the same percent (16.4%) of current smokers as Washington State (15.5%).

- Cigarette smoking rates varies from 7.7% to 25.8% for specific zip codes in the CHI Franciscan Health Harrison Medical Center service area (Figure 5).

**Figure 5. Tobacco use**

CHI Franciscan Health Harrison Medical Center service area, 2012-2016

**Cigarette smoking (adults)**

2012-2016

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>16.4%</td>
</tr>
<tr>
<td>WA State</td>
<td>15.5%</td>
</tr>
<tr>
<td>White, NH</td>
<td>18.6%</td>
</tr>
<tr>
<td>Non-White</td>
<td>25.9%</td>
</tr>
<tr>
<td>Male</td>
<td>16.8%</td>
</tr>
<tr>
<td>Female</td>
<td>16.0%</td>
</tr>
</tbody>
</table>


* too few cases to protect confidentiality and/or report reliable rates.
CIGARETTE SMOKING (YOUTH)

Most adult smokers begin smoking as teenagers. In Washington State, about 7 kids under the age of 18 start smoking cigarettes each day, and 104,000 Washington kids under the age of 18 and alive today will die prematurely from a smoking-caused disease. Additionally, smoking is associated with the increased risk of drug use and low academic performance.

In 2016, 6.2% of 10th graders in the CHI Franciscan Health Harrison Medical Center service area smoked. This rate was about the same as Washington State’s rate (6.8%).

E-CIGARETTE USE (YOUTH)

Most electronic cigarettes (e-cigarettes or e-cigs) contain nicotine, which is a highly addictive and harmful drug. Nicotine use by teens or children may increase their likelihood of tobacco addiction as adults.

Findings from the 2016 National Youth Tobacco Survey show that e-cigarette use among U.S. high school students has decreased from 2015 to 2016, which is the first decrease after years of an increasing trend.

In the CHI Franciscan Health Harrison Medical Center service area, the percent of 10th graders who used an e-cigarette in the past 30 days was 10.0%.

Source: Healthy Youth Survey, 2016
**Nutrition and Healthy Living Assets and Resources include:**

- **CHI Franciscan Health Harrison HealthPartners Outpatient Nutrition Education Center** in Bremerton has certified registered dietitians who offer complete nutrition care services and education.

- **CHI Franciscan Diabetes Support Groups** provide education and support for those diagnosed with diabetes.

- Local parks, private gyms, walking trails, bike clubs, community centers and others offer places for physical activities; some offer programs and scholarships tailored to community needs.

- **Supplemental and Nutrition Assistance Program (SNAP-Ed)**’s goal is to improve the likelihood that persons eligible for SNAP will make healthy choices within a limited budget and choose active lifestyles consistent with the current Dietary Guidelines for Americans and MyPlate.

- The **Fresh Bucks** program helps low-income residents afford more fruits and vegetables at farmers markets.

- The **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)** helps pregnant women, new mothers, and young children eat well, learn about nutrition, and stay healthy.

- Food banks and other feeding programs, sponsored by faith-based organizations, are working to provide healthier options to their customers.

- The **Kitsap Healthy Eating, Active Living (HEAL) Coalition** is a community-based initiative in Kitsap County to promote the accessibility and affordability of healthy food and physical activity for all.

- **YMCA** Programs: Journey to Healthy Living (Life University); Diabetes Prevention Program

- **CHI Institute for Research & Innovation**

**Opportunities include:**

- Providing education and information through free or low-cost cooking and exercise programs.

- Continuing to publicize CHI classes, events, support groups and resources in the local area designed to promote healthy lifestyles.

- Improving access to places for physical activity in cooperation with employers, coalitions, organizations, and communities. Work with community groups on ongoing efforts to change the local environment to create new opportunities for physical activity or reduce the cost of existing opportunities. Improved access is typically achieved through a multi-component strategy that includes training or education for participants.
■ Offering fitness programs in a variety of community settings including community wellness, fitness, community, and senior centers.

■ Helping residents increase their ability to afford healthy food by supporting job training programs, community economic development, living wages and local and organizational policies that improve access and reduce barriers.

Substance use prevention & control assets and resources include:

■ Kitsap County Substance Abuse Prevention Program, Bremerton Substance Abuse Prevention Coalition, North Kitsap Substance Abuse Prevention Coalition and South Kitsap Substance Abuse Prevention Coalition

■ The Kitsap County Board of Health and Public Health District’s Secure Medicine Return Regulation, Smoking/Vaping in Public Places Laws and Marijuana and Tobacco Prevention Programs are aimed at minimizing harmful effects of legal substance use.

■ The Kitsap County Recovery Center (KRC) in Port Orchard provides both inpatient and outpatient substance abuse treatment services, primarily for low-income and Medicaid-eligible clients.

■ The Washington State Quitline provides tobacco cessation services.

■ West Sound Treatment Center is dedicated to substance use disorder recovery through education and support services.

■ Agape Unlimited is a non-profit, state-certified, outpatient chemical dependency treatment program, supplemented by a range of support services.

■ Suquamish Tribe’s Wellness Program and Port Gamble S’Klallam Tribe’s Wellness Program help community members address chemical dependency and mental health issues through prevention and outreach services.

■ More substance use prevention resources can be found on Kitsap Public Health District’s website at https://www.kitsappublichealth.org.

Opportunities include:

■ Hospital and public health district partnerships to communicate with the public and patients about the impacts of and ongoing need for tobacco and e-cigarette use prevention and cessation, as well as to advocate for tobacco-free policies.

■ Brief tobacco screening and interventions in emergency departments, primary care, dental, and other healthcare settings can improve quit rates. This is an evidence-based practice.

■ Advocate for tobacco-cessation insurance coverage, which currently varies by health plan. No mandated coverage standard exists in Washington State.
Access to comprehensive, quality health care services is an important factor to achieving a healthy life for everyone. Limited access to health care is any decrease in the ability of residents to utilize services, which could be due to a variety of barriers. Limited access impacts people’s ability to reach their full health and well-being potential. Barriers to achieving optimal health care include, but are not limited to: lack of insurance coverage, high cost of that coverage and health services, lack of availability of services, lack of knowledge of how or when to access services, lack of transportation to services, and language gaps that prevent adequate utilization of services. These barriers can lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented.

Community input:
Community members identified access to quality, affordable healthcare as one of the most defining factors of a healthy community. Opportunities include bringing more high-quality medical, dental and mental health providers to the area to help decrease wait times, strategically locating clinics and urgent care facilities near populations of higher need (i.e. low-income and seniors), exploring innovative ways of providing medical care to patients electronically, partnering with Kitsap Transit to improve public transportation efficiency and availability to make public transportation to appointments easier and quicker, providing assistance for people without health insurance or who struggle to afford insurance premiums and co-pays (particularly seniors and children), working with local school districts to provide screening and preventive care, working to find innovative ways to decrease healthcare costs, and advocating for increased Medicaid reimbursement.
Health insurance coverage (adults) 2012-2016 average

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>White, NH</th>
<th>Non-White</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2016 average</td>
<td>89.8%</td>
<td>87.2%</td>
<td>90.5%</td>
<td>68.3%</td>
<td>89.4%</td>
<td>90.2%</td>
</tr>
</tbody>
</table>


Unmet health care needs because of cost (adults) 2012-2016 average

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>White, NH</th>
<th>Non-White</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2016 average</td>
<td>10.2%</td>
<td>13.1%</td>
<td>9.6%</td>
<td>12.7%</td>
<td>8.6%</td>
<td>11.8%</td>
</tr>
</tbody>
</table>


Health Insurance Coverage (Adults)

- From 2012 to 2016, 89.8% of adults in the CHI Franciscan Health Harrison Medical Center service area had health insurance coverage. This rate was statistically higher than Washington State’s rate (87.2%).

- The rate of health insurance coverage is statistically lower for non-White residents than it is for White, non-Hispanic residents.

Unmet Health Care Needs Due to Cost (Adults)

Unmet health care needs may occur for several reasons including treatment costs, long waiting times, transportation barriers, not being able to take time off work and needing to look after children.

- From 2012 to 2016, 10.2% of residents in the CHI Franciscan Health Harrison Medical Center service area had unmet health care needs due to cost. This was statistically lower than the state’s rate of 13.1%.
UNMET HEALTHCARE NEEDS FOR REASONS OTHER THAN COST (ADULTS)

From 2012 to 2016, 31.5% of residents in the CHI Franciscan Health Harrison Medical Center service area had unmet healthcare needs because of a reason other than cost, such as long wait times, not able to take time off work, childcare and transportation issues.

Unmet health care needs for reasons other than cost (adults) 2012-2016 average

<table>
<thead>
<tr>
<th>Category</th>
<th>2012-2016 Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>31.5%</td>
</tr>
<tr>
<td>WA State</td>
<td>32.9%</td>
</tr>
<tr>
<td>White, NH</td>
<td>29.5%</td>
</tr>
<tr>
<td>Non-White</td>
<td>38.9%</td>
</tr>
<tr>
<td>Male</td>
<td>27.0%</td>
</tr>
<tr>
<td>Female</td>
<td>36.2%</td>
</tr>
</tbody>
</table>

Source: Behavioral Risk Factor Surveillance System, 2012-16

NO PRIMARY CARE PROVIDER (ADULTS)

Primary care providers work to prevent disease, maintain health, manage chronic disease, diagnose medical problems, refer patients to specialists and coordinate medical care for a patient population. A strong primary care system provides accessible, cost-effective and high-quality care.

People with regular primary care receive more preventive services, are better at complying with their treatment, and have lower rates of illness and premature death than those without such care. They also use emergency rooms less and are hospitalized less often than those without primary care.

As Medicaid service providers move towards integrated behavioral and physical health care, the lack of a medical home is a critical missed opportunity to ensure patients receive whole person care.

- In 2016, 27.3% of residents in the CHI Franciscan Health Harrison Medical Center service area reported not having a personal doctor.
- There was no difference in percentage of the population reporting not having a personal doctor by race or gender.
No primary care provider (adults) 2016


HEALTH PROFESSIONAL SHORTAGE AREAS

Health Professional Shortage Areas are designated as having a shortage of primary medical, dental or mental health providers. They may be urban or rural areas, population groups, or medical/public facilities.

In the Harrison Medical Center service area, primary care shortage areas are Bremerton low income/migrant farmworker/homeless and Peninsula Community Clinic. The dental health shortage area is Peninsula Community Health. The entire county has been designated a mental health shortage area.xv

DENTAL CHECKUP (ADULTS)

Most adults should see a dentist twice a year for a routine dental checkup, which typically includes teeth cleaning, an evaluation of gums and sometimes X-rays. This process provides a dentist with information regarding tooth decay and other health conditions.

Between 2012 and 2016, an average of 69.8% of adults in the CHI Franciscan Health Harrison Medical Center service area had a routine dental checkup in the previous year.

Dental checkup (adults) 2012, 2014-2016

Access to Care, Uses of Clinical Preventive Services and Oral Health

DENTAL CHECKUP (YOUTH)

Dental checkups are important to start as early as toddler age. Tooth decay is a chronic condition that can start with baby teeth and typically lasts into adulthood with greater costs and risk of diseases such as stroke, diabetes, and heart disease.

- In 2016, 83.4% of students in 10th grade in the CHI Franciscan Health Harrison Medical Center service area reported having a dental checkup in the last year. This rate is statistically the same as that of Washington State (85.0%).

Dental checkup (10th graders) 2016

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, NH</td>
<td>84.6%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Non-White</td>
<td>80.6%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

Source: Healthy Youth Survey, 2016

IMMUNIZATIONS

Immunizations are one of the best ways parents can protect their children from many potentially harmful diseases. Efforts to increase vaccination coverage can focus on increasing access to preventive care, changing parental attitudes, and improving knowledge about the safety and effectiveness of vaccines.

- As of December 31, 2016, 48.4% of children 19 to 35 months old residing in the service area had not completed the recommended series of childhood immunizations, a statistically higher proportion than that of Washington State.

- In addition, almost half (48.6%) of adolescents ages 13 to 17 had not received any HPV vaccinations, statistically higher than Washington State (47.7%).

Children age 19-35 months with incomplete vaccination series* 2016

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, NH</td>
<td>48.4%</td>
<td>40.5%</td>
</tr>
<tr>
<td>Non-White</td>
<td>48.6%</td>
<td>40.5%</td>
</tr>
</tbody>
</table>

*Percentage of children 19-35 months old who have not completed the recommended 4313314 vaccination series [4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 pneumococcal conjugate vaccines (PCV)].
COLORECTAL SCREENING GUIDELINES MET

Adults 50 to 75 years who are at average risk for developing colorectal cancer should be screened by using one or more of the following methods: fecal occult blood testing every year, sigmoidoscopy every five years or colonoscopy every ten years. The data below show the percent of adults age 50 to 75 who met these screening guidelines.

- From 2014 to 2016, 75.5% of adults age 50 to 75 in the CHI Franciscan Health Harrison Medical Center service area reported meeting screening guidelines.

Colorectal screening guidelines met
2014-2016 average

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>White, NH</th>
<th>Non-White</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>75.5%</td>
<td>69.9%</td>
<td>76.6%</td>
<td>67.1%</td>
<td>73.4%</td>
<td>78.2%</td>
</tr>
</tbody>
</table>


PREVENTABLE HOSPITAL STAYS

A preventable hospital stay is one that might have been avoided with better medical care outside of the hospital. The Prevention Quality Indicators (PQIs) are a set of measures taken from hospital discharge data to identify quality of care for “ambulatory care sensitive conditions.” Early intervention and good outpatient care can potentially prevent the need for hospitalization and prevent complications or more severe disease from occurring for these conditions.

These indicators provide insight into the community health care system (outside of the hospital setting). They can help flag potential health care quality problems that need further investigation.

- Congestive heart failure, breathing problems and bacterial pneumonia were the PQIs with the highest rates in Kitsap County in 2015. These same PQIs showed the highest rates in Washington State in 2015.

- Kitsap County had higher rates of preventable hospital stays for dehydration, short-term diabetic complications, high blood pressure and burst appendix compared to the state average, and similar rates for acute PQIs, pneumonia, long-term diabetic complications, diabetic amputations, adult asthma and heart failure. For all other PQIs, Kitsap County had lower rates of preventable hospital stays compared to the state average.
### Preventable hospital stays

**Washington State, 2015**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Counts</th>
<th>Rate per 100,000†</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Composite - All*</td>
<td>48,891</td>
<td>857.7</td>
</tr>
<tr>
<td>PQI Composite - Acute**</td>
<td>17,561</td>
<td>308.1</td>
</tr>
<tr>
<td>Dehydration</td>
<td>3,960</td>
<td>69.5</td>
</tr>
<tr>
<td>Bacterial Pneumonia</td>
<td>8,406</td>
<td>147.5</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>5,195</td>
<td>91.1</td>
</tr>
<tr>
<td>PQI Composite - Chronic***</td>
<td>31,330</td>
<td>549.6</td>
</tr>
<tr>
<td>Diabetes - Short Term Complications</td>
<td>3,545</td>
<td>62.2</td>
</tr>
<tr>
<td>Diabetes - Long Term Complications</td>
<td>3,393</td>
<td>59.5</td>
</tr>
<tr>
<td>High Blood Sugar Complications</td>
<td>212</td>
<td>3.7</td>
</tr>
<tr>
<td>Lower Extremity Amputation - Diabetics</td>
<td>686</td>
<td>12.0</td>
</tr>
<tr>
<td>Adult Asthma (Age 19-39)</td>
<td>524</td>
<td>22.4</td>
</tr>
<tr>
<td>Breathing Problems (Asthma or Other Lung Conditions)</td>
<td>7,429</td>
<td>221.2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1,339</td>
<td>23.5</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>14,574</td>
<td>255.7</td>
</tr>
<tr>
<td>Burst Appendix</td>
<td>1,335</td>
<td>23.4</td>
</tr>
</tbody>
</table>

**Source:** Washington State MONAHRQ 2015 data (www.wamonahrq.net).

†Observed rate per 100,000 residents age 18 and older

Community input:

Community members identified access to high-quality, affordable healthcare as one of the most defining factors of what makes a healthy community. Community leaders identified access to healthcare services as a contributing factor to chronic illness prevention and management. Community members...
highlighted affordability and billing transparency, provider workforce capacity, and transportation and logistical problems with access as the most significant barriers.

Community stakeholders expressed concern for healthcare affordability. While the Affordable Care Act has provided coverage to an increasing number of residents, many are not eligible for subsidies or Medicaid. They struggle to afford increasing premiums, deductibles and co-pays, while having difficulty understanding the limitations of their current insurance plans and financially covering the gaps in insurance coverage. This leaves many community members, including middle income earners, with limited access to routine healthcare. Prevention-based services are often most impacted as residents must make decisions between necessary services and basic needs such as food or housing. Seniors and those with specialty care needs are particularly impacted by limited coverage for specialty care, adult dental care and behavioral health services. Community members value free or subsidized-cost services on a consistent basis for any resident (e.g., free clinics, discounts for cash payments, sliding scale payments, etc.). The second most common request is that actual service costs be lowered (e.g., lower cost of vaccinations).

Understanding eligibility for specific providers, clinics, services and benefits is seen as an ever-changing challenge, which prevents access when residents are unable to predict healthcare costs upfront and therefore delay needed care due to a fear of unforeseen costs. Increasing billing transparency and improved cost-estimating, as well as increased availability of community health workers, hospital navigators, and in-person assisters are seen as very helpful.

Community members expressed concerns of severe shortages in healthcare provider workforce capacity affecting primary care, dental and mental healthcare, leading to extreme wait times for appointments. Community members value health care providers’ knowledge about addressing root causes of poor health, time listening to patients’ needs and compassionate approaches that reflect community diversity including racial, ethnic, cultural, linguistic, sexual identity and gender diversity. They appreciate providers who spend more time with patients with complex needs, allowing for more discussion.

Successfully addressing barriers to care includes improving transportation to service sites, increasing services in rural areas (especially those with little to no bus access) and improving coordinated care, according to community members. Community members suggested alternative transportation options, such as
providing bus tokens to get to appointments and shuttle services for older and/or disabled adults and low-income families.

Participants asked health systems to increase provider capacity in local facilities close to residential areas, increase mobile services, work to coordinate physical care services with behavioral health and social services, and get involved with legislation, advocating for efficient, transparent healthcare insurance and payment systems.

Inadequate Medicaid reimbursement restricts access to child and adult dental care in Kitsap County, especially for those in need of dentures. Residents expressed the need for increased access to dental services, citing many of the same barriers to overall access to medical and mental health care.

**Assets and resources include:**

- **Access to Baby and Child Dentistry** connects Medicaid-eligible children to preventive and restorative dental care.

- **Peninsula Community Health Services** is a federally-qualified health clinic offering integrated physical, behavioral and oral health care throughout the county.

- **Lindquist Dental Clinic for Children (LDCC)** provides accessible, compassionate dental care to Puget Sound children in need.

- **Project Access Northwest** helps low-income patients connect with primary health care and specialty providers to improve health outcomes and reduce inappropriate emergency room use. Project Access also provides premium assistance for individuals on the health exchange.

- **Kitsap Connect** is an intensive outreach and engagement collective impact program which serves the highest utilizers of clinical and social services, who struggle with substance use disorder, severe mental illness and/or homelessness.

- **Kitsap Transit Access Program** provides transportation for seniors and people with disabilities who are unable to use the regular routed buses.

- **Olympic Community of Health (OCH)** is an accountable community of health focused on practice transformation improvements and strengthening community clinical linkages to reach the Triple Aim.

**Opportunities include:**

- Ensure that Project Access and premium assistance, as well as other available services, are promoted by providers and understood by community members.

- Explore additional opportunities to assist people without health insurance or who struggle to afford insurance premiums (particularly seniors).

- Work to bring Kitsap rates of preventable hospitalizations for dehydration, high blood pressure, short-term diabetic complications and burst appendix down closer to WA rates.
Improving the well-being of mothers, infants, and children determines the health of the next generation and can reduce future public health challenges for families, communities and health care systems. Because maternal health is closely linked to newborn health, preventive efforts such as early and adequate prenatal care and breastfeeding can help reduce infant mortality and morbidity. Prevention of Sudden Infant Death Syndrome (SIDS) and low birth weight are two important ways to improve the survival and well-being of newborns.

INFANT MORTALITY

The infant mortality rate is the number of babies who die before their first birthday per 1,000 live births in a given year. In Washington State two-thirds of infant deaths are associated with labor and delivery-related conditions, birth defects and prematurity. Because many of these deaths are preventable, infant mortality is a measure of the overall health of a population.

From 2011 to 2015, the infant mortality rate in the CHI Franciscan Health Harrison Medical Center service area was 5.8 deaths for every 1,000 live births. This is statistically higher than the Washington State average.

Infant mortality
2011-2015 average

<table>
<thead>
<tr>
<th></th>
<th>Rate per 1,000^</th>
</tr>
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<tbody>
<tr>
<td>Harrison</td>
<td>5.8</td>
</tr>
<tr>
<td>WA State</td>
<td>4.7</td>
</tr>
</tbody>
</table>


^Rate = Infant deaths per 1,000 live births
Sudden Infant Death Syndrome (SIDS) is the sudden, unexpected death of an apparently healthy baby under one year of age that remains unexplained after a complete postmortem investigation, including an autopsy, examination of the death scene and a review of the medical history. While SIDS occurs in all demographic groups in Washington State, from 2011 to 2015, Pacific Islander, American Indian/Alaska Native babies and babies of more than one race are two to three times more likely to die of SIDS than White babies.\textsuperscript{viii}

From 2006 through 2015, twenty-three sleep-related infant deaths occurred among residents of the CHI Franciscan Health Harrison Medical Center service area.

EARLY AND ADEQUATE PRENATAL CARE

Starting prenatal care early in pregnancy and having regular visits improves the chances of a healthy pregnancy. This indicator measures births for which 1) prenatal care started before the end of the 4th month, and 2) 80% or more of the recommended number of visits occurred.

From 2012 to 2016, just over half of the expectant mothers in the CHI Franciscan Health Harrison Medical Center service area (57.7%) received early and adequate prenatal care, statistically lower than the state average of 63.2%.

Early and adequate prenatal care 2012-2016 average

BREASTFEEDING INITIATION

Breastfeeding initiation is defined as mothers who start breastfeeding before leaving the hospital. A high percent of breastfeeding initiation is a positive indicator of an effective hospital preventive health program supporting mothers to successfully begin breastfeeding.

- From 2012-2016, 92.6% of women giving birth who reside in the CHI Franciscan Health Harrison Medical Center service area initially breastfed their infants. This was lower than the state average.

- Native Hawaiian/Pacific Islanders, American Indian/Alaskan Native, Hispanic and Black mothers were less likely to initiate breastfeeding when compared to White women.

Breastfeeding initiation
2012-2016 average

<table>
<thead>
<tr>
<th></th>
<th>2012-2016 average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>92.6%</td>
</tr>
<tr>
<td>WA State</td>
<td>94.2%</td>
</tr>
<tr>
<td>White, NH</td>
<td>93.3%</td>
</tr>
<tr>
<td>Black, NH</td>
<td>88.5%</td>
</tr>
<tr>
<td>AIAN, NH</td>
<td>87.7%</td>
</tr>
<tr>
<td>Asian, NH</td>
<td>93.3%</td>
</tr>
<tr>
<td>NHPI, NH</td>
<td>90.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>89.4%</td>
</tr>
</tbody>
</table>

LOW BIRTH WEIGHT

An infant born weighing less than 2500 grams (about 5.5 pounds) is considered low birth weight. Low birth weight infants are at higher risk of infant mortality, respiratory disorders and neuro-developmental disabilities. Low birth weight can add to the length of hospital stays and the cost of health care.

- From 2012 to 2016, 4.9% of infants born to residents of the CHI Franciscan Health Harrison Medical Center service area were low birth weight, approximately the same as the state average.

- The rate of low birth weight varied by zip code from 0% to 7.2% in the Harrison Medical Center service area (Figure 6).

Low birth weight
2012-2016 average

Community input:

Community members cite the impact of poverty and inadequate social support as primary barriers to healthy development of infants, especially for first time mothers. Local community groups and strong partnering health care systems are appreciated for their collaborative work to provide support to pregnant women and parenting families. Building family support networks by holding community events provides opportunities for maternal/child-related health education, as well as building relationships between parents.

Assets and resources include:

- The Northwest Infant Survival & SIDS Alliance is dedicated to reducing the risk of sudden unexpected infant death.

- The Native American Women’s Dialogue on Infant Mortality (NAWDIM), a Native-led collective whose members are concerned about high rates of infant mortality in their communities.

- Governor Inslee’s statewide Results Washington framework which calls for reducing birth outcome disparities.

- CHI Franciscan Health Harrison Medical Center is a baby-friendly hospital and supports breastfeeding support drop-in sites staffed by a public health nurse.

- Healthy Start Kitsap Nurse Family Partnership promotes health and helps build problem-solving skills that promote self-sufficiency and a positive life course.

- Parents as Teachers promotes the optimal early development, learning and health of young children by supporting and engaging their parents and caregivers.

- The Parent-Child Assistance Program is an evidence-based federal research program helping mothers build and maintain healthy, independent family lives, assure that children are in safe, stable homes and prevent future births of alcohol and drug exposed children.
The Period of PURPLE Crying curriculum helps parents understand this time in their baby’s life and is a promising strategy for reducing the risk of child abuse.

Women, Infants and Children (WIC) provides support for pregnant women, nursing moms, and children under five to improve access to healthy foods, receive health education and screening services, increase breast feeding and access other health and social services.

Cribs for Kids National Infant Safe Sleep Initiative partners have been making an impact on reducing the rate of infant sleep-related deaths due to accidental suffocation, asphyxia or undetermined causes in unsafe sleeping environments.

Head Start and Early Head Start Programs provide free preschool programs for children ages 0 to 5 from income-eligible families and children with special needs.

Perinatal Learning Collaborative is a multi-disciplinary group of clinicians, lay leaders, home visitors, administrators, lactation specialists and perinatal service providers learning together and developing solutions to promote better holistic outcomes among women and babies in our community.

Kitsap County Breastfeeding Coalition protects, promotes and supports breastfeeding through education and resources for new mothers.

In collaboration with CHI Franciscan, Kitsap Public Health District provides weekly, no-cost, bilingual (English-Spanish) New Parent Support Groups to pregnant women, new parents and family members, which include breastfeeding support, education, community resources and parenting information.

Opportunities include:

Prenatal care can offer an opportunity to address all aspects of preventive medicine, as well as family and ongoing health issues with women. Emphasis should be put on encouraging Kitsap women to begin prenatal care early, continue through all recommended prenatal care appointments and initiate breastfeeding.

Increase referrals to the evidence-based Nurse-Family Partnership program and Maternity Support Services and First Steps.
Injuries and violence cross all boundaries and can affect anyone, regardless of age, sex, race or socioeconomic background. Injuries and violence are the leading cause of death and disability for people ages one to 44 in both the state and nationwide. While injuries and violence can have a dramatic impact on a person’s ability to lead an active, fulfilling life, they are largely preventable. Those who survive unintentional and violence-related injuries may face life-long mental and physical problems. Recognizing the social and economic burden of injury and violence is critical to determine the appropriate level of intervention and investment into prevention activities.

HOMICIDE

Homicide is death resulting from the intentional use of force or power, threatened or actual, against another person. Homicide is related to community well-being and wider social conditions such as poverty and low education, racial composition and the disruption of family structure.

From 2012 to 2016, the homicide rate in the CHI Franciscan Health Harrison Medical Center service area was 2.0 per 100,000 population.

The White, non-Hispanic, homicide rate was 1.6 per 100,000. The non-White homicide rate could not be calculated because there were fewer than 10 cases in the five-year period 2012 to 2016.

Homicide
2012-2016 average

<table>
<thead>
<tr>
<th></th>
<th>Rate per 100,000^</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>2.0</td>
</tr>
<tr>
<td>WA State</td>
<td>3.2</td>
</tr>
<tr>
<td>White-NH</td>
<td>1.6</td>
</tr>
<tr>
<td>Non-White</td>
<td>n&lt;10</td>
</tr>
</tbody>
</table>

^Rate: cases per 100,000 population; age-adjusted to 2000 US population.
*All races other than White, non-Hispanic, have too few cases to protect confidentiality and/or report reliable rates individually.
SUICIDE

Suicide is a serious public health problem with lasting harmful effects for individuals, families and communities. While its causes are complex, the goal of suicide prevention is simple: reduce factors that increase suicide risk and increase protective factors that promote resilience. Effective prevention strategies are needed to promote awareness of suicide and encourage a commitment to social change.

- The 2012-2016 suicide rate in the CHI Franciscan Health Harrison Medical Center service area was 15.2 per 100,000 population.
- White, non-Hispanic residents had a higher rate of suicide deaths than non-White residents.


*Rate: cases per 100,000 residents, age-adjusted to the 2000 US population.
*All races/ethnicities other than White, non-Hispanic, have too few cases to protect confidentiality and/or report reliable rates individually.
INTENTIONAL INJURY HOSPITALIZATIONS

Intentional injuries can be physical and/or emotional and result from purposeful human action, whether directed at oneself or others. Examples include injuries resulting from attempted suicides or assaults.

- From 2011 to 2015, the average rate of intentional injury hospitalizations for the CHI Franciscan Health Harrison Medical Center service area was 54.3 cases per 100,000 population. This is statistically lower than the state’s rate of 71.8 per 100,000.
- Children under 15 years old and those ages 55 and older were least likely to be hospitalized for intentional injuries.


^Rate=cases per 100,000 population, age-adjusted to the 2000 US population; subgroups are crude rates.

*too few cases to protect confidentiality and/or report reliable rates.
UNINTENTIONAL INJURY DEATHS

Unintentional injury deaths are deaths due to unintended causes. From 2012 to 2016, the top three causes in Washington State and the CHI Franciscan Health Harrison Medical Center service area were falls, poisonings and motor vehicle crashes. Poisonings includes drug and alcohol-related injuries.

- From 2012 to 2016, the unintentional injury death rate in the CHI Franciscan Health Harrison Medical Center service area was 35.5 cases per 100,000 population, which is statistically lower than the state’s rate of 40.0 per 100,000.

- American Indian/Alaskan Native (AI/AN) residents had the highest rate of unintentional injury deaths, but the difference was not statistically significant because there are relatively few AI/AN residents in the population. White, non-Hispanic residents had higher rates of unintentional injury deaths than Asian, non-Hispanic residents and all other races and ethnicities combined.


^Rate: cases per 100,000 residents, age-adjusted to the 2000 US population; subgroups are crude rates.

*All races/ethnicities other than White, non-Hispanic, American Indian/Alaskan Native and Asian, non-Hispanic, have too few cases to protect confidentiality and/or report reliable rates individually.
UNINTENTIONAL INJURY HOSPITALIZATIONS

Unintentional injury hospitalizations are non-fatal hospitalizations due to unintentional injuries. In 2015, the top three causes of unintentional injuries resulting in hospitalization in the state and Kitsap County were falls, motor vehicle crashes and poisonings. Poisoning includes drug and alcohol-related injuries.

- From 2011 to 2015, the unintentional injury hospitalization rate in the CHI Franciscan Health Harrison Medical Center service area was 431.5 hospitalizations per 100,000 population. This is statistically lower than the state average rate.

- After age five, the unintentional injury hospitalization rate increases with age, peaking at 3,941.8 hospitalizations per 100,000 among residents age 85 and older.


^Rate: cases per 100,000 population; age-adjusted to the 2000 US population.
Community input:

Injury prevention

Safety was cited as one of the top three most important features in defining a healthy community, and Kitsap community members remain concerned, despite lower rates than state averages, with almost a quarter of surveyed residents mentioning crime and violence as one of the biggest problems to their community’s overall health. School violence (including bullying) was also mentioned as one of the big problems for youth in our communities. Lack of gainful employment due to shortages of living wage jobs, poverty-related stress, mental health needs, chemical dependency, and limited healthy socialization are seen as the root causes of most criminal and violent behavior.

Community stakeholders felt that one of the most valuable assets of their community is the community members themselves, citing a cohesive community where people know each other and are accepting and respectful of all others as one of the aspects of a healthy community. There is a need to create safe spaces to meet, live and be active in order to make a community where people want to live. Residents recommend building community social capital by holding more frequent community events where residents can come together to build relationships.

Suicide prevention

Community residents share a great concern for people with mental health and chemical dependency illnesses and recognize them as risk factors for suicide. Surveyed residents were especially concerned about suicidal ideation in children and youth in their communities. They saw increasing societal pressure on children, a lack of access to offline social opportunities, and concerns about local and world affairs as contributing. The community strongly supports holistic, integrated wrap-around care, and mental health and suicide risk screening as part of suicide prevention.

Opportunities identified include patient and family education, support groups and classes; hospital discharge planning; wrap-around services, referrals and associated follow-up; and education and support groups for parents, children and families struggling with stressors.
Assets and resources include:

Drug and alcohol-related injury and death prevention

- The Target Zero Task Force, which focuses on reducing traffic crashes and traffic-related injuries to zero by the year 2030.

- Kitsap Public Health District Syringe Exchange helps prevent HIV, hepatitis and other bloodborne disease transmission, in addition to providing access to prevention counseling.

- Additional substance use prevention resources can be found in the Actual Causes of Illness section.

Suicide prevention

- Kitsap Community Suicide Prevention Coalition is committed to reducing the deaths by suicide in Kitsap County.

- Crisis Clinic of the Peninsulas provides over-the-phone crisis intervention, information referral and a supportive listening ear to people in our community who are experiencing situational distress.

- Forefront, a research organization based at the University of Washington, is training health professionals to develop and sharpen their skills in the assessment, management, and treatment of suicide risk.

- WA House Bill 2315 and other bills passed over the past several years require school staff, behavioral healthcare providers, and other healthcare providers to participate in suicide prevention training as part of their licensure.

- National Suicide Prevention Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for individuals and families, and best practices for professionals.
Injury prevention

- **ThinkFirst National Injury Prevention Foundation** has award-winning evidence-based programs to help people learn to reduce their risk for injury.

- Community and senior centers offer physical activity programs for seniors.

- **Northwest Region EMS and Trauma Care Council** works in collaboration with agencies in the region to provide injury prevention resources.

- Kitsap Public Health District has additional injury prevention resources on their website, www.kitsappublichealth.org.

**Opportunities include:**

**Drug and alcohol-related injury and death prevention**

- Primary care intake assessments that include screening for substance use and driving while impaired.

- Support opioid and other drug overdose prevention programs and policies

**Suicide prevention**

- Patient and family education, support groups, and classes for friends and families of people who are suicidal or have a mental illness or substance abuse disorder can help reduce stigma and make it easier for those in need to access care.

- Improvements in hospital discharge planning and “warm hand-off” referrals (in which primary care providers directly introduce clients to their behavioral healthcare providers at the time of their medical visits) can help transfer trust and rapport to the new relationship.

**Injury prevention**

- Environmental modifications in seniors’ homes can reduce the risk of readmissions for repeat falls.

- Potential partnerships with community organizations that address injury prevention and promote health and fall prevention among seniors.
Mental health is essential to a person’s well-being and ability to live a full and productive life. People of all ages, including children and adolescents, with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, and co-occurring disorders, including alcohol or drug abuse. Information and resources that better integrate behavioral health services into the overall health care system can lower the risk of poor health outcomes.

**FREQUENT MENTAL DISTRESS (ADULTS)**

Frequent mental distress is defined as adults reporting poor mental health (includes stress, depression, and problems with emotion) on 14 or more days in the past 30 days.

From 2012 to 2016, 11.4% of adults in the CHI Franciscan Health Harrison Medical Center service area experienced frequent mental distress. This percent is the same as the state average of 11.3%.

**Frequent mental distress (adults)**
**2012-2016 average**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>11.4%</td>
</tr>
<tr>
<td>WA State</td>
<td>11.3%</td>
</tr>
<tr>
<td>White, NH</td>
<td>13.2%</td>
</tr>
<tr>
<td>Non-White</td>
<td>*</td>
</tr>
<tr>
<td>Male</td>
<td>9.3%</td>
</tr>
<tr>
<td>Female</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

*too few cases to protect confidentiality and/or report reliable rates
DEPRESSION PREVALENCE (ADULTS)

Adult depression includes depression, major depression and dysthymia (minor depression) in adults ages 18 years or older. Continued sadness including loss of interest/enjoyment in doing things, as well as feeling down, could be signs of depression.

- From 2012-2016, 24.9% of adults in the CHI Franciscan Health Harrison Medical Center service area reported being told they had a depressive disorder, which is higher than the state average.

- Women were almost twice as likely to report having a depressive disorder as men.

Depression (adults)
2012-2016 average

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>24.9%</td>
</tr>
<tr>
<td>WA State</td>
<td>22.0%</td>
</tr>
<tr>
<td>White, NH</td>
<td>25.5%</td>
</tr>
<tr>
<td>Non-White</td>
<td>25.5%</td>
</tr>
<tr>
<td>Male</td>
<td>18.0%</td>
</tr>
<tr>
<td>Female</td>
<td>31.9%</td>
</tr>
</tbody>
</table>


DEPRESSION (YOUTH)

Youth depression is based on the percent of youth in 10th grade who reported that during the past 12 months they had felt so sad or hopeless almost every day for two weeks or more in a row that they had stopped doing some usual activities.

- In 2016, 37.2% of 10th graders in the CHI Franciscan Health Harrison Medical Center service area felt so sad or hopeless for two weeks or more that they stopped doing their usual activities.

Depression (10th graders) 2016

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrison</td>
<td>37.2%</td>
</tr>
<tr>
<td>WA State</td>
<td>35.2%</td>
</tr>
<tr>
<td>White-NH</td>
<td>36.5%</td>
</tr>
<tr>
<td>Non-White</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

Source: Healthy Youth Survey, 2016
BINGE DRINKING (YOUTH)

Binge drinking is defined as the percent of students in 10th grade who report having had five or more drinks in a row in the last two weeks. The effects of binge drinking among youth may include school or social problems, abuse of other drugs and an increased risk of unintentional and intentional injury. Additionally, negative health effects of alcohol are associated with greater quantities and longer duration of use.

■ In 2016, 7.6% of 10th grade students in the CHI Franciscan Health Harrison Medical Center service area reported binge drinking in the past 30 days, statistically lower than the Washington rate.

# Binge drinking (10th graders) 2016

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>White-NH</th>
<th>Non-White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7.6%</td>
<td>9.5%</td>
<td>6.7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Female</td>
<td>7.6%</td>
<td>9.5%</td>
<td>6.7%</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

Source: Healthy Youth Survey, 2016

MARIJUANA USE (YOUTH)

Marijuana use among youth is an emerging, concerning trend in Washington State. Effects of early marijuana use are still largely unknown.

■ In 2016, 15.0% of 10th grade students in the CHI Franciscan Health Harrison Medical Center service area reported using marijuana in the past 30 days, statistically lower than the Washington state rate of 17.3%.

■ There was no difference by race or gender.

# Marijuana use (10th graders) 2016

<table>
<thead>
<tr>
<th></th>
<th>Harrison</th>
<th>WA State</th>
<th>Male</th>
<th>Female</th>
<th>White, NH</th>
<th>Non-White</th>
</tr>
</thead>
<tbody>
<tr>
<td>10th</td>
<td>15.0%</td>
<td>17.3%</td>
<td>14.1%</td>
<td>16.5%</td>
<td>14.7%</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

Source: Healthy Youth Survey, 2016
DRUG-RELATED HOSPITALIZATIONS

Drug-related hospitalizations are hospitalizations related to all drugs other than alcohol and tobacco.

- From 2013 to 2015, there were 358 hospitalizations related to drugs for every 100,000 residents, statistically lower than the Washington rate. Approximately 46% of the drug-related hospitalizations are due to opioids.

- Drug-related hospitalizations occur at a statistically higher rate in women and younger adults ages 18-34 years.

Drug-related hospitalizations 2013-2015 average

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Harrison Rate</th>
<th>Wa State Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 17</td>
<td>358</td>
<td>519</td>
</tr>
<tr>
<td>18-34</td>
<td>320</td>
<td>627</td>
</tr>
<tr>
<td>35-64</td>
<td>389</td>
<td>403</td>
</tr>
<tr>
<td>65+</td>
<td>233</td>
<td>75</td>
</tr>
</tbody>
</table>


ADVERSE CHILDHOOD EVENTS (ACEs)

Adverse Childhood Events (ACEs) are categorized by experiences of abuse, neglect and/or family dysfunction during the first 18 years of life. More ACEs increase the risk for poor mental health, poor health behaviors and poor health outcomes.

It is difficult to collect data on ACEs in our population because they are often not reported. The following data is based on self-reports of experiences related to abuse, neglect and family dysfunction.

- In 2016, 63.5% of 8th, 10th and 12th grade students in the service area reported experiencing 1 or more of the events potentially classifiable as ACEs*.

ACEs (8th, 10th and 12th graders) Percentage with 1 or more ACE(s)*, 2016

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Harrison</th>
<th>WA State</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 17</td>
<td>63.5%</td>
<td>62.3%</td>
</tr>
<tr>
<td>18-34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Healthy Youth Survey, 2016

* Out of 5 potential proxy questions for ACEs (ever being intentionally physically hurt by an adult, ever being put down or insulted by a parent, being hurt in the past year by someone they were dating, being threatened or having their activities limited in the past year by someone they were dating and ever being forced to engage in kissing, sexual touch or intercourse).
In 2011, 66.4% of adults in the Harrison Medical Center service area reported experiencing 1 or more adverse events in their youth.

**ACEs (adults)**

Percentage with 1 or more ACE(s)*, 2011

Source: Behavioral Risk Factor Surveillance System, 2011 (questions have not been asked again in more recent years).

*Out of 9 potential proxy questions for ACEs (lived with someone who was mentally ill or suicidal, lived with a problem drinker or alcoholic, lived with an illegal or prescription drug abuser, lived with parents who abused each other, lived with someone who served time in jail, parents were divorced or separated, intentionally physically hurt by an adult, put down or insulted by a parent, and experienced sexual abuse).

**Community input:**

Community members felt that behavioral health needs and substance abuse were the two biggest problems to our community’s overall health. Drug and alcohol abuse (including tobacco) was also the highest ranked problem for youth in our community, while depression was the third most commonly reported problem.

While there is a need for crisis-related behavioral health services, there is also recognition of the need to invest resources into screening and support services for non-crisis individuals with behavioral health needs. Insurance premiums, deductibles, co-pays and regulatory barriers can limit the pursuit and/or use of services, particularly for residents not yet in crisis.

Community members and leaders strongly support efforts to integrate social services, behavioral and physical health care services to address complex needs or dual diagnosis patients, as well as increasing access to behavioral health services, particularly for middle-income residents. Integrated health care provides a better opportunity to address subtler mental health needs, such as depression associated with chronic illnesses like diabetes or unmet basic needs like housing. Many healthcare organizations are increasing their capacity for integrated care, such as incorporating behavioral health specialists into primary care settings and using physical-behavioral health and social services “side-by-side” care models. In addition, community stakeholders valued the following approaches to behavioral health:

- Cross-training staff to provide holistic, wrap-around care (screening, referrals, discharge planning).
- Addressing contributing factors for suicide, including basic needs, such as employment and housing, and stressors, such as parenting.
Training of healthcare staff on recognition of drug-seeking behaviors and current prescribing practices, as well as supporting prescribing database projects.

The need for support for children and youth with behavioral health concerns, such as depression, that may go unrecognized when more immediate concerns (such as housing, jobs and food) overwhelm their parents.

**Assets and resources include:**

- **Kitsap Strong** is a collective impact initiative with public and private partners, committed to reducing childhood adversity, reducing intergenerational poverty and building resiliency.

- **Kitsap Mental Health Services (KMHS)** is a private, not-for-profit community mental health center that provides mental health and behavioral health care services to children, families, adults and seniors.

- The **1/10 of 1% Mental Health-Chemical Dependency-Therapeutic Courts Tax** provides funding for diverse projects focused on mental health and chemical dependency prevention and treatment.

- **Suquamish Tribe’s Wellness Program** and **Port Gamble S’Klallam Tribe’s Wellness Program** help community members address chemical dependency and mental health issues through prevention and outreach services.

- **Catholic Community Services** provides an array of services, including counseling, case management, information and referral, chemical dependency services, mental health services and family support services to children, adults and families in need.

- An objective of the **Public Health Improvement Partnership** is to prevent or reduce the impact of adverse childhood experiences.

- Additional **substance use prevention resources** can be found in the Actual Causes of Illness section.

- Additional **suicide prevention resources** can be found in Violence and Injury Prevention section.

**Opportunities include:**

- Increased resources for free or low-cost family support programs, such as “family nights” where parents can socialize.

- Coordination of discharge planning across care services.

- Increased systemic capacity for integrated physical and behavioral health care services.

- Increased family support services, and increased outpatient and inpatient options for behavioral health-related and substance use cessation services.
i. Office of Superintendent of Public Instruction (OSPI), Dropout and Graduation Rates (2015-2016). All students, 4-year graduate and dropout results, class of 2016, school year 2015-16 results.


iii. The Homelessness Housing and Assistance Act, ESSHB 2163-2005, RCW43.185C.030.

iv. Washington State Department of Commerce, Annual Point in Time Count, Kitsap County, WA.

v. Department of Social and Health Services (DSHS): Foster Care Placement Services.


viii. America’s Health Rankings, United Health Foundation


x. Centers for Disease Control and Prevention, CDC Growth Charts, U.S.

xi. Centers for Disease Control and Prevention, State System, State Tobacco Activities Tracking & Evaluation


xv. Health Resources and Services Administration: Data Warehouse, HPSA Find


xxi. Centers for Disease Control and Prevention, 2016. About the CDC-Kaiser ACE Study.
This report includes both primary and secondary data sources. Primary data consists of new information gathered directly from the community through surveys, interviews, or community workshops. Secondary data is information that has already been collected by another entity.

QUANTITATIVE DATA SOURCES AND METHODS

Much of the secondary data in this report comes from several key sources. These sources, the methods used to analyze the data, and the data limitations are briefly described below.

Behavioral Risk Factor Surveillance System (BRFSS)

This is the largest, continuously conducted telephone health survey in the world. The survey collects information on a vast array of health conditions, health-related behaviors, and risk and protective factors related to individual adult (18 years and older) health. It enables the Centers for Disease Control and Prevention (CDC), state and local health departments, and other health agencies to monitor modifiable risk factors for chronic disease and other leading causes of death.

Data are reported annually. More information can be found at http://www.cdc.gov/brfss/index.html.

Beginning in 2011, new methods were used to make the BRFSS results more representative of the population. First, the sample now includes respondents who have cell phones but no landline; this group was not included in previous surveys. Second, the data were weighted by various demographic characteristics to compensate for under-representation of certain demographic subgroups. Both these changes should improve the accuracy of the BRFSS results. However, because of these methodological changes, the BRFSS data values starting in 2011 are not comparable to prior years.

Healthy Youth Survey (HYS)

This school-based survey is administered in even numbered years throughout Washington State. The survey includes grades 6, 8, 10 and 12. For this report, we used data from 10th grade students. We included data from schools that were physically located in the hospital service area, recognizing that this may include responses of students residing outside the service area and exclude information about students living in the service area but attending school elsewhere. HYS topics include health risk behaviors, family, community risk and protective factors and
current health conditions. Like other survey data, it is subject to social desirability bias and recall error. Unaggregated data of ten or fewer counts was not displayed in order to protect anonymity of the participants. More information can be found at https://www.askhys.net/.

**Death certificate data**

For death certificates, funeral directors collect information about the deceased person, including race and ethnicity, from an informant who is usually a family member or close personal friend of the deceased. A certifying physician, medical examiner or coroner generally provides information about the cause of death. Cause-of-death data come from underlying causes of death and not immediate causes. For example, if a person dies of a complication or metastasis of breast cancer, breast cancer would be the underlying cause of death. Data are compiled by the Washington State Department of Health, Center for Health Statistics. More information can be found at http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData.aspx.

**Birth certificate data**

The birth certificate system contains records on all births occurring in the state and nearly all births to residents of the state. Information is gathered about the mother, the father, the pregnancy and the child. The information is collected at hospitals and birth centers from worksheets completed by parents or medical staff, through the review of medical charts or by a combination of these sources. Midwives and family members who deliver a baby complete the birth certificate and collect the information from a parent or from their records. Data are compiled by the Washington State Department of Health, Center for Health Statistics. More information can be found at http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData.aspx.

**American Community Survey (ACS)**

The ACS is a mailed survey conducted every year by the U.S. Census Bureau to estimate a wide variety of social and economic data for the U.S. population. The ACS replaces the long form of the census for collecting detailed population data and has the advantage of being released annually rather than at ten-year intervals. The ACS location of residence is based on census tracts, which don’t align with zip code boundaries. To better align with zip codes, when
required, we used ZCTAs (Zip Code Tabulation Areas) developed by the ACS to simulate zip codes. More information can be found at https://www.census.gov/programs-surveys/acs/.

The Office of the Superintendent of Public Instruction

The Washington State Report Card provides data on graduation and free/reduced price meal data through the Comprehensive Education Data and Research System (CEDARS), an online system that captures information regarding students in Washington State. To calculate graduation rates, the adjusted cohort method was used, which follows a single cohort of students for four years based on when they first entered 9th grade. The cohort is “adjusted” by adding in students who transfer into the school and by subtracting out students who transfer out of the school. More information can be found at http://www.k12.wa.us/.

Washington State Department of Health (DOH), Immunization Information System

The IIS is a lifetime registry that tracks immunization records for people of all ages in Washington. Immunization rates for children, adolescents, and adults are available through the IIS. This data source is best used to calculate childhood immunization rates.

The Department of Health publishes annual data for immunization coverage among toddlers, children, and adolescents by county and state. Immunization data is available at https://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/Immunization/ImmunizationInformationSystem.

Washington State DOH, Enhanced HIV/AIDS Reporting System (eHARS)

This is a browser-based application provided by the Centers for Disease Control and Prevention (CDC). The Washington State DOH uses eHARS to collect, manage and report HIV/AIDS case surveillance data to CDC. http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/HIVAIDSData/SurveillanceReports.aspx.

Washington State DOH, Washington State Cancer Registry (WSCR)

The WSCR monitors the incidence of cancer in the state to better understand, control and reduce the occurrence of cancer. In 1995, WSCR received funding through the CDC’s National Program of Central Cancer Registries. This program is designed to standardize data collection and provide information for cancer prevention and control programs. More information can be found at https://fortress.wa.gov/doh/wscr/.
Additional Data Sources

Health Professional Shortage Areas
Health Resources and Services Administration (HRSA): HRSA Data Warehouse/Map Tool
http://datawarehouse.hrsa.gov/

Foster Care
Department of Social and Human Services (DSHS): Foster Care Placement Services
https://www.dshs.wa.gov/ca/foster-parenting

Homelessness
Washington State Department of Commerce: Washington State “Annual Point in Time Count” 1/26/2017. The Homeless Housing and Assistance Act (ESSHB 2163-2005) requires each county to conduct an annual point in time count of sheltered and unsheltered homeless persons (RCW 43.185C.030) in accordance with the requirement of the U.S. Department of Housing and Urban Development (HUD).

Prevention Quality Indicators
Agency for Health Care Research and Quality (AHRQ): Prevention Quality Indicators (PQIs).
http://www.wamonahrq.net


Kitsap County rates are based on hospital discharge data collected from hospitals. County populations are from U.S. Census Bureau data.

Calculating and Interpreting Rates

Rates: Most health data are reported as percentages (%). In other cases, we use rates to compare risk between groups. A rate converts the ratio of events (e.g., number of births per year) in a target population to a ratio that represents the number of events that would have occurred in a standard size population (usually either 1,000 or 100,000). This removes the variability associated with the size of the sample. Since each rate has a standard denominator that is specified, rates can be compared between different populations.
Age-Adjustment: All age-adjusted mortality and disease rates in this report are adjusted to the 2000 U.S. population. The risk of death and disease is affected primarily by age. As a population ages, its collective risk of death and disease increases. As a result, a population with a higher proportion of older residents will have higher crude (unadjusted) death and disease rates. To control for differences in the age compositions of communities being compared, death and disease rates are age-adjusted. This aids in making comparisons across populations.

Averages: Multiple year average estimates were used to increase sample sizes and to minimize widely fluctuating frequencies from year to year.

Confidence Intervals: Hospital service area comparisons to Washington State and comparisons among subpopulations were calculated using 95% confidence intervals. Confidence intervals (error bars on the graphs) indicate the margin of error for the value estimated by describing an upper and lower limit of an estimate. Using confidence intervals is a conservative approach to determine if differences among groups are statistically significant. If the confidence interval of two different estimates do not overlap, we can most often conclude that the difference is statistically significant and not due to chance.


Stratification: Where possible (i.e., the population size or counts were adequate to determine significance and protect anonymity), we analyzed the indicators by race/ethnicity and/or gender. We used the following terms to describe race/ethnicity:

NH: Non-Hispanic
White, NH: Non-Hispanic White
Black, NH: Non-Hispanic Black
Hispanic: Hispanic as a race
Asian, NH: Non-Hispanic Asian
AIAN, NH: Non-Hispanic American Indian/Alaskan Native
NHPI, NH: Non-Hispanic Native Hawaiian/Pacific Islander
Multi-Race: Multiple or more than one race
Non-White: All races/ethnicities other than White, NH

In cases where there were too few numbers to separate race into the above categories, we combined the population groups, most often into two groups, White, NH, and non-White.
QUALITATIVE METHODS

Community survey – An online survey was available for 6 weeks from October through November 2017 in English. The survey received 919 responses from community members.

The questions included:

1. How satisfied are you with the quality of life in your community?
2. How socially connected do you feel to your community? Connected means being socially involved with others in your community.
3. What do you think are the three most important things that make a healthy community?
4. Which of the following do you wish were more present in your community? (Please pick your top 3.)
5. What three things cause the biggest problems to your community’s overall health?
6. What three things cause the biggest problems to children and youth in your community?
7. How would you rate your community’s health overall?
8. What do you think is the most important way to work on health problems in your community?
9. How satisfied are you with health care in your community?
10. What has kept you from getting health care you need.
11. What can health care providers, hospitals or clinics do to help make communities healthier?

Community workshops – Four community forums or workshops were conducted throughout Kitsap County. Workshop participants were asked up to four questions:

1. How do you define a healthy community?
2. What do you think are the strengths (or positives or resources) that help Kitsap County be healthy?
3. What do you think are the challenges (or negatives or barriers) to being healthy here?
4. What do you need to be healthy in the next 1 to 3 years?

To answer these questions, a variety of interactive methods were used. All workshops involved active discussion of the questions among participants for at least part of the session. Notes were taken during the workshop and transcribed verbatim.
**Key informant interviews** - Seven key informant interviews were conducted with people who serve in leadership roles or who are subject matter experts in various aspects of community health. Each interview was conducted individually via email or phone. The questions asked included:

1. What are the main concerns you have about the health of Kitsap County residents right now?

2. What programs or projects are happening or planned that are most relevant to these concerns?

3. How can hospitals and health systems be involved in addressing these concerns?

4. What are the most significant gaps in resources, coordination, etc.?

5. What do you feel are the key elements in Kitsap County that promote health, safety and/or community strength?

6. Is there anything else you would like to add?
SELECTION OF PRIORITY HEALTH NEEDS

The selection of priority health needs followed a process of reviewing both the qualitative and quantitative data elements in the report. Three criteria were used to determine priorities:

■ Was a health concern or indicator significantly worse in the hospital service area than in the state?
■ Were relatively large numbers of people impacted by a health concern or indicator?
■ Was a health concern repeatedly voiced during the community engagement portion of the assessment (e.g., survey, workshops or interviews)?

The health concerns or indicators that met the most criteria became the priority health needs for the hospital service area.

This approach was efficient at identifying areas of concern that are also of importance to community members, however it has limitations. Selection of criteria was subjective. Different selection criteria might have resulted in a different list of priority areas. The decision about whether large numbers of people were impacted was also a subjective judgment based on reviewers’ experience and knowledge, not on a numeric threshold. Finally, the process identifies problem areas, but not solutions. For some problem areas, solutions may be unknown or impractical. For these reasons, the list of priority needs should be viewed as a starting point for discussion, not a definitive short list requiring action.