

2025 Community Health Assessment

Tacoma-Pierce County Health Department

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Executive summary

About Tacoma-Pierce County Health Department

We operate through an interlocal partnership between Pierce County and City of Tacoma. This enables us to address public health issues that require coordinated responses across municipal boundaries.

We ground our work in the core public health functions: assessment, policy development, and assurance. Through surveillance, community engagement, and data analysis, we:

- Identify priority health issues.
- Support evidence-informed decision-making.
- Work with partners to improve population health.



We convene partners and elevate community voices to support shared understanding and coordinated action. The Community Health Assessment (CHA) is one of our foundational tools.

Health equity

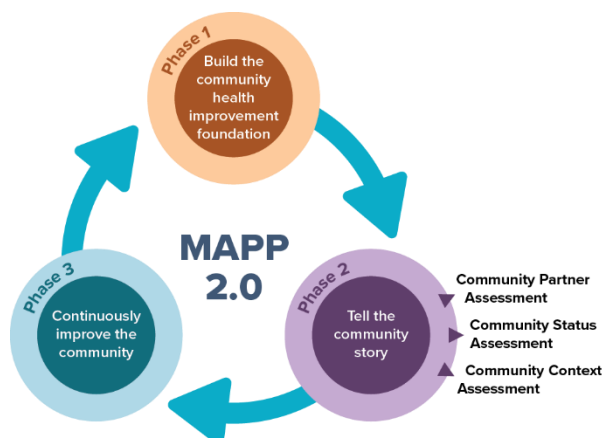
Health equity is the CHA's guiding principle. Health outcomes in Pierce County are not evenly distributed. Disparities across race, ethnicity, income, geography, and ability aren't the result of individual choice. They stem from long-standing structural and systemic inequities.

This assessment recognizes some conditions shape health more than medical care alone, including:

- Housing stability.
- Access to transportation.
- Environmental exposures.
- Economic opportunity.
- Access to culturally responsive services.

The CHA centers these upstream drivers by blending quantitative data with community knowledge and lived experience.

We used the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework to prioritize shared leadership, community participation, and accountability. We embedded equity in the way we chose data, elevated community voice, and used findings to inform action.





Findings

The 2025 CHA identifies the most pressing health and well-being challenges in Pierce County and the structural barriers that drive them. Drawing on community voices, quantitative health data, and organizational insights, this assessment reveals five recurring issues that require coordinated action. Residents continue to face significant challenges related to:

- Housing stability and affordability.
- Behavioral health access and stigma.
- Transportation and mobility.
- Digital access.
- Sustainability of community organizations that carry out equity-focused work.

These challenges appear consistently across our data sources and reflect long-standing structural barriers that shape opportunity and well-being in Pierce County. They represent both the complexity of health inequities in our region and the foundation for transformative collective action.

This CHA informs the 2025–2030 Community Health Improvement Plan (CHIP) and reflects the collective wisdom, experiences, and concerns of Pierce County residents and organizations that serve them. These issues appear across data sources and reflect long-standing structural barriers that influence opportunity and well-being.

The data we analyzed for this report points to several health issues that demand coordinated, equity-centered action.

Health concerns

These nine health concerns reveal where inequities are most stark and where we most need coordinated action. Many reflect the structural barriers and social determinants of health (SDOHs) we identified. They expose significant disparities across Pierce County populations.



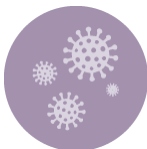
Life expectancy—Lower life expectancy and elevated years of potential life lost signal downstream effects of inadequate prenatal care, poor mental health, housing instability, and preventable deaths. Drug poisoning—usually involving fentanyl or methamphetamine—is a leading cause of unintentional death.



Chronic disease—Obesity and asthma, like many chronic diseases, reflect the cumulative impact of poverty, food insecurity, transportation barriers, and limited access to opportunities for physical activity.



Adult depression—Depression, like many other behavioral health conditions, calls for expanded behavioral health services and community-based support. They must be culturally relevant, linguistically appropriate, and accessible.



Infectious disease—Chlamydia and gonorrhea rates remain higher in Pierce County than statewide, despite recent declines. Disparities are clear. They point to a need for direct, equitable access to prevention, screening, and testing, as well as treatment and supportive services.



Discrimination—Discrimination in healthcare, housing, food access, and everyday life compounds existing inequities. It also reflects structural barriers embedded in institutional policies and power structures.



Homelessness—Housing instability creates cascading barriers to health, including limited access to routine medical care, chronic disease management, and mental health support.



Tobacco—Smoking effects ripple throughout our communities. They affect healthy births, chronic disease burden, and overall survival.



Pregnancy and childbirth—Many families lack adequate prenatal care. Improving access would support healthy childbirth, help prevent adverse birth outcomes, and set children on a path toward long-term health and success in life.



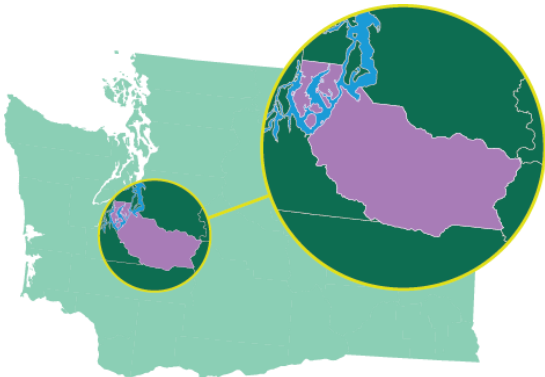
Youth substance use and mental health—A substantial minority of youth report mental health challenges and substance use. Social connection and access to mental health care are critical to addressing these concerns.



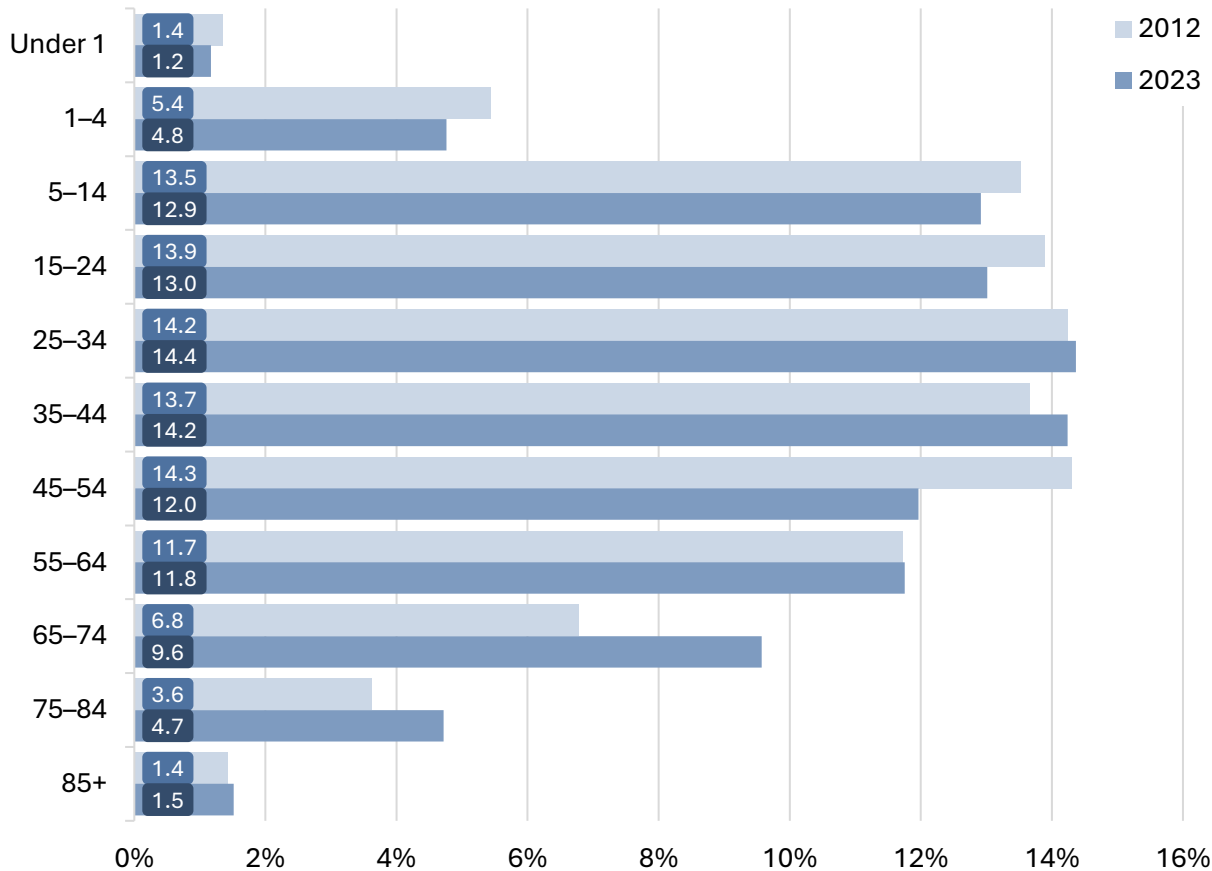
Who lives in Pierce County?

Demographics

In 2023, an estimated 946,300 people lived in Pierce County.¹ That’s a 15% increase since 2012. While average age rose over this period from about 37 to 39 years, it masks big differences by age group. The number of Pierce County children younger than 5 years grew slightly, while residents 65 and older increased by about 55%.



Population by age group (years), Pierce County, 2023

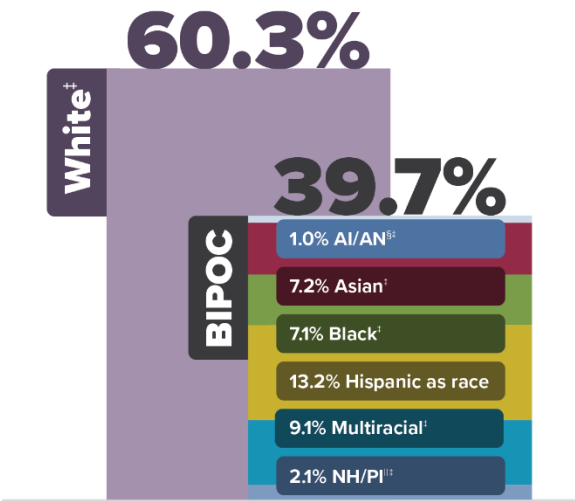


Source: Washington State Office of Fiscal Management (OFM).

¹ Washington State Office of Financial Management. (2023). “April 1 Official Population Estimates,” accessed January 2025. ofm.wa.gov/data-research/population-demographics/estimates



Population by race/ethnicity, Pierce County, 2023



§ American Indian/Alaska Native
† Non-Hispanic
‡ Native Hawaiian/Pacific Islander
Source: OFM.

Language

Linguistic diversity reflects this population trend. After English, the most common languages spoken at home were Spanish (7.3%), Korean (1.7%), and Tagalog (1.5%). Another 3.2% of households spoke other Asian and Pacific Islander languages, and 1.4% speak Russian, Polish, or other Slavic languages.

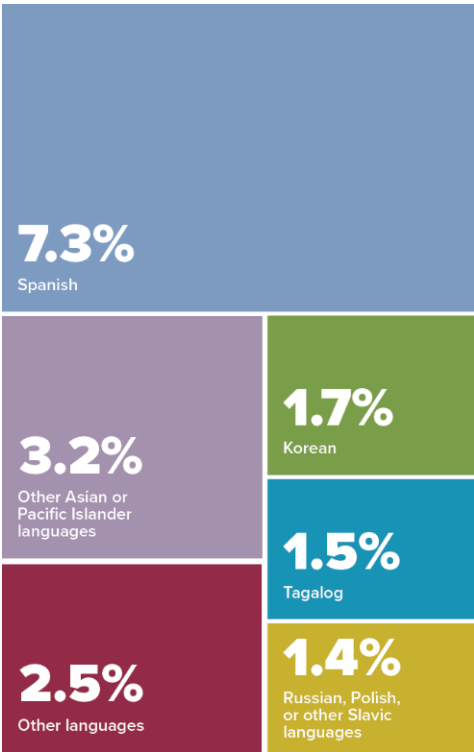
Why language access matters

Language access is a critical component of health equity. Every Pierce County community should have access to essential health services. That’s why we offer multilingual services, qualified interpretation, and culturally and linguistically responsive communication.

Race/ethnicity

Our population has become more diverse since 2012. Nearly 40% of residents now identify as Black, Indigenous, or person of color (BIPOC). This shift is more pronounced in young people. Among people younger than 25, 52.5% identify as BIPOC. For people 25 or older, it’s about one-third.

Most common non-English languages spoken at home, Pierce County, 2023



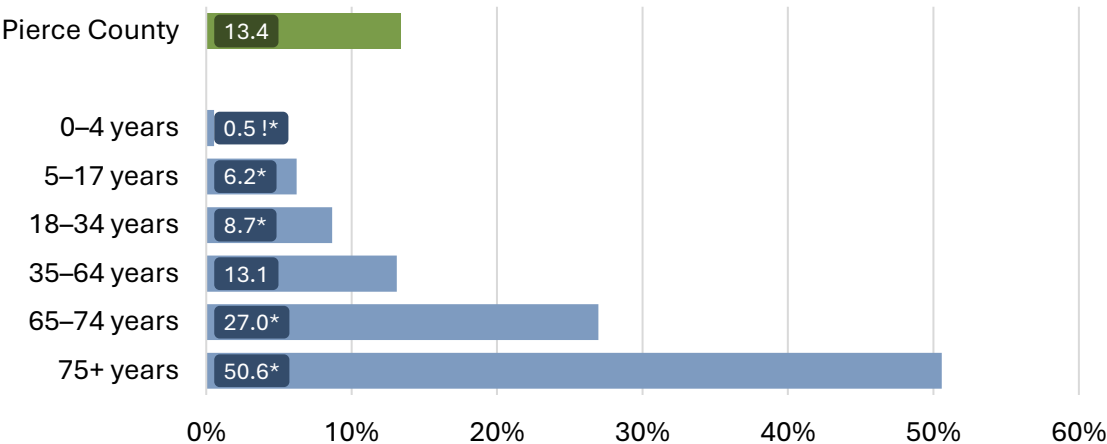
Source: OFM.



Disability

More than 1 in 10 residents live with a disability. The likelihood significantly increases with age.

Disability prevalence, Pierce County, 2018–2022



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: USCB, ACS.

Socioeconomic status

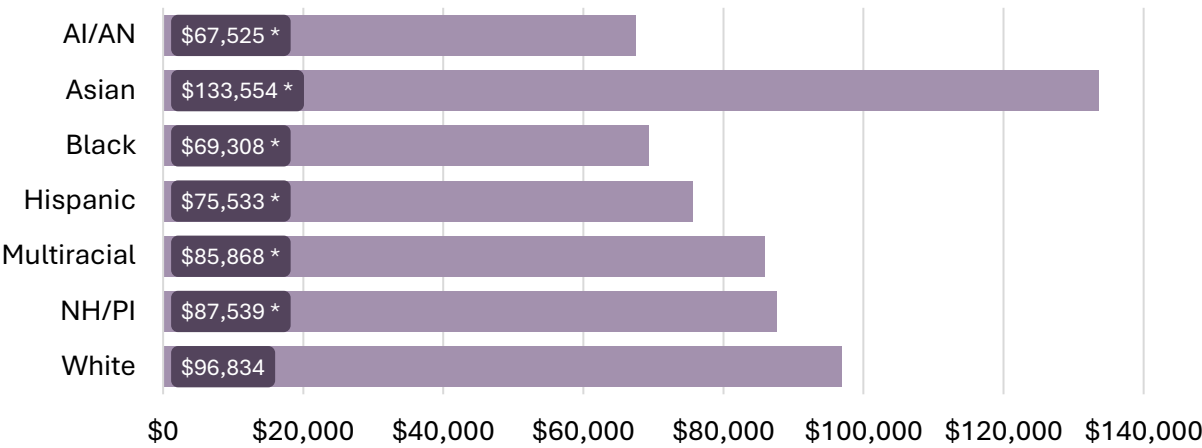
Socioeconomic status (SES) is a key driver of health outcomes. It’s primarily determined by your income, education, and occupation. They shape you and your family’s access to resources and opportunities, including those that directly affect your health.

Income

From 2019 to 2023, the median household income in Pierce County was about \$96,000. That’s slightly higher than the state’s median of \$94,952. Individual income varied considerably by gender. The median income for men was \$68,466, compared to \$51,943 for women. Differences by race/ethnicity were even more pronounced. The median income for Asian residents was more than \$133,000, while half of AI/AN residents earned less than \$67,525.



Median income, Pierce County, 2019–2023

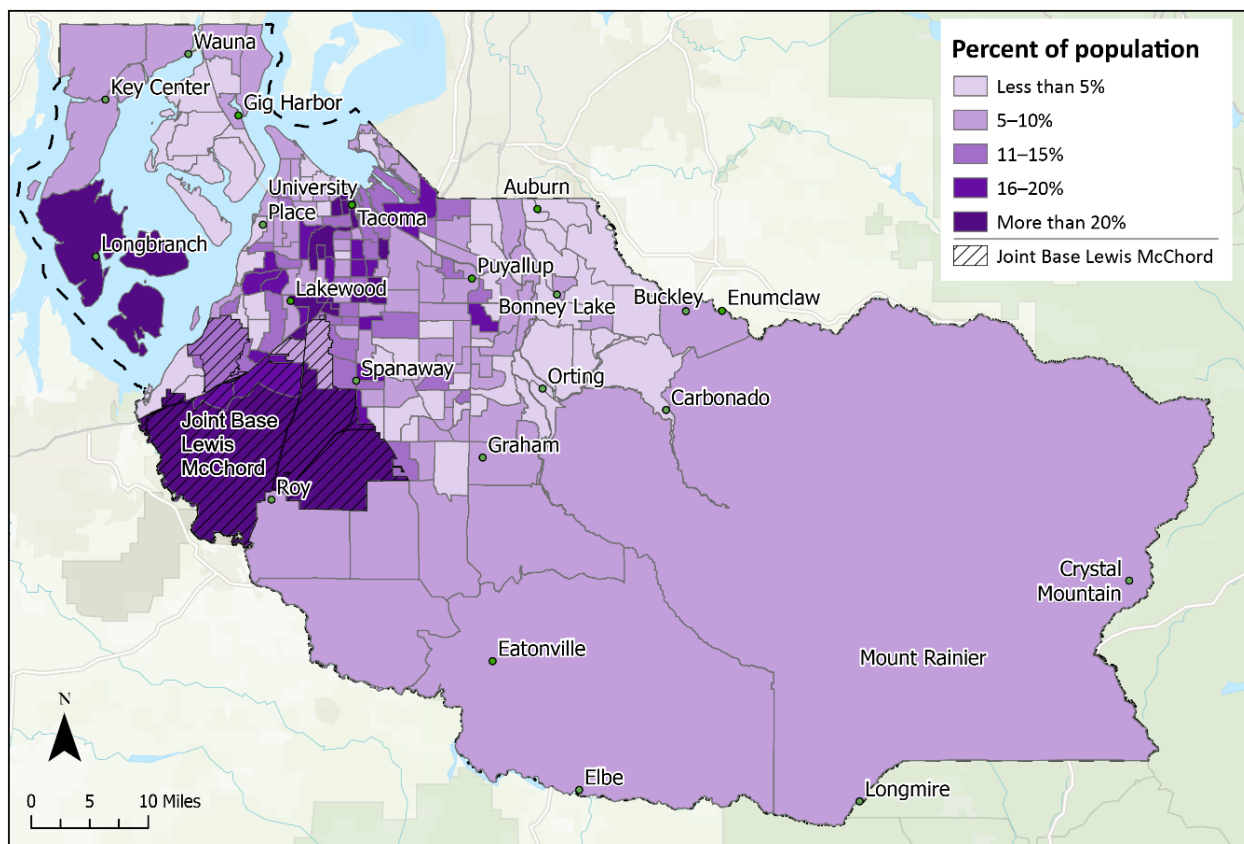


* Statistically significant difference from overall Pierce County

Source: USCB, ACS.

Poverty

SES is a well-established determinant of health. Poverty in particular limits people’s ability to meet their basic needs. The share of Pierce County residents living below 100% of the federal poverty level declined from 10.4% in 2015–2019 to 8.9% in 2019–2023. That’s significantly below Washington’s rate of 9.9%. Women are more likely to live in poverty than men. Black and NH/PI residents face significantly higher rates of poverty than Pierce County overall. Poverty exists throughout Pierce County, though its impact is not evenly distributed.

*Percent of population below federal poverty limit, Pierce County, 2019–2023*

Data sources: U.S. Census Bureau (2019–2023), Pierce County Geographic Information System (GIS). Created on July 13, 2026. All Tacoma-Pierce County Health Department data is expressly provided “as is” and “with all faults.” The Health Department makes no warranty of any kind, express or implied, concerning this information, including but not limited to any warranties of merchantability or fitness for any purpose. The Health Department assumes no responsibility or legal liability concerning the data’s accuracy, reliability, completeness, timeliness, or usefulness.

Unemployment

U.S. Census Bureau’s (USCB’s) American Community Survey (ACS) measures the employment rate among adults 16 or older who are employed or actively looking for work. About 5% of Pierce County residents 16 or older are unemployed, a rate comparable to the state estimate. Unemployment rates are similar for Pierce County women and men. By race/ethnicity, Black (7.5%) and multiracial (6.8%) residents have significantly higher rates of unemployment than the county overall, while Asian residents have a significantly lower rate (3.9%).

Education

In 2019–2022, 29.3% of Pierce County adults 25 years or older held at least a bachelor’s degree, significantly below the state average of 38%. Education level widely varies among race/ethnicity groups. NH/PI residents have the lowest rate of bachelor’s degree attainment (8.5%), while Asian residents have the highest (33%). These patterns are closely tied to income. Adults with incomes at or above the poverty level are more than twice as likely to hold a bachelor’s degree (30.7%) as those with incomes below the poverty level (14.4%).



Food insecurity

Food insecurity—the inability to consistently access enough food—has a measurable impact on health and quality of life. From 2022 to 2023, an average of 12% of Pierce County adults reported the food they bought did not always last and they lacked the resources to buy more. This rate was higher than the two-year state average of 10.5%. During the 2023–2024 school year, 51.4% of students in Pierce County were eligible for free or reduced-price lunches, which is slightly lower than the state (52.5%).

Food access indicators, Pierce County, 2022–2024

Indicator	Pierce County	Washington
Food insecurity	12.0%	10.5%
Eligible for free or reduced-price lunch	51.4%	52.5%

Source: BRFSS; Office of the Superintendent of Public Instruction (OSPI).

Key inequities and disparities

Adult health outcomes

This section summarizes how Pierce County adults fare across multiple health indicators including mortality, chronic conditions, behavioral health, and infectious disease. It highlights where outcomes diverge from state benchmarks and where they fall unevenly across demographic groups.

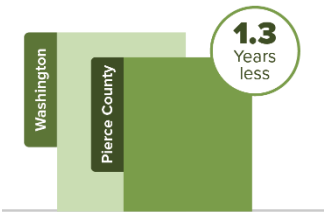


Life expectancy

Key findings

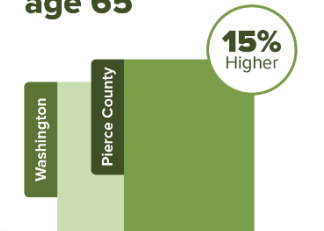
Pierce County's **life expectancy** of 78.1 years falls below Washington's average of 79.4 years.

Life expectancy



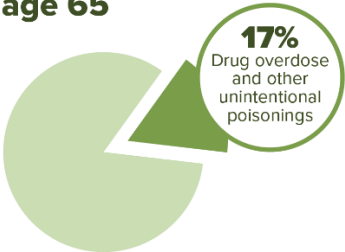
Premature death reduces overall life expectancy and can be measured through **years of potential life lost (YPLL)** before age 65. The YPLL rate is about 15% higher in Pierce County (4,600 per 100,000 people) than Washington (4,000 per 100,000 people).

Years of potential life lost before age 65



Drug overdose and other unintentional poisonings make up 17% of Pierce County's years of potential life lost.

Years of potential life lost before age 65



Disparities

AI/AN Black NH/PI	Highest rates of years of potential life lost and lowest life expectancy among Pierce County race/ethnicity groups.
Men	Shorter life expectancy and higher rates of unintentional deaths than women.
AI/AN Black	Highest rates of drug-related deaths among Pierce County race/ethnicity groups.
Age 55–64	Most common age for drug-related deaths.
Age 75+	Most common age for deaths from unintentional falls.



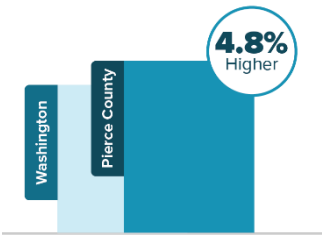
Chronic disease

Key findings

Obesity is defined as having a body mass index (BMI) of 30 or higher based on self-reported height and weight. Although BMI is commonly used for population-level surveillance, it provides an indirect measure of adiposity (body fat) and may not accurately reflect differences in body composition across people and populations.

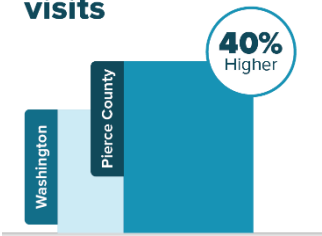
Pierce County residents are significantly more likely to be **obese** (34.3%) than residents statewide (29.5%).

Adult obesity



Emergency department (ED) visits for **asthma** occur at a rate nearly 40% higher in Pierce County (520.7 per 10,000 visits) than Washington (374.7 per 10,000 visits).

Asthma-related emergency department visits



Disparities

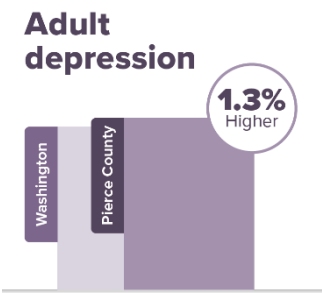
Age 45–54	Most common age for obesity. People 24 or younger are least likely to be obese.
Women	Significantly more likely to experience asthma-related ED visits than men. As age increases, the likelihood of asthma-related ED visits decreases.



Adult depression

Key findings

About 25.3% of Pierce County adults report being diagnosed with **depression**. That’s similar to the 24% reported statewide.



Reported depression diagnoses become less common with increasing age and household income. This highlights important social and economic inequities and protective factors in mental health outcomes.

Disparities

**AI/AN
Multiracial** Report substantially higher rates of depression (47.6% and 34.4% respectively) than other Pierce County race/ethnicity groups. Asian residents report the lowest rates (8.7%).

Women Significantly more likely to report being diagnosed with depression (32.5%) than men (17.8%).

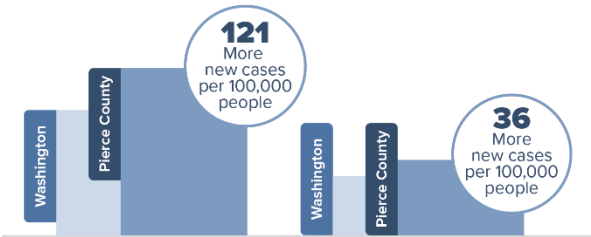


Infectious disease

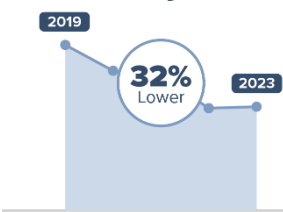
Key findings

Rates of chlamydia and gonorrhea in Pierce County remain higher than Washington overall, despite having declined by more than 30% in recent years. The trend mirrors state patterns.

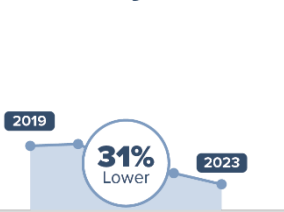
Rates of chlamydia and gonorrhea



Rates of chlamydia in recent years



Rates of gonorrhea in recent years



Persistently elevated rates may reflect barriers to healthcare access, delays in testing and treatment, and ongoing stigma around STIs.

Disparities

Black	Experience disproportionately high rates of STIs.
Men Black	More likely to be living with HIV.



Social determinants of health

Health is shaped far more by the conditions in which you are born, grow, live, work, and age than by medical care. These SDOH include:

- Education.
- Healthcare.
- Financial stability.
- Environment.
- Social context.

These aren't distributed evenly across populations and account for the majority of the differences in health outcomes between groups. Medical care is estimated to account for only about 20% of a population's health outcomes. The rest comes from:

- Health behaviors (30%).
- Social and economic factors (40%).
- Physical environment (10%).

This helps explain why health is not distributed equally across Pierce County. Differences in life expectancy, chronic disease, and other outcomes often track with underlying social and economic conditions. Understanding these determinants is essential to interpreting the disparities discussed here. It will help us identify where policy and community-level action can most effectively improve population health.





Discrimination

Key findings

In Pierce County, 12.3% of respondents said they **experienced discrimination** sometimes, often, or always. That’s a significantly higher percentage than the statewide figure of 10.2%.



Disparities

Black	Most likely to report experiencing discrimination (but a small number of respondents produced wide confidence intervals).
Hispanic Multiracial	Significantly more likely to report discrimination than Pierce County residents overall or white non-Hispanic residents.
Age Income	Rate declined as income and age increased.



Homelessness

Key findings

Pierce County Human Services’ Pierce County Homeless Crisis Response System is a network of services for people who:

- Are experiencing homelessness.
- Are at risk of experiencing homelessness.
- Experienced homelessness in the past.

In 2024, the system served 21,418 people. Of those, 9,772 were currently homeless. That was a 14% increase over 2022 and the highest number served in any recent year.

People who received homeless services



Disparities

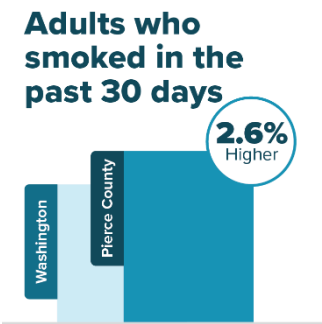
Women	Slightly more likely (50.9%) to receive services than men (46.9%).
Men	Slightly more likely (52.7%) to be currently homeless than women (45.1%).
AI/AN Black NH/PI	Highest rates of homelessness.
Asian White	Lowest rates of homelessness.



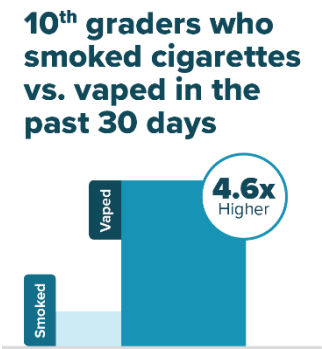
Tobacco

Key findings

In Pierce County, 13.3% of adults **smoked cigarettes** in the past 30 days. That was significantly more than the statewide figure of 10.7%.



Among 10th graders, cigarette smoking was far lower. The 2% who reported **smoking cigarettes** in the past 30 days was not significantly different from the state’s 1.9%. Vaping was more common among youth. In Pierce County, 9.6% of 10th graders reporting **vaping**, again not notably different than statewide.



Tobacco use is a major contributor to premature death, including from chronic lower respiratory disease.

Disparities

Age 18–24	Significantly less likely to smoke than other age groups.
Age 65+	
Age 55–64	Highest smoking rate.
Youth	More likely to vape than smoke cigarettes.
Income	Current smoking decreased as income level increased.



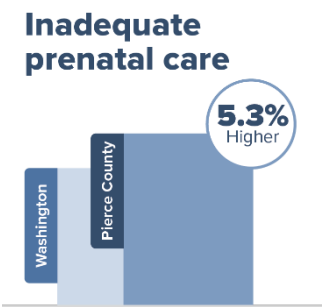
Child and youth health

Child and adolescent health spans from birth through age 18. This period is marked by immense change, growth, and development. Youth are the future and their experiences today will shape the well-being of our community tomorrow.

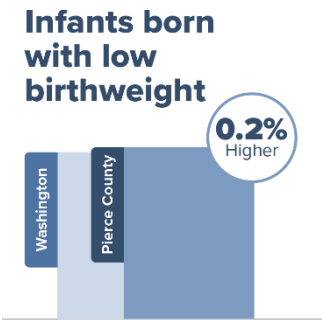
Pregnancy and childbirth

Key findings

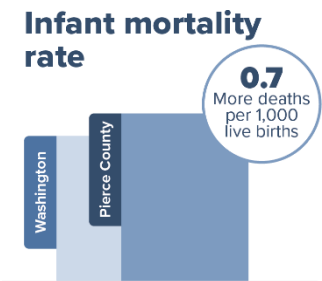
In Pierce County, 26.2% of pregnant people receive **inadequate prenatal care**, compared to 20.9% in Washington.



Seven percent of babies are born with **low birth weight**, similar to the state average.



The county's **infant mortality** rate is 5.2 deaths per 1,000 live births, compared to 4.5 per 1,000 statewide.



Disparities

Age 20 or younger Age 35+	Greatest risk of having a low birth weight baby.
AI/AN Black NH/PI	High rates of inadequate prenatal care, low birth weight, and infant mortality.
Live in a highly vulnerable community	More likely to receive inadequate prenatal care (40.7%) and have a low birth weight baby (8.2%).

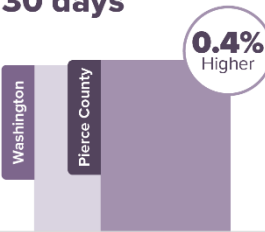


Youth Substance Use and Mental Health

Key findings

Among Pierce County 10th graders, 13.9% report using alcohol, marijuana, painkillers, or other illicit drugs in the past 30 days.

10th graders who report substance use in the past 30 days



Nearly a third report symptoms of poor mental health: 32.5% report feeling anxious and 31.8% report feeling depressed.

10th graders who report symptoms of poor mental health



Disparities

Race/ethnicity	Substance use varies sharply by race and ethnicity among 10 th graders.
AI/AN	Most likely to report anxiety. Most likely to report using alcohol, marijuana, painkillers, or other illicit drugs (28.8%). Asian youth reported the lowest rates (7.2%).
Multiracial	Most likely to report depression.
Females	Twice as likely as males to report anxiety or depression.
Low income	More likely to report anxiety or depression. Higher rates of substance use (17.7%) than moderate- or high-income youth (13.2%).



Next steps: Community Health Improvement Plan

These priorities provide a clear foundation for the next phase of this work: the development of the CHIP. It will translate these needs into actionable strategies, measurable outcomes, and shared commitments across sectors.

Meaningful progress will require sustained collaboration among:

- Public health.
- Healthcare.
- Human services.
- Education.
- Housing.
- Economic development.
- Community-based organizations.

It will demand accountability to equity principles and a willingness to shift power, resources, and decision-making toward the communities most impacted by inequities. We must commit to working together to address the challenges we face and use our community resources to find solutions.

The CHA is not the end. Rather, it is the beginning of a call to action grounded in community voice and evidence. Data alone is not enough, but we can use it to drive meaningful action. We must invest in people, communities, and organizations that are already doing the daily work to ensure residents are healthy and that we're serving those most impacted by inequities. This assessment offers a well-rounded snapshot of the collective status of Pierce County. By aligning community insights and epidemiologic data with strategic planning and cross-sector partnership through the CHIP process, we have a foundation to build a healthier future where everyone thrives.





Message from the Director

Pierce County is home to a remarkable and diverse community. It's shaped by resilience, aspiration, and an unwavering commitment to one another's well-being. The 2025 Community Health Assessment (CHA) reflects that. It's a data-informed look at our county's health, grounded in the voices of the people and organizations who live and work here.

At Tacoma-Pierce County Health Department, our mission is to protect and improve the health of all people and places in Pierce County. Our vision is simple and ambitious: Healthy people in healthy communities. We believe we can achieve that vision. This CHA is one of our most important steps toward making it a reality.

Public health is essential for all of us. Every day, the dedicated work of our staff and community partners ensures residents can enjoy a healthy meal, drink clean water, breathe healthy air, and live free from preventable diseases. That work happens all around us—often quietly—and it makes a difference. The CHA is our chance to gather data on that progress, look for gaps, and recommit to our mission.

What gives me the greatest hope is that the people behind this process were determined to incorporate a range of community voices. We engaged more than 100 representatives from 83 organizations spanning:

- Government.
- Healthcare.
- Education.
- Social services.
- Faith communities.
- Grassroots organizations grounded in the neighborhoods they serve.

The community partners' participation is a powerful reminder that Pierce County does not lack for compassion, commitment, or creativity. We are a county full of people who care, and who are already doing the work to ensure we realize our priorities.

The findings will serve as the foundation for our 2025–2030 Community Health Improvement Plan (CHIP). It will translate cross-cutting priorities into targeted, equity-centered strategies for collective action. This is where listening becomes learning, and learning becomes leading.

I am deeply grateful to every partner, community member, and staff member who contributed time, knowledge, and trust to this process. Your voices are represented throughout these pages, and your commitment gives me confidence that the path ahead, however challenging, is one we will walk together.

With gratitude and hope,

Chantell Harmon Reed, MS-HCM, Doula, FACHE
Director of Public Health, Tacoma-Pierce County Health Department



Acknowledgements

Land and labor



We acknowledge Pierce County is located on the ancestral and contemporary lands of the Coast Salish peoples, including the Puyallup, Muckleshoot, Nisqually, and Squaxin Island Tribes. We honor Tribal sovereignty and the ongoing leadership of Tribal Nations in protecting community health, culture, and the environment. We also acknowledge Urban Indigenous people and Native community members who live in Pierce County and who may not be enrolled in a federally recognized Tribe. That includes those whose connections to land, culture, and community were disrupted by colonization, forced relocation, and exclusionary federal policies.

We acknowledge the labor of Black, Indigenous, immigrant, and working-class communities whose work built and sustains Pierce County. Too often, that work was under conditions shaped by structural racism and inequitable access to opportunity. The conditions described in the CHA reflect this history and highlight the role of partnership, accountability, and sustained investment in community-led solutions.



Partners

This Community Health Assessment (CHA) was made possible through the leadership, partnership, and generosity of many community-based organizations, public agencies, and people across Pierce County. We are grateful to all who contributed their time, expertise, lived experience, and trust.

We extend our sincere thanks to the following community and agency partners. They supported community engagement, facilitated focus groups, contributed art and storytelling, and reviewed and affirmed our findings.

- Bethel School District, Community Connections.
- Tahoma Indian Center.
- Coordinated Care.
- Tacoma Public Schools.
- Elevate Health.
- Franklin Pierce Schools.
- Oasis Youth Center.
- Tacoma Rescue Mission.
- Pierce County Human Services, Aging and Disability Resources.
- Blue Zones Project.
- Child Care Aware.
- Neighborhood Clinic.



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About this assessment

Every five years, Tacoma-Pierce County Health Department takes stock of our communities’ health. We ask an essential question: **What do Pierce County residents need to live healthier, more vibrant lives?**

While our communities’ core needs may not dramatically change over time, this process helps us see where we stand, the progress we’ve made, and where inequities persist.

The Community Health Assessment (CHA) is a comprehensive evaluation of the county’s health and the factors that shape it. Through this work, we listen to data, stories, and the people who call Pierce County home. This 2025 CHA is grounded in the Mobilizing for Action through Planning and Partnership (MAPP) 2.0 framework. It emphasizes health equity, community voice, and data-driven decision-making.

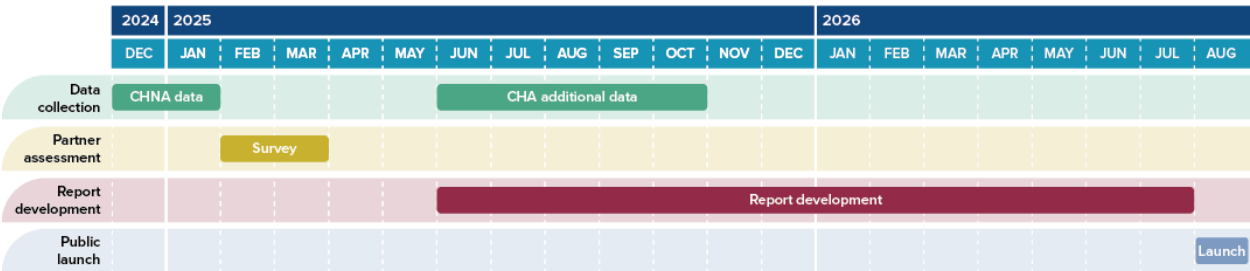
Building on the foundation the 2019 CHA laid, this 2025 CHA reaches deeper. Using a new framework, we expanded our methods to engage in a richer dialogue with community partners and continue our commitment to understanding the experiences of the people behind the data.

Pierce County communities are vibrant and diverse, yet many continue to face the persistent challenge of inequitable access to things like:

- Healthcare.
- Affordable housing.
- Safe transportation.
- Healthy food.
- Substance use services.
- Opportunities for meaningful work.

These social and structural factors profoundly influence health. This 2025 CHA harnesses data and stories to illuminate where we are today and inform where we need to go to create healthier communities. Figure 1 shows when we collected data, conducted the partner assessment, and developed and launched this report.

Figure 1: 2025 Community Health Assessment timeline





Purpose and scope

This 2025 CHA has three objectives:

- **Understand and document Pierce County’s current health landscape.** We analyzed quantitative indicators and qualitative insights from community leaders to share what residents say about their neighborhoods, how they experience health and well-being, and how social, economic, and environmental factors shape these outcomes. The CHA highlights catalysts of and barriers to health. It creates a foundation for understanding evolving community needs and emerging challenges.
- **Guide strategic decision-making and resource allocation.** The CHA informs both this report and the subsequent Community Health Improvement Plan (CHIP). It ensures we and our partners align efforts with the most pressing community needs, fulfill regulatory requirements, and maintain public health accreditation. By providing guidance on potential action steps, the CHA supports a coordinated, equitable approach to improving community health.
- **Strengthen partnerships and accountability.** The CHA is an invitation for the Health Department to partner with community members, community-based organizations, healthcare providers, schools, businesses, and policymakers to co-create solutions that advance shared goals in our communities. The CHA is grounded in listening and learning. It reflects a commitment to transparency, continuous improvement, and a collaborative mindset in addressing priority issues.

Due to the collaborative and inclusive nature of the MAPP 2.0 process, conducting the CHA and developing this report is a way to create a shared understanding of **what** to measure to understand the health of our community and **how** to measure it. This shared foundation promotes alignment of key players in local public health. By leading this process and creating this resource, we can increase access to health data for organizations without the skillset or capacity to provide their own—or even organizations in other sectors.

Mobilizing for Action through Planning and Partnership 2.0 framework

This 2025 CHA is guided by the MAPP 2.0 framework,² an equity-focused, nationally recognized approach to assess and improve community health. It relies on quantitative data, organizational

² National Association of County and City Health Officials. (2023). *Mobilizing for Action through Planning and Partnerships (MAPP) 2.0: Community context assessment*. naccho.org/programs/public-health-infrastructure/performance-improvement/mapp



perspectives, and lived experience. The MAPP 2.0 framework emphasizes broad participation, shared power, and system alignment to support actionable, community-informed priorities.

Under the MAPP 2.0 framework, we organized the CHA into three connected assessments:

- **Community Context Assessment (CCA).** Centers lived experience by highlighting qualitative data and narratives that help explain how structural and social contexts shape health.
- **Community Status Assessment (CSA).** Analyzes quantitative data to describe Pierce County residents' health across key indicators.
- **Community Partner Assessment (CPA).** Gathers insights from local organizations, agencies, and systems we partner with to identify shared challenges and opportunities.

We integrated these findings to identify crosscutting themes. Together, these assessments will provide the evidence base for the 2025–2030 CHIP.

For more about the MAPP 2.0 framework, see naccho.org/uploads/card-images/public-health-infrastructure-and-systems/MAPP-2.0-Launch-V3.pdf.

Alignment with Health Department vision and values

Strategic Plan

This 2025 CHA is rooted in the Health Department's 2025–2029 Strategic Plan. Our vision—healthy people in healthy communities—is realized through our mission: To protect and improve the health of all people and places in Pierce County. Guided by the values of equity, respect, integrity, and leadership, we applied these principles to every stage of this assessment.

Our Strategic Plan has three priorities:

- Improve health outcomes.
- Improve organizational culture.
- Increase efficiency and effectiveness.

These priorities align directly with the aims of the CHA. By integrating the MAPP 2.0 framework with our strategic goals, this report moves beyond a static snapshot of health indicators to telling a dynamic story about our communities. We'll look at where we've been, what we've learned, and how we'll work together to make Pierce County a place where everyone can thrive.



Understanding community health through social determinants of health and health equity

Health is not created in clinics or hospitals alone. It is largely shaped by the conditions in which people are born, live, learn, work, worship, play, and age. These social determinants of health (SDOH), shown in figure 2, profoundly influence well-being and life expectancy. They include things like:

- Housing.
- Education.
- Income.
- Neighborhood safety.
- Transportation.

While many of these conditions lie beyond the Health Department's direct control, acknowledging them allows us to understand and address the broader systems that affect health outcomes.

This 2025 CHA presents data through the lens of SDOH, illustrating how place, opportunity, and community resources intersect to create disparities or promote resilience. It also recognizes no single measure fully captures the complexity of health. Instead, understanding emerges through the interplay of data, history, and lived experience.

For more about SDOH, see tpchd.org/social-determinants-of-health-infographic.

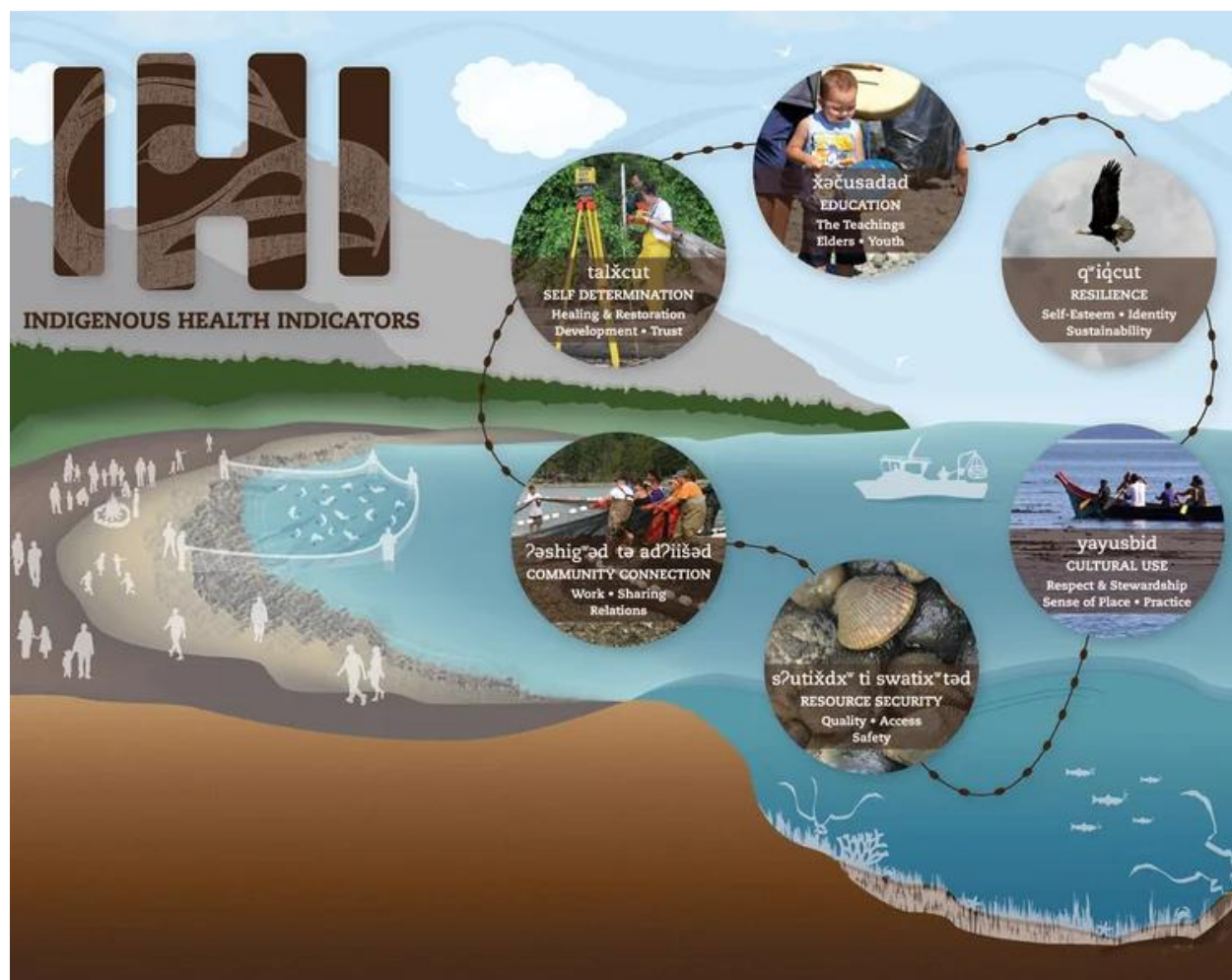
In addition to SDOH, we acknowledge the Indigenous Health Indicators (IHI) developed by the Swinomish Climate Change Initiative. IHI highlight non-physical dimensions of health—like cultural use, community connection, and natural resource security—that are essential to well-being. These perspectives are especially important in Pierce County, home to the Puyallup Tribe of Indians and many other American Indian and Alaska Native people, whose health is shaped by cultural continuity, connection to land, intergenerational knowledge, and Tribal sovereignty. Elevating IHI alongside Western measures of risk ensures our understanding of health reflects both scientific evidence and cultural wisdom.

Figure 2: Social determinants of health





Figure 3: Indigenous Health Indicators developed by the Swinomish Climate Change Initiative



For more about the Swinomish Climate Change Initiative and IHI, see swinomish-climate.com/community-environmental-health.



Section 1: Community Context Assessment

Overview

This CCA is the first of three sections of the 2025 CHA. The CCA gathers qualitative data to include the views, insights, values, cultures, and focus of people with lived experience and expertise in Pierce County. It aims to describe the experiences and mechanisms of how people make healthcare and health behavior choices. We conducted this assessment using qualitative methods. Our goal was to move beyond interventions that rely on perceived community needs to truly understand our community's strengths, assets, and culture.

The CCA looks at:

- Community strengths and assets.
- Built environment.
- Forces of change.

It includes diverse qualitative data sources, including:

- Systematic review of existing qualitative data from community and agency partner assessments.
- Community engagement for data collection, including focus groups, community conversations, creative arts submissions, and community leader interviews.

Methods

Data collection

Systematic review of existing qualitative data

We conducted a thorough review of existing qualitative data through publicly available assessments conducted by the Health Department and other Pierce County community-based organizations and agencies. It represents the voices of residents from specific population groups in Pierce County. The 25 documents we selected were published between 2020 and 2024 and coded using a deductive qualitative thematic analysis approach. Emerging themes from this review reflect community priorities since 2020 and during the COVID-19 pandemic response and recovery.



These reports often asked specific questions about health topics like vaccine hesitancy, behavioral and mental health, access to care, and others.

Table 1: Existing qualitative data review, phase I criteria

Inclusion	Exclusion
- CHA, Community Health Needs Assessment (CHNA), or other health assessments published 2018–2024 that asked: - What do you like about your community? - Strengths/assets that support your health and well-being. - What needs to change in your community? - Health or non-health needs to support health and well-being.	- Health assessment reports focused on a specific health topic that ask more detailed questions related to health issues or community priorities (e.g., access to care, food access, behavioral or mental health needs, etc.). - Reports we do not have permission to access.

We looked for reports using various sources, like search engines, for broad exploration of relevant Pierce County community assessment reports. Our search included:

- Partner and agency websites.
- Health Department website for published community health assessments and evaluation reports.
- Health Department internal SharePoint site for internal assessment and evaluation reports.
- Word-of-mouth recommendations for local reports from subject matter experts (SMEs).

See appendix A for the reports we reviewed.

Table 2: Existing qualitative data review, phase II criteria

Inclusion	Exclusion
- Qualitative data collected, analyzed, and reported by the Health Department or other Pierce County agencies or community-based organizations 2018–2024, including: - Focus groups. - Surveys. - Interviews. - Listening sessions.	- Incomplete or raw data requiring qualitative analysis. - Reports containing only quantitative data.

Community engagement activities

Our community engagement activities allowed us to collect primary qualitative data. We collected them from Pierce County residents representing populations experiencing disproportionate health



outcomes. We also engaged with organizational and agency leaders who offered valuable insight into systemic inequities, challenges in accessing care, and emerging community priorities. This included:

- Four focus groups.
- One opportunity to submit creative arts.
- Eight community leader interviews.
- Two community conversations representing specific populations.

Focus groups

Each focus group lasted about one hour. We told participants their involvement was confidential and obtained informed consent prior to recording and note-taking. We compensated participants with \$100 gift cards for their lived experience and time. We used Environmental Systems Research Institute (ESRI) Survey123 to collect self-reported demographic data from participants. The questions explored how specific marginalized populations perceived community health, including:

- Local assets and barriers.
- Recent and anticipated changes.
- Forces shaping health at the local, regional, and broader levels.

See appendix B for the questions we asked.



Creative arts submissions

As an alternative to focus groups, we offered lesbian, gay, bisexual, transgender, queer, intersex, asexual, and more (LGBTQIA+) young people a chance to submit creative writing, painting, drawing, or other art that reflected on our assessment questions.

Participants received a \$100 gift card as an incentive. We recruited participants via a flyer distributed by Oasis Youth Center. Oasis Youth Center staff dedicated a program night to providing art supplies and helping young people navigate submission forms. We used ESRI Survey123 to create a digital submission form artists could use to upload art in various file formats.

We obtained informed consent using digital signature and distributed information forms for parent/guardian review (see appendix C).

Figure 4: Creative arts project recruitment flyer



We collected self-identified demographics using the submission form. See appendix D for creative arts submitted and appendix E for our analysis methods.

Community leader interviews

We conducted eight community leader interviews with Pierce County organizational leaders across eight sectors. They represent or serve populations experiencing disproportionate health outcomes.

We selected participants based on their sector and organizational role. We engaged people with direct lived experience or those working closely with these communities. This provided critical insights into systemic barriers and health disparities. Interviews lasted 60 minutes in a one-on-one format. We conducted them in person, virtually, over the phone, or via an online submission based on participant preference. This flexible approach accommodated diverse needs and encouraged broader participation. Participants provided informed consent while being assured of confidentiality to encourage candid responses.

Community conversations: Speak Up Teen Leadership Conference and Lens of Equity Summit

We added two community conversations to include additional youth and community perspectives.



About 75 youth participated in the Speak Up Teen Leadership Conference session “What Shapes Your Health?” We designed it to center youth voice and explore how community environments influence well-being.

At the Lens of Equity Summit, 80 participants self-selected for a session called “Mapping Equity: Bridging Gaps Together.” Participants engaged in activities connecting equity-centered data with lived experience. The session included partner mapping, a data walk, and a sticky note exercise aligning community voice with quantitative indicators.

Data analysis

Systematic review of existing qualitative data

In phase I of the systematic review of existing qualitative data, analysts used a deductive approach using a codebook of 16 identified themes (see appendix F). It was based on a previous review of qualitative data collected by the Health Department from 2018 to 2022. In phase II, analysts used an inductive reasoning approach to review literature both internal and external to the Health Department for 2020 to 2024 that addressed a specific community health need.

Focus groups, community leader interviews, and community conversations

The facilitator and a Health Department analyst looked at notes and transcripts from the focus groups and interviews. They used the same deductive approach as the earlier systematic review of existing qualitative data, performing thematic analysis to identify emerging patterns or themes in textual data. They identified new and recurring concepts that were not adequately captured in the existing codebook. We added these emergent ideas inductively, as appropriate, to the coding framework. Analysts used ATLAS.ti software³ to code notes and transcripts when available. We held regular analytic meetings to discuss coding consistency, resolve discrepancies, and refine thematic interpretation of data. We followed consensus discussions, ensuring the final codebook included both the enduring themes and newly emerging priorities within the community context. This iterative process ensured the analysis reflected previously established priorities and evolving community needs.

Creative arts submission

We used art-based inquiry (ABI) methods to analyze creative arts submissions, along with the same deductive coding process used for focus groups. Oasis Youth Center partners were invited to submit up to three art entries. See appendix E for ABI analysis methods.

Human subject protections

The Health Department’s human protections administrator reviewed the CCA to ensure it is not human subjects research, does not intend to generate or contribute to generalizable knowledge,

³ ATLAS.ti Web. (2025). *ATLAS.ti Web* [computer software]. ATLAS.ti Scientific Software Development GmbH.



and is within the realm of public health surveillance activities as defined under 45 Code of Federal Regulations (CFR) 46.102(l)(2).⁴ We conducted all community engagement activities in accordance with ethical standards and obtained informed consent prior to participation. Participants and community partner hosts were invited to codesign focus group and interview guides, and review summary drafts of this report to ensure we didn't miss anything from their shared experiences. We incorporated their edits into our final report.

Findings

Findings indicated the majority of previously identified themes remained relevant to current community health priorities. The qualitative analysis of community data sources identified 18 themes relevant to understanding the community's health landscape. Of those, 15 were validated as ongoing community priorities. The review also surfaced three emerging themes that reflect new dimensions of community health need and concern. We determined one theme, COVID-19-specific care, was no longer applicable given the transition from pandemic to endemic.

Systematic review of existing qualitative data results

Emerging themes

- **Access to community resources**—Vital for community members and their health. “Resources” covers things like information, services, activities, and parks. It can also describe the dynamic or unique physical setting of the neighborhood or community.
- **Access to care**—A community's ability to easily obtain medical and health services. Strategies include restructuring healthcare to increase access, as well as improving social, economic, and environmental conditions of health (like housing and employment).
- **Celebrating diversity**—An environment where ethnic and cultural diversity are valued. All people are accepted and feel a sense of belonging, and everyone is respected for the value they bring.
- **Culturally grounded information**—Centers a person's cultural practices, values, and experiences. Within the public health and healthcare systems, a lack of culturally grounded information perpetuates distrust and inaccessibility.
- **Early child development**—Supporting the social, cognitive, emotional, and physical development of children from birth to three years old.
- **Economic stability**—Having enough financial resources to afford basic needs.
- **Education access**—Schools' ability to ensure high quality education and advancement for all students.

⁴ hhs.gov/ohrp/sachrp-committee/recommendations/attachment-public-health-authority-and-surveillance-activities/index.html



- **Heathy food affordability and accessibility**—People can buy healthy food without straining their income. People can easily access healthy food options. Lack of healthy food is related to many chronic diseases.
- **Housing affordability and accessibility**—People can comfortably pay for housing with their existing income. Community members shared the need for safe, reliable, and affordable housing. Specifically, there is a need for low-income housing and support for people displaced or made homeless by gentrification or economic hardship.
- **Healthy community planning and built environment**—Community-led neighborhood planning processes focused on human-created surroundings.
- **Safety**—In community health, *safety* refers to a community that is protected from physical, psychological, and environmental hazards—allowing people to live without fear of harm or injury. It includes access to necessary resources and services to maintain well-being, like crime prevention, quality healthcare, and a supportive social environment. A *safe* community is one in which people feel secure in their daily lives and have the ability to thrive.⁵ Some people referred to community violence (e.g., crime or domestic violence), while others referred to authoritative violence (e.g., discrimination in healthcare settings) that affect their feeling of safety.
- **Social connections**—A sense of belonging to others and to a neighborhood or community. Social connections can give you a support system and improve your mental health, physical health, longevity, and a community's ability to recover after emergencies.
- **Transportation**—Accessing basic health needs and services can be challenging without good transportation.
- **Youth activities**—A community's desire to create more activities and programs that support youth development inside and outside school. Examples include organized youth sports, meditation, computer animation programs, psychological support, cultural and community events, and more libraries and parks within walking distance.
- **Youth behavioral health**—Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral healthcare refers to the prevention, diagnosis, and treatment of those conditions.

Three new themes emerged in the literature:

- **Environmental health or climate factors**—Mentioned several times in relation to transportation, the need to protect air and water quality, and sustaining a healthy environment for young people.
- **Civic engagement**—Community members were interested in increasing civic engagement and informing/educating others about its importance.

⁵ Raheemy, Y., Sherratt, F. & Hallowell, M. R. (2025). What is safety? Contemporary definitions and interpretations across North America. *Safety Science*, 185, Article 106798.



- **Structural racism**—People widely discussed structural racism as an important SDOH and barrier to accessing and receiving quality health care. Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values and distribution of resources.⁶

Community engagement results

We engaged more than 200 community members and organizational leaders for CCA qualitative data collection.

- Four focus groups with about 40 participants.
- Eight interviews with community leaders.
- Two community conversations with 155 participants.
- Seven artists submitted seven works of art, including one story-poem, five visual artworks (painting, collage, figurative and abstract, etc.), and one mixed medium.

Community engagement activities yielded findings consistent with the systematic document review, providing evidence of thematic saturation. One additional theme emerged through the forces of change discussion: addressing past, present, and future forces contributing to structural inequities in the community.

Demographic characteristics

See table 3 for focus group participants demographic data. Respondents had the option to select multiple race/ethnicity and gender identities from a list. As a result, individual respondents may be represented in more than one demographic category. We asked these questions across adult focus groups and the youth art project, with responses from both groups represented here.

⁶ Bailey Z. D., Krieger, N., Agénor, M., Graves J., Linos, N. & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, 389(10077), 1453–1463.



Table 3: Focus group demographics

Age group (N=42)	Count
Under 18	1–5
18–24	1–5
25–34	6–10
35–44	6–10
45–54	6–10
55–64	1–5
65+	1–5

Gender identity (N=42)	Count
Agender/bigender/nonbinary	1–5
Man	11–15
Trans man	1–5
Trans woman	1–5
Woman	16–20
My gender is not listed	1–5
I prefer not to answer	1–5

Sexual orientation (N=35) [‡]	Count
Asexual	1–5
Bisexual	1–5
Gay/homosexual/lesbian	1–5
Straight/heterosexual	26–30
My sexual orientation is not listed	1–5

Race/ethnicity (N=42)	Count
American Indian/Alaska Native (AI/AN)	6–10
Asian/Asian American	1–5
Black/African American	1–5
Hispanic/Latino	1–5
Middle Eastern/North African (ME/NA)	1–5
Multiracial (unspecified)	1–5
Native Hawaiian/Pacific Islander (NH/PI)	1–5
White	16–20
I prefer not to answer	1–5

Insurance type (N=35) [‡]	Count
Combination of Medicare and Medicaid	6–10
Combination of marketplace/private plan and Medicaid or Medicare	1–5
Marketplace plan/private only	1–5
Medicare only	1–5
Medicaid only	11–15
Employer	1–5
Currently uninsured	6–10
I prefer not to answer	1–5

Served in the United States Armed Forces or National Guard (N=35) ^{§‡}	Count
No	32
Yes	1–5
I prefer not to answer	1–5

[‡] Only adults answered this question.

[§] Full question: Have you served on active duty in the United States Armed Forces (Army, Navy, Air Force, Coast Guard, Space Force) or in a National Guard/military reserve unit?

Community conversations demographics

We did not collect demographic data for community conversations.

About 75 youth participated in the Speak Up Teen Leadership Conference session “What Shapes Your Health?” It represented Pierce County school districts, with most identifying as Black, Indigenous, or person of color (BIPOC) 14–19 years old.

The Lens of Equity Summit session, “Mapping Equity: Bridging Gaps Together,” engaged about 80 community members, including agency staff, nonprofit and grassroots leaders, and residents. Participants reflected a range of racial, ethnic, cultural, and linguistic backgrounds, with participation from organizations and communities serving:

- BIPOC residents.
- LGBTQIA+ young people.



- AI/AN communities.
- People experiencing homelessness.
- Immigrant, refugee, and asylum-seeking populations.

Community strengths and assets

Social connection and community support

Across all community engagement activities, social connection emerged as a key source of community strength. Participants described how community members support one another. They often do so through resource sharing, word of mouth, mutual aid, and cultural events.

People identified community gatherings like potlucks, sporting events, and cultural celebrations as essential spaces for building relationships and fostering belonging. One participant described this collective approach to supporting youth:

“[There is strength in] the village—to raise our youth, hold them accountable and raise them together.”

Diversity and cultural programs

Participants emphasized the strength of community organizations in celebrating diversity and providing culturally relevant programming. They highlighted senior centers and cultural community centers as important venues that provide activities and programs that bring people together. As one participant said:

“[Some strengths are] the senior centers. Asian/Korean centers have good programs, they do dance, tai chi, games. Very effective way of getting people together. People can be together with people that speak a common language.”

Multiple participants said diversity is integral to their community’s way of life and is not considered optional. Community leader interviews with organizational leaders reinforced the value of cross-cultural collaboration, agreeing people make strong connections when we celebrate diversity. One interviewee shared:

“[There is] collaboration and intersectional solidarity among BIPOC communities during times of crisis or community wide trauma. Community workshop participants viewed health

Figure 5: “You are not alone” by Monty Goff, an Oasis Youth Center creative arts submission





not just as individual effort, but as something supported by strong, accessible, and culturally grounded community systems.”

Access to nature and outdoor spaces

Throughout community engagement activities, participants identified outdoor spaces as critical assets that contribute to mental and physical health. Pierce County residents have a deep connection to nature, and people described how important it is to go outside daily for their mental health and social connection.

Participants especially found strength in accessing nature trails, parks, and other green spaces. Indigenous participants specifically highlighted land sovereignty and stewardship as fundamental indicators of community health and well-being.

Figure 6, an Oasis Youth Center creative arts submission from an LGBTQIA+ young person, highlights outdoor spaces as an asset to well-being. The artist described it as:

“A painting of my friend in a tunnel that’s in one of the beautiful forests in the pacific northwest.”

Figure 6: “M dawg in the tunnel” by Billy M., an Oasis Youth Center creative arts submission



Access to healthy food

Healthy food access was a key strength emphasized by community members. Food banks are a great asset to help provide healthy food in the community. They also mentioned the value of community gardens and farmers markets.

Participants representing the Slavic community said they feel empowered when they cook at home and have access to organic food. They expressed food as a social connector that has the power to heal. Indigenous focus group participants emphasized how food sovereignty is vital to their mental and physical health and is rooted in healing practices:

“Decolonizing western ideas of what food is... To our people, it comes back to the original message of what our people learned, and what sustained for thousands and thousands and thousands of years.”



Healthcare coordination

Participants noticed collaboration among health centers, clinics, organizations, and agencies working together to address the needs of the community. They mentioned the effectiveness of the Federally Qualified Health Center (FQHCs) partnering with health clinics, and community-based organizations collaborating to facilitate culturally relevant coordinated care. They also noticed the community health workers (CHWs) and other peer navigators help take care of health needs and share resources. One community leader interviewee noted:

“Many leaders of community-based organizations and those with lived experience are starting to be included at the (health systems) table to address systemic, organizational, and community-wide gaps in health and social care.”

Community members emphasized strength in being able to take care of their own health. Both Slavic and Indigenous groups discussed the effectiveness of traditional medicine, including:

- Healthy food.
- Time outdoors.
- Herbal remedies.
- Saunas/cold plunges.
- Time together with community.
- Cultural programming and events.
- Preventive care.

They expressed power in health autonomy and how community-based organizations are vital to well-being, self-efficacy, and getting health needs met. They said they were often frustrated with lack of culturally informed care in healthcare settings.

Health needs and priorities

Healthcare access and barriers

Participants experienced multiple barriers to accessing healthcare and community resources, including:

- Limited transportation options and affordability.
- Lack of awareness about existing community resources.
- Healthcare costs and insurance coverage gaps.
- Shortage of culturally responsive, informed care providers.

Community members expressed the need for CHWs and cultural navigators to help residents connect with resources and navigate healthcare systems. They said it helps people feel empowered to take care of their own health, because it can be hard to reach healthcare providers to discuss concerns. While acknowledging technological advancement in healthcare delivery, participants questioned whether these changes are advancing equitably. Contributing factors included provider shortages, long wait times, and loss of insurance coverage.



Digital access and literacy

Internet access emerged as a barrier, particularly for community members in rural areas. Limited connectivity restricts access to health resources, telehealth services, and social connections. Beyond access, participants identified the need for technical assistance and digital literacy support to use online tools. Aging disabilities resources focus group participants shared:

“Major barrier is no public transportation at all and very spotty internet. That is huge for everyone. There are areas that are horrible with DSL⁷ lines, and a real nightmare.”

“Tech changed the game but is it equitable? When accessing test results, people are not understanding how to access it. AI is a problem, because it’s harder to get to talk to an actual person. ...Navigating through the hoops to be able to get help is a barrier.”

Multiple focus groups discussed challenges accessing 211 services. 211 services are free and confidential. Calling 211 or visiting wa211.org connects users to local health and human services, like housing, food, mental health support, and financial assistance. Participants shared poor experiences and feedback from their peers who use the service. People said lack of phone or internet access creates additional barriers to resource navigation.

Healthy food access

Access to affordable, nutritious food was identified as a key health focus by community members across engagement activities.

Many people mentioned the need for green and garden spaces to grow their own foods, and Indigenous community members connected the need for healthy food with land sovereignty. Indigenous participants expressed how quality of food is deeply connected to health outcomes and noted how important it is to take care of the land that provides the food. One participant shared:

“How much more does healthcare cost if you don’t have your own traditional foods, traditional medicines and access to that, right? How much did that cost you and your own health?”

Community conversation participants highlighted additional contributing factors including lack of time or skills to prepare healthy meals and low-quality school or community food options.

Economic stability and workforce development

Community members identified economic stability as essential to health and well-being. Participants emphasized the need for job training, technical skills certification, and other formal education opportunities. They stressed workforce programs should be available county-wide, meeting people where they live, work, and gather.

They also called for equitable wages, humane working conditions, and benefits that honor time off. Many described being caught between financial stress and limited time or resources to prioritize

⁷ Digital subscriber line (DSL) is an internet connection that uses a modem to transmit digital data over standard copper phone lines.



health. Residents identified affordable housing, fair pay, and flexible work policies as fundamental to improving well-being and reducing stress-related health impacts.

Affordable transportation

Lack of access to affordable transportation poses barriers to medical care, obtaining food, and making social connections. Transportation emerged as an intersecting concern influencing economic stability. Participants said people who are aging or have disabilities all over Pierce County need better options. The challenge is especially pronounced for people living in rural areas and those experiencing homelessness. Long commutes mean time lost from health-promoting activities that have a positive effect on your well-being and prevent you from getting timely access to care. Participants experiencing homelessness discussed how lack of access to transportation prevents them from getting to their jobs and accessing resources.

Mental and behavioral health

Community members need stronger mental health support and behavioral health services for adults and youth. They emphasized addressing mental health services is crucial to combating stigma, early prevention, improving access, and culturally relevant approaches.

Participants said they face ongoing struggles with anxiety, generational trauma, and societal pressures.

Figure 7, an Oasis Youth Center creative arts submission from an LGBTQIA+ young person, illustrates reflections on mental health.

According to the artist:

“This piece is about the difficulties of managing your time and how that can be a barrier for taking care of your own health and wellness, when there’s so much to do, work, school, college, socio personal relationships, self-care often comes up.”

Figure 7: “Never enough time” by Ray Fitzpatrick, an Oasis Youth Center creative arts submission



Organizational leaders echoed the need to integrate behavioral health services into primary care and community-based settings to improve accessibility and continuity of care, which are undeniable needs for Pierce County communities.



Structural racism and cultural relevance in care

Structural racism is an important SDOH that can be a barrier to accessing resources and comprehensive care. Participants shared personal experiences of discrimination in healthcare settings and voiced frustration that public health models often fail to recognize and include culturally rooted approaches to wellness:

“Public health is from a white model. They don’t include our (native) ways as health. It (our ways) is just seen as ‘extra’ or ‘that’s a folk art or folk tradition,’ but it isn’t. It’s how we stay alive.”

“I don’t even go to the doctor anymore because I feel like they dismiss what I’m telling them. Like, they don’t take me seriously when I did go to the doctor.”

Community members expressed the importance of in-language and culturally relevant health information and healthcare when providing comprehensive health services. One participant emphasized this need:

“Therapy! Finding competent care that is culturally relevant. ...The hard part is finding culturally appropriate or competent care.”

An organizational leader further described how structural racism shows up in the community, including funding limitations that disproportionately affect marginalized communities:

“Many of those who are most marginalized and experience lower health outcomes are being pushed to this region due to the high cost of living in the city. Supporting Pierce County in a holistic manner requires not just resources, but also adequate funding and tools to support newcomers and residents alike. The current trickle-down of resources simply isn’t enough. As resources are spread thin, our communities receive the crumbs, when we truly need much more to thrive.”

Community members discussed many more experiences of structural racism and discrimination. These experiences spotlight how health is approached, and the need for institutional reflection and action to correct and prevent systemic inequities that perpetuate harm to marginalized communities.



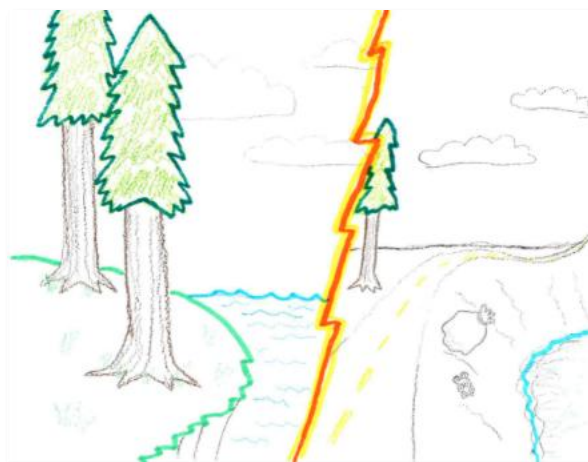
Environmental health and climate impact

Environmental health and climate change were discussed in all focus groups spanning a wide range of ages, 14 to 65 years or older. They proposed solutions and prioritizing funding to prevent further damage and improve response to natural disasters.

Youth creative arts submissions showed the importance of a safe and healthy environment and the need to protect Pierce County green space. The artist of figure 8, an Oasis Youth Center creative arts submission, said their piece illustrates:

“The benefits of walking outside yet the harm of pollution.”

Figure 8: “Our outdoors” by Tommy Griffith, an Oasis Youth Center creative arts submission



The environment has a direct impact on health, and people noted the price they suffer from careless acts against the environment like the dumping of toxic waste. They discussed environmental health in relation to structural racism and discrimination. Indigenous community members highlighted the connections between historical trauma, environmental health, and diseases like cancer.

Forces of change

The forces of change domain uses a health equity lens to help identify what affects the community and how past, present, and future forces contribute to structural inequities. Mental health focus group participants said several forces of change were particularly burdensome.

Climate change

People living in rural areas within Pierce County discussed climate anxiety related to an increase in pollution, wildfires, and wildfire smoke. One focus group member said:

“It’s hard to get out, because there is only one road for access. The wildfires and earthquakes bring worry.”

Legislative environment and policy changes

The current legislative environment and policy changes were commonly expressed as a force of uncertain change on both state and federal levels. Specifically, people expressed concern about policy related to immigration status, funding for programs that affect aging populations, and affordable housing for everyone. Community conversation participants discussed issues affecting public funding, equity initiatives, and social safety nets, which are seen as the main forces shaping community health.



Violence

Violence was of particular concern, including:

- Firearms.
- Criminal activity.
- Domestic violence.
- Sexual assault among people experiencing homelessness.

People said interpersonal violence^{8,9,10} is a direct result of systems of oppression facing marginalized communities. Violence has a profound impact on their mental and physical health.

“It’s the trauma and all these other problems then we enact on each other within a community. So, it’s like the lateral violence within the community created by forces outside of the community. And there’s a lot of harm within our community amongst each other. How do you fix that?”

Some violence stems from discrimination, as a community member experiencing homelessness shared:

“I’ve seen that happen just down the street. A guy was just walking, and this guy got rounded up, and he wasn’t doing anything. That’s against his rights. But he didn’t know his rights. That’s happening right now, just because people are homeless. This guy who wasn’t doing anything wrong. ...he was innocent.”

Workshop participants were concerned about systemic racism as a “force of change,” including anti-immigrant sentiment and rollbacks on diversity and equity efforts. They feel these factors threaten inclusion, trust, and equitable access to resources.

Limitations

Focus group and interview results may not be entirely generalizable to a larger population. This means the experiences of a few individuals or groups may not reflect those of a larger group or have statistical applicability to large populations. Instead, qualitative data provides deep and meaningful insights into specific experiences that may be transferable or relevant to similar settings.

Instrumentation/facilitation error

In the community conversation sessions, questions were asked differently in both breakout groups which limits our ability to draw conclusions and make comparisons of two different questions.

⁸ Lateral violence, sometimes called horizontal violence, is hostility among people on the same hierarchical level within a community or organization. ebsco.com/research-starters/social-sciences-and-humanities/lateral-violence

⁹ Bidirectional violence is when both partners in a couple use and experience intimate partner violence.

¹⁰ Stover, C. S., Krauss, A., Yeterian, J., DeMoss, L., Funaro, M., Webermann, A., Presseau, C. & Portnoy, G. A. (2025). Scoping review of bidirectional intimate partner violence using dyadic data. *Trauma, Violence & Abuse*. doi.org/10.1177/15248380251316193



Conclusion

CCA participants described how structural racism, cultural and linguistic disconnects, and inequitable access to resources shape health outcomes across the county. At the same time, community members emphasized existing strengths, including social connection, mutual aid, culturally grounded programs, and access to nature as protective factors that support well-being. Youth perspectives, gathered through community conversations and creative arts submissions, reinforced the importance of mental well-being, environmental health, and access to safe, supportive spaces. Together, these findings highlight the need for sustained investment in community-informed, culturally responsive, and place-based systems that reflect how residents experience and define health in their daily lives.

Looking ahead, CCA results will help anchor the community's voice in the results of the remaining sections. The next section, CSA, is our quantitative look at Pierce County's health. By examining indicators across individual, community, and policy levels, this assessment will reveal which populations face the greatest burdens and help guide how we prioritize issues.



Section 2: Community Status Assessment

Overview

The CSA provides a comprehensive, data-driven picture of health in Pierce County. It highlights quantitative indicators, risk factors, conditions, and outcomes that shape health and well-being across neighborhoods, identities, and generations. We categorized these indicators across domains:

- Demographics.
- Socioeconomic status.
- Access to care.
- Chronic disease.
- Maternal and child health.
- Climate health.
- Behavioral health.

Each indicator is accompanied by a short narrative highlighting community impact and disparities or equity. Together, these indicators help identify patterns of strengths, weaknesses, and opportunities to improve people's health across Pierce County. All data shown are for Pierce County unless otherwise noted. These data will inform the CHIP and the Health Department's strategic planning.

The final section of the CSA highlights data related to youth health and well-being, providing insight into the experiences and opportunities young people face in the wake of the COVID-19 pandemic. While this section is data-focused, it can help inform future opportunities for youth-informed and youth-led solutions.

Methods

Data sources and timeframe

We compiled quantitative indicators from public health surveillance systems, vital statistics (birth and death data), census and other national survey estimates, hospital discharge data, and other sources. We reported on the most recent data available—typically 2019–2023—but to accommodate differences in data availability across sources, we sometimes presented averages of 2018–2023 or shorter time periods. With some indicators, current rates may differ from previously published rates or figures because of updated population estimates or methodological changes in the data sources. For more information on individual data sources, see appendix G.



Indicator selection

We chose indicators based on:

- **Alignment with MAPP 2.0 domains.** We prioritized measures spanning multiple domains including chronic disease, behavioral health, maternal/child health, access to care, and environmental health to reflect an emphasis on health equity and upstream drivers.
- **Data availability and granularity.** Indicators had to be available at the county level and allow subgroup analyses by race/ethnicity, sex, age, or geography.
- **Community relevance.** We consulted the CPA (section 3) to identify themes that were important to organizational partners and residents.
- **Equity considerations.** We gave preference to indicators known to exhibit disparities across population groups (i.e., race, ethnicity, sex, geography, and income).

Following the initial selection process, we incorporated additional indicators to strengthen the assessment's focus on health equity and population context. These included descriptive demographic and socioeconomic indicators drawn from the Health Department's core health indicators,¹¹ and measures such as perceived discrimination that help illustrate social and structural determinants of health. Together, these indicators provide a balanced view of health outcomes and the conditions that shape them.

Equity stratification

Consistent with MAPP 2.0's equity foundation, we stratified indicators by race/ethnicity, sex, age, income, and geography, whenever sample sizes allowed. We interpreted disparities as the products of systemic inequities rather than deficiencies within specific populations.

Statistical analysis and interpretation

For each indicator, we calculated rates or percentages with 95% confidence intervals. We examined the overlap of confidence intervals between different geographies (i.e., Pierce County vs. Washington or specific demographic groups). Non-overlapping intervals suggest a meaningful difference and we labeled them as significantly different. For U.S. Census Bureau (USCB) and American Community Survey (ACS) data, we present 90% confidence intervals.

We assessed precision using the relative standard error (RSE). We based estimates for many subgroups (e.g., age and race/ethnicity) on a relatively small number of respondents. As a result, they may have wide confidence intervals and a large RSE. Generally, an RSE greater than 25–30%

¹¹ The Health Department's core indicators include a set of about 70 health indicators intended to assess the status of and trends in health within Pierce County, ranging from demographics, infectious disease, chronic disease, access to care, etc. These indicators will routinely be modified to match data availability and community health trends.



indicates that the estimates are unreliable¹² and could be very different from the value calculated. In this report, we assume an RSE greater than 30% has limited reliability, and these results are marked with “!” to alert the reader to use caution when interpreting the estimates. We suppressed data when necessary to protect confidentiality and avoid misleading interpretations. Data are sometimes not shown when significant amounts of data are unreliable or suppressed.

Data quality and limitations

The COVID-19 pandemic led to the disruption or delay of several data sources and surveys. USCB noted that the 2020 decennial census was conducted under unprecedented conditions, such as pandemic disruptions and system upgrades.¹³ It did not release the standard 2020 ACS one-year estimates because it had an all-time low 71% response rate due to pandemic-related challenges.¹⁴ As a result, rates computed using 2020 and later population denominators may not be directly comparable with earlier estimates.¹⁵ Moreover, 2020–2022 pandemic-related disruption and public health restrictions most likely altered health behaviors and healthcare-seeking behaviors. Consequently, you should interpret with caution indicators using 2020–2022 data when you compare them to pre-pandemic (2018–2019) data and 2023–2025 data. Data collected from 2020 to 2022 may not be representative of Pierce County before or after the pandemic. Other limitations of the CSA results include:

- **Sampling variability.** Many surveys rely on sampled populations where estimates for subgroups (e.g., AI/AN or NH/PI) are calculated from a small sample size. These data can produce unreliable estimates, leading to suppression or cautionary flags (e.g., “!”).
- **Hospitalization data changes.** Due to changes in data availability, hospitalization estimates from 2022 on may vary from those in existing reports or dashboards.
- **Changes in survey instrument methods.** Survey instruments such as Healthy Youth Survey (HYS) and Behavioral Risk Factor Surveillance System (BRFSS) occasionally change question wording or screening guidelines, limiting direct comparisons across years.

¹² doh.wa.gov/sites/default/files/legacy/Documents/1500/SmallNumbers.pdf

¹³ Daily, D., Cantwell, P. J., Battle, K. & Waddington, D. G. (2021). *An assessment of the COVID-19 pandemic's impact on the ACS 1-year data*. (ACS Research and Evaluation Report Memorandum Series # ACS21-RER-04). U.S. Census Bureau. census.gov/content/dam/Census/library/working-papers/2021/acs/2021_CensusBureau_01.pdf

¹⁴ Ibid.

¹⁵ Arias, E., Liebler, C. A., Garcia, M. A. & Sáenz, R. (2025). Data impacts of changes in the U.S. Census Bureau procedures for rate and ethnicity data. *SSM - Population Health*, 29, Article 101742. sciencedirect.com/science/article/pii/S2352827324001435



Demographics

Populations are described with demographics including age, sex, race, ethnicity, and others. These basic characteristics can be combined with information about wealth and education to describe the vulnerability of the population—not the people within it—to poor health outcomes.

Age and sex

The number of people in Pierce County increased by about 15% since 2012 (from about 814,200 to 946,300). At the same time, the average age of the population increased from about 37 years to nearly 39 years, masking big differences by age group. The number of children under 5 years old in Pierce County increased by 2% (from ~55,300 to 56,700), while those 65 or older increased by about 55% (from 96,400 to 149,600). From 2012–2023, the percent of the population 1–4 years of age dropped from 5.4% to 4.8%. The percent of the population who are 65–74 years old increased from 6.8% to 9.6%, while those 75–84 years old increased from 3.6% to 4.7%. Typically, slightly more boys than girls are born; yet, as people age, women are more likely to survive. In Pierce County, as of 2023, the male-to-female ratio is about 1:1 over the entire population, typical of the United States as a whole.¹⁶

Race and ethnicity

Pierce County’s population is 60% white, non-Hispanic. In 2023, 13% of the population identified as Hispanic. The next largest group was people who identified as multiracial, non-Hispanic.

Since 2012, the Pierce County population has become more diverse, with 39.7% of the population identifying as BIPOC vs. 31.4% in 2012. This increase is particularly noticeable among the younger

Table 4: Demographics, Pierce County, 2023

Total population	Count	Percent
Pierce County	946,300	100.0

Age (years)	Count	Percent
Under 1	11,082	1.2
1–4	45,055	4.8
5–14	122,231	12.9
15–24	123,155	13.0
25–34	135,968	14.4
35–44	134,768	14.2
45–54	113,217	12.0
55–64	111,212	11.8
65–74	90,594	9.6
75–84	44,678	4.7
85+	14,340	1.5

Sex	Count	Percent
Male	471,071	49.8
Female	475,229	50.2

Race/ethnicity	Count	Percent
White [‡]	571,039	60.3
Black [‡]	67,272	7.1
AI/AN [‡]	9,484	1.0
Asian [‡]	67,668	7.2
NH/PI [‡]	19,888	2.1
Multiracial [‡]	85,949	9.1
Hispanic as race	125,001	13.2

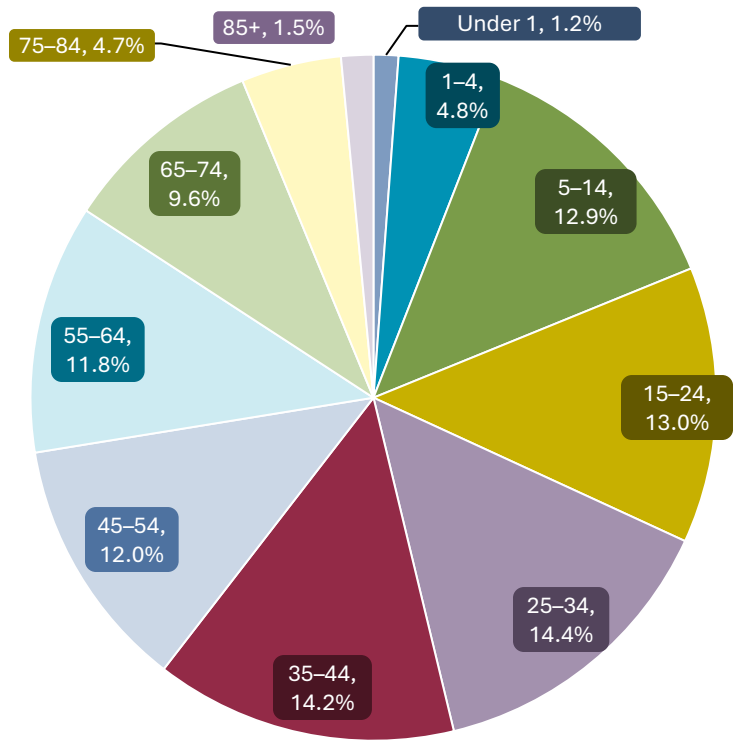
[‡] Non-Hispanic
Source: Washington State Office of Fiscal Management (OFM), 2025 estimate.

¹⁶ www2.census.gov/library/publications/decennial/2020/census-briefs/c2020br-06.pdf



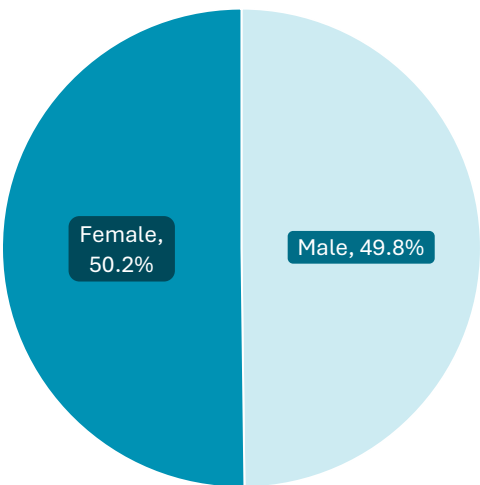
population. In 2023, the percent of people younger than 25 who identified as BIPOC was 52.5%, while about one-third (33.6%) of those 25 or older identified as BIPOC.

Figure 9: Population by age group (years), Pierce County, 2023



Source: OFM.

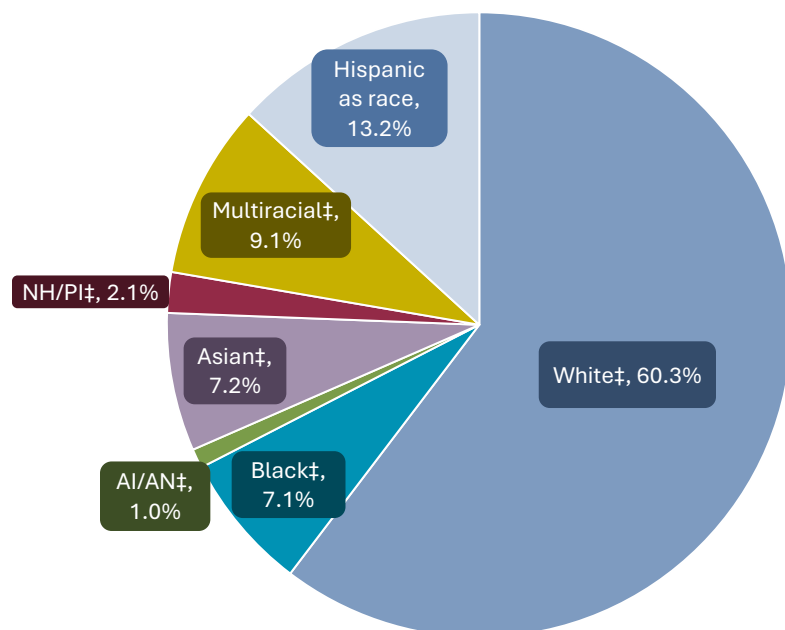
Figure 10: Population by sex, Pierce County, 2023



Source: OFM.



Figure 11: Population by race/ethnicity, Pierce County, 2023



‡ Non-Hispanic

Source: OFM.

Limited English proficiency

Many people in Pierce County speak one or more languages in addition to English. Of these households, 18.7% did not speak English as their primary language at home. After English, the languages most commonly spoken at home were Spanish (7.3%), Korean (1.7%), and Tagalog (1.5%). In their homes, 3.2% of households spoke other Asian or Pacific Islander languages and 1.4% spoke Russian, Polish, or other Slavic languages.

Among people 5 years or older, 5.8% spoke English “less than very well,” which is lower than the statewide level (7.7%). The highest proportion of individuals who spoke English “less than very well” spoke an Asian or Pacific Islander language (45%), followed by other Indo-European languages (35%) and Spanish (32%).



Health equity and social vulnerability

The conditions in which people live significantly affect their health and well-being. Those in wealthier neighborhoods generally experience better health outcomes than those in lower-income areas. Similarly, people facing racism and other forms of discrimination were more likely to experience poor health. According to Centers for Disease Control and Prevention (CDC), health equity is achieved when everyone can reach their full health potential without being disadvantaged by social or economic factors.¹⁷ Achieving equity requires ongoing efforts to address historical and current injustices, remove barriers to health and healthcare, and eliminate preventable disparities.

CDC's Social Vulnerability Index (SVI) helps measure a community's resilience to external stressors like natural disasters, disease outbreaks, and economic hardships. Communities that are more vulnerable often face greater challenges in protecting their own health. Reducing social vulnerability strengthens communities and improves their overall well-being.

Social vulnerability does not measure individual health or personal resilience. Instead, it reflects the conditions in which a community lives and its ability to thrive, stay healthy, and respond to challenges.

Traditionally, social vulnerability is assessed using individual factors. SVI combines 15 indicators—including income, education, race/ethnicity, housing, and transportation—into a single score at the census-tract level. Lower scores indicate greater resilience, while higher scores indicate greater vulnerability.¹⁸

By analyzing SVI, we can uncover disparities that might otherwise go unnoticed and identify areas that could benefit from targeted interventions. We ranked the SVI scores for all Pierce County census tracts, dividing them into four tiers. We then compared disease rates across these groups to better understand the patterns of health inequity. Due to data availability at the census tract level, we only calculated SVI for:

- Disability.
- Percent with health insurance.
- Inadequate prenatal care.
- Low birth weight.
- Colorectal cancer.
- Breast cancer.

¹⁷ cdc.gov/health-disparities-hiv-std-tb-hepatitis/about/index.html

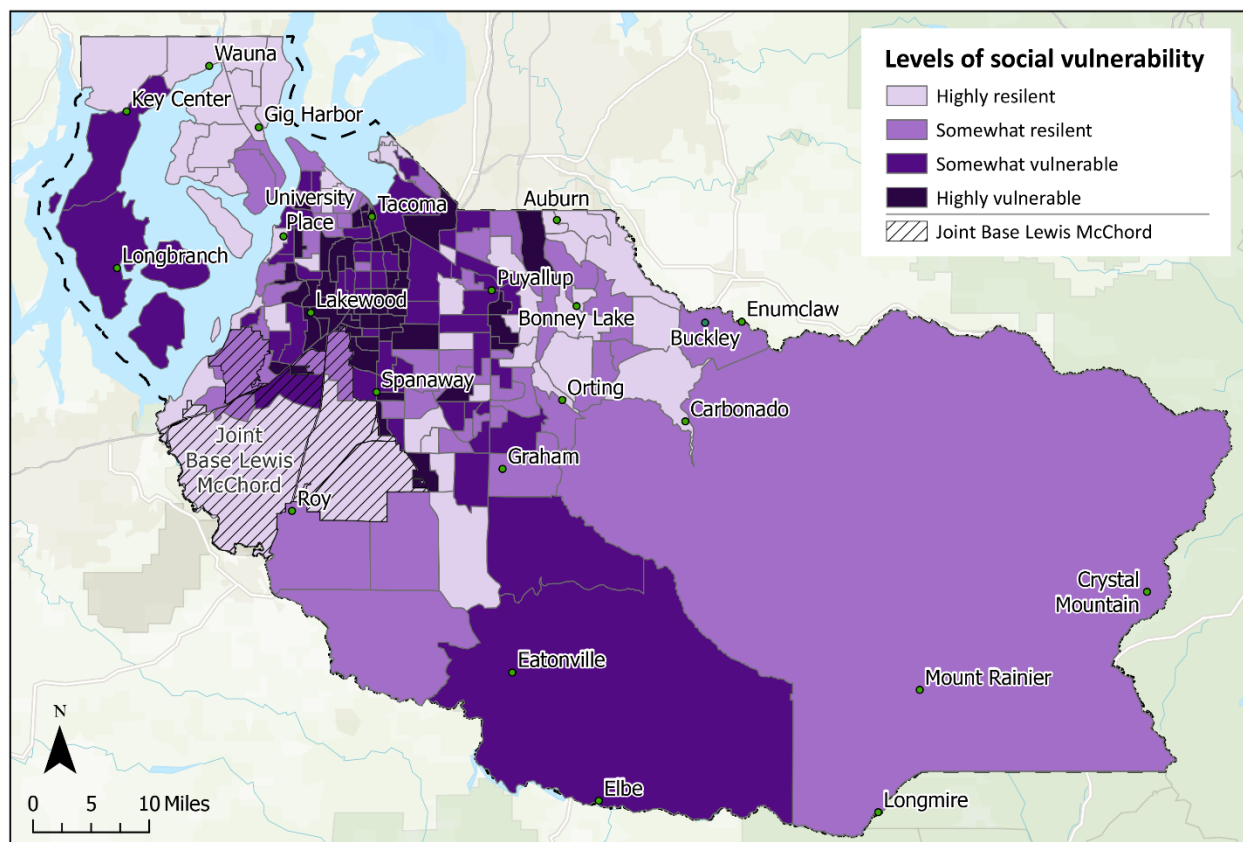
¹⁸ For more about CDC's SVI, see atsdr.cdc.gov/place-health/php/svi/index.html. A lower SVI score corresponds to greater resiliency in a community. We grouped SVI scores into these categories: 0.0–5.9: highly resilient; 6.0–7.6: somewhat resilient; 7.7–9.3: somewhat vulnerable; 9.4 or greater: highly vulnerable.



We grouped SVI scores into these categories:

- 0.0–5.9: Highly resilient.
- 6.0–7.6: Somewhat resilient.
- 7.7–9.3: Somewhat vulnerable.
- 9.4 or greater: Highly vulnerable.

Figure 12: Social vulnerability index scores by census tract, Pierce County, 2022



Data sources: Centers for Disease Control and Prevention Social Vulnerability Index (2022), U.S. Census Bureau, Pierce County Geographic Information System (GIS). Created on July 13, 2026. All Tacoma-Pierce County Health Department GIS data is expressly provided "as is" and "with all faults." The Health Department makes no warranty of any kind, express or implied, concerning this information, including but not limited to any warranties of merchantability or fitness for any purpose. The Health Department assumes no responsibility or legal liability concerning the data's accuracy, reliability, completeness, timeliness, or usefulness.

Socioeconomic status

Socioeconomic status (SES) is a key driver of the health of a person, family, or household. Income, education, and occupation are all components of SES that help describe access to resources and opportunities, including health.

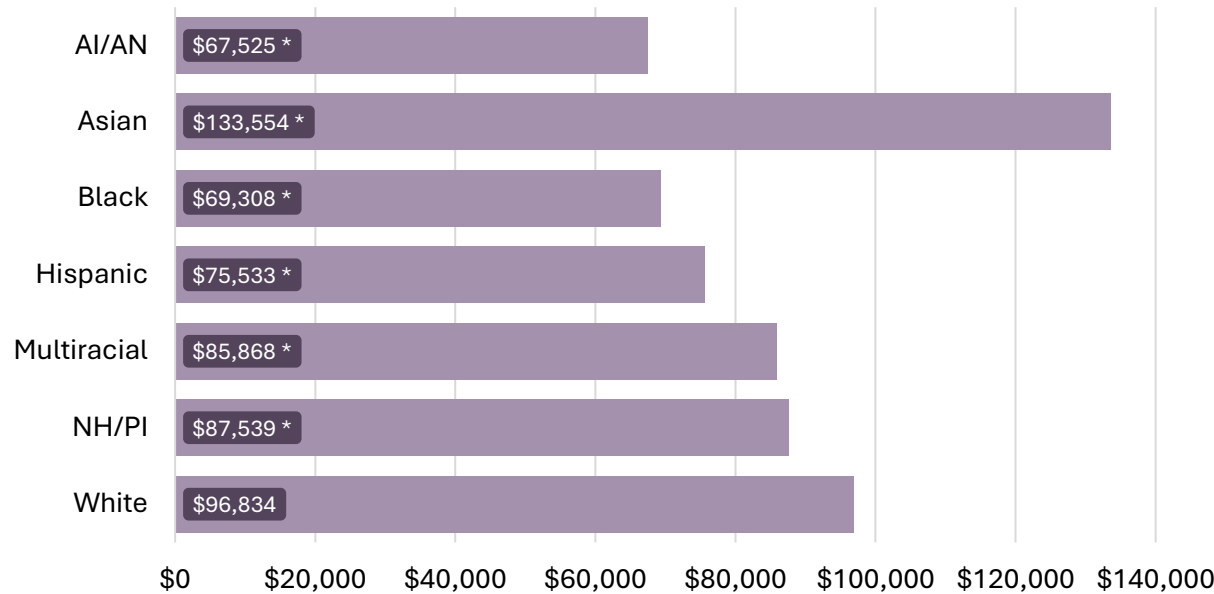
Income

The median household income in Pierce County from 2019 to 2023 was more than \$96,000, slightly higher than the statewide median of \$94,952. Independent of household status, the median



income for men was \$68,466; for women, it was \$51,943. Median income level also differs by race and ethnicity. Half of the Asian population earned more than \$133,000, while half of the AI/AN population earned less than \$67,525.

Figure 13: Median income, Pierce County, 2019–2023

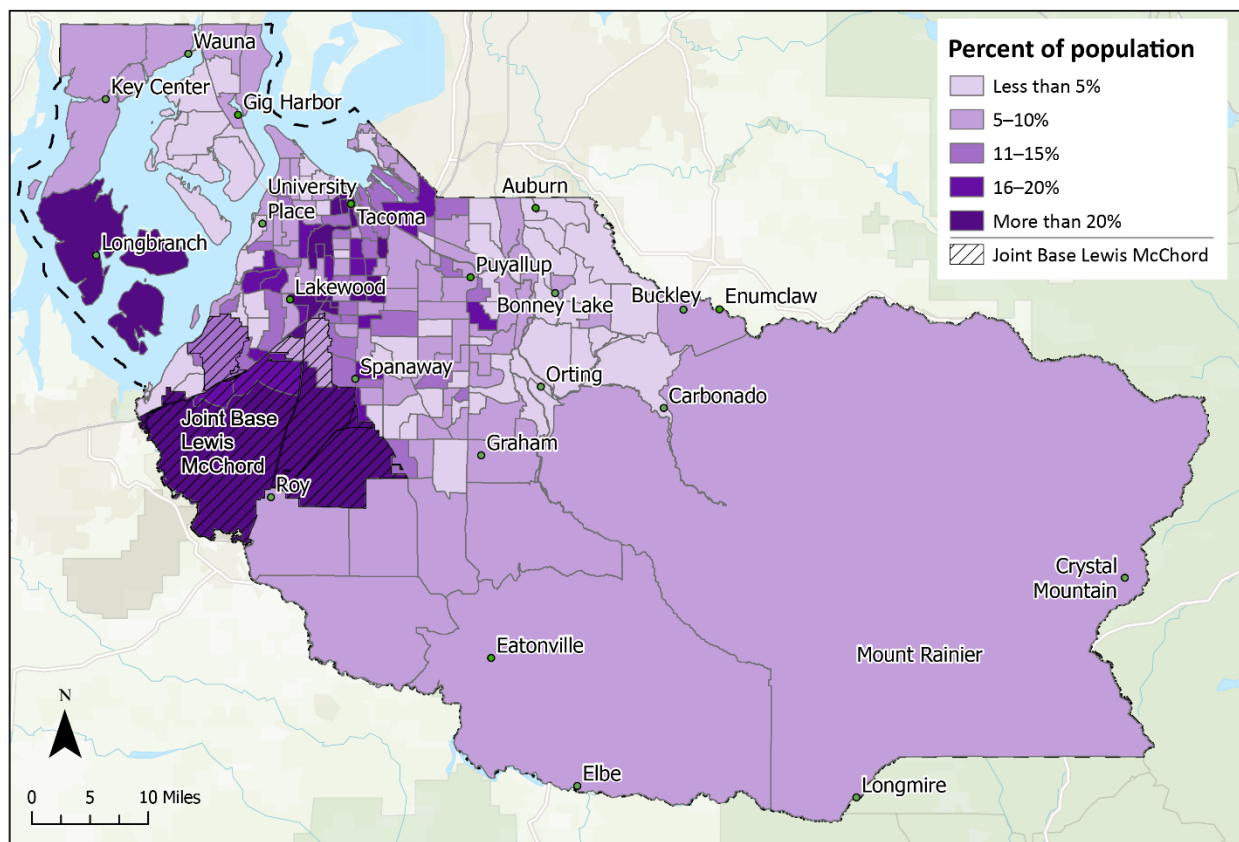


* Statistically significant difference from overall Pierce County

Source: USCB, ACS.

Poverty

Poverty affects people’s ability to meet their basic needs. The percent of Pierce County residents living below 100% of the federal poverty level decreased from 10.4% in 2015–2019 to 8.9% in 2019–2023. Pierce County’s poverty rate of 8.9% in 2019–2023 was significantly lower than the statewide rate (9.9%). Women are more likely to live in poverty than men. Black and NH/PI people are significantly more likely to live in poverty than Pierce County as a whole. Poverty exists throughout Pierce County, with some areas more affected than others as shown in figure 14.

*Figure 14: Percent of population below federal poverty limit, Pierce County, 2019–2023*

Data sources: U.S. Census Bureau (2019–2023), Pierce County Geographic Information System (GIS). Created on July 13, 2026. All Tacoma-Pierce County Health Department data is expressly provided “as is” and “with all faults.” The Health Department makes no warranty of any kind, express or implied, concerning this information, including but not limited to any warranties of merchantability or fitness for any purpose. The Health Department assumes no responsibility or legal liability concerning the data’s accuracy, reliability, completeness, timeliness, or usefulness.

Unemployment

USCB’s ACS measures unemployment among people 16 or older who are not in the labor force.¹⁹ About 5% of Pierce County people 16 or older were unemployed in 2019–2023, same as the statewide estimate for this period. Men and women in Pierce County have similar unemployment rates. Black (7.5%) and multiracial (6.8%) residents have significantly higher rates of unemployment than Pierce County as a whole, while Asian residents (3.9%) have significantly lower rates of unemployment.

Educational attainment

In 2019–2022 in Pierce County, the percent of adults 25 or older who earned at least a bachelor’s degree (29.3%) is significantly lower than the statewide average (38%). Among race/ethnicity groups, NH/PI residents have the lowest rate of bachelor’s degree attainment (8.5%), while Asian residents have the highest (33%). Education level is closely tied to income. People with incomes at

¹⁹ USCB defines “not in the labor force” as people who are neither employed nor actively looking for work. This includes retirees, students, and homemakers.

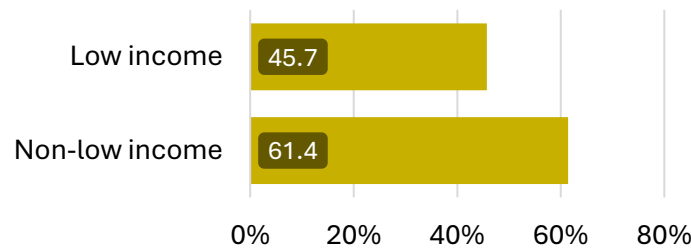


or above the poverty level (30.7%) were more likely to hold a bachelor’s degree than those with incomes below the poverty level (14.4%).

Kindergarten readiness

Office of the Superintendent of Public Instruction (OSPI) reports on kindergarteners’ readiness to learn in six domains: social-emotional, physical, language, literacy, cognitive, and mathematics.²⁰ Pierce County students’ level of readiness is similar to Washington students’ (54.6% vs. 53.6%). More than 60% of female students are ready to learn vs. 50% of male students. Family SES is highly correlated with readiness to learn. About 45% of kindergarteners from low-income families (making 185% of the federal poverty level or less) were ready to learn. About 61% of children from non-low-income families (making more than 185% of the federal poverty level) were ready to learn.

Figure 15: Kindergarten readiness, Pierce County, 2023–2024



Source: OSPI.

Food insecurity

Food insecurity occurs when people cannot access the food they need to live their lives to the fullest extent. From 2022 to 2023, an average of 12% of adults in Pierce County reported the food they bought always or sometimes did not last, and that they did not have enough money to buy more. This was higher than the statewide average of 10.5%.

Table 5: Food access indicators, Pierce County, 2022–2024

Indicator	Pierce County	Washington
Food insecurity	12.0%	10.5%
Eligible for free or reduced-price lunch	51.4%	52.5%

Source: BRFSS; OSPI.

²⁰ ospi.k12.wa.us/data-reporting/data-portal



Free and reduced-price lunch

The federal free and reduced-price meal program provides food to students whose household income is less than or equal to 130% of the federal poverty limit level for free, or between 130% and 185% of the federal poverty limit level at a reduced price. During the 2023–2024 school year, 51.4% of students in Pierce County were eligible for free or reduced-price lunches, which is slightly lower than the state (52.5%).

Living costs

Housing, childcare, and transportation rank among the largest annual expenses for many families, often forcing them to make difficult decisions about which bills they can pay. Affordable housing is critical to family stability. Affordable and reliable childcare helps families achieve economic stability and provides a safe environment for early development.

More than half of Pierce County renters spent at least 30% of their income on housing and are considered highly cost burdened. About 7% spent at least 15% of their income on transportation (i.e., vehicle costs, transit costs, ride-share costs, and the value of time spent on transportation) and are considered highly cost burdened.²¹ In Pierce County, 5.2% of households lack access to a vehicle, lower than the 6.9% in Washington households. And 17.5% of one-person households do not routinely have access to a vehicle, compared to 3.9% of two-person households. While childcare costs are similarly burdensome, Pierce County residents do not have as high a childcare cost burden as Washington households as a whole. In 2023, a married couple in Washington would pay 21% of their income to center-based daycare for two toddlers, whereas in Pierce County, they would spend 19%. For a single mother with one infant, childcare would consume 48% of her income in Washington compared to 39% in Pierce County.

Table 6: High housing and transportation burdens

	High housing burden (2019–2023)			High transportation burden (2016–2020)
	Rent	Mortgage	No mortgage	
Pierce County	52.2%	30.9%	13.9%	7.4%
Washington	49.3%	29.2%	13.4%	9.8%

Source: Institute for Transportation and Development Policy;²² USCB, ACS.

Homelessness

The Pierce County Homeless Crisis Response System is a coordinated network of services run by Pierce County Human Services Department. It helps people who are experiencing homelessness,

²¹ transportation.gov/sites/dot.gov/files/2023-11/Cost%20Burden%20KPI%20Public%20Summary%20Review%2011.28.2023.pdf

²² Institute for Transportation and Development Policy. “The High Cost of Transportation in the United States,” published online Jan. 24, 2024. itdp.org/2024/01/24/high-cost-transportation-united-states



are at risk of experiencing homelessness, or have experienced homelessness in the past. These services include coordinated entry, diversion, street outreach, emergency shelters, and permanent housing options. Their data provides the best available insight into critical housing needs for Pierce County residents. In 2024, Pierce County served 21,418 people, of whom 9,772 were homeless.²³ This represents a 14% increase over 2022, resulting in a higher number being served than in any recent year. More women were provided services than men (50.9% vs. 46.9%), while more men who were homeless were provided services (52.7% vs. 45.1%). Black, AI/AN, and NH/PI populations experienced the highest rates of homelessness, with Asian and white populations the lowest.

Access to care

Access to healthcare is a key determinant of health and well-being. Health insurance is one of the key drivers of access. It funnels people to healthcare providers who deliver preventive care, case management, and emergency services. Even people with health insurance may find healthcare too costly to access necessary services. People and families may still struggle to afford the care they need. That can result in delays in accessing care or forgoing care all together.

Health insurance coverage

Lack of access to healthcare can be particularly burdensome for people who don't have adequate health insurance. Since the implementation of the Patient Protection and Affordable Care Act²⁴ in 2014, the proportion of residents without health insurance has significantly decreased.²⁵

The percent of Pierce County residents with health insurance (94%) was not significantly different from that of state residents (93.7%). Within the county, insurance coverage was high among both men and women. Although coverage was significantly lower among men (93.2%) than women (94.7%), the absolute difference was small (1.5 percentage points). Hispanic people were significantly less likely to have insurance than Asian, white, or multiracial people. Health insurance coverage was lowest among early- to middle-aged adults (18–44 years old).

The percent of the population with health insurance decreased as the social vulnerability of the census tract where people lived increased. Those living in highly vulnerable census tracts were significantly less likely to have health insurance (90.6%) than those living in more resilient areas.²⁶

²³ Pierce County Homeless Crisis Response System. open.piercecountywa.gov/stories/s/Homeless-Crisis-Response-System/7wee-rgqc

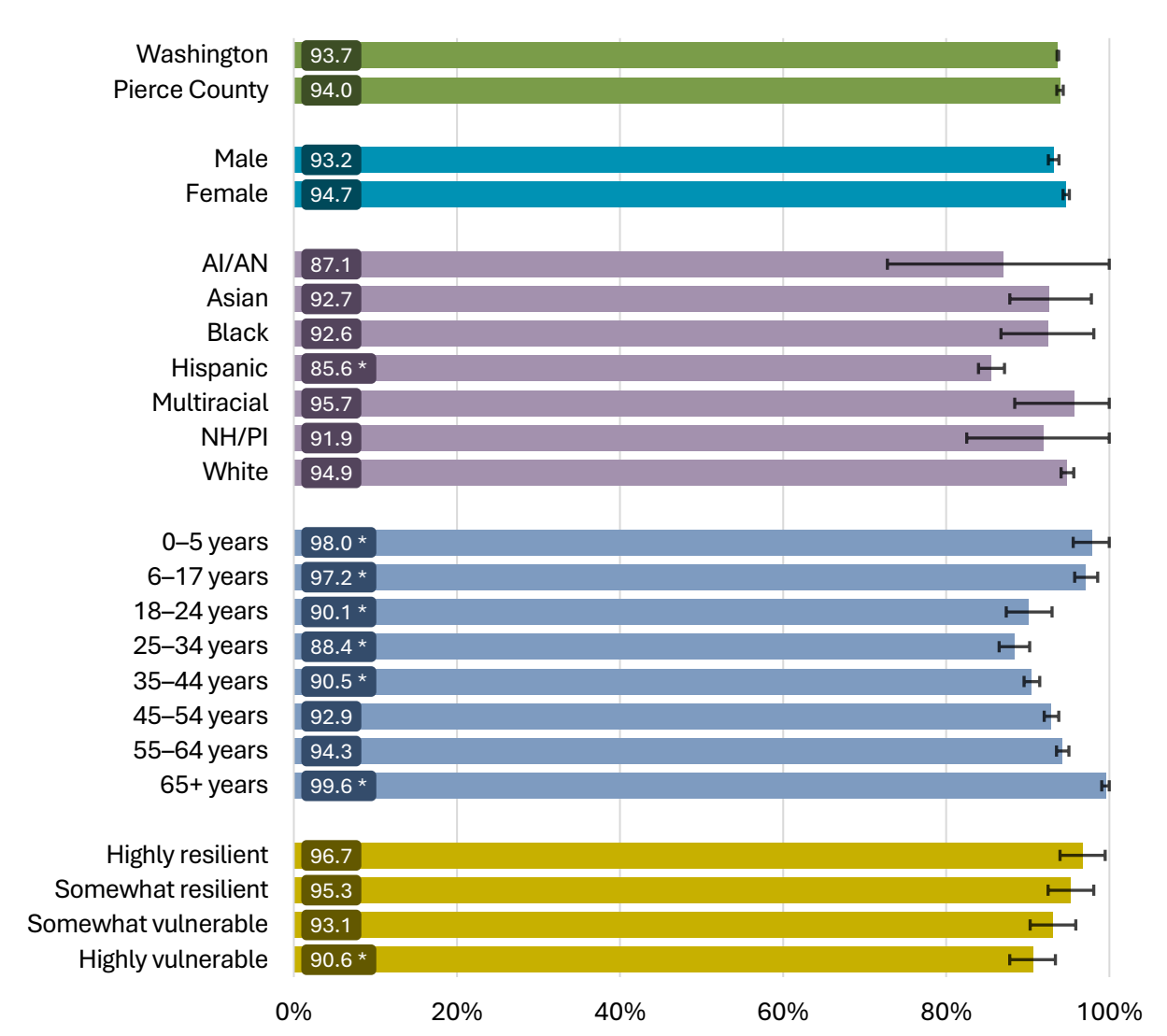
²⁴ congress.gov/bill/111th-congress/house-bill/3590

²⁵ kff.org/affordable-care-act/health-policy-101-the-affordable-care-act/?entry=table-of-contents-what-did-the-aca-change-about-health-coverage-in-the-u-s

²⁶ For more about CDC's SVI, see atsdr.cdc.gov/place-health/php/svi/index.html. A lower SVI score corresponds to greater resiliency in a community. We grouped SVI scores into these categories: 0.0–5.9: highly resilient; 6.0–7.6: somewhat resilient; 7.7–9.3: somewhat vulnerable; 9.4 or greater: highly vulnerable.



Figure 16: Have health insurance, Pierce County, 2018–2022



* Statistically significant difference from overall Pierce County

Source: USCB, ACS; CDC SVI.

Cost to access care

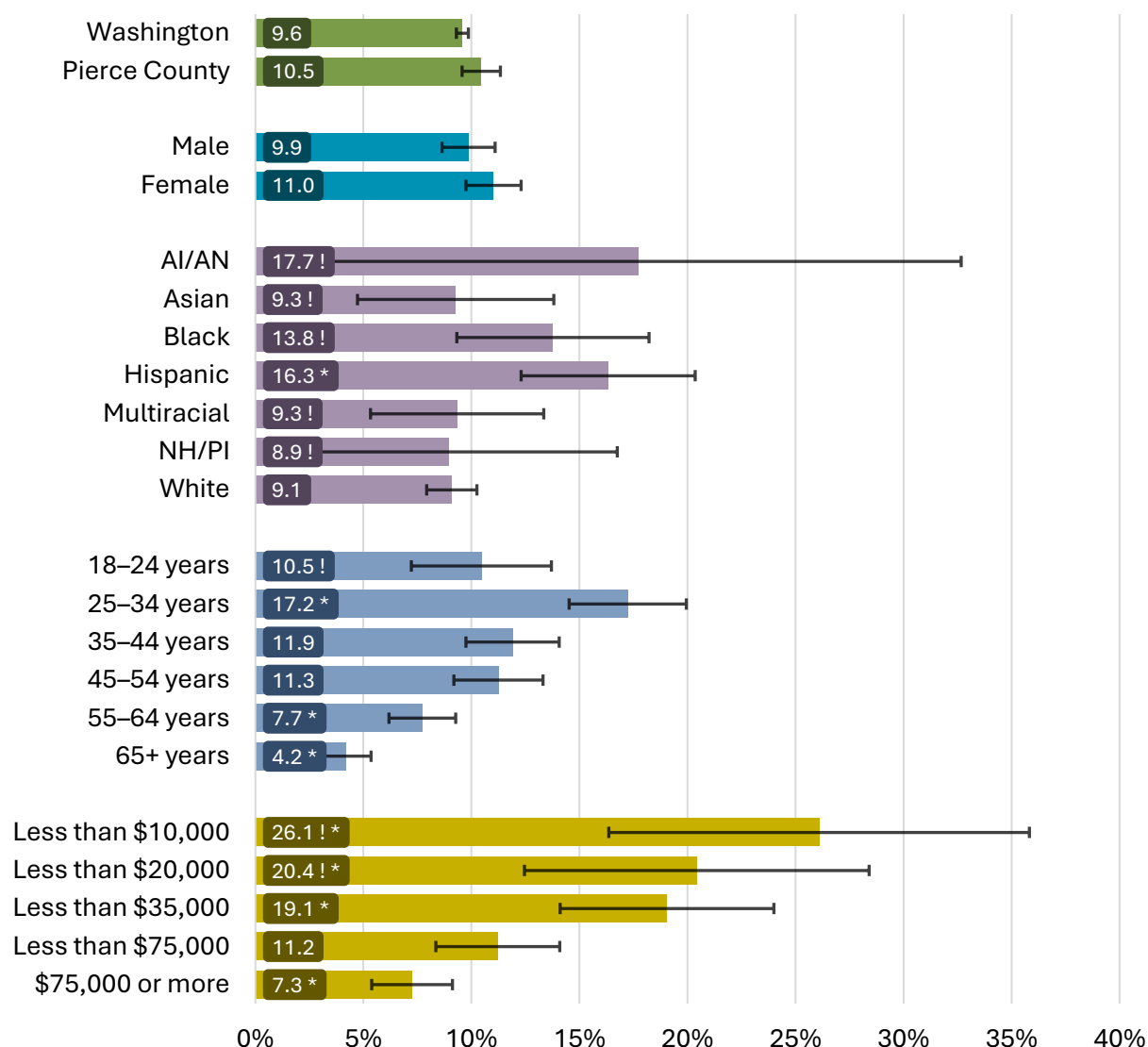
The ability to receive adequate care is often influenced by financial resources. BRFSS asks adults if they need to see a doctor but are unable to do so for financial reasons.

The percent of adults who did not see a doctor due to costs was similar in Pierce County and Washington. Women in Pierce County were more likely than men to report cost as a barrier to care, although the difference was not significant. Hispanic residents were significantly more likely to forgo medical care due to costs than white residents. Due to uncertainty in the data for other race/ethnic groups, interpret the results with care.



People 25–34 years old were significantly more likely to have an unmet healthcare need due to cost than other age groups. In contrast, those 65 or older were significantly less likely to have unmet healthcare needs due to cost. The percent of individuals who did not see a doctor due to costs increased as income decreased, highlighting the connection between financial stability and access to care.

Figure 17: Did not see a doctor due to cost, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: BRFSS.

Preventive care

Clinical preventive services play a vital role in disease prevention and detection. Some services reduce the prevalence of chronic conditions, while others deliver the necessary care before the

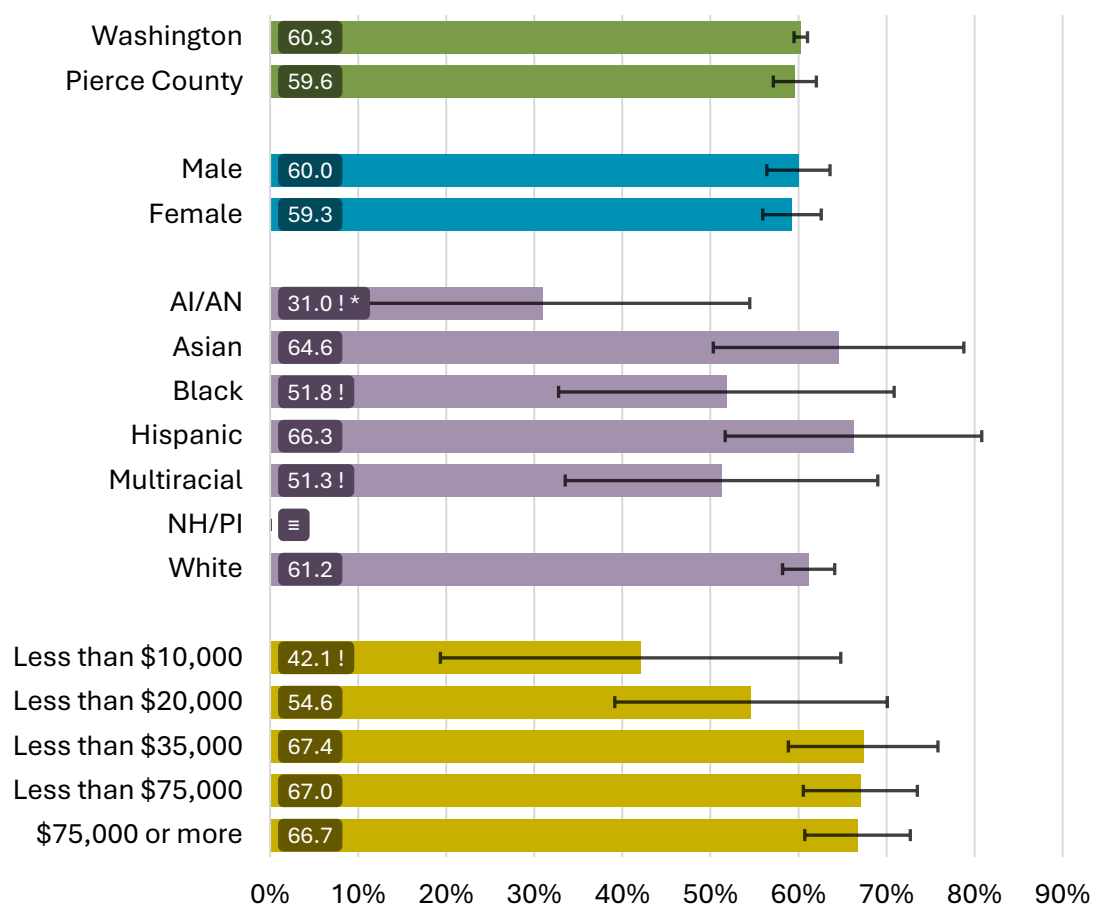


disease becomes severe. Immunization is one of the greatest public health achievements, significantly reducing the burden of infectious diseases worldwide.

Flu vaccination

Annual flu vaccination helps prevent hospitalization and protects high-risk populations. Uptake varies by age, race, and income. We found 59.6% of adults 65 or older got flu vaccine in the last 12 months, similar to 60.3% across Washington. Men and women also showed similar uptake rates (60% and 59.3%, respectively). Although the number of people who responded to the question was small, only 31% of AI/AN adults 65 or older got flu vaccine, versus 66% of Hispanic and 65% of Asian adults 65 or older. People with the lowest income (less than \$10,000) were the least likely to get flu vaccine.

Figure 18: Adults 65 or older who got flu vaccine in the last 12 months, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: BRFSS.



Annual dental checkup

Oral health is an often-overlooked component of a robust healthcare system. Regular dental check-ups play a crucial role in preventing cavities and can reduce the risk of chronic diseases, such as heart disease and diabetes, which are linked to poor oral hygiene.

In Pierce County, 68% of adults had a routine dental checkup in the past year, similar to the 69% state average. We observed no significant differences in terms of sex or race/ethnicity. Adults 65 or older were significantly more likely to have had a routine dental checkup than those 25–34 years old. People earning \$75,000 or more per year were significantly more likely to have had a routine dental checkup than those with lower incomes. People earning \$35,000 or less were less likely to have undergone a dental checkup in the past year than the county average.

Cancer screening

Regular screening can help detect cancer early. BRFSS provides data on screening for breast and colorectal cancers. Before 2024, United States Preventative Services Task Force guidelines recommended women in their 40s talk with their healthcare providers about breast cancer screening with a mammogram. In 2024, all women were recommended to be screened every other year for breast cancer, starting at 40 years old.²⁷ Colorectal cancer screening for all adults should begin at 45 years old and continue until 75 years old.²⁸

Within the past two years, 63% of women 40 or older got mammograms, while 78% of adults 45–75 years old were screened for colorectal cancer. These rates were not different from statewide rates. AI/AN women were least likely to have had a mammogram in the past two years, but the difference was not statistically significant. Women 45 or older were significantly more likely to have had a mammogram within the past two years than women 35–44 years old—as expected given that breast cancer screening typically starts at 40. We didn’t find any significant differences in terms of income.

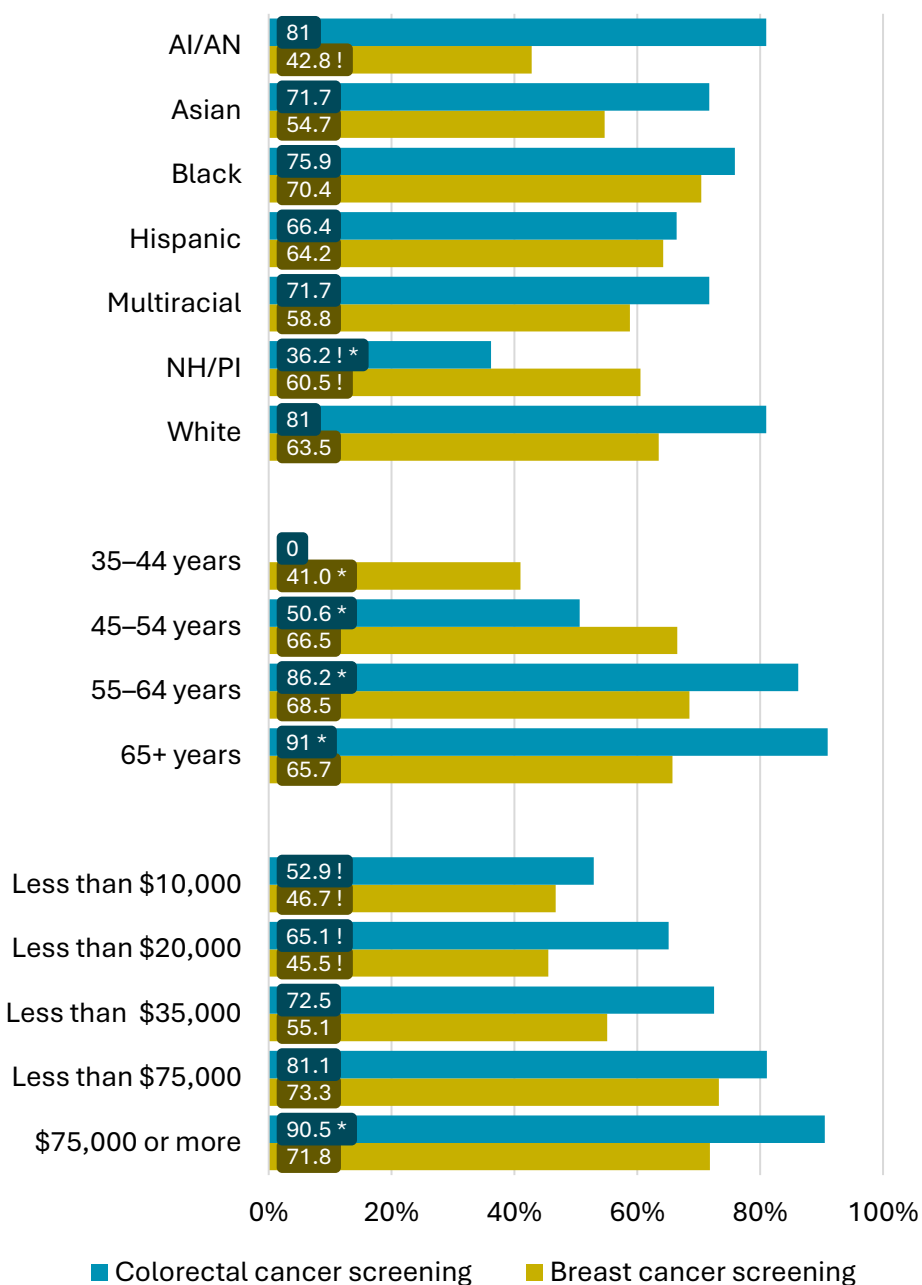
Hispanic adults were significantly less likely to be screened for colorectal cancer than non-Hispanic Black and non-Hispanic white adults. No significant differences were observed between the sexes. Adults 45–54 years old were significantly less likely to be screened for colorectal cancer than those 55 or older. Colorectal screening increased as income increased, with people making \$75,000 or more significantly more likely to be screened than those making less.

²⁷ United States Preventative Services Task Force. “Final Recommendation Statement: Breast Cancer Screening,” April 30, 2024. uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening

²⁸ United States Preventative Services Task Force. “Final Recommendation Statement: Colorectal Cancer: Screening,” May 18, 2021. uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening



Figure 19: Cancer screening, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: BRFSS.



Health behaviors

New cases of chronic disease often can be linked to health behaviors. These behaviors are shaped by the places we live, the resources we have, and the environment, in addition to personal choice. Obesity,²⁹ physical activity, and tobacco use contribute to a person's risk of developing chronic disease.

Obesity

Many factors can affect obesity, including diet, exercise, and genetics. In Pierce County, the prevalence of obesity among adults was significantly higher than the state average. Within the county, Asian people and those 18–24 years old are less likely to be obese than other race/ethnicity and age groups.

Physical activity

U.S. Department of Health and Human Services recommends adults get at least 150 minutes of moderate-intensity aerobic activity per week, plus two days of muscle-strengthening.

In Pierce County, the percent of adults who met these recommendations was not significantly different from that of the state. Adults earning \$75,000 or more were more likely to meet recommendations compared to other income levels, although this difference was not statistically significant.

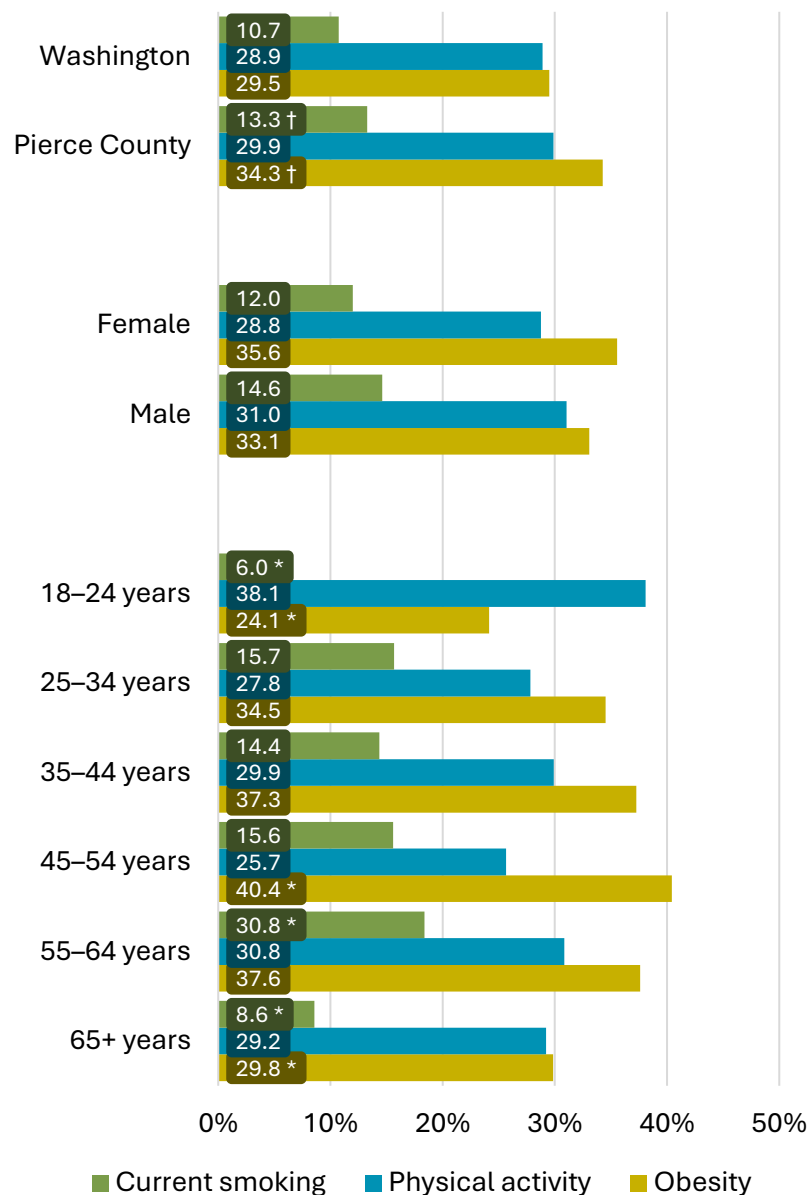
Tobacco

Tobacco use causes many illnesses, like heart disease, stroke, lung cancer, and chronic obstructive pulmonary disease (COPD). It's a significant contributor to mortality due to chronic lower respiratory illnesses. Adults living in Pierce County were significantly more likely to be current smokers than Washington residents. Adults 18–24 years old and 65 or older were significantly less likely to be smokers than other age groups. People 55–64 years old had the highest rate of smoking. The percent of current smokers decreased as income level increased.

²⁹ Obesity is defined as having a body mass index (BMI) of 30 or higher. It was calculated from self-reported height and weight when responding to the BRFSS.



Figure 20: Health behaviors, Pierce County, 2019–2023



† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

Source: BRFSS.

Chronic conditions

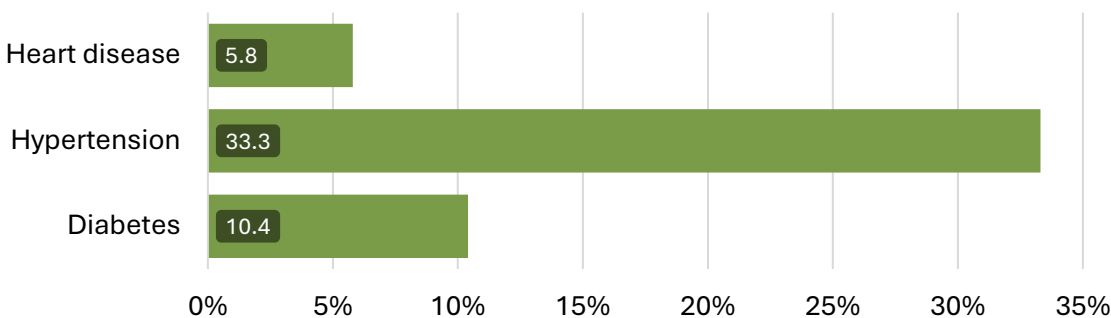
Chronic diseases and conditions are among the most prevalent, costly, and preventable health concerns within our communities. Addressing these conditions is essential for improving long-term health outcomes and reducing the burden on individuals, families, and healthcare systems.



Diabetes, hypertension, and heart disease—including angina, coronary artery disease, and heart attack—were self-reported by adults as part of BRFSS. In Pierce County, the prevalence of diabetes has gradually increased in recent years, rising from 9.2% in 2012–2016 to 10.4% in 2019–2023.

From 2019 to 2023, the prevalence of diabetes and hypertension in Pierce County was significantly higher than the state average. Black people were significantly more likely to have hypertension. Men were significantly more likely to report having heart disease than women. Age is a significant driver of all three chronic conditions, with rates highest in people older than 65 and lowest among those 18–24 years old.

Figure 21: Select chronic conditions, Pierce County, 2019–2023



Source: BRFSS.

Cancer incidence

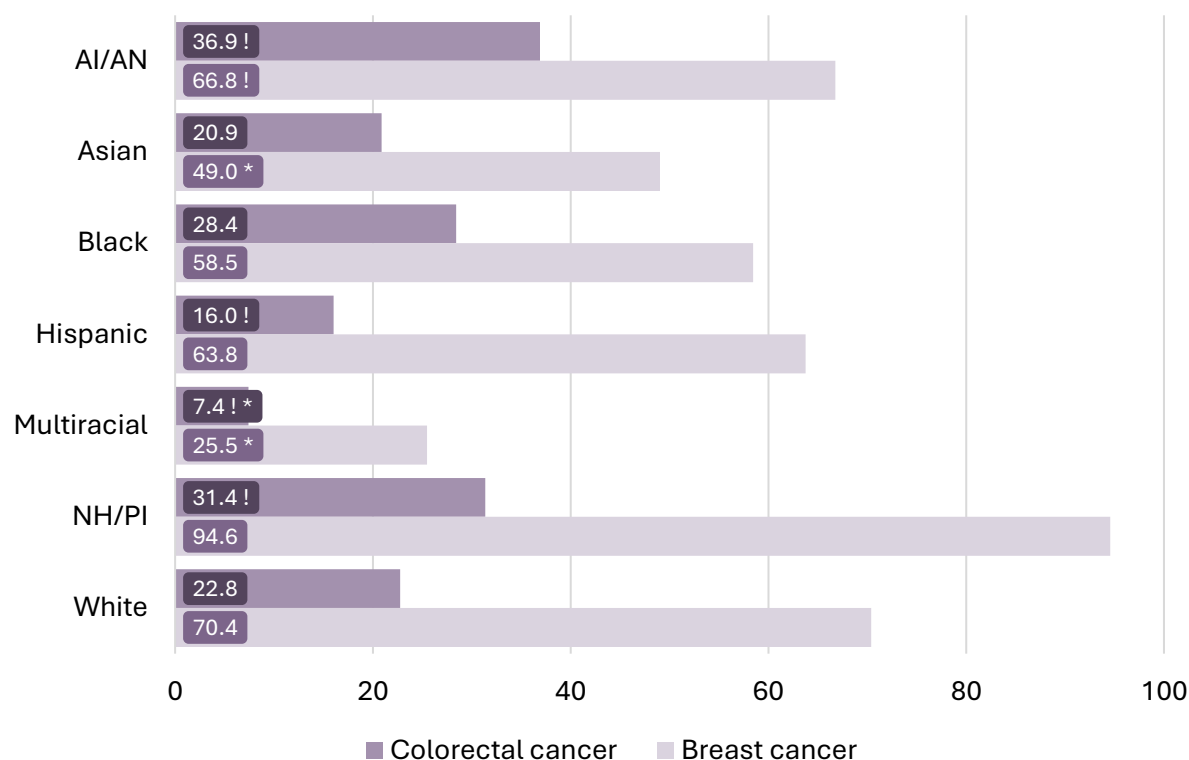
In the simplest terms, cancer is characterized by uncontrolled cell growth.³⁰ Cancer can result from factors like age, environment, and genes. Cancer remains a leading cause of death across all age groups and sexes. Washington State Cancer Registry (WSCR) tracks new cases. Colorectal³¹ and breast cancer are two of the most common. Early detection through regular screening can significantly improve the chances of successful treatment for both types of cancer.

³⁰ National Cancer Institute. “What is Cancer?”. updated May 5, 2021. cancer.gov/about-cancer/understanding/what-is-cancer

³¹ Affects the lower end of the digestive tract.



Figure 22: Age-adjusted colorectal cancer and breast cancer incidence per 100,000 people, Pierce County, 2016–2020



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: WSCR.

Pierce County's incidence of colorectal and breast cancer were similar to the state's (23.3 vs 23.2 per 100,000 people). Both types occur more frequently with age. Men in the county were more likely to be diagnosed with colorectal cancer than women (25.6 vs 20.9 per 100,000). Asian and multiracial people were significantly less likely to be diagnosed with breast cancer than Pierce County residents overall. Multiracial people were significantly less likely to be diagnosed with colorectal cancer than Pierce County residents overall.

Asthma-related emergency department visits

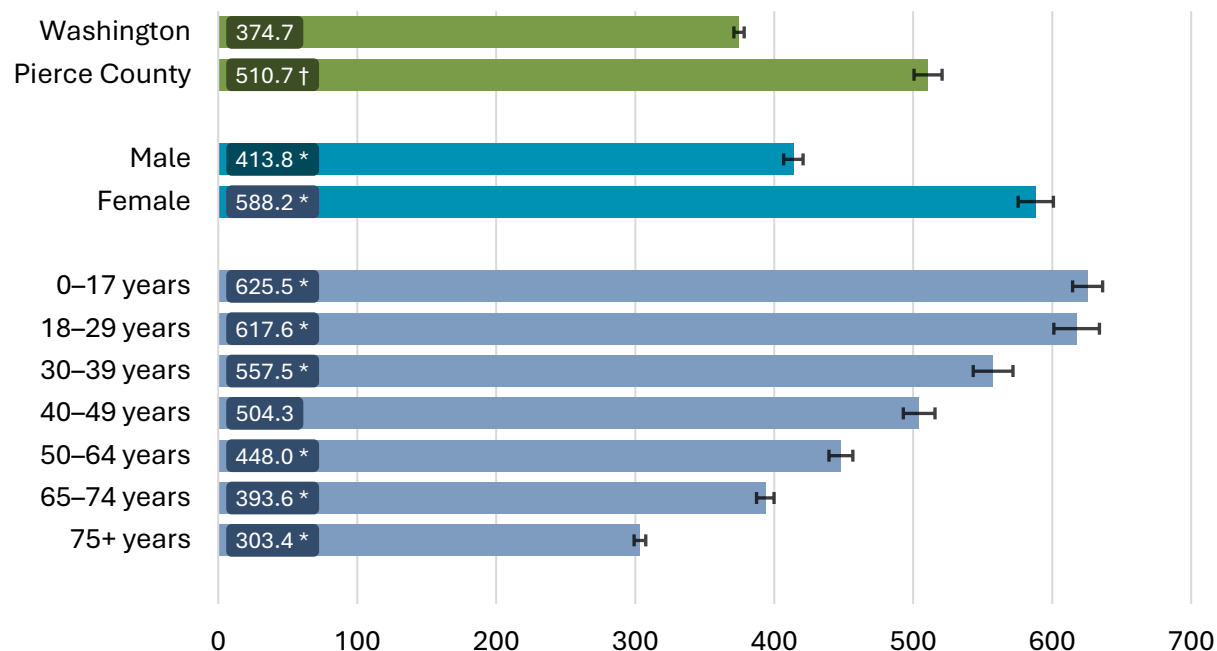
The Pierce County rate of asthma-related emergency department (ED) visits³² was significantly higher than the statewide rate. Women were significantly more likely to visit the ED for asthma-related reasons than men. Generally, the rate of asthma-related ED visits decreases with age.

³² Asthma visits are identified by searching medical records for signs of "asthma," "bronchospasm," and other similar terms and associated International Classification of Diseases (ICD) codes.



Children younger than 18 years had about twice the rate of asthma-related ED visits as those 75 or older. High rates of asthma-related ED visits not only reflect challenges in people's health management but also strain healthcare systems and community resources.

Figure 23: Asthma-related emergency department visits per 10,000 visits,[‡] Pierce County, 2021–2023



[‡] Rates are visit-based. A person with repeat visits may be counted more than once.

† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

Source: National Syndromic Surveillance Program (NSSP), Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE).

Disability prevalence

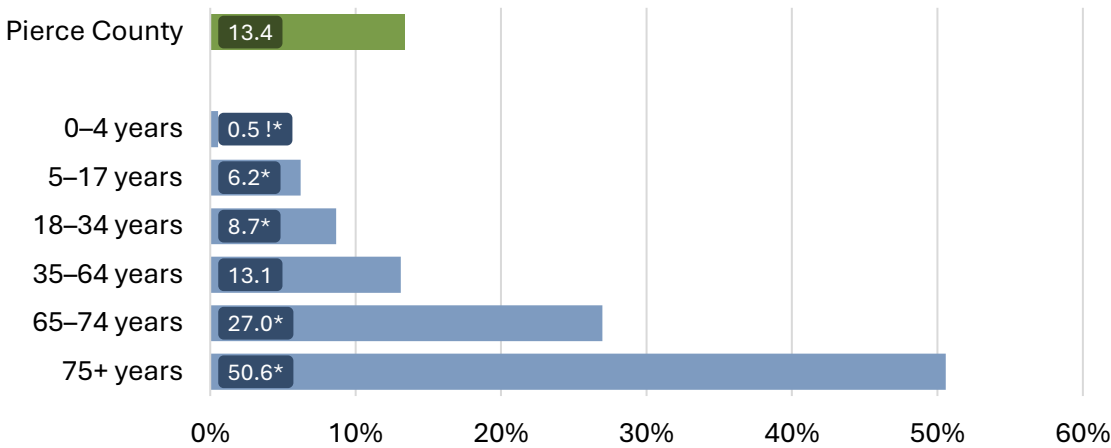
Disabilities are chronic conditions that people live with which can affect hearing, vision, cognition, mobility, self-care, or independent living.³³ In Pierce County, disability impacts more than one in ten residents, with the likelihood increasing significantly with age. Additionally, the prevalence of disability rises alongside higher levels of social vulnerability.³⁴

³³ U.S. Census Bureau. “How Disability Data are Collected from The American Community Survey,” updated Oct. 8, 2021. census.gov/topics/health/disability/guidance/data-collection-acss.html

³⁴ For more about CDC’s SVI, see atsdr.cdc.gov/place-health/php/svi/index.html. A lower SVI score corresponds to greater resiliency in a community. We grouped SVI scores into these categories: 0.0–5.9: highly resilient; 6.0–7.6: somewhat resilient; 7.7–9.3: somewhat vulnerable; 9.4 or greater: highly vulnerable.



Figure 24: Disability prevalence, Pierce County, 2018–2022



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: USCB, ACS.

Infectious disease

Infectious diseases, like acute respiratory illnesses and sexually transmitted infections (STIs), affect thousands of Pierce County residents each year. CDC estimates at least 1 million Americans were hospitalized and 70,000 died from respiratory illness in 2024 to 2025.³⁵ Vaccines and antibodies can prevent the respiratory viruses leading to the most hospitalizations and deaths: COVID-19, respiratory syncytial virus (RSV), and influenza. Most STIs are easily treatable with appropriate access to care and daily medication can manage HIV.

Respiratory infections

We identified ED visits for COVID-19, RSV, and influenza, representing respiratory infections that required care.³⁶ From October 2024 to September 2025, influenza accounted for nearly 2% of ED visits in Pierce County. COVID-19 was responsible for 0.7% and RSV for 0.2%. RSV was concentrated in children younger than 5 years, while COVID-19 was concentrated in children one year or younger and adults older than 65. The highest rate of influenza ED visits per 10,000 visits was among those 2–17 years old, while deaths were most common in those 65 or older.³⁷ Rates of all respiratory illnesses were highest in NH/PI people. Black residents had the lowest rates of ED visits for RSV or COVID-19, while white people had the lowest rate of ED visits for influenza.

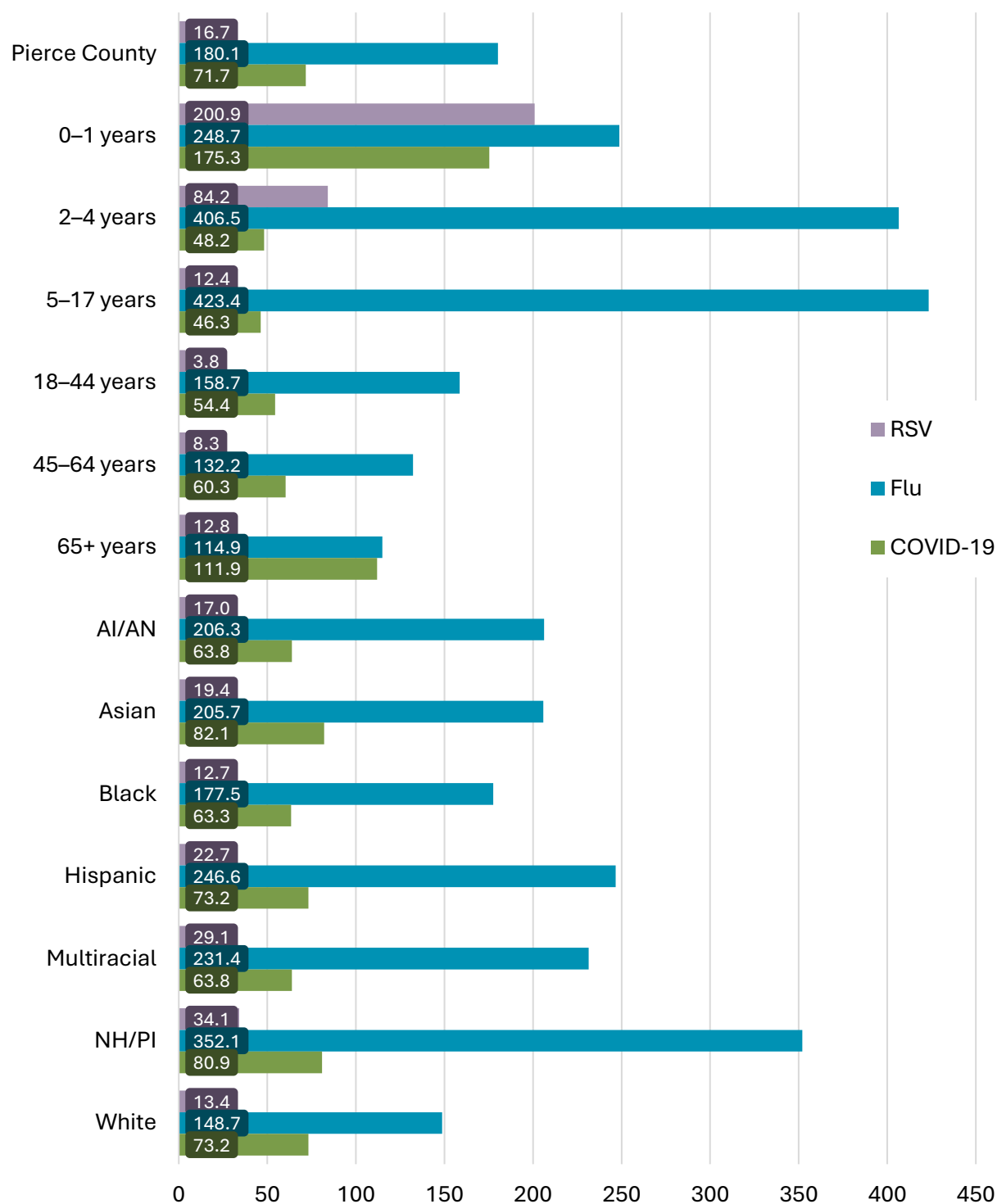
³⁵ cdc.gov/respiratory-viruses/about/index.html

³⁶ More than one virus may be identified during a single visit, and one person may have multiple visits.

³⁷ wonder.cdc.gov/ucd-icd10-expanded.html



Figure 25: Respiratory infection emergency department visits per 10,000 visits, October 2024–September 2025



Source: NSSP, ESSENCE.



Sexually transmitted infections

Each year, thousands of Pierce County residents are diagnosed with STIs. Many more infections remain asymptomatic or otherwise undiagnosed. Syphilis can cause illness and death in an infant if the mother is infected with the bacteria responsible for the disease. STIs like chlamydia and gonorrhea can impact fertility and increase the risk of contracting HIV and other infections. Appropriate treatment can cure these acute illnesses. HIV, on the other hand, leads to a chronic infection that must be managed with lifelong treatment.

STI spotlight

Why it matters

STIs, especially if untreated, can cause long-term health issues, resulting in many years of stigma, infertility, and chronic illness.

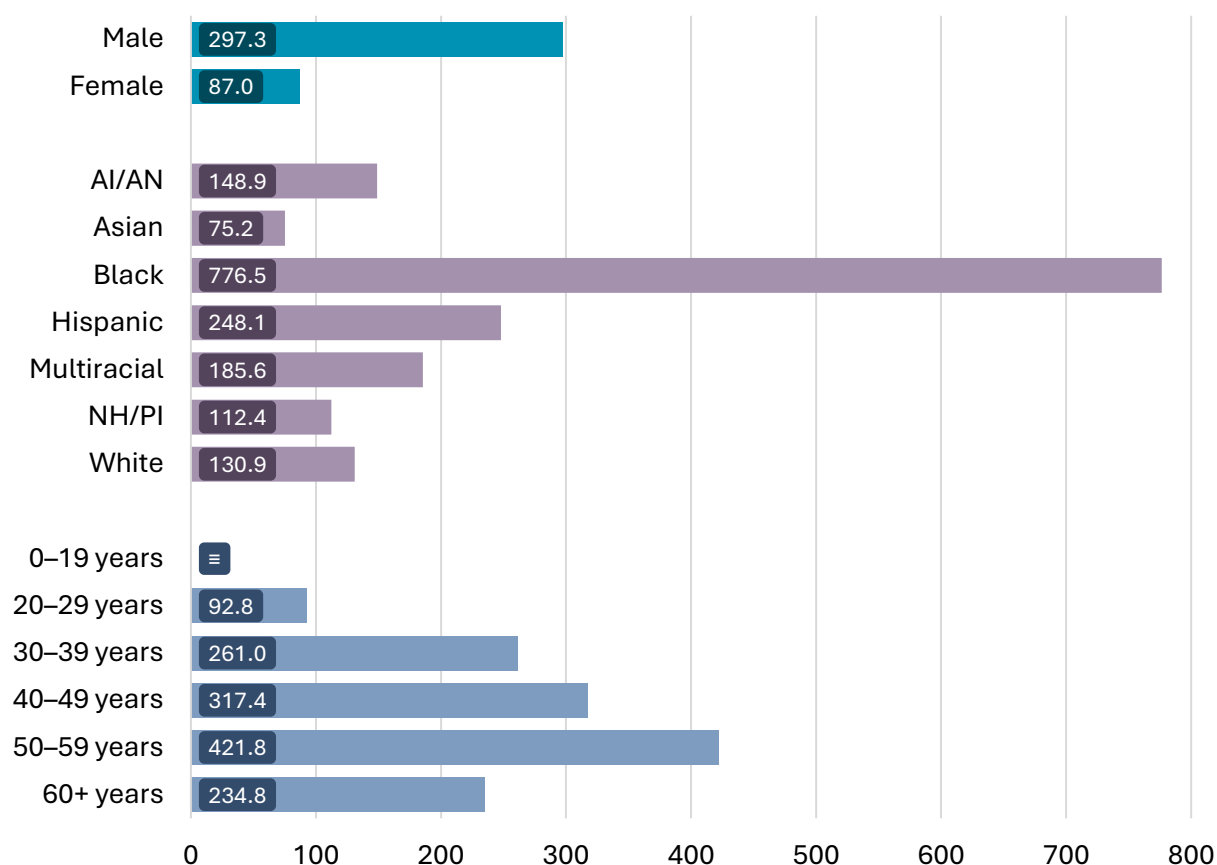
Community snapshot

In 2023, Pierce County residents had higher rates of STIs than we see statewide. The highest rates of new case of both gonorrhea and chlamydia were in people 20–29 years old. This age group had the second-highest rate of new cases of syphilis.

People younger than 20 were less impacted by STIs. Syphilis incidence was 4 per 100,000 in this age group, compared to 72 per 100,000 for those 20–29 years old. Gonorrhea had an incidence rate of 91 in people younger than 20, compared to 618 for those 20–29 years old. In 2019 to 2023, chlamydia incidence in people younger than 20 was 439 per 100,000, compared to 2,190 per 100,000 seen in those 20–29 years old. In 2024, fewer than ten people younger than 20 were living with HIV in Pierce County. From 2015 to 2024, 18 people younger than 20 were diagnosed with HIV.

Implications

The STI most likely to affect people younger than 20 is chlamydia, which is often asymptomatic. Access to testing and treatment, as well as using condoms, can help prevent transmission.

*Figure 26: People living with HIV per 100,000 people, Pierce County, 2024*

≡ Data suppressed; too few cases

Source: Enhanced HIV/AIDS Reporting System (eHARS), Washington State Department of Health (DOH).

In 2024, the rate of new cases of HIV in Pierce County was 6.4 per 100,000 people, versus 5.1 per 100,000 across the state. However, as HIV is a lifelong illness, many more people are living with it. Males account for three-quarters of people living with HIV. Men who have sex with men (MSM) made up 60% of people living with HIV in 2024. The Black, non-Hispanic population in Pierce County has the highest rate of people living with HIV, followed by Hispanic and multiracial people. Asian residents have the lowest rate. People 20-39 years old account for the highest number of new cases of HIV. The highest rate of people living with HIV is found among those 50-59 years old.

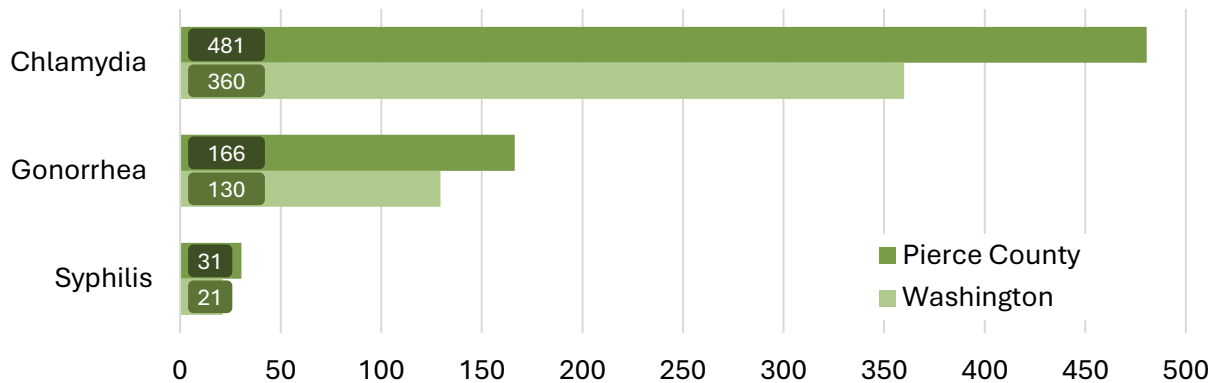
The incidence of chlamydia, gonorrhea and syphilis³⁸ is significantly higher in Pierce County than in Washington. Between 2019 and 2023, diagnoses of chlamydia and gonorrhea declined by more than 30% in Pierce County, similar to declines across the state. This is in contrast to the two- to three-fold increase seen for syphilis. In 2023 to 2024, Black residents of Pierce County had syphilis,

³⁸ Primary and secondary syphilis only.



chlamydia, and gonorrhea incidence rates about three times the overall county rate. Asian, multiracial, and white residents have rates of all three STIs significantly lower than the overall county rate. New cases of syphilis are highest in people 30–39 years old, while new cases of chlamydia and gonorrhea are highest in people 20–29 years old. Men are more likely to be diagnosed with syphilis or gonorrhea, while women are more likely to be diagnosed with chlamydia.

Figure 27: Sexually transmitted infection incidence per 100,000 people, 2023



Source: Public Health Issue Management System–Sexually Transmitted Disease (PHIMS-STD), DOH.

Congenital syphilis

Congenital syphilis occurs when a mother infected with syphilis passes it to a newborn during pregnancy or childbirth. It is typically diagnosed in infants before they turn one year old. According to CDC, the number of infants born in the United States in 2022 with congenital syphilis was more than 10 times the number in 2012.³⁹ The rate of congenital syphilis 2019–2023 was significantly higher in Pierce County (1.2 per 100,000 infants) than in the state (0.6 per 100,000 infants).⁴⁰

Maternal and child health

The health of mothers, infants, and children is a crucial indicator of the health of our community. By supporting family health, we pave the way for a more equitable future.

³⁹ Centers for Disease Control and Prevention. “U.S. Syphilis Cases in Newborns Continue to Increase: A 10-Times Increase Over a Decade,” reviewed Nov. 7, 2023. [cdc.gov/media/releases/2023/s1107-newborn-syphilis.html](https://www.cdc.gov/media/releases/2023/s1107-newborn-syphilis.html)

⁴⁰ Washington State Department of Health, Infectious Disease, STD Services Section, PHIMS-STD, 1992–2023, Community Health Assessment Tool, January 2025.



Prenatal care adequacy

Early and consistent prenatal care helps prevent complications and improve outcomes for pregnant people and infants. It also connects people with valuable resources, like tobacco cessation and nutrition programs.

The adequacy of prenatal care is assessed using Kotelchuck's Adequacy of Prenatal Care Utilization index, which considers both the timing of prenatal care initiation (the earlier the better) and the number of recommended visits completed. In Pierce County, 36.2% of mothers received inadequate prenatal care, a significantly higher percent than the state (30.9%).⁴¹ More than 40% of AI/AN and NH/PI parents lack adequate prenatal care. Less than half of teen mothers receive adequate prenatal care. More than 40% of the mothers in highly vulnerable census tracts lack adequate prenatal care.⁴²

Maternal and child health spotlight

Why it matters

Healthy mothers, infants, and children pave the way for a more equitable future for all.

Community snapshot

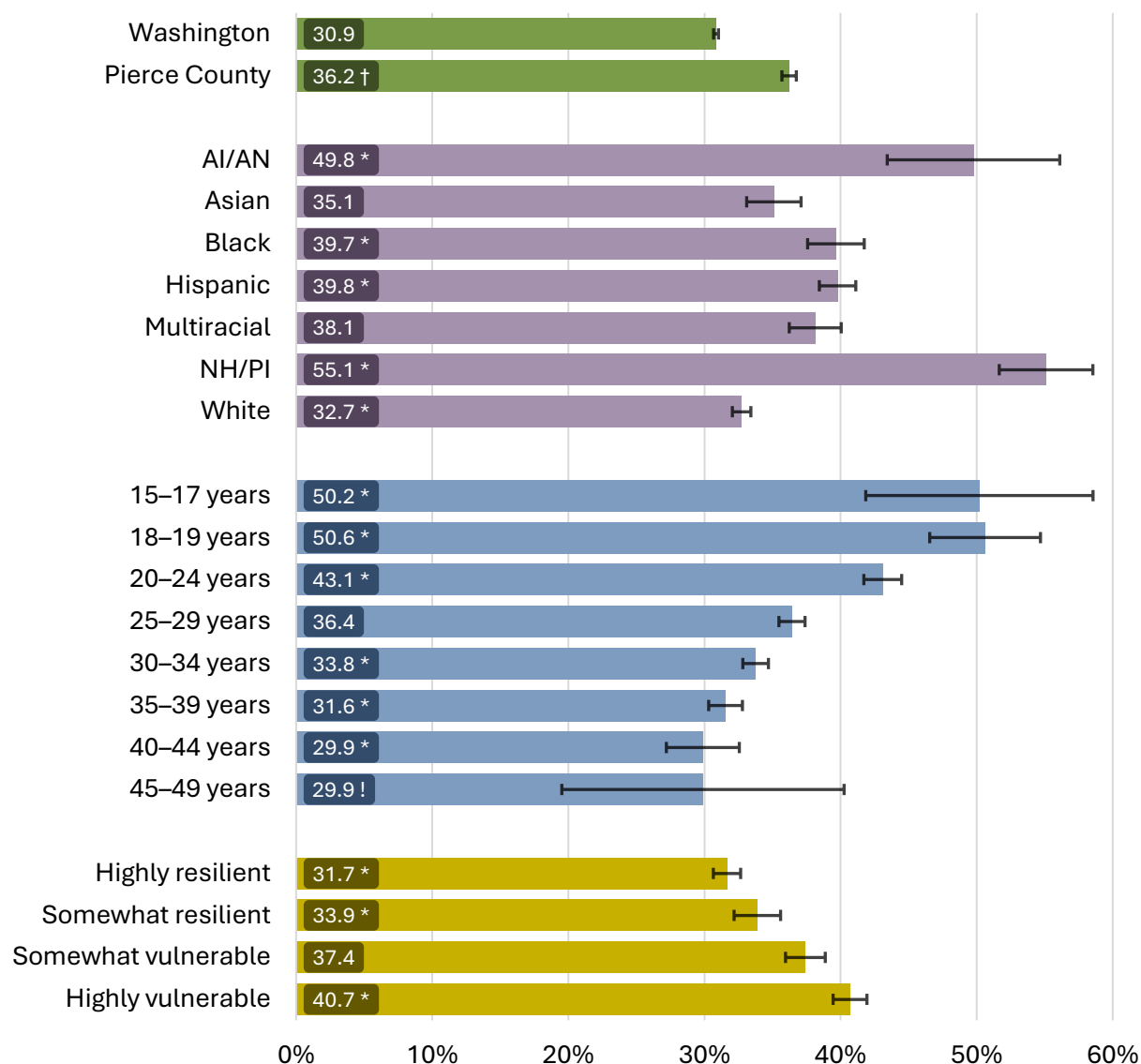
- Parents younger than 25 have the highest inadequate prenatal care and infant mortality.
- Parents younger than 20 and older than 35 are at greatest risk of a low birth weight baby.
- NH/PI, AI/AN, and Black parents have high rates of inadequate prenatal care, low birth weight, and infant mortality.

Implications

Parents who are younger than 25, NH/PI, AI/AN, Black, or in highly vulnerable communities need care to improve perinatal health outcomes.

⁴¹ Washington State Department of Health, Center for Health Statistics, birth certificate data, Community Health Assessment Tool, January 2025.

⁴² For more about CDC's SVI, see atsdr.cdc.gov/place-health/php/svi/index.html. A lower SVI score corresponds to greater resiliency in a community. We grouped SVI scores into these categories: 0.0–5.9: highly resilient; 6.0–7.6: somewhat resilient; 7.7–9.3: somewhat vulnerable; 9.4 or greater: highly vulnerable.

Figure 28: Inadequate prenatal care, Pierce County, 2019–2023[‡]

[‡] Age and race/ethnicity are those of the mother.

† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: DOH, Center for Health Statistics (CHS), Community Health Assessment Tool (CHAT).

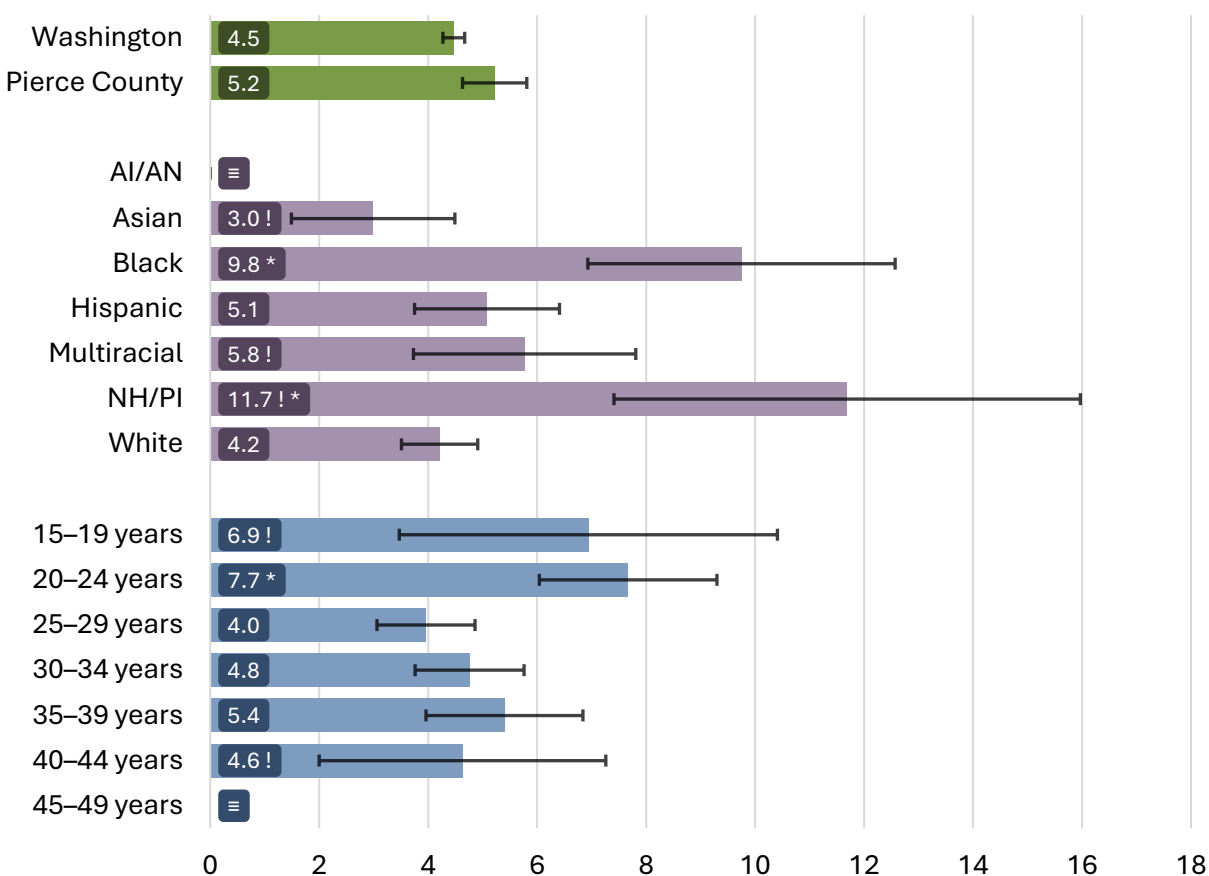
Infant mortality

Infant mortality refers to the death of a child within the first 365 days of life. While improvements in prenatal care and healthcare access have led to significant reductions in infant mortality rates, this remains a concern in many communities.



In Pierce County, the rate of infant mortality is similar to that of the state. We see disparities in Pierce County, although there were few deaths in many race/ethnicity groups and wide confidence intervals.⁴³ NH/PI and Black mothers had significantly higher infant mortality rates than white, Hispanic, or Asian mothers. Infants of mothers 20–24 years old had a significantly higher mortality rate than those of mothers 25–34 years old.

Figure 29: Infant mortality rate per 1,000 live births, Pierce County, 2019–2023[‡]



[‡] Age and race/ethnicity are those of the mother.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: DOH, CHS, CHAT.

⁴³ See “A note about quantitative data” section for further discussion of limitations.



Low birth weight

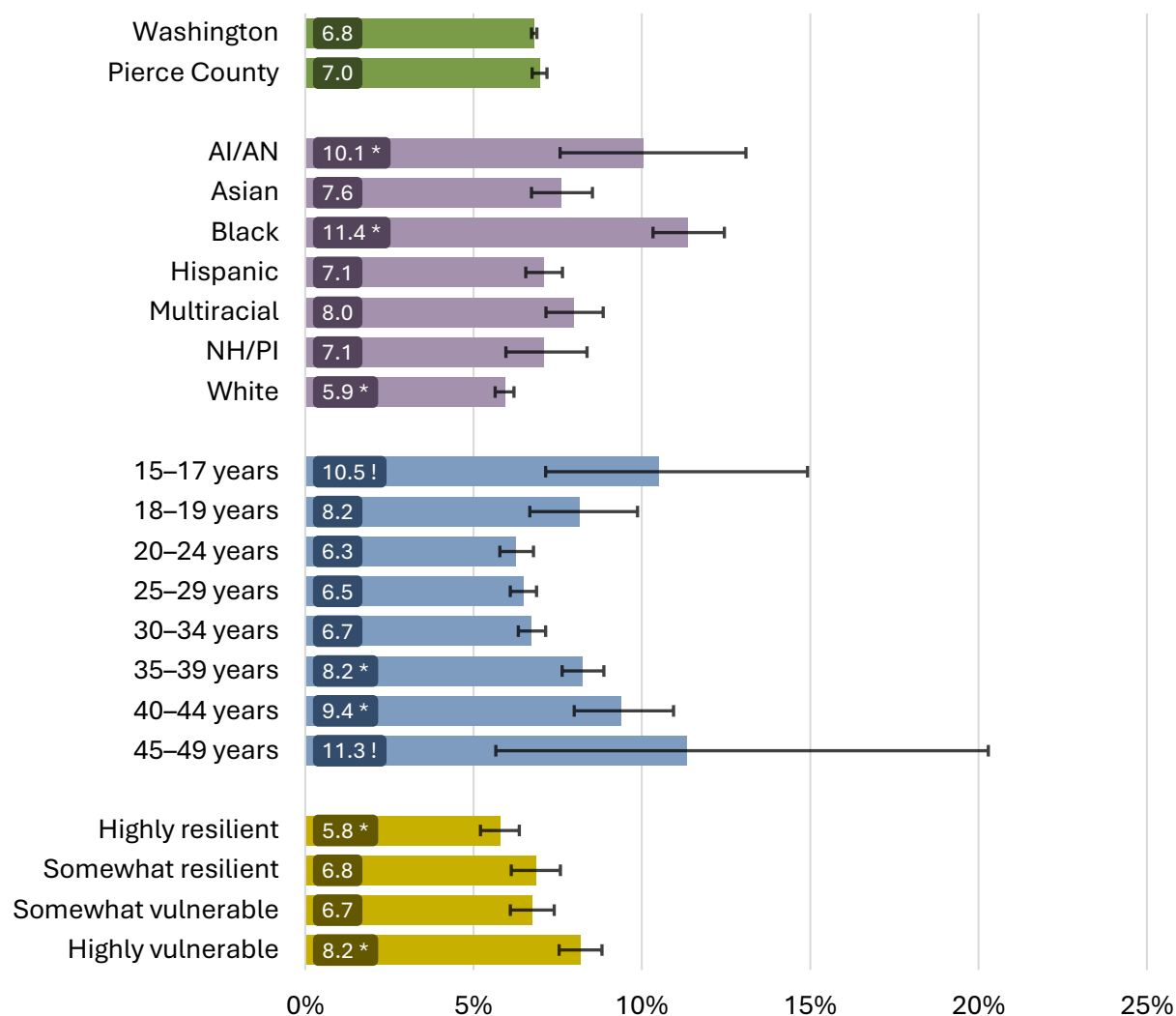
Low birth weight is a critical indicator of newborn health and well-being. Low birth weight is the proportion of infants born weighing 2,500 grams (about 5.5 pounds) or less. It is a risk factor for complications, including developmental delays, respiratory issues, and mortality.

The percent of infants with low birth weight in Pierce County was similar to that of the state. Within the county, Black mothers had a significantly higher percent of births with low birth weight than Asian, Hispanic, NH/PI, white, and multiracial parents. AI/AN mothers had a significantly higher percent of low birth weight babies than white mothers. Mothers younger than 18 or 35–44 years old had a significantly higher percent of low birth weight babies than mothers 20–34 years old.

The percent of babies born with a low birth weight increased in census tracts with higher social vulnerability.



Figure 30: Low birth weight, Pierce County, 2019–2023[‡]



[‡] Age and race/ethnicity are those of the mother.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE > 30%

Source: DOH, CHS, CHAT; CDC SVI.

Climate health

Climate change is an emerging health concern that threatens ecosystems, countries, and humans. World Health Organization estimates climate change is expected to cause 250,000 additional



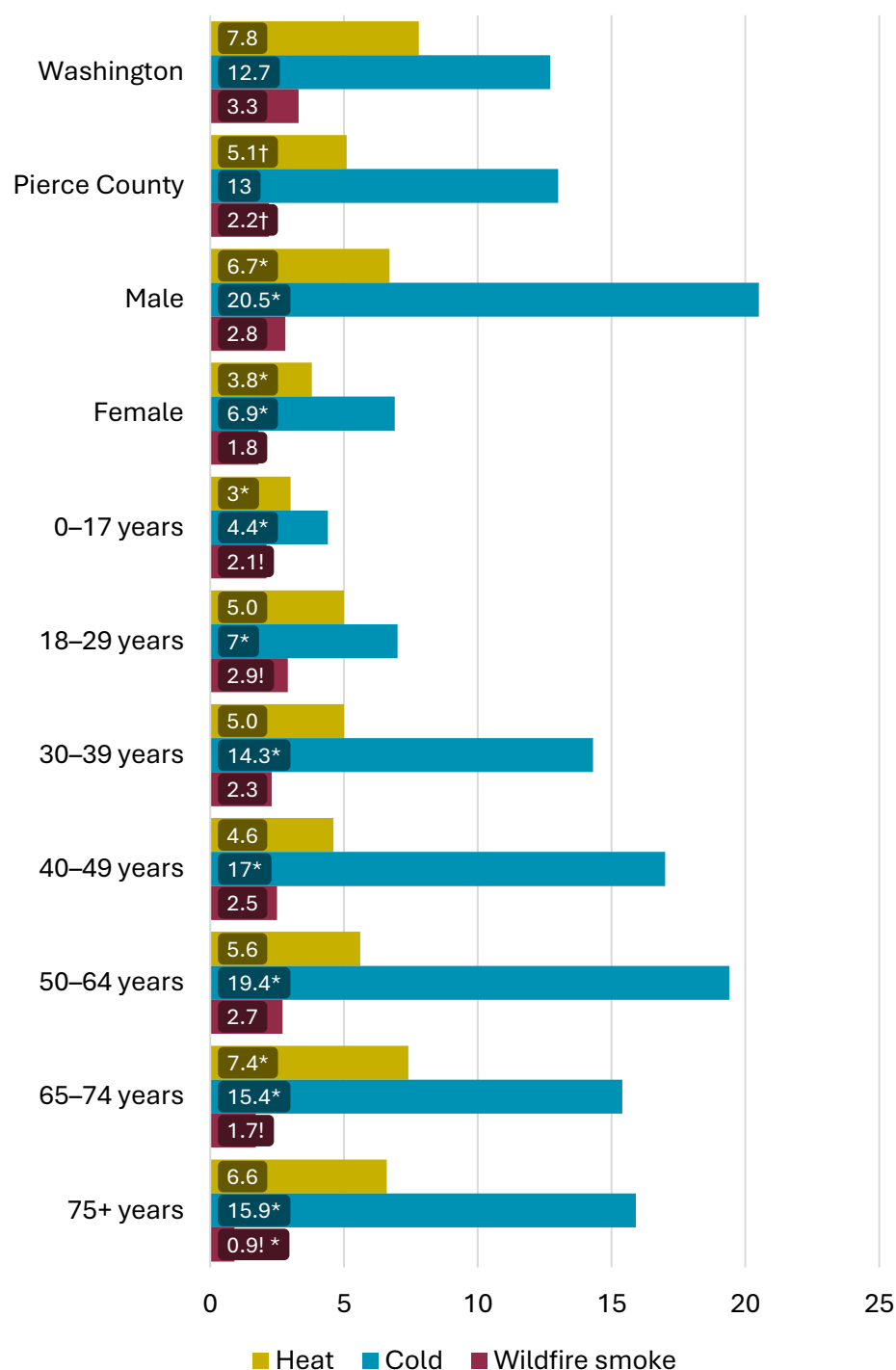
deaths annually 2030 through 2050 and cost several billion dollars each year by the end of this decade.⁴⁴

ED visits for heat, cold, and wildfire smoke show how climate change affects Pierce County. The rate of heat-related and wildfire smoke-related ED visits was significantly lower than that of the state, while cold-related ED visits were not different. Men were significantly more likely to visit the ED for both heat- and cold-related illnesses than women. Children younger than 18 were least likely to visit for heat-related illness, while those younger than 30 were least likely to visit for cold-related illness. Heat-related visits peaked in those 65 years or older, while cold-related visits were most common in those 50–64 years old. Wildfire smoke-related visits were uniformly low but highest in those 18–29 years old. All climate-related ED visits were likely underreported, as exacerbations of existing illnesses—like asthma, COPD, or heart disease—are unlikely to be considered climate-related.

⁴⁴ World Health Organization. “Climate change.” [who.int/health-topics/climate-change#tab=tab_1](https://www.who.int/health-topics/climate-change#tab=tab_1)



Figure 31: Climate-related emergency department visits per 10,000 visits, Pierce County, 2021–2023



† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: NSSP, ESSENCE.



Mental and behavioral health concerns

Social connections and mental health are essential for a person's well-being and ability to live a full and productive life. In a typical year, one in five Americans (20%) experience mental illness.^{45,46} People of all ages with untreated mental health disorders are also at greater risk of other health problems, including substance use disorders.

Estimates for youth anxiety and depression—presented in the youth data insights section—rely on data from 2023. Adult mental health estimates cover 2019–2023. Each time period may reflect different impacts from the COVID-19 pandemic. Thus, youth and adult data may not be directly comparable.

Social connections

About one-third of the United States population reports experiencing social isolation, defined as having two or fewer people on whom a person can rely in times of need. Research shows a lack of strong social connections can have profound health implications—people with fewer than three strong connections face a 91% increased risk of mortality. Strong social ties are essential for overall well-being, and contribute to mental, emotional, and physical health.⁴⁷

Loneliness has a profound impact on health and significantly reduces life expectancy. Its effects are comparable to smoking 15 cigarettes per day and exceed the health risks associated with obesity.⁴⁸ Communities with stronger social bonds and higher levels of trust tend to experience lower rates of obesity, hypertension, and diabetes.

BRFSS asked adults if they felt they received the social and emotional support they needed. The percent of Pierce County adults who felt they rarely or never received the social or emotional support they needed was similar to the statewide percent. Men were more likely to report having no social support than women, although the difference was not statistically significant.

We observed differences in terms of race/ethnicity, age, and income. Due to the uncertainty in the data, we're not showing those results.

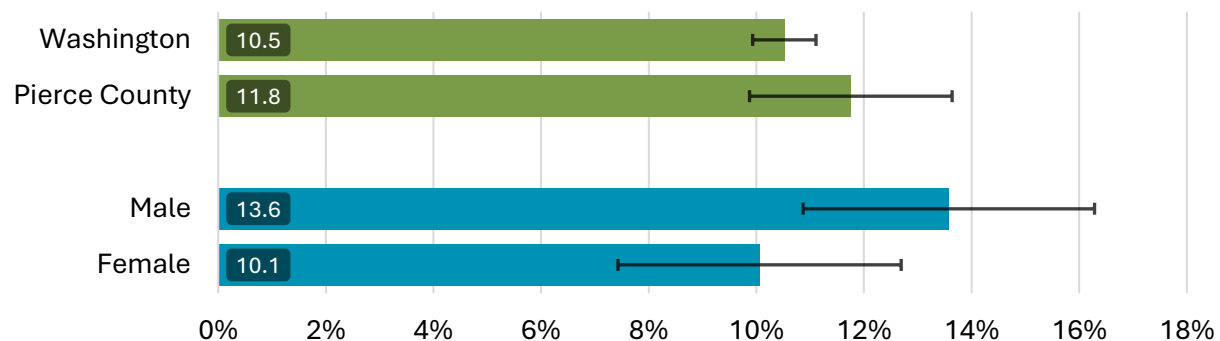
⁴⁵ National Alliance on Mental Illness. “Mental Health By the Numbers,” accessed Dec. 10, 2024.

nami.org/mhstats

⁴⁶ “Adults with a mental illness” was defined as adults with any mental, behavioral, or emotional disorder in the past year that met **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)** criteria, excluding developmental and substance use disorders.

⁴⁷ Holt-Lunstad, J., Smith, T. B. & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7(7), Article e1000316.

⁴⁸ Holt-Lunstad, J., Robles, T. F. & Sbarra, D. A. (2017). Advancing social connection as a public health priority in the United States. *American Psychologist*, 72(6), 517–530.

Figure 32: No social or emotional support, Pierce County, 2022[‡]

[‡] Interpret results with caution due to sample size limitations.

Source: BRFSS.

Depression in adults

Depression diagnoses among adults are self-reported through BRFSS, which collects data on mental health conditions and other health-related behaviors. Adult rates are based on a broad timeframe (2019–2023), capturing experiences before, during, and after the COVID-19 pandemic. The survey questions for adults are worded differently than those for youth, which may influence responses and comparability.

In Pierce County, adult depression rates were not different from the state overall. Women were significantly more likely than men to report a depression diagnosis. Many race/ethnicity groups had low sample sizes and wide confidence intervals, making results difficult to interpret.⁴⁹ Considering this, AI/AN adults were significantly more likely to be depressed compared to those who were Asian, Hispanic, or white. Adults who identified as Asian were significantly less likely to be depressed than all other races, except those who were NH/PI.

Depression prevalence decreased with age. Adults 65 or older were significantly less likely to report depression than younger adults. Prevalence also declined as income levels increased, with adults in higher income groups significantly less likely to report depression than those with lower incomes.

⁴⁹ See “A note about quantitative data” section for further discussion of limitations.



Mental and behavioral health spotlight

Why it matters

Mental health is foundational for well-being.

Community snapshot

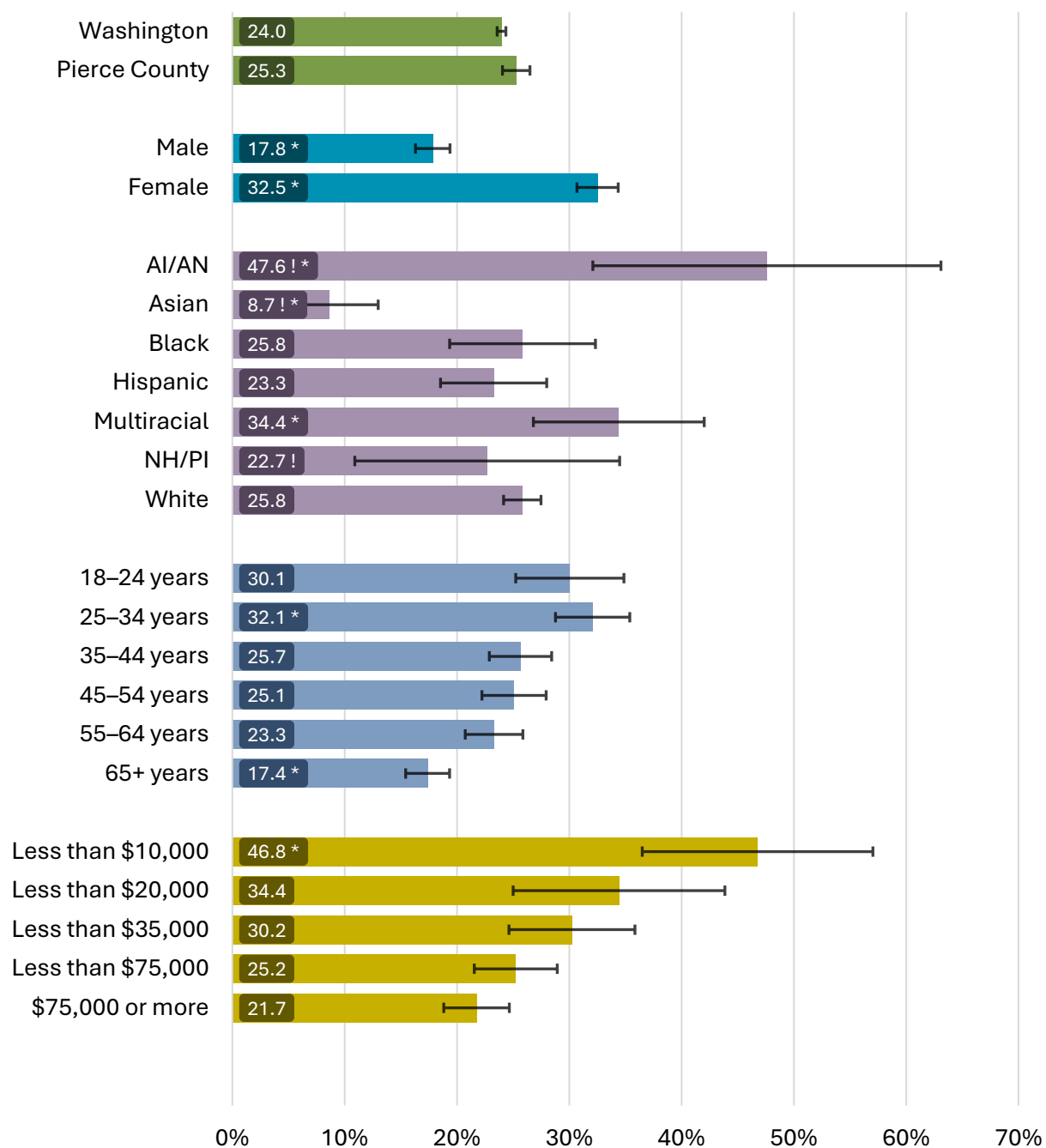
- Adult depression prevalence in Pierce County is similar to the state average.
- Women reported depression at significantly higher rates than men.
- AI/AN adults are most likely to report depression.
- Adults 65 years or older are least likely to report depression.
- Low SES is associated with greater rates of adult depression.

Implications

Poor mental health is correlated with age, race, and SES. These structural risk factors can point to new ways of reaching those at greatest risk of poor mental health.



Figure 33: Adults diagnosed with depression, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: BRFSS.



Discrimination

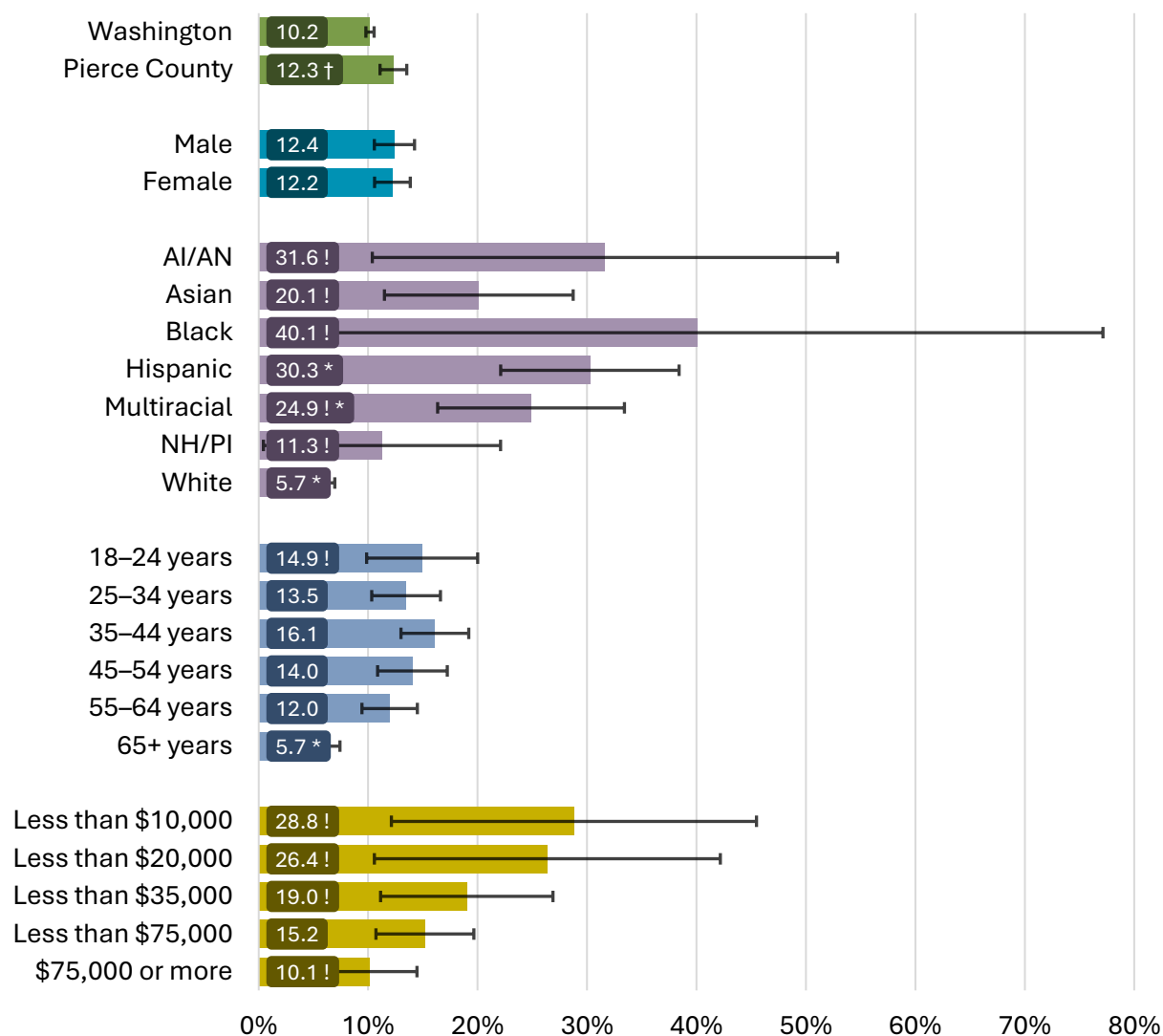
Discrimination is unjust or prejudicial treatment,⁵⁰ often based on race, ethnicity, age, sex, gender identity, sexual orientation, or disability. It can affect well-being and willingness to interact with people and systems.

Starting in 2021, BRFSS asked whether people experienced discrimination. In Pierce County, 12.3% of respondents said they experienced discrimination sometimes, often, or always. That's a significantly higher percent than Washington (10.2%). Men and women were equally likely to report experiencing discrimination. Hispanic and multiracial people were significantly more likely to report experiencing discrimination than Pierce County residents overall or white non-Hispanic Pierce County residents. Black residents were most likely to report discrimination, although the small number of respondents resulted in wide confidence intervals. People 65 years or older were significantly less likely to report experiencing discrimination. The higher the income, the less likely people were to report experiencing discrimination. However, there was wide variation in these rates as there were only three years of data. Many of the results were unreliable due to small sample sizes (indicated with "!" in figure 34).

⁵⁰ [merriam-webster.com/dictionary/discrimination](https://www.merriam-webster.com/dictionary/discrimination)



Figure 34: Discrimination, 2021–2023



† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: BRFSS.

Injury and violence prevention

Injuries—both intentional and unintentional—and violence are leading causes of death and disability in our society. The most common types of injury death include overdose (poisoning), falls, firearms, motor vehicle crashes, and suffocation. In Pierce County, the percent of deaths due to any



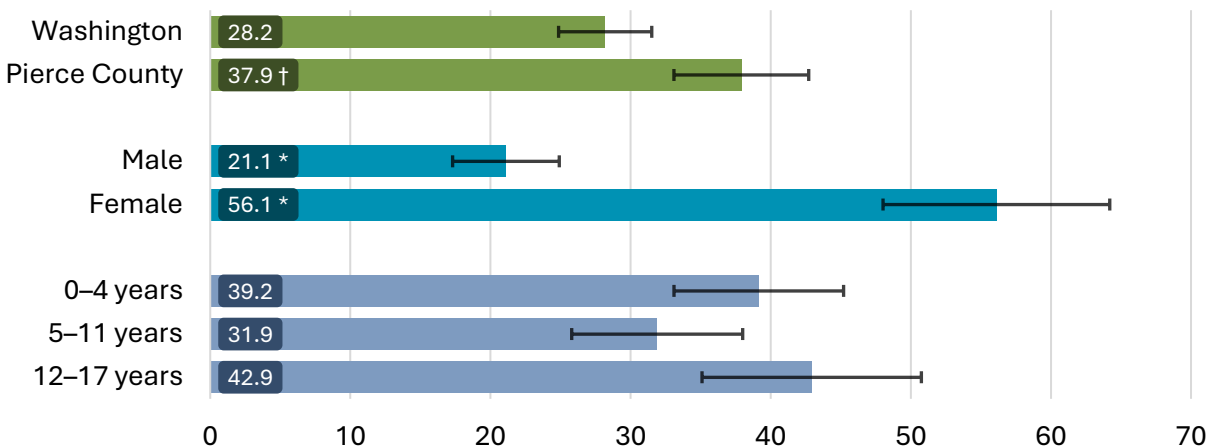
form of injury or violence increased from 8.6% in 2018 to 13.7% in 2023,⁵¹ primarily from increased overdose (poisoning) deaths.

Child abuse and neglect

We can identify ED and urgent care visits related to child abuse and neglect. A person may be counted more than once if they have repeated visits for related reasons. Child abuse and neglect are often underreported, so these numbers are likely an undercount.

Pierce County had a significantly higher rate of ED/urgent care visits for child abuse and neglect compared to the state average. Within Pierce County, girls were disproportionately affected. We didn't observe significant differences based on a child's age.

Figure 35: Child abuse and neglect per 10,000 emergency department/urgent care visits,[‡] 2022–2023



[‡] Rates for those younger than 18 years at time of visit.

Source: NSSP, ESSENCE.

Intentional injuries

Intentional injuries, whether self-inflicted like attempted suicides or caused by others like assaults, are public health issues. They are preventable and can have a profound, long-lasting impact on people and communities.

Assaults reported to police and homicides increased each year from 2018 to 2022, then declined in 2023 and 2024. Firearm-related assaults and homicides followed a similar trajectory, with data from 2024 indicating further declines.⁵² Suicide mortality rates fluctuated notably from 2018 to

⁵¹ Washington State Department of Health, Center for Health Statistics, death certificate data, 1990–2024, Community Health Assessment Tool, January 2025.

⁵² Washington State Department of Health, Center for Health Statistics, death certificate data, 1990–2024, Community Health Assessment Tool, October 2025.



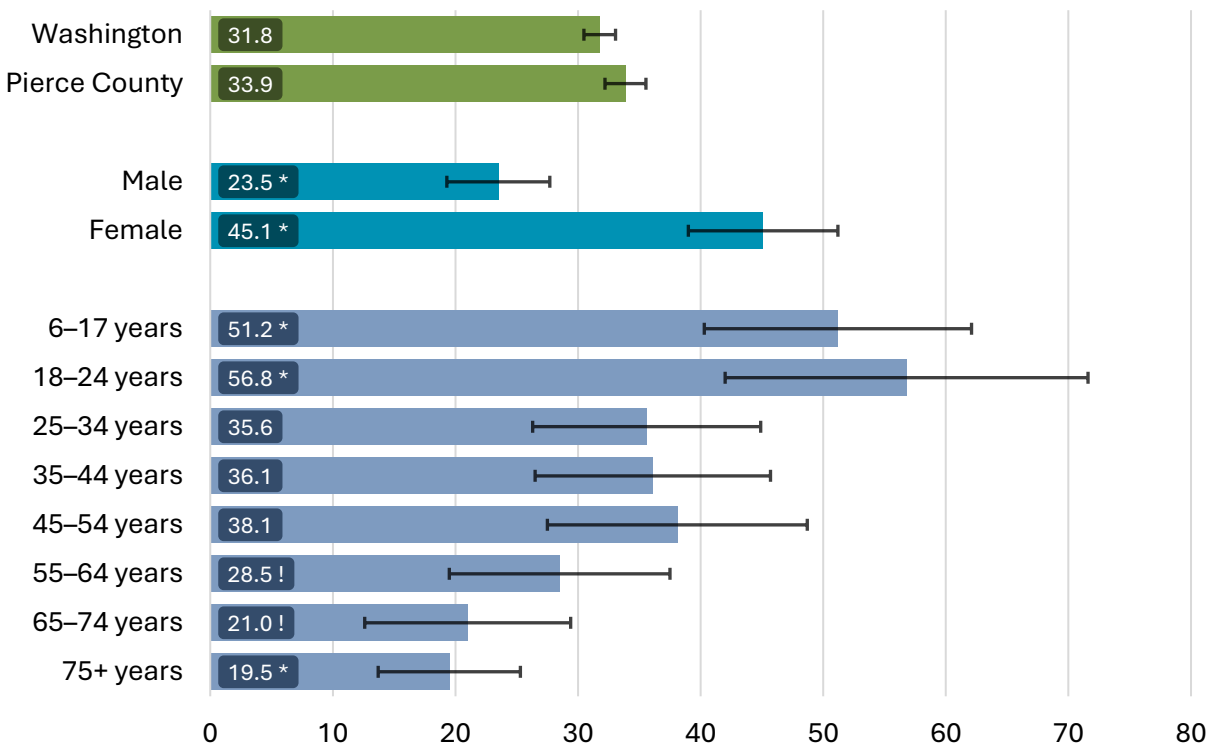
2024, with the highest rate of 19.5 per 100,000 people in 2019 and the lowest of 13.7 per 100,000 people in 2024.⁵³

Attempted suicide

In Pierce County, the attempted suicide hospitalization rate was similar to the state.

Women were significantly more likely to be hospitalized for suicide attempts than men. People 18–24 years old were at highest risk, followed by children 6–17 years old. Both were significantly more likely to be hospitalized than overall Pierce County. The rate of attempted suicide hospitalizations decreased with age. People older than 75 had the lowest rate, which was statistically significantly lower than overall Pierce County.

Figure 36: Hospitalizations for attempted suicide per 100,000 people, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS); DOH, CHS, CHAT.

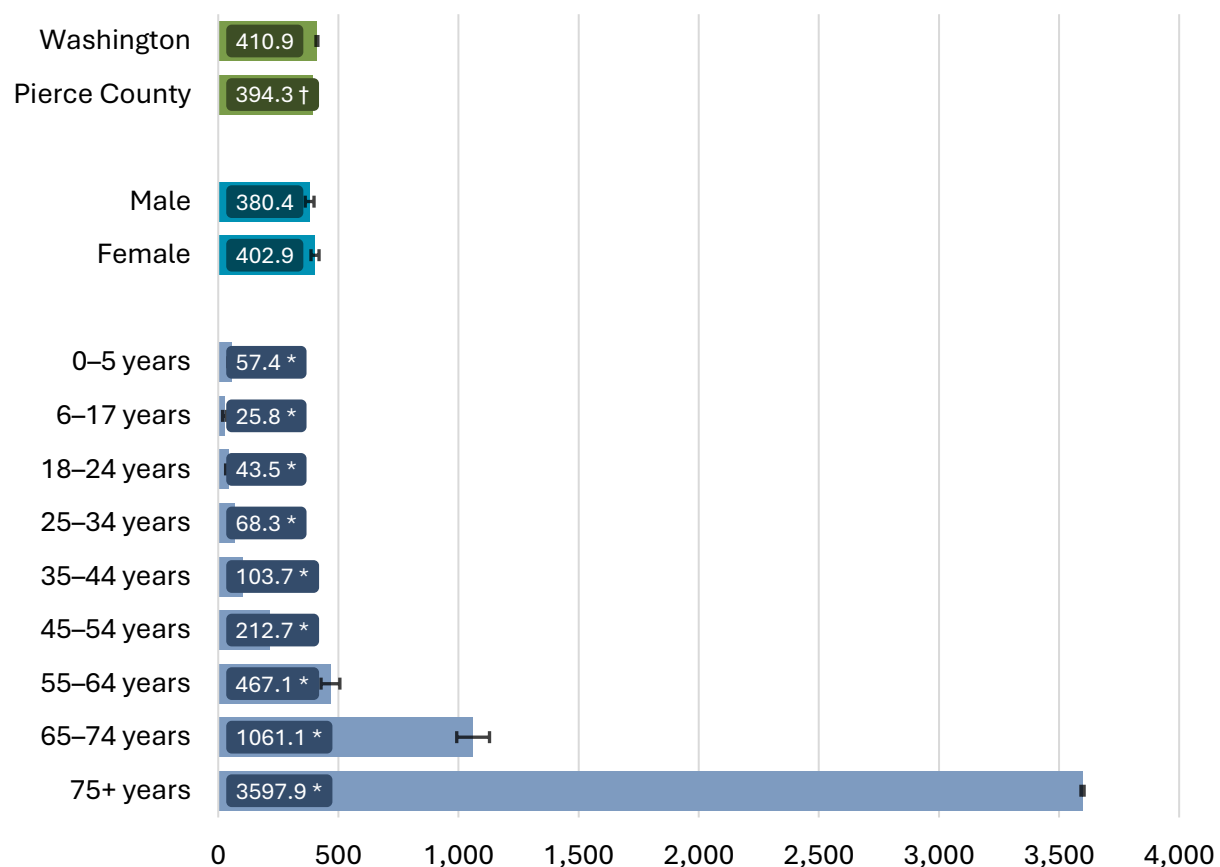
⁵³ Ibid.



Fall-related hospitalizations

Accidental injuries are one of the leading causes of hospitalization and death nationwide. Falls are the most common cause of injury-related hospitalization and the second most common cause of injury-related mortality (after drug overdose which is categorized as poisoning).⁵⁴ Hospitalizations caused by falls include both non-fatal and fatal falls. The age-adjusted⁵⁵ fall-related hospitalization rate in Pierce County (394.3 per 100,000 people) was significantly lower than the statewide rate (410.9 per 100,000 people). Women were more likely to be hospitalized due to falls compared to men. The rate increased with age, from a low of 25.8 per 100,000 for those 6–17 years old to a high of 3,597.9 at 75 years or older.

Figure 37: Fall-related hospitalizations per 100,000 people, † Pierce County, 2019–2023



† Rates by age are age-specific.

† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

Source: Washington Hospital Discharge Data, CHARS; DOH, CHS, CHAT.

⁵⁴ wonder.cdc.gov/ucd-icd10-expanded.html

⁵⁵ Age-adjusted rates are standardized to the United States population in 2000.



Hospitalizations, deaths, and life expectancy

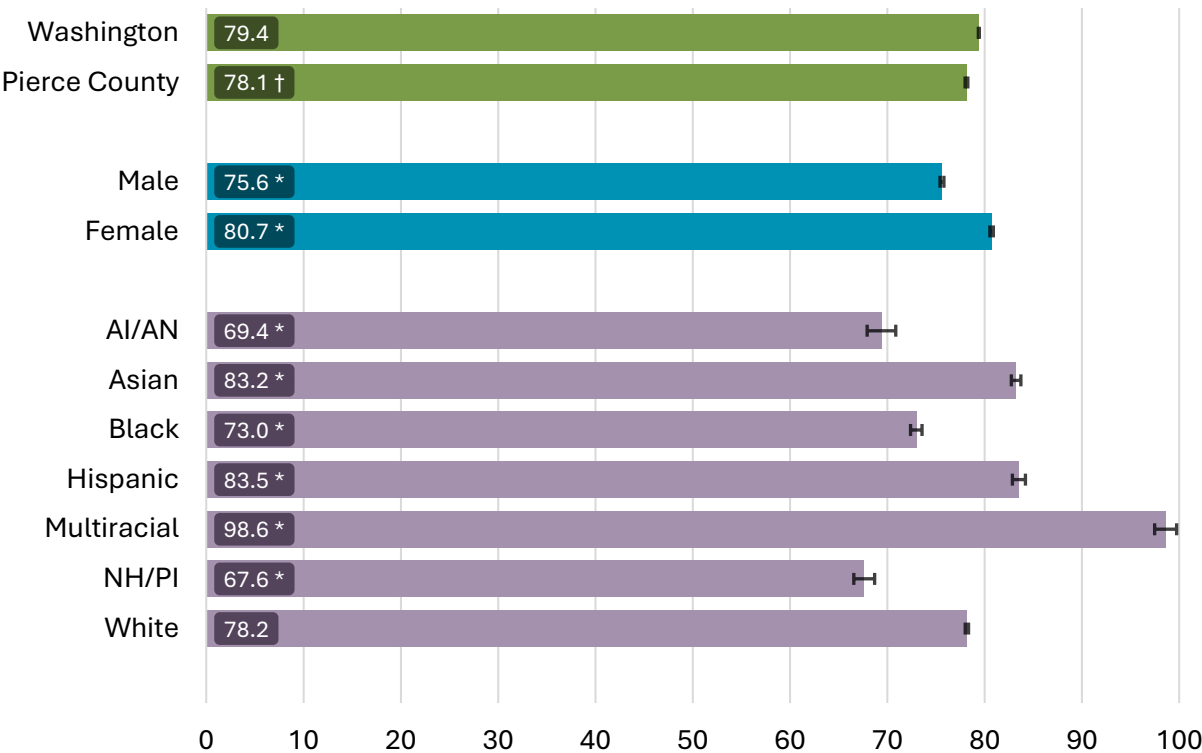
Causes of hospitalization and death are key indicators of population health. Many premature deaths are accidents or suicides. Life expectancy—the average number of years a person can expect to live based on current death rates—describes the cumulative effect of all causes of death. Years of life lost summarizes the cumulative impact of premature death before 65 years old. It’s influenced by controllable factors like environment and behavior and uncontrollable factors like genetics.

Life expectancy

Life expectancy in Pierce County is lower than the state average. Women generally had a longer life expectancy than men. Among race/ethnicity groups, multiracial people had the highest life expectancy (98.6 years), while NH/PI had the lowest (67.6 years).

The higher-than-expected life expectancy for people who identify with more than one race may be partly due to the varying degree with which people self-select the multiracial category. This group is relatively small and more likely to be younger, and people’s identity preferences between multiracial and other categories may shift over time. The small number of deaths resulted in relatively wide confidence intervals.

Figure 38: Life expectancy (years), Pierce County, 2019–2023



† Statistically significant difference from Washington
* Statistically significant difference from overall Pierce County
Source: DOH, CHS, CHAT.



Hospitalizations, deaths, and life expectancy spotlight

Why it matters

Understanding why and when people are hospitalized or die can identify areas for prevention.

Community snapshot

- Cardiovascular disease is a key driver of both hospitalizations and deaths and a huge burden on our healthcare system and population.
- Overdose (which is categorized as poisoning) is the main driver of potential years of life lost and is concentrated in men 25–64 years old.
- NH/PI people have the highest rates of mortality for many chronic diseases, COVID-19, and unintentional injuries.
- The rates of unintentional injury and suicide deaths are highest among AI/AN people.
- Assault is among the top 10 causes of death in the Black population.

Implications

Risk factors for heart disease and injury are modifiable and should be a focus of prevention. Programs should be tailored to the specific populations affected, considering age, sex, and race/ethnicity.

Leading causes of hospitalizations

Understanding the causes of hospitalization is essential for effectively allocating resources, planning public health interventions, and identifying areas in which focused efforts can improve health outcomes.

Severe non-childbirth-related blood stream infection caused by bacteria (septicemia)⁵⁶ was the leading cause of hospitalization in both men and women, followed by hypertension with complications.

Men were more likely to be hospitalized for circulatory system diseases, while women were more frequently hospitalized for mood disorders. Men were uniquely hospitalized for heart attack and alcohol-related reasons, while many hospitalizations among women were related to pregnancy.

⁵⁶ Hospitalizations were categorized according to the **Clinical Classifications Software (CCS)** categories as defined by **Agency for Healthcare Research and Quality (AHRQ)**. Minor changes were made to some of the names to clarify interpretation for non-technical audiences.



Table 7: Leading causes of hospitalization per 100,000 people,[‡] Pierce County, 2018–2023

Overall	Male	Female	Female—not pregnancy-related
Severe non-labor bloodstream bacterial infections (septicemia) 741.0	Sever non-labor bloodstream bacterial infections (septicemia) 792.4	Severe non-labor bloodstream bacterial infections (septicemia) 699.7	Severe non-labor bloodstream bacterial infections (septicemia) 699.7
Hypertension with complications and secondary hypertension 367.4	Hypertension with complications and secondary hypertension 430.8	Other complications of birth; puerperium affecting management of mother 463.5	Hypertension with complications and secondary hypertension 311.1
Other complications of birth; puerperium affecting management of mother 226.2	Complication of device; implant or graft 219.5	Hypertension with complications and secondary hypertension 311.1	Mood disorders 250.0
Mood disorders 205.6	Diabetes mellitus with complications 200.1	Polyhydramnios and other problems of amniotic cavity 290.0	Acute cerebrovascular disease (stroke) 150.6
Complication of device: implant or graft 179.0	Acute cerebrovascular disease (stroke) 187.0	Hypertension complicating pregnancy; childbirth and the puerperium 278.2	Complication of device; implant or graft 148.3
Acute cerebrovascular disease (stroke) 168.2	Acute myocardial infarction (heart attack) 185.2	Mood disorders 250.0	Diabetes mellitus with complications 138.9
Diabetes mellitus with complications 167.7	Alcohol-related disorders 170.1	Prolonged pregnancy 244.7	Respiratory failure; insufficiency; arrest (adult) 132.6
Cardiac dysrhythmias (improper beating of the heart) 137.1	Mood disorders 163.4	Previous C-section 233.4	Urinary tract infections 129.1
Acute myocardial infarction (heart attack) 134.7	Cardiac dysrhythmias (improper beating of the heart) 155.9	Other complications of pregnancy 198.5	Osteoarthritis 118.4
Respiratory failure; insufficiency; arrest (adult) 131.3	Respiratory failure; insufficiency; arrest (adult) 130.2	Acute cerebrovascular disease (stroke) 150.6	Cardiac dysrhythmias (improper beating of the heart) 119.9

[‡] Age-adjusted, standardized to the United States population in 2000.

Source: Washington Hospital Discharge Data, CHARS.



Leading causes of death

As public health practices, prevention of disease, and healthcare services continue to advance—resulting in longer lifespans—the leading causes of death have shifted. They now include chronic health conditions, like cancer, heart disease, and chronic lower respiratory illness.⁵⁷ Women had lower age-adjusted mortality rates for most conditions than men, with Alzheimer’s disease being an exception.

Table 8: Leading causes of death per 100,000 people,[‡] 2019–2023

	Washington	Pierce County		
		Overall	Male	Female
Cancer	140.2	146.6	170.5	129.6
Heart disease	136.6	144.7	186.2	111.1
Unintentional injury	59.2	69.6	94.8	45.4
Cerebrovascular disease	35.1	44.4	44.5	43.3
Alzheimer’s	41.3	32.7	25.9	37.2
Chronic lower respiratory illness	29.8	31.5	33.1	30.5
COVID-19	27.5	29.0	36.4	23.1
Diabetes	22.0	25.1	30.8	20.3
Suicide and intentional self-inflicted means	15.3	16.7	26.7	6.8 [§]
Chronic liver disease	14.0	13.9	16.7	11.3
Essential hypertension	9.7 [§]	12.0 [§]	12.8 [§]	11.2

[‡] Age-adjusted, standardized to the United States population in 2000.

[§] Included for completeness; not part of the top ten causes of death for that column.

Source: DOH, CHS, CHAT.

Among race/ethnicity groups, NH/PI people experienced the highest age-adjusted rates for many leading causes of death. That includes heart disease, diabetes, cancer, and cerebrovascular disease (including stroke). COVID-19 affected people across all sexes and race/ethnicity groups. Women, NH/PI people, and AI/AN people had the highest age-adjusted mortality rates related to COVID-19, while white and multiracial people had the lowest.

⁵⁷ Chronic lower respiratory illness includes long-term lung conditions, like COPD, emphysema, asthma, and chronic bronchitis.



Table 9: Leading causes of death by race/ethnicity per 100,000 people,[‡] Pierce County, 2019–2023

AI/AN	Asian	Black	Hispanic	Multiracial	NH/PI	White
Heart disease 230.1	Cancer 115.8	Heart disease 190.0	Cancer 96.4	Cancer 66.4	Heart disease 312.6	Cancer 150.8
Cancer 175.1	Heart disease 86.5	Cancer 170.9	Heart disease 80.9	Heart disease 53.4	Cancer 262.8	Heart disease 148.3
Unintentional injury 164.3	Cerebrovascular disease 39.5	Unintentional injury 97.9	Unintentional injury 53.2	Unintentional injury 44.2	COVID-19 172.8	Unintentional injury 70.7
COVID-19 44.1	Unintentional injury 32.6	Cerebrovascular disease 72.2	Cerebrovascular disease 36.6	Cerebrovascular disease 19.2	Diabetes 123.2	Cerebrovascular disease 42.4
Alzheimer's 42.1	Alzheimer's 28.2	Diabetes 52.2	COVID-19 33.6	Essential hypertension 16.2	Cerebrovascular disease 101.4	Chronic lower respiratory illness 34.4
Chronic lower respiratory illness 39.3	COVID-19 27.9	Alzheimer's 37.2	Diabetes 28.3	Diabetes 11.5	Unintentional injury 65.8	Alzheimer's 33.7
Cerebrovascular disease 39.2	Diabetes 25.9	COVID-19 36.4	Alzheimer's 22.5	Chronic lower respiratory illness 10.4	Chronic lower respiratory illness 37.4	COVID-19 27.3
Chronic liver disease 37.6	Essential hypertension 13.1	Chronic lower respiratory illness 32.2	Chronic liver disease 17.1	COVID-19 10.3	Parkinson's 32.1	Diabetes 22.4
Suicide and intentional self-inflicted means 32.0	Chronic lower respiratory illness 12.5	Assault 26.4	Chronic lower respiratory illness 13.0	Alzheimer's 9.7	Alzheimer's 31.8	Suicide and intentional self-inflicted means 19.1
Diabetes 28.5	Suicide and intentional self-inflicted means 9.2	Essential hypertension 22.8	Suicide and intentional self-inflicted means 12.2	Suicide and intentional self-inflicted means 8.2	Nephritis 30.9	Chronic liver disease 14.9

[‡] Age-adjusted, standardized to the United States population in 2000.

Source: DOH, CHS, CHAT.

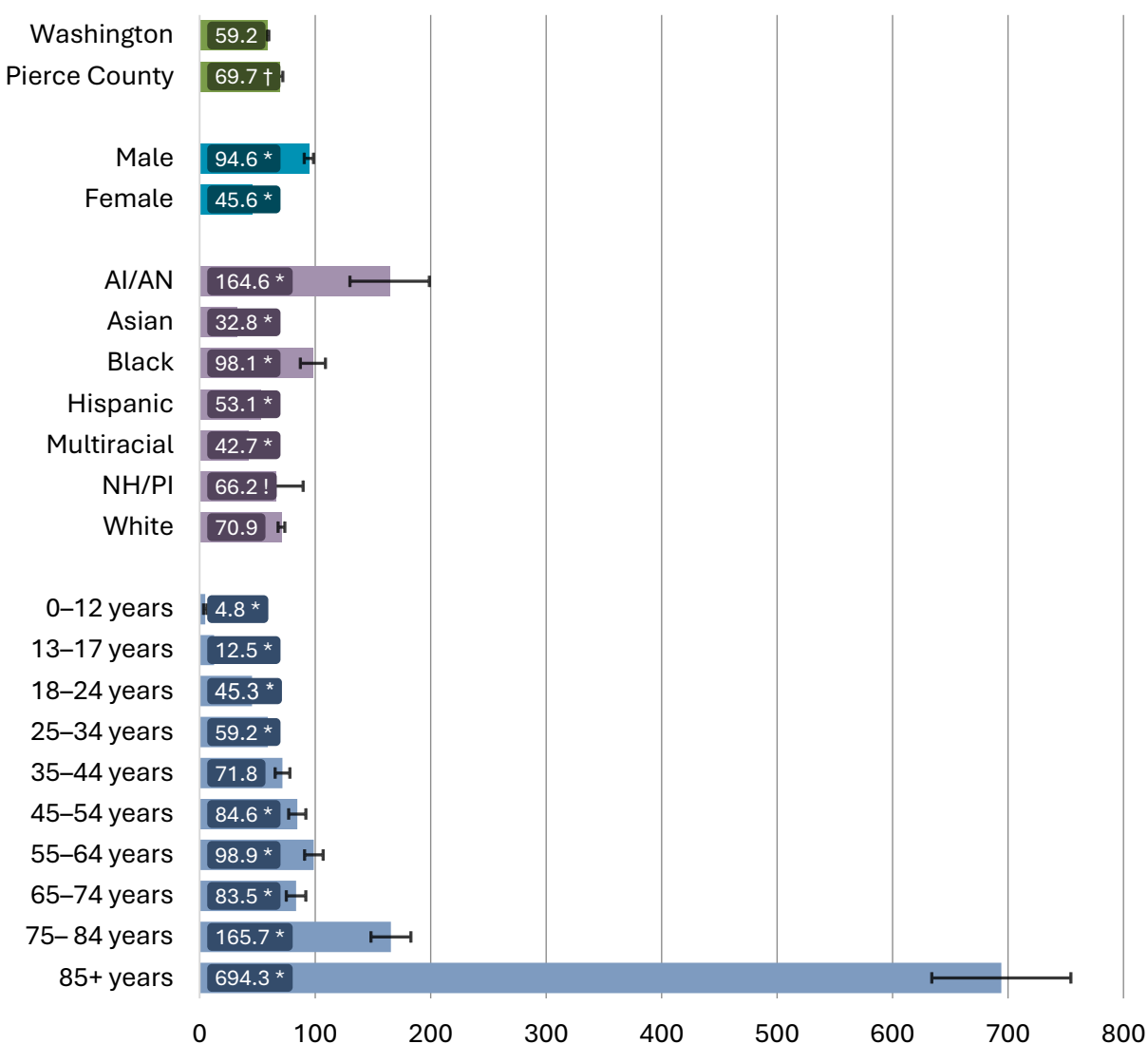


Unintentional deaths

Unintentional or accidental deaths are among the leading causes of preventable deaths. The most common causes of unintentional injury death are poisoning (includes drug overdose), falls, and motor vehicle crashes. Unintentional injury death rates in Pierce County are significantly higher than the state average.

Within the county, men were more likely than women to die from unintentional injuries. AI/AN people had a notably higher likelihood of dying from unintentional injuries than other race/ethnicity groups.

The risk of accidental death generally increased with age, with older people experiencing higher rates largely due to falls, although the 65–74 years old group did not strictly follow this trend.

Figure 39: Unintentional deaths per 100,000 people,[‡] Pierce County, 2019–2023

[‡] Rates by age are age-specific.

† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: DOH, CHS, CHAT.

Drug-related deaths

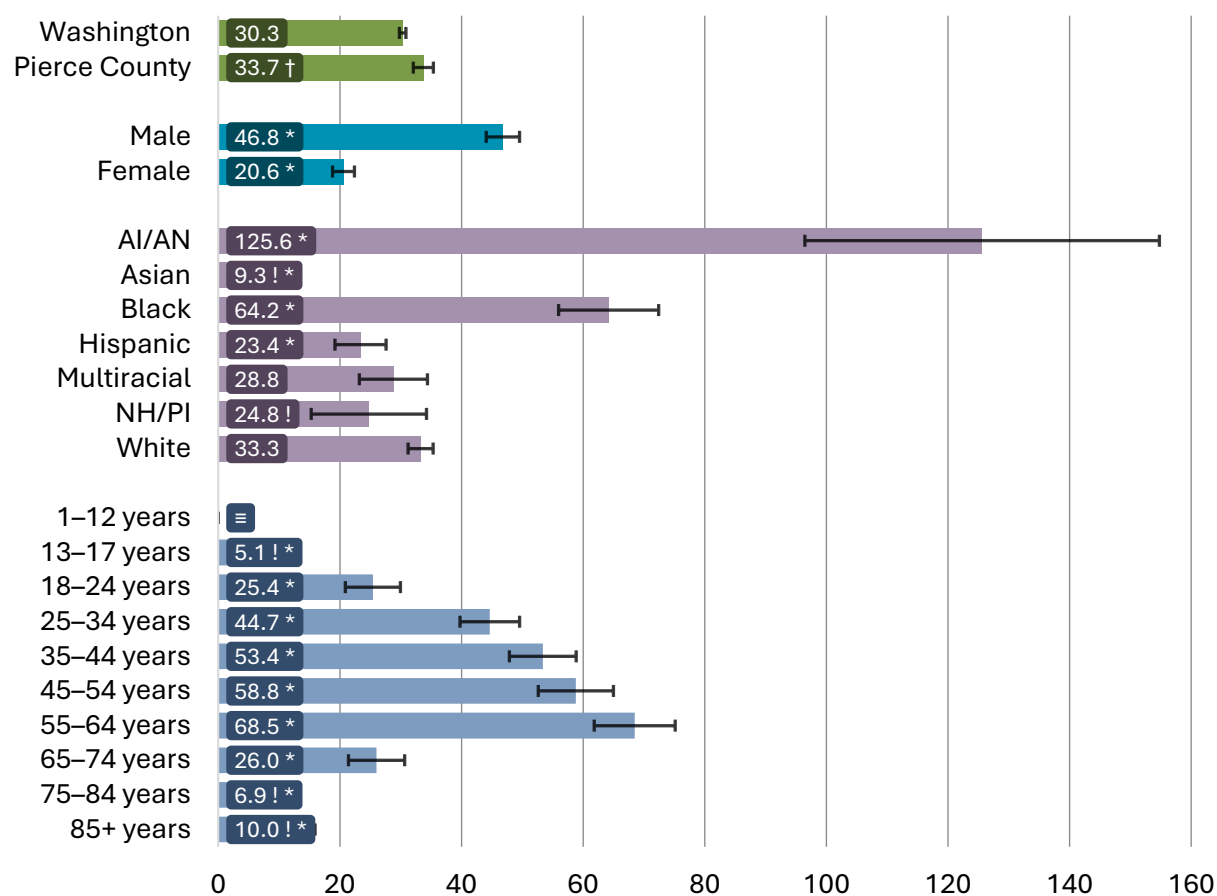
Substance use, including illicit drug use, poses significant personal, financial, and health risks. It can contribute to health conditions like dental problems, chronic illnesses, and even certain types of cancers. It also increases the risk of death.



In Pierce County, the rate of drug-related deaths (also known as poisoning or overdose deaths) is notably higher than the state average. Men were more likely than women to die from drug-related causes. AI/AN and Black people faced significantly higher drug-related mortality rates than other race/ethnicity groups.

The highest rates of drug-related deaths were in people 45–64 years old. The rate generally increased with age up to 65 years before decreasing sharply.

Figure 40: Drug-related deaths per 100,000 people,[‡] Pierce County, 2019–2023



[‡] Rates by age are age-specific.

† Statistically significant difference from Washington

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: DOH, CHS, CHAT.

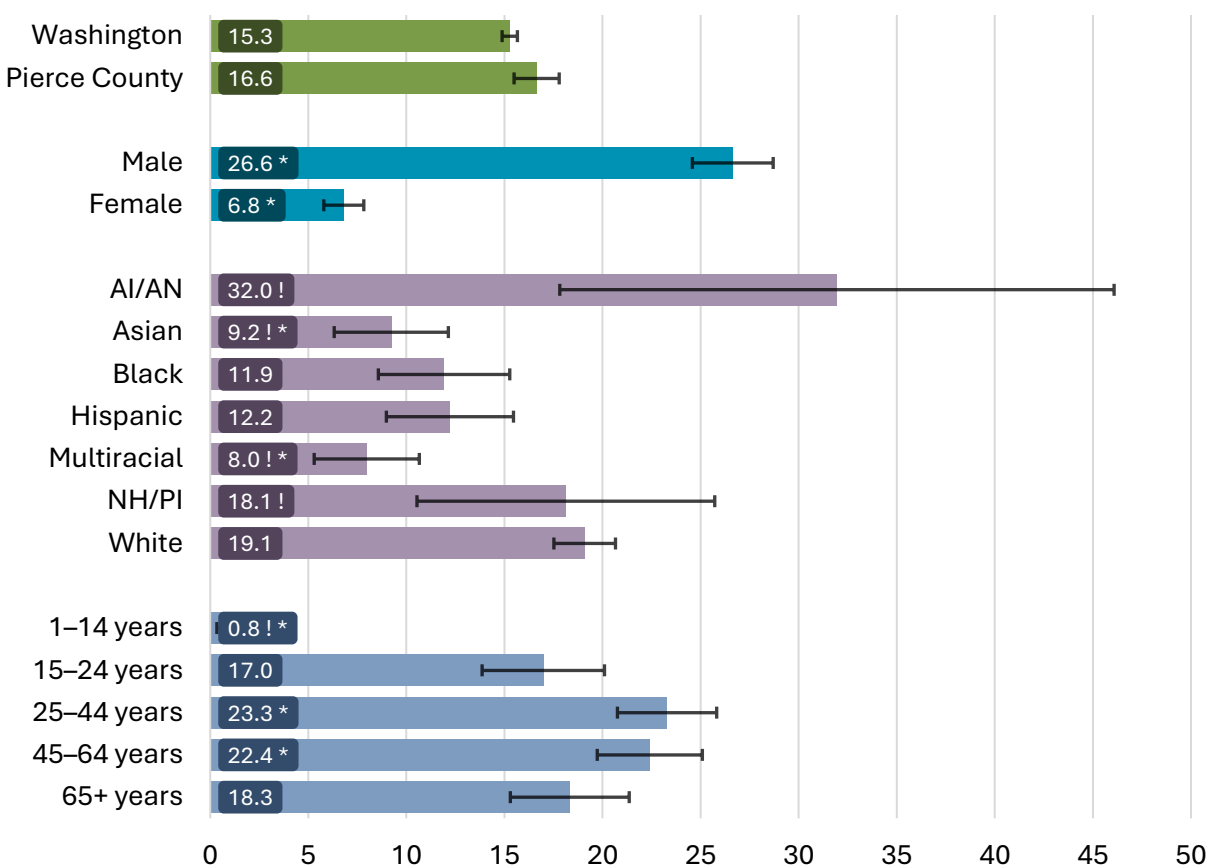


Suicide

Suicide is one of the leading causes of death. The rate of suicide is the number of deaths caused by intentional, self-inflicted means per 100,000 people.

Pierce County did not have a significantly higher suicide rate than the state. While data show women attempt suicide more often, men are significantly more likely to die from suicide. The number of suicides by race/ethnicity is very small, leading to notable uncertainty and wide confidence intervals around unstable rates. With this in mind, AI/AN people have the highest suicide rates, while multiracial and Asian people had the lowest.

Figure 41: Suicides per 100,000 people, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: DOH, CHS, CHAT.

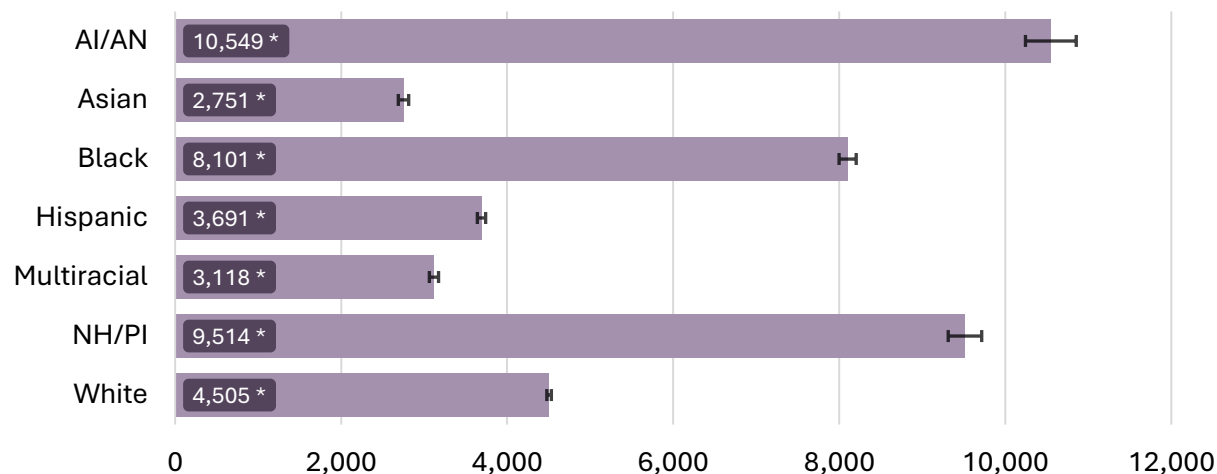


Years of potential life lost

Years of potential life lost highlights premature deaths—those that occur before age 65. The younger a person dies, the more they contribute to this measure. In 2019–2023, the number of years of potential life lost in Pierce County was 15% higher than in Washington (4,634 vs. 4,038 per 100,000 people). Within Pierce County, males had a significantly higher rate of years of potential life lost than females and the county as a whole. AI/AN people had the highest rate of potential life lost, which is significantly higher than all race/ethnicity groups and the county. The NH/PI and Black rates are both significantly higher than Pierce County and the white non-Hispanic rates.

Unintentional poisoning (including drug overdose) accounts for nearly 17% of the potential years of life lost, followed by cancer (12%), cardiovascular disease (12%), and suicide (9%). Together, these four causes account for more than 49% of potential years of life lost in Pierce County.

Figure 42: Years of potential life lost before age 65 per 100,000 people, Pierce County, 2019–2023



* Statistically significant difference from overall Pierce County

Source: DOH, CHS, CHAT.

Child and youth data insights

We looked closely at four categories of youth-specific indicators that reflect the physical, mental, and social health challenges Pierce County children and youth face:

- Access to care.
- Health conditions.
- Physical activity and screen time.
- Substance use and mental health.



These domains will help inform targeted strategies. Youth are the future and this spotlight highlights their experiences to help us understand the areas that have the potential to affect their future health outcomes and consequences.

Access to Care

Early childhood vaccination

Health professionals recommend a series of at least nine early childhood vaccines to reduce the population burden of infectious disease.⁵⁸ Recent research suggests these common vaccines prevented at least 24 million episodes of disease in the United States in 2019 alone.⁵⁹ Interrupting transmission often requires very high vaccination coverage—sometimes above 90%—to effectively prevent community spread of communicable diseases. In the 2023–2024 school year,⁶⁰ the percent of Pierce County kindergarteners who were fully vaccinated was 88.4%, slightly higher than Washington’s 87.6%.⁶¹ Vaccination rates have been declining since the 2021–2022 school year, when they were just over 91% in both Pierce County and the state.

Routine dental checkup

Routine dental checkups are essential to prevent cavities and promote healthy dental hygiene practices.

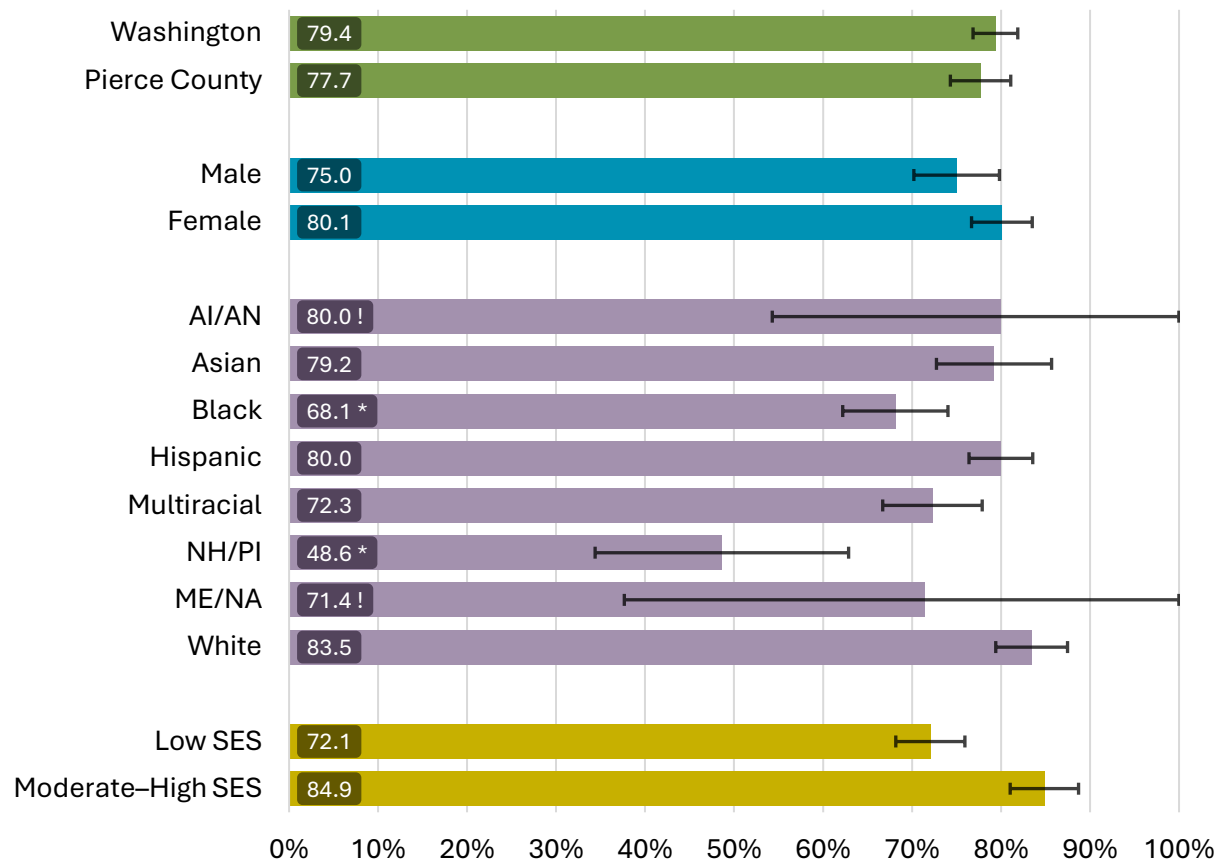
In Pierce County, the percent of youth with routine dental visits in the past year was similar to the state average, with no significant differences by sex. NH/PI youth were significantly less likely to have had a dental checkup than their Asian, white, or multiracial peers. The large RSE seen for some race/ethnicity groups means these differences should be interpreted with caution. The likelihood of having a routine dental checkup significantly increased with higher SES, indicating access to care is closely tied to income.

⁵⁸ Recommended early childhood vaccination include four diphtheria, tetanus, acellular pertussis; three polio; one measles, mumps, rubella; three hepatitis B; three *Hemophilus influenza* type B; 1 chickenpox; and four pneumococcal conjugate.

⁵⁹ Talbird, S. E., Carrico, J., La, E. M., Zhou, F., Groseclose, S. L. & Santibanez, T. A. (2022). Impact of routine childhood immunization in reducing vaccine-preventable diseases in the United States. *Pediatrics*, 150(3), Article e2021056013.

⁶⁰ Data provided by public and private schools in Washington; no data available for homeschooled youth.

⁶¹ Washington State Department of Health. “School Immunization Data Dashboard.” doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/school-immunization/dashboard

Figure 43: 10th graders who had a routine dental checkup in the past year,[‡] Pierce County, 2023

[‡] Low SES was defined as having a mother with a high school diploma/General Educational Development (GED) or lower. High SES was having a mother who had at least some college or technical training after high school.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: HYS.

Health conditions

Youth asthma

Asthma affects people of all ages but most commonly begins in childhood. In the HYS, students self-report whether a doctor has diagnosed them with asthma.

The prevalence of youth asthma in Pierce County was not significantly higher than the state, and we don't see significant differences by sex. Multiracial youth were significantly more likely to have been diagnosed with asthma than their Asian or white peers.



Youth obesity

Youth are classified as obese when their BMI is in the top 5% for their age and sex based on CDC growth charts.⁶²

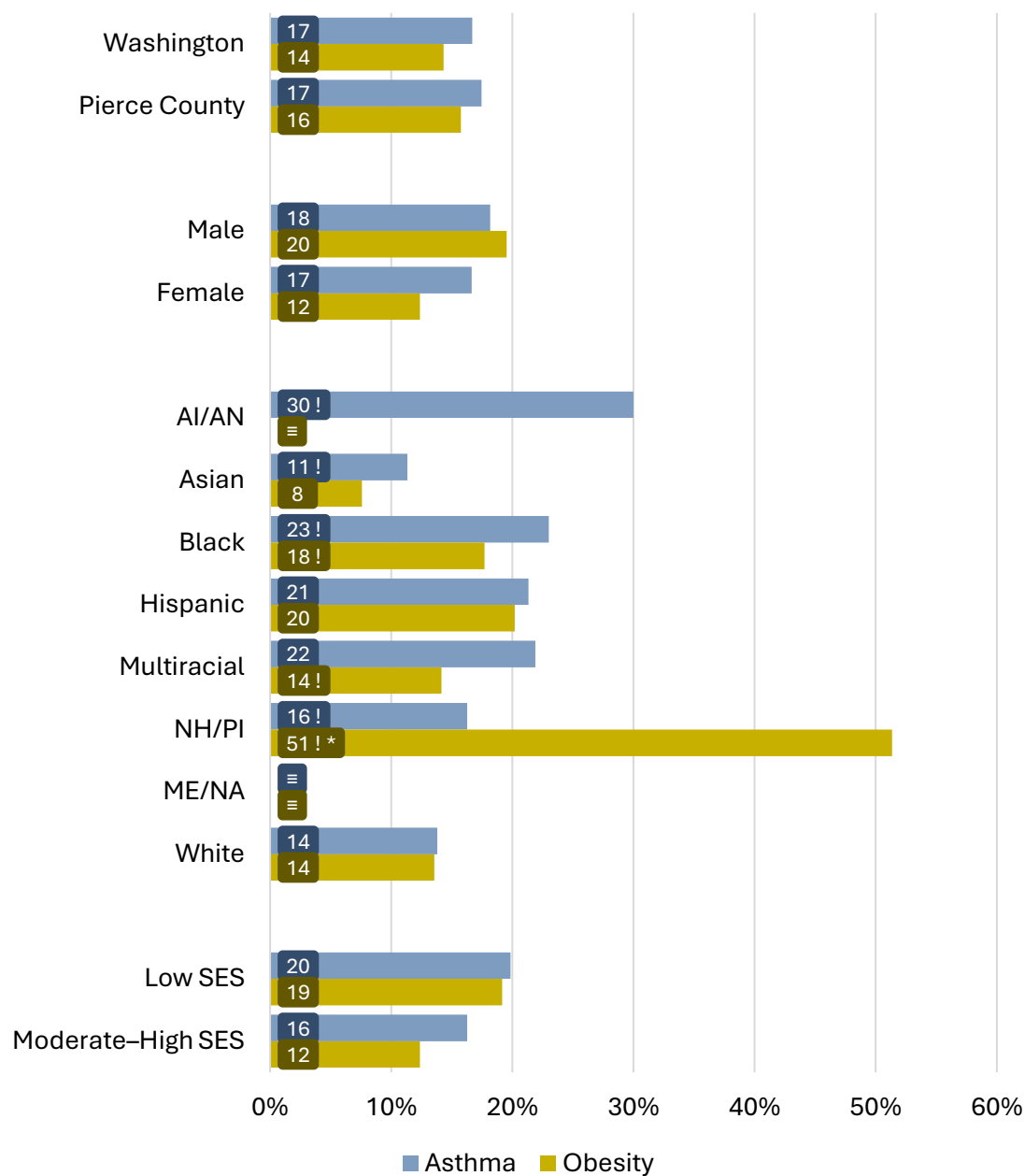
We saw no significant differences in obesity rates between Pierce County youth and those across the state. However, NH/PI and Hispanic youth were significantly more likely to be obese than youth of other races/ethnicities in Pierce County. Asian youth were least likely to be obese and were significantly less likely to obese than Hispanic or NH/PI youth. However, the small sample size for many of these estimates leaves great uncertainty around the exact numbers.

Youth with a lower SES were significantly more likely to be obese than those with moderate or high SES.

⁶² cdc.gov/growthcharts/cdc-growth-charts.htm



Figure 44: 10th graders with asthma or obesity,[‡] Pierce County, 2023



[‡] Low SES was defined as having a mother with a high school diploma/GED or lower. High SES was having a mother who had at least some college or technical training after high school.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: HYS.



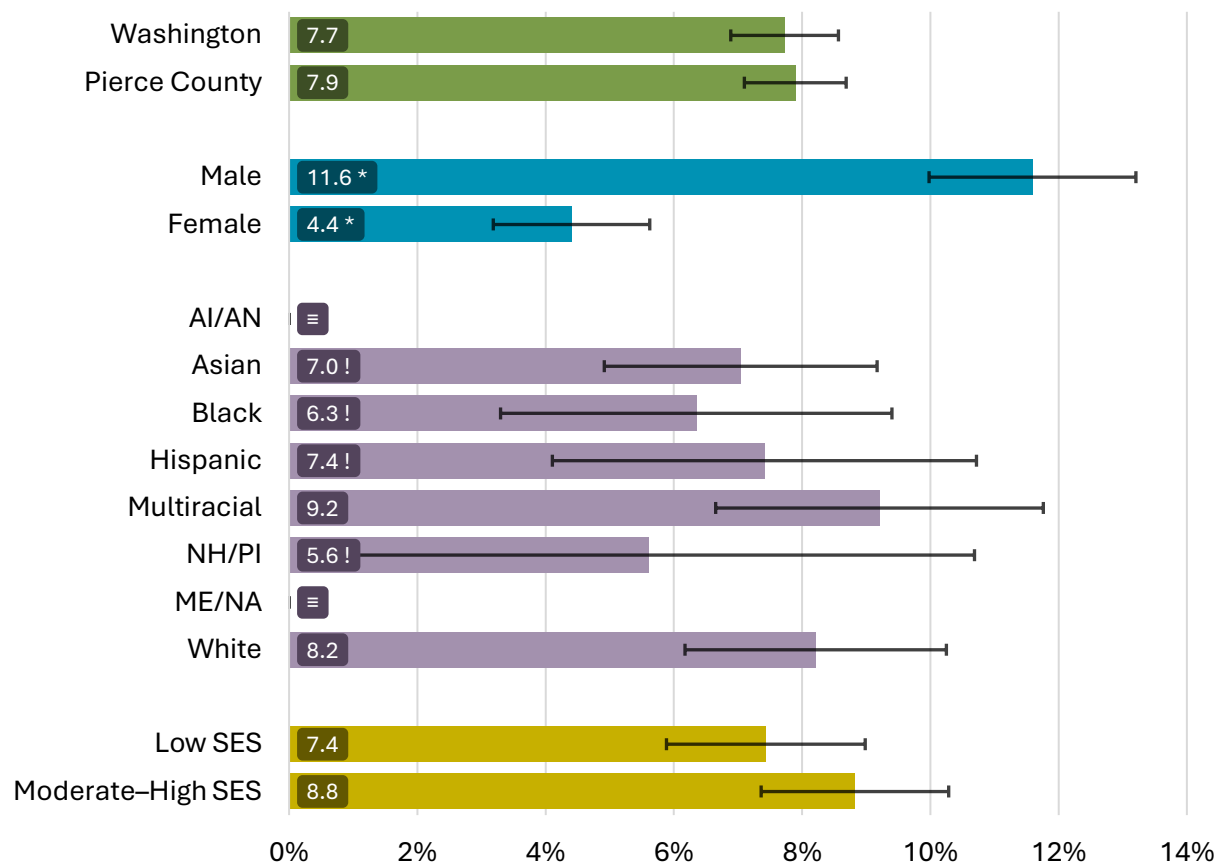
Physical activity and screen time

Engaging in physical activity during childhood and adolescence is crucial for developing a healthy lifestyle that continues into adulthood. U.S. Department of Health and Human Services recommends children and adolescents be active at least 60 minutes every day, including three days of muscle strengthening activities.⁶³ Meeting these recommendations can significantly contribute to overall health, reduce the risk of chronic diseases, and support mental, emotional, and social well-being. Regular physical activity during childhood sets the foundation for maintaining an active lifestyle throughout life. Excess screen time has the potential to limit youth's participation in physical activity.

Physical activity guidelines

The percent of Pierce County youth who met physical activity recommendations was similar to the state average. Boys were significantly more likely to meet physical activity guidelines than girls. Multiracial youth were most likely to meet the recommendations, although this difference was not statistically significant due to the small sample size. Youth with moderate or high SES were more likely to meet physical activity guidelines, but the difference was not statistically significant.

⁶³ U.S. Department of Health and Human Services. (2018). *Physical Activity Guidelines for Americans* (2nd ed.).

Figure 45: 10th graders who met physical activity guidelines,[‡] Pierce County, 2023

[§] Low SES was defined as having a mother with a high school diploma/GED or lower. High SES was having a mother who had at least some college or technical training after high school.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: HYS.

Screen time

Among youth, a long time spent using screens is associated with less physical activity, sleep disruption, and mental health concerns. Youth and parents identified balanced use of screens and alternatives to screen use as priorities. When responding to the HYS in 2023, more than 75% of Pierce County 10th graders reported they spent more than three hours each day on their devices (not including schoolwork). That's similar to 70% for all Washington 10th graders. NH/PI youth had the lowest rate of screen use, with 56% reporting they were using screens three or more hours each day.



Substance use and mental health

Substance use and mental health are often intertwined. Substance use can exacerbate other mental health issues, while some people use substances in an effort to cope with mental health issues.

Cigarette use

While the rate of starting to use tobacco has been declining nationwide, it remains a significant concern among youth. Preventing youth from becoming addicted to tobacco reduces the likelihood of smoking in adulthood and its associated long-term health risks. In Pierce County, 2% of 10th graders had smoked cigarettes in the past 30 days, which was not significantly different from the state average. Tenth grade girls in Pierce County were more likely to report having smoked cigarettes (2.4%) than boys (1.6%). There were too few responses to draw conclusions about race/ethnicity and cigarette use.

Vaping (e-cigarettes)

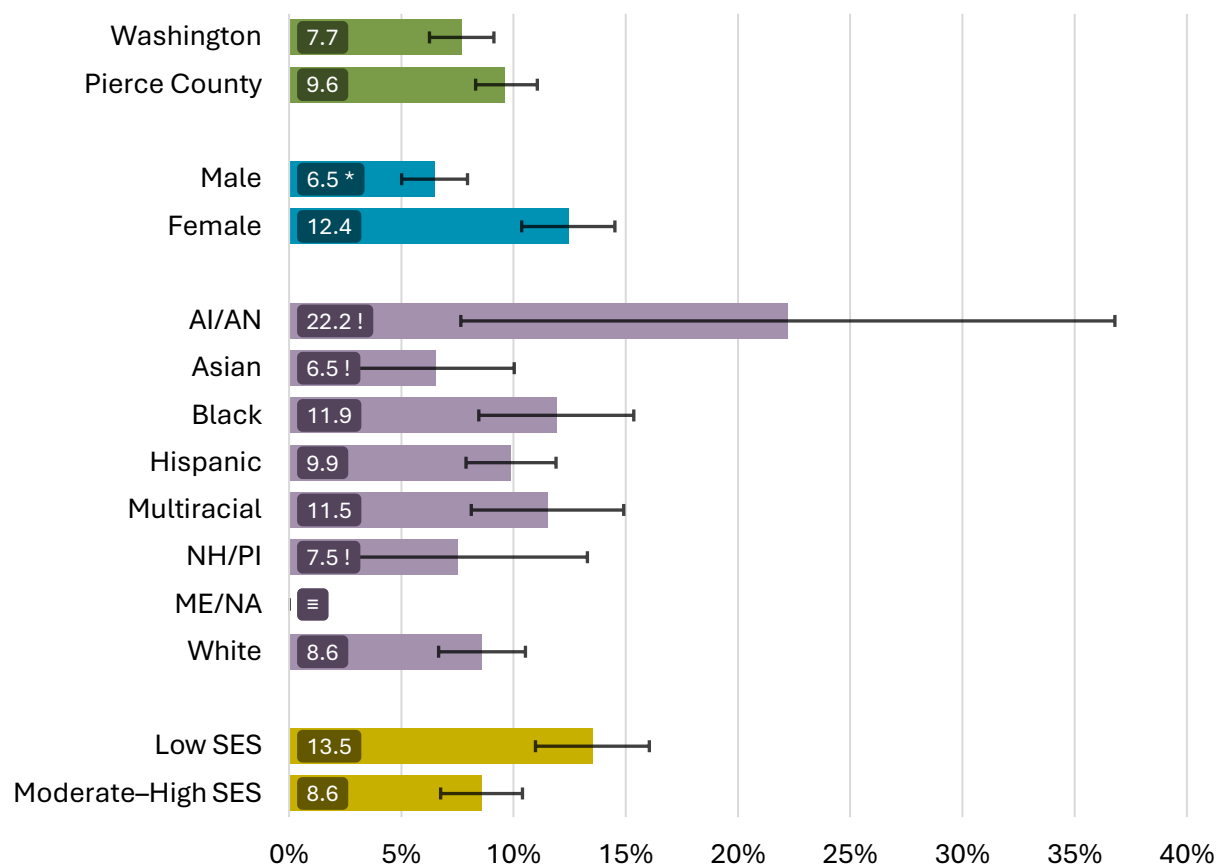
Although cigarette use has declined nationwide, a new public health concern is the increasing prevalence of vape (e-cigarette) products. The long-term effects of using these products are still being studied, but preliminary data suggest they may be negative.^{64,65}

The percent of Pierce County 10th graders who had vaped (used e-cigarettes) in the past 30 days was not significantly different than the state average. In Pierce County, girls were significantly more likely to vape (use e-cigarettes) than boys. We don't see significant differences by race/ethnicity.

Youth from lower socioeconomic backgrounds were significantly more likely to have used e-cigarettes than their peers from moderate or high SES.

⁶⁴ U.S. Department of Health and Human Services. (2016). *E-cigarette use among youth and young adults: A report of the Surgeon General*. Centers for Disease Control and Prevention. stacks.cdc.gov/view/cdc/44007

⁶⁵ Centers for Disease Control and Prevention. "Health Effects of Vaping," updated May 15, 2024. cdc.gov/tobacco/e-cigarettes/health-effects.html

Figure 46: 10th graders who vaped (used e-cigarettes) in the past 30 days,[§] Pierce County, 2023

[§] Low SES was defined as having a mother with a high school diploma/GED or lower. High SES was having a mother who had at least some college or technical training after high school.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: HYS.

Alcohol, marijuana, painkillers, and other illicit drug use

The misuse of mind-altering substances, both legal and illegal, poses a significant challenge to society. Use early in life can have significant short-term and long-term health impacts. Substances of public health concern include alcohol, marijuana, stimulants, and opioids, both illicit and prescription. Youth who use marijuana are at increased risk of addiction and academic struggles, while alcohol poses similar risks. Both substances are connected to risky behaviors among youth which can be a potential pathway to other illicit drug use.

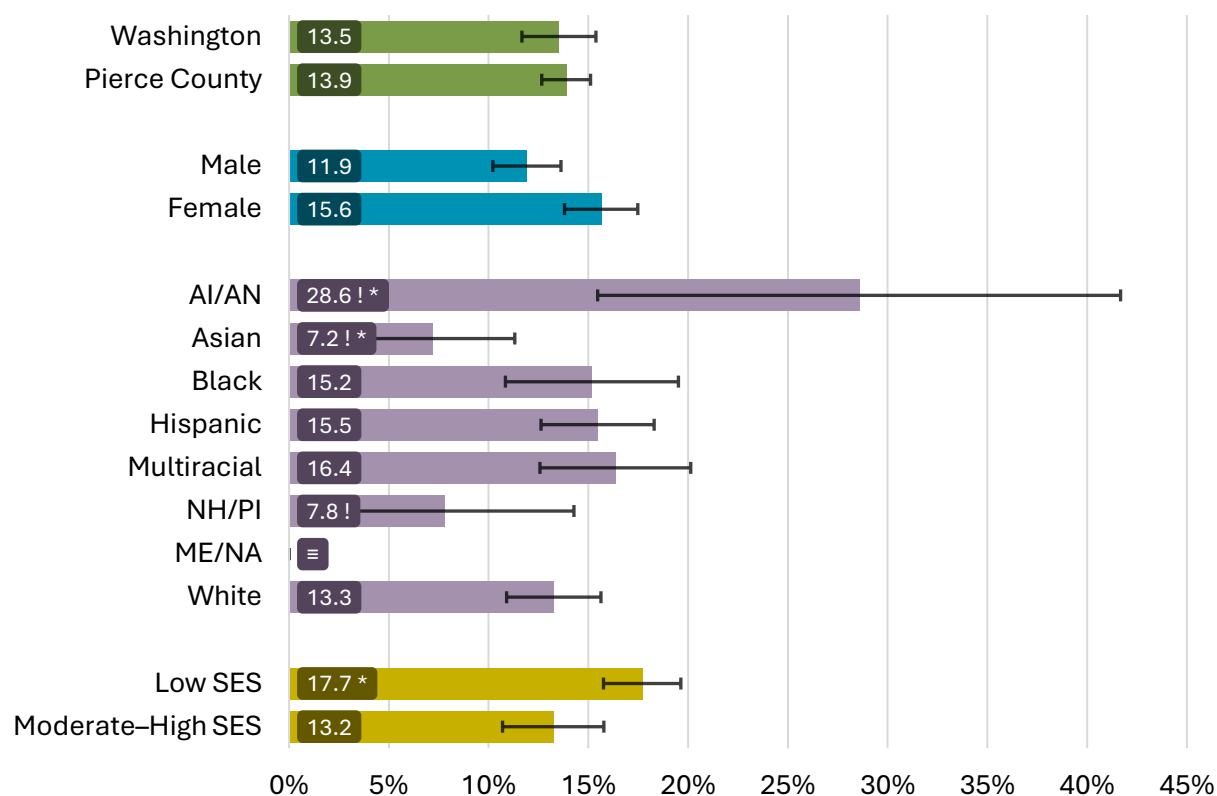


The percent of Pierce County 10th graders who reported consuming alcohol, marijuana, painkillers, or other illicit drugs in the past 30 days was similar to the state average. Girls were significantly more likely to report consuming one of the substances than boys.

Due to small sample sizes and wide confidence intervals for race/ethnicity groups, it's difficult to interpret the results. Asian youth in Pierce County reported significantly lower rates of alcohol consumption and marijuana, painkillers, or illicit drug use in the past 30 days than AI/AN, Hispanic, or multiracial youth. AI/AN youth had significantly higher substance use rates than NH/PI and Asian peers.

Youth from lower socioeconomic backgrounds were more likely to report alcohol or drug use, though the difference was not statistically significant.

Figure 47: 10th graders who used alcohol, marijuana, pain killers, or other illicit drugs,[§] Pierce County, 2023



[§] Low SES was defined as having a mother with a high school diploma/GED or lower. High SES was having a mother who had at least some college or technical training after high school.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

≡ Data suppressed; too few cases

Source: HYS.



Adverse childhood experiences

Adverse Childhood Experiences (ACEs) are known to negatively impact physical and mental health in adulthood. Commonly reported experiences include abuse, neglect, substance abuse in the home, experiencing or being exposed to violence, and parental divorce. Starting in 2021, the HYS gathered information on ACEs among 10th graders.⁶⁶ In 2023, more than one in six Pierce County 10th graders reported experiencing at least four ACEs.

Safe at school

Feeling safe at school is fundamental to learning and emotional development. Nearly one in five Pierce County 10th graders in Pierce County (19%) and Washington (18%) said they did not feel safe at school. There were no significant differences by race/ethnicity or sex. However, transgender (35.2%), gay or lesbian (29.5%), and bisexual (29.4%) youth all had rates significantly higher than the county average.

Anxiety and depression

Anxiety and depression directly reduce youth well-being and increase risks of academic struggles, substance use, self-harm, and suicide. Youth are considered to have experienced anxiety if they reported feeling bothered by nervousness, being on edge, or feeling anxious more than half the time in the past two weeks. Youth were considered to have experienced depression if they reported feeling so sad or hopeless almost every day for at least two weeks in a row that they stopped engaging in some of their usual activities within the past 12 months. This youth depression data reflects the post-COVID-19 pandemic period (2023), while the adult depression data in this report covers before, during, and after the pandemic (2019–2023). Additionally, the wording of the questions is somewhat different, so the data cannot be directly compared.

The percent of Pierce County 10th graders experiencing anxiety or depression was not significantly different from that in the state. Girls were significantly more likely to report feeling anxious or depressed than boys.

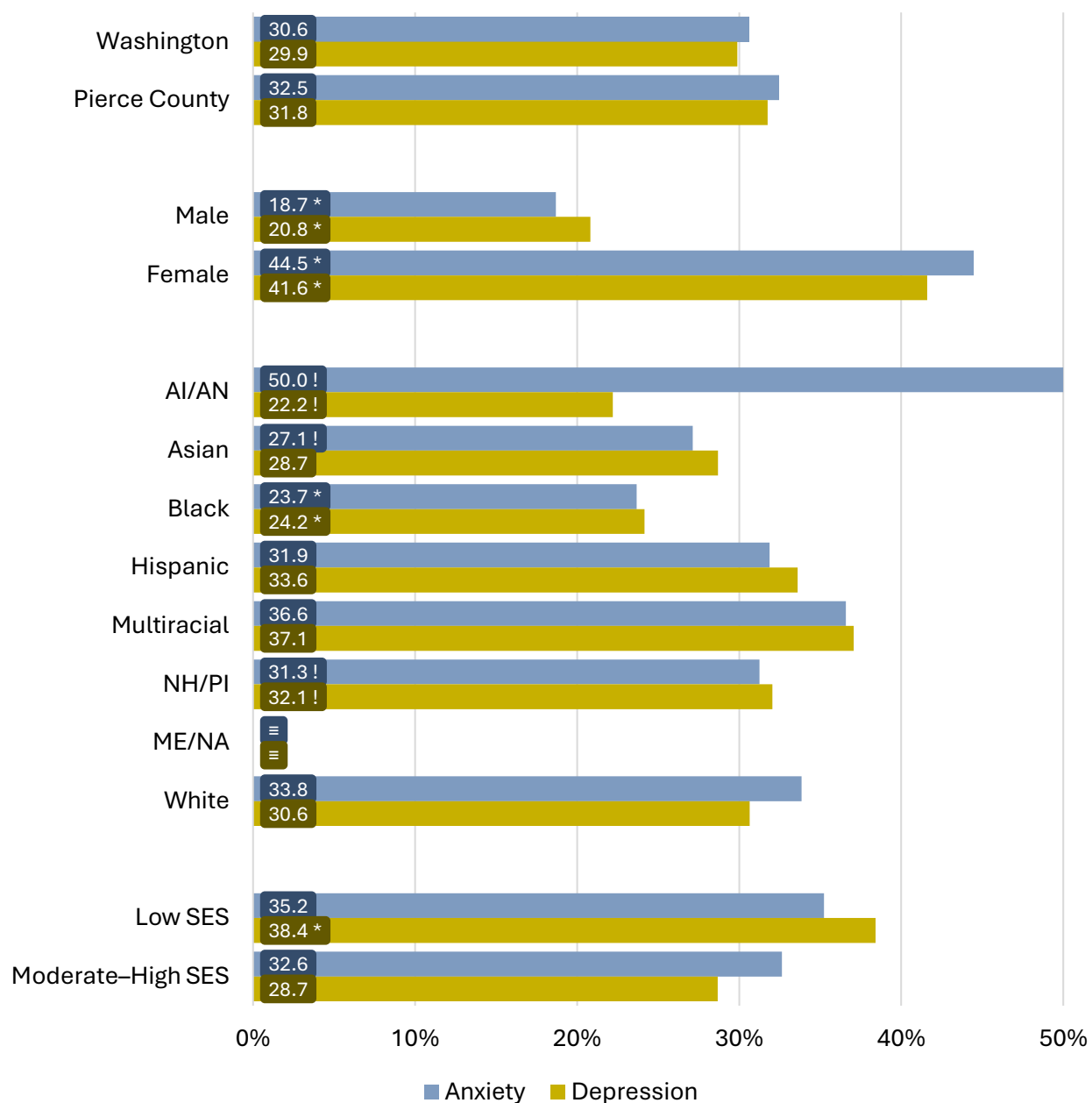
While AI/AN youth had the highest reported rate of anxiety, the difference compared to other race/ethnicity groups was not statistically significant. Black youth were significantly less likely to report feeling bothered by nervousness, anxiety, or being on edge than Pierce County youth as a whole, white youth, or multiracial youth. Black youth were significantly less likely to report depression than Pierce County youth as a whole, Hispanic youth, or multiracial youth.

There was no relationship between rates of anxiety and SES. Youth with lower SES were significantly more likely to report depression compared to youth with moderate or high SES.

⁶⁶ askhys.net/HYS/GetDocument?path=Training&fileName=WAH-ACEs%20Interpretive%20Guide.pdf



Figure 48: 10th graders who self-reported anxiety or depression,[§] Pierce County, 2023



[§] Low SES was defined as having a mother with a high school diploma/GED or lower. High SES was having a mother who had at least some college or technical training after high school.

* Statistically significant difference from overall Pierce County

! Interpret with caution; RSE >30%

Source: HYS.

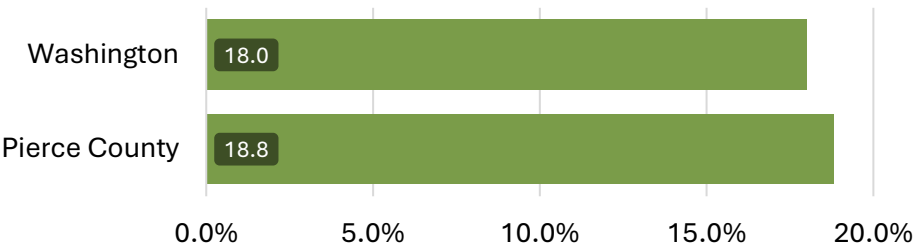


Suicide plan

Youth suicide is a preventable public health crisis that reflects deeper gaps in mental health support, trusted relationships, and access to care. When young people report suicidal ideation, they are signaling distress that demands immediate attention and a compassionate response. Without timely intervention and access to trusted support, young people may progress from thoughts of suicide to plans to attempts. In Pierce County, 15% of 10th graders reported having made a suicide plan, slightly higher than the state average of 12%. More than 17% of girls and 10% of boys reported doing so. There were no significant differences by race/ethnicity. Transgender (49%), gay or lesbian (29%), or bisexual (35%) 10th graders were at least twice as likely to report planning to commit suicide than the county as a whole (15%).

These data are notably different than data on hospitalizations for suicide attempts and suicide mortality earlier in this report. Women are more likely than men to be hospitalized for a suicide attempt. The highest rates are among people 6–24 years old. In contrast, men are more likely to die by suicide than women, with the highest rates of suicide death in people 25–44 years old.

Figure 49: 10th graders who made a plan to commit suicide, Pierce County, 2023



Source: HYS.



Youth mental health spotlight

Why it matters

Anxiety and depression increase risks of self-harm, substance use, and academic struggles.

Community snapshot

- Nearly one in three youth report feeling anxious or on edge most of the time.
- Youth substance use overlaps with mental health challenges, amplifying risks.
- Girls report significantly higher anxiety and depression than boys.
- AI/AN, multiracial, and Hispanic youth show higher burdens of mental health challenges. Asian youth report significantly lower rates.
- Youth from lower SES households are more likely to report mental health challenges.

Implications

Youth-driven solutions, school-based supports, and culturally safe prevention efforts are critical. Elevating youth voices will shape meaningful interventions.

Next steps

The data presented in this CSA confirm that, while Pierce County offers many strengths and opportunities, health outcomes and lived experiences vary significantly across the population. Disparities by age, race/ethnicity, sex, gender, and geography emerged across nearly every domain.

Documenting disparities does not provide solutions for these challenges. Numbers tell us what is happening and where, but they do not explain why these inequities persist or how to effectively address them. Understanding the root causes of health disparities and identifying paths to equity requires examining the broader context in which communities live, work, and thrive.

The findings in this assessment set the stage for the CPA which examines the capacity, resources, strengths, and barriers of organizations working to improve health and well-being across Pierce County. Together, the CCA, CSA, and CPA help us decide what to prioritize. These three assessments will help us develop the CHIP and guide future strategic planning for Tacoma-Pierce County Health Department. By integrating community voice, health data, and organizational capacity, we move closer to a shared understanding of both the challenges we face and the collective assets we can mobilize to create lasting change.



Section 3: Community Partner Assessment

Overview

The primary objective of the CPA is to formalize the participation of community organizations in the CHA and CHIP processes, enhancing our collaboration with our partners. The CPA is the last of three assessments in the broader CHA report. It's a systematic examination of the organizational ecosystem addressing health and mental health outcomes in Pierce County. Specifically, this assessment investigates which entities are actively engaged in community health work, identifies existing collaborative networks and partnership gaps, and evaluates how organizations are strategically positioned to advance health equity initiatives across the county.

The CPA reflects MAPP 2.0's emphasis on partnership-driven planning. Effective community health improvement requires a comprehensive understanding of the stakeholder landscape. By establishing a baseline understanding of organizational capacity, collaborative infrastructure, and equity readiness, the CPA informs and strengthens the rest of the CHA and CHIP process.

For this assessment, we engaged 103 representatives from 83 organizations spanning multiple sectors, including:

- Government.
- Healthcare.
- Education.
- Social services.
- Grassroots community organizations.
- Faith-based institutions.

We documented their organizational strengths, operational challenges, and collective abilities for advancing health outcomes in Pierce County.

Methods

Our approach to the CPA was rooted in community-based participatory research (CBPR) principles. They emphasize transparency, inclusion, and shared learning. Our data collection focused on capturing nuanced organizational perspectives from partners on their capacity, engagement practices, and systemic barriers. At the same time, we sought to ensure our engagement with



community partners was culturally responsive and informed by partner priorities, recognizing variation across organizations and engagement contexts. See appendix H for further details.

Participant recruitment and engagement

To identify suitable participants, we employed a stakeholder-mapping framework that prioritized organizations serving communities with significant health disparities. This involved a comprehensive review of internal partnership records and previous evaluations of community health and programs.

Additionally, we used the Health Department's Communities of Focus (CoF) geographies as an equity-based lens to facilitate more intentional recruitment. CoF is an initiative focused on addressing systemic problems related to health and well-being for six communities—East Tacoma, Key Peninsula, Parkland, Springbrook, South Tacoma, and White River—that experience disproportionate disparities in health and social and economic outcomes.

We took this equity-based approach to ensure the CPA not only represents large institutions and organizations, but also includes smaller, grassroots, culturally specific partners that serve these communities.

We wanted to identify which organizations had worked with us in the past, including previous CHA processes. The review allowed us to pinpoint sectors, geographic regions, and types of organizations that were either overrepresented or underrepresented in previous engagement efforts. That helped guide targeted recruitment for the CPA survey and interviews.

Our outreach strategy included word-of-mouth, local community events, public meetings, and targeted outreach to community leaders, coalitions, partners, and agencies. By combining broad outreach with targeted invitations, we included long-standing partners and groups who hadn't worked with us before.

Survey content and administration

We modified the MAPP 2.0 CPA survey instrument to assess the capacity and community health service interests of our partner organizations. We asked about things like organizational capacity, focus areas, community engagement strategies, and resource gaps. See appendix I for survey questions.

We emailed the online survey and it was open Feb. 1–March 31, 2025. Some community partners wanted to participate in brief interviews rather than complete the online survey. We used the same questions in the interviews and integrated the data into our analysis. Participation was voluntary. We designed the methodology to make participation easy and ensure comprehensive input from organizations integrated into and accountable to the communities they serve. We provided compensation to those who completed the survey outside of their paid employment duties.



Data analysis

We used descriptive statistics to analyze the responses. This involved calculating frequencies and percentages of categorical response variables. We also incorporated open-text survey responses into the results to enrich the summary data.

Finally, we engaged participants after sharing the results with community organization partners to ensure inclusion and accuracy of findings.

Findings

Overview

Two domains emerged from the data:

- Capacity and resources.
- Community engagement.

Each domain captures strengths, challenges, and opportunities for enhancing partnerships across Pierce County to improve both public and population health.

Organizational descriptives

Communities and populations

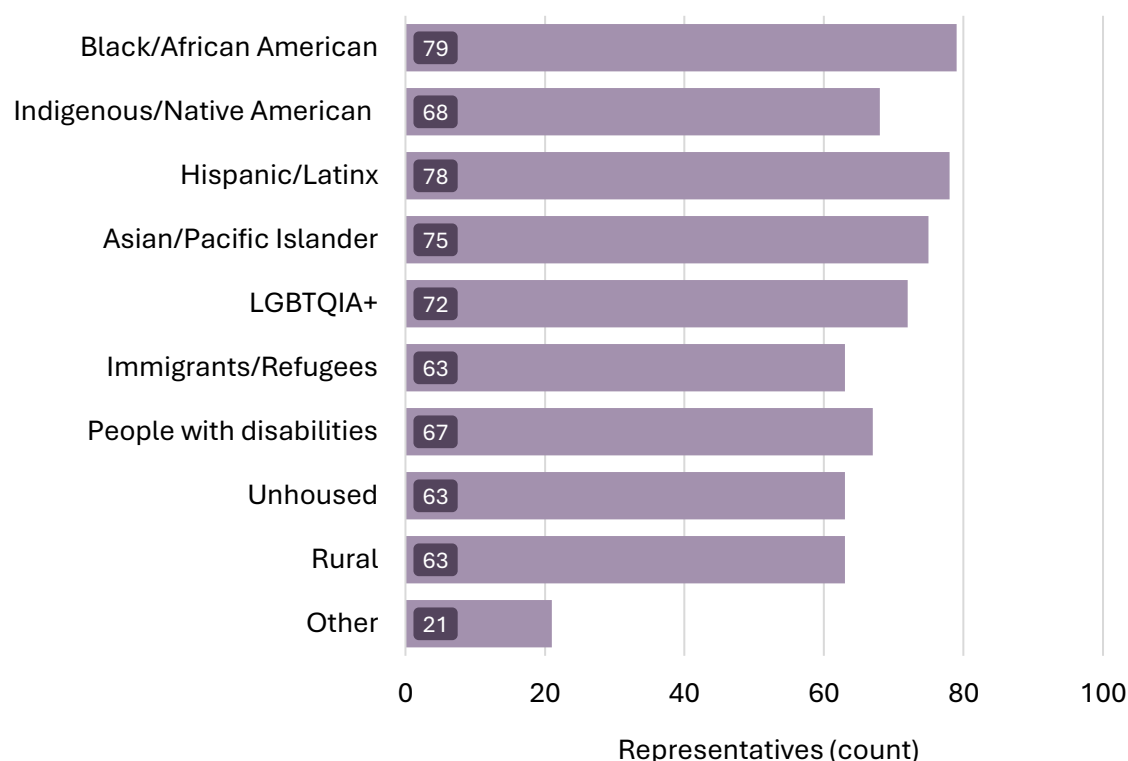
A total of 103 representatives from 83 organizations responded. Participants included hospitals and health systems, social service agencies, governmental agencies, community-based organizations, schools, and faith-based organizations. See appendix J for details. This breadth underscores the collaborative nature of public health and the broad commitment to improving health in Pierce County.

Communities and populations served

We wanted to know more about how community partners serve communities or populations affected by disparities. A substantial majority of respondents reported they provide services to a diverse array of underrepresented ethnic groups, including Black, Indigenous, and Hispanic communities. A slightly smaller proportion reported serving immigrants/refugees, people with disabilities, people living unhoused, and rural populations. Many serve multiple communities and populations. See figure 50 for details.



Figure 50: Community or population groups organizations serve, reported by representatives



Partners also identified geographic and population-level gaps in access to services. As one noted:

“Rural and low-income communities are often underserved. People who are unhoused or living in unstable housing face additional barriers. Services and resources are less accessible the further away you get from Tacoma, which means that communities in East Pierce have more unmet needs. Anywhere there are transportation gaps, we are going to have unmet needs.”

Organizational capacity and resources

Organizational alignment with the ten essential public health services

A critical dimension of assessing partner capacity is learning how they contribute to the broader public health system. We asked respondents to identify which of the ten essential public health services (EPHS) they support, with the option to select more than one. See figure 51 for details.

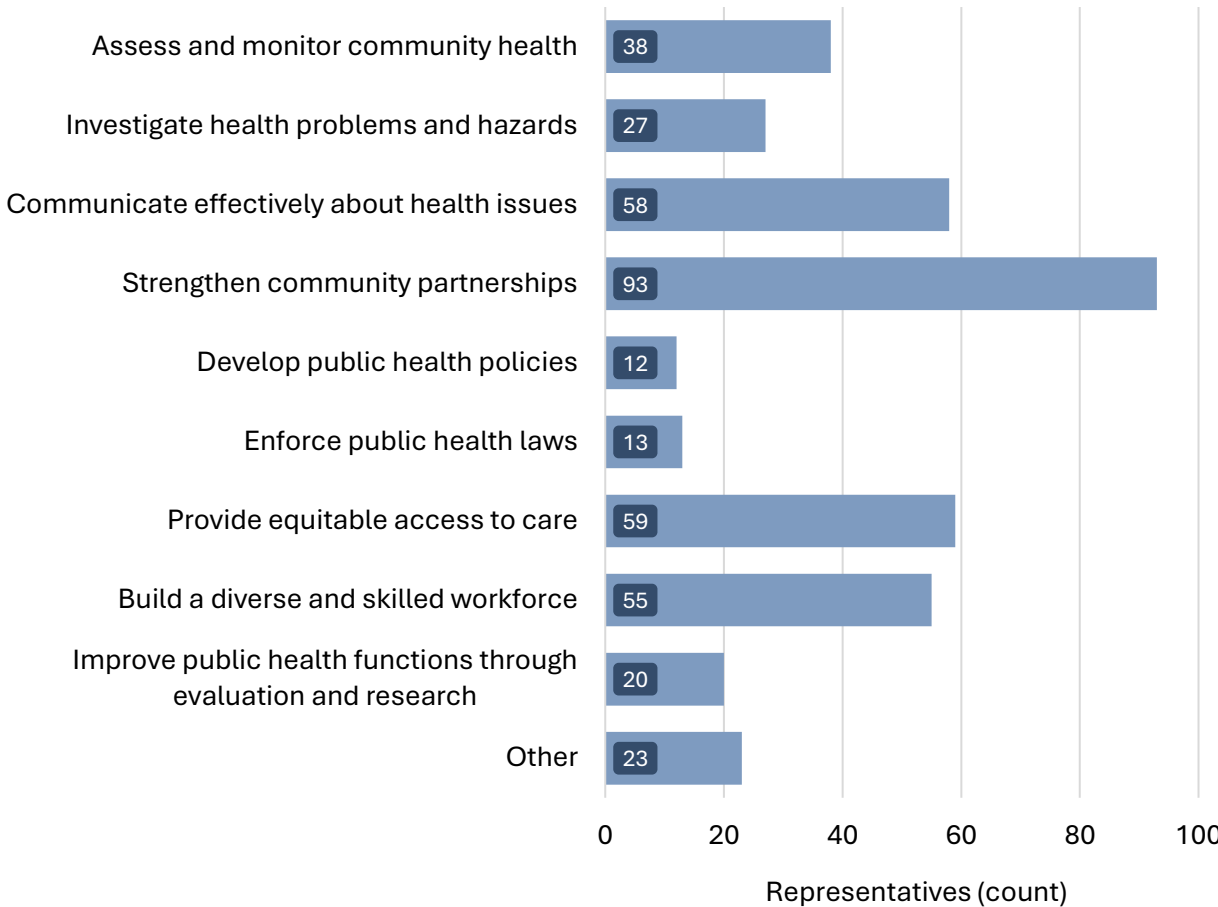
The distribution of organizational engagement across the EPHS framework reveals notable patterns in Pierce County’s public health infrastructure. The most widely supported essential service was “strengthen community partnerships,” with 93 actively doing so. This was followed by 59 supporting “provide equitable access to care” and 58 supporting “communicate effectively about health



issues.” This suggests substantial capacity in those domains. Fifty-five supported efforts to “build a diverse and skilled workforce.”

Because some EPHS are primarily carried out by government agencies, we expected lower levels of organizational representation in some areas. This reflects an appropriate distribution of roles, rather than a lack of capacity.

Figure 51: Organizations that support the ten essential public health service focus areas, reported by representatives



Organizational service focus areas

Understanding our partners’ primary service domains provides critical insight into the capacity and coverage of our health and social service landscape. Within the CPA framework, it identifies areas of concentrated organizational focus and potential service gaps that may require partnership development or resource allocation.



We asked partners to identify their top three focus areas from a list of service domains. See figure 52 for details. The distribution reveals a concentration of effort within specific service sectors. The top three were:

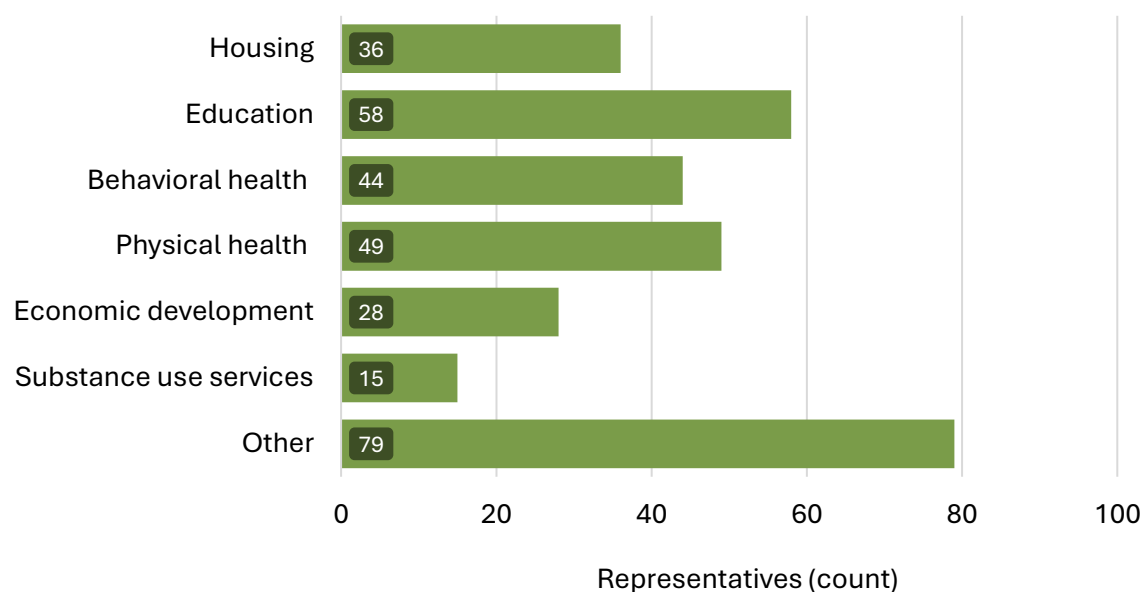
- Education (58).
- Physical health (49).
- Behavioral health (44).

Notably, 79 organizations selected “other.” The open-text responses indicate substantial activity in additional areas, including:

- Aging services.
- Violence prevention.
- Maternal and child health.
- Care coordination.
- Food access.
- Transportation.
- Environmental health.
- Youth development.
- Community safety.

These highlight the breadth of community health work in Pierce County.

Housing represented a moderate level of organizational focus (n=36), while economic development (n=28) and substance use services (n=15) were cited considerably less frequently. This distribution pattern indicates organizational focus is concentrated in education and physical and behavioral health services.

*Figure 52: Organizational service focus areas, reported by representatives*

Organizational strengths and resources

A comprehensive assessment of organizational capacity also requires identifying the assets and capabilities partners contribute to the public health infrastructure. Respondents were asked to identify the strengths and resources their organizations bring to improving community health, with the option to select multiple attributes. See figure 53 for details.

The distribution of organizational assets reveals a strong foundation of relational and collaborative capacity within our health ecosystem. The most common strengths were:

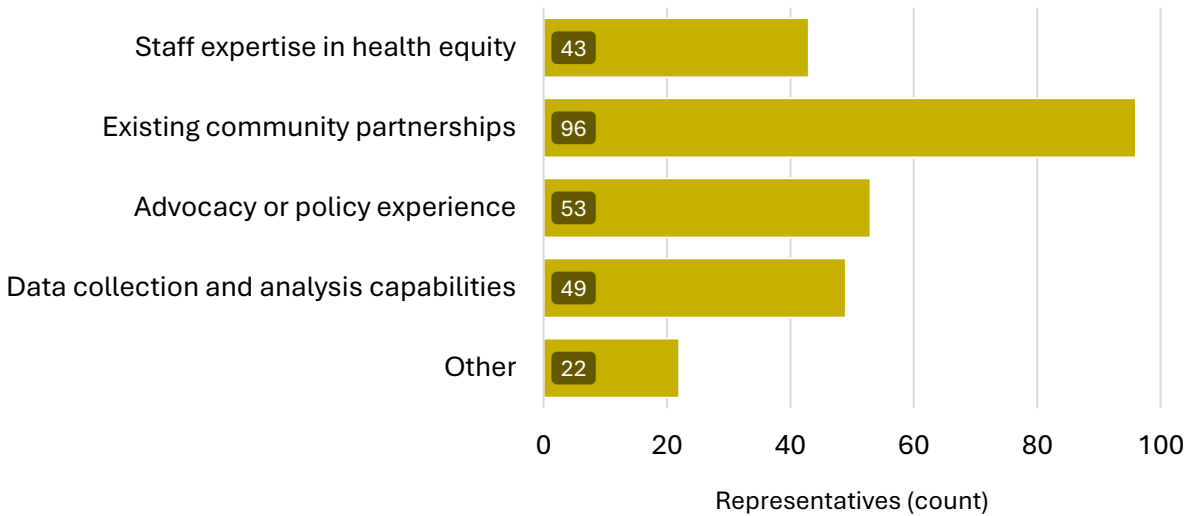
- Existing community partnerships (96).
- Advocacy or policy experience (53).
- Data collection and analysis (49).

This suggests meaningful capacity for both system-level change and evidence-informed decision-making. Additionally, 43 organizations reported staff expertise in health equity, indicating growing organizational competency in addressing structural determinants of health disparities. Twenty-two organizations selected “other.”

Partners also identified areas they want to strengthen, especially engagement, equity-focused practices, data capacity and policy or advocacy.



Figure 53: Organizational strengths and resources, reported by representatives



Organizational service and resource gaps

Understanding gaps in services and resources is an essential component of the CPA. These deficits illuminate unmet community needs and inform strategic priorities for collective action. We asked respondents to identify the most significant gaps affecting the communities they serve.

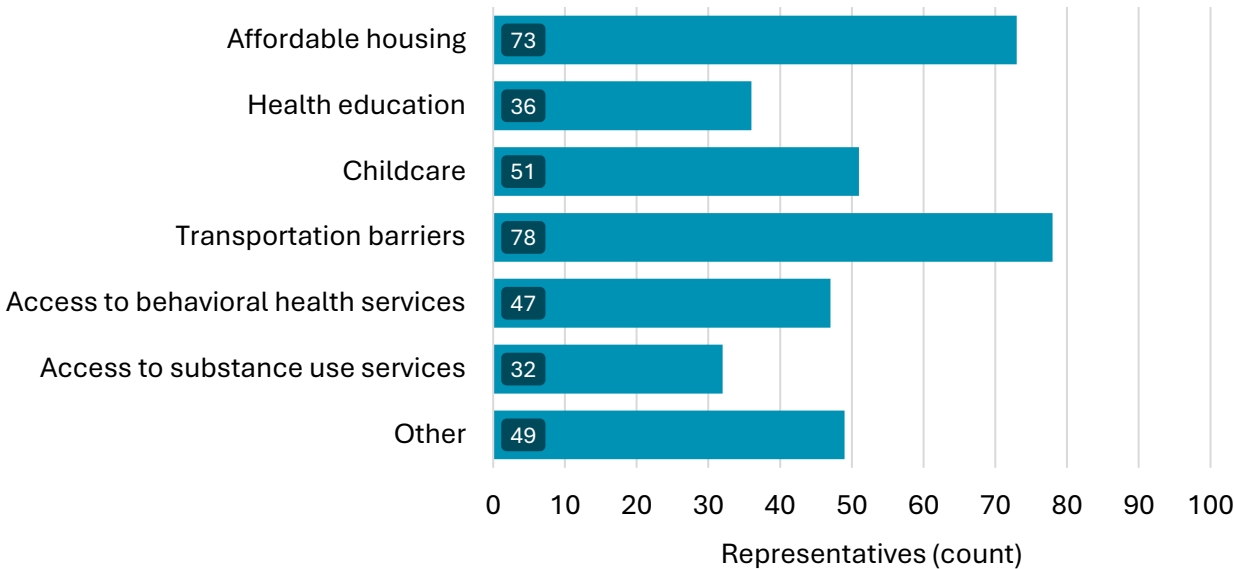
The results reveal substantial and multifaceted needs across Pierce County. See figure 54 for details. Transportation barriers (n=78) and affordable housing (n=73) emerged as the most frequently cited service gaps, highlighting critical deficiencies in foundational social determinants health. Childcare access (n=51), access to behavioral health services (n=47), and health education (n=36) also represented significant areas of unmet need. Access to substance use services received comparatively fewer selections (n=32), though this may reflect either lower perceived need or limited organizational awareness of substance use disorder in their service populations. Forty-nine organizations selected “other.”

“Transportation is huge. No access to care if a person can't get where they need to go.”

“Equity of services. ...not all in geographical populated areas. ...many of the people I serve have no way to afford to get to town. They need the services to come closer to them.”



Figure 54: Organizational gaps in specific services or resources, reported by representatives



Organizational community engagement

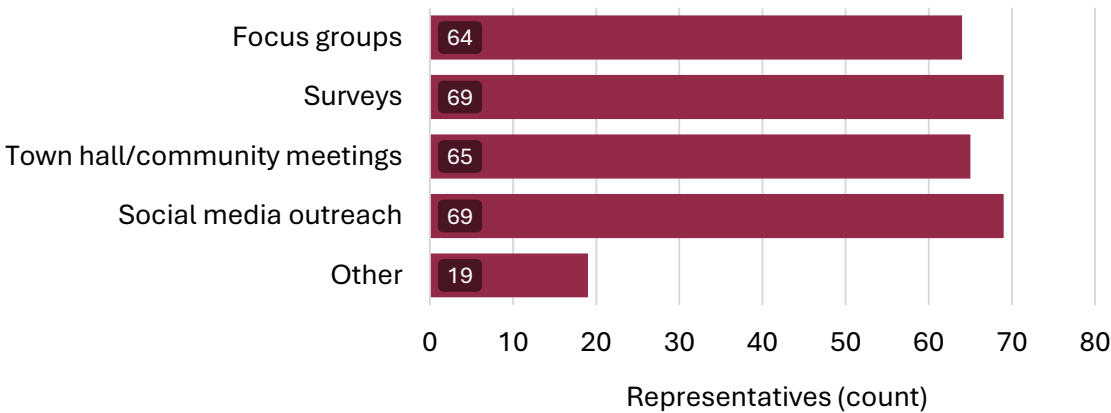
Improving community health requires meaningful engagement with residents and community leaders, particularly populations experiencing health inequities. Understanding how organizations currently facilitate community participation provides insights into the collective capacity for inclusive, equity-centered health planning processes. We asked respondents to identify the engagement strategies their organizations employ, with the option to select multiple approaches. See figure 55 for details.

The distribution of engagement methods reveals a diversified approach to community participation across Pierce County’s organizational landscape. Surveys (n=69) and social media outreach (n=69) were the most frequently used, reflecting both traditional data collection methods and the growing importance of digital communication platforms in reaching out to varied audiences. Town halls and community meetings (n=65) also represented a widely adopted approach. That they continue to value in-person deliberative forums. Focus groups (n=54) were employed by a substantial proportion of organizations, indicating capacity for structured qualitative inquiry. Nineteen organizations selected “other.” Qualitative responses elaborated on the principles and practices underlying effective community engagement partners emphasized.

“Strengthening relationships with trusted leaders within specific communities; Reducing barriers to engagement (translations/translators; providing childcare and food); Engagement facilitated by those embedded/part of community that is focus of engagement/intended audience; Compensating people for their time and expertise.”



Figure 55: Organizational engagement strategies, reported by representatives



Organizational practices for centering underserved populations in decision-making

A fundamental equity principle in community health work is that populations most affected by inequities must be meaningfully involved in decisions that shape policies, programs, and resource allocation. The extent to which organizations formally operationalize this directly influences the equity impact of community health improvement efforts. To better understand how organizations implement health equity principles, respondents were asked to identify the specific strategies they use to ensure the voices of underserved populations are included in organizational decision-making processes.

The results reveal varied approaches to inclusive governance and participatory decision-making. Partnerships with community leaders emerged as the predominant strategy (n=88), indicating widespread recognition that effective engagement with underserved populations requires authentic relationships with trusted community leaders and representatives. This was followed by feedback loops like follow-up surveys or meetings (n=61), culturally specific outreach methods (n=58), and representation on advisory boards (n=54). See figure 56 for details.

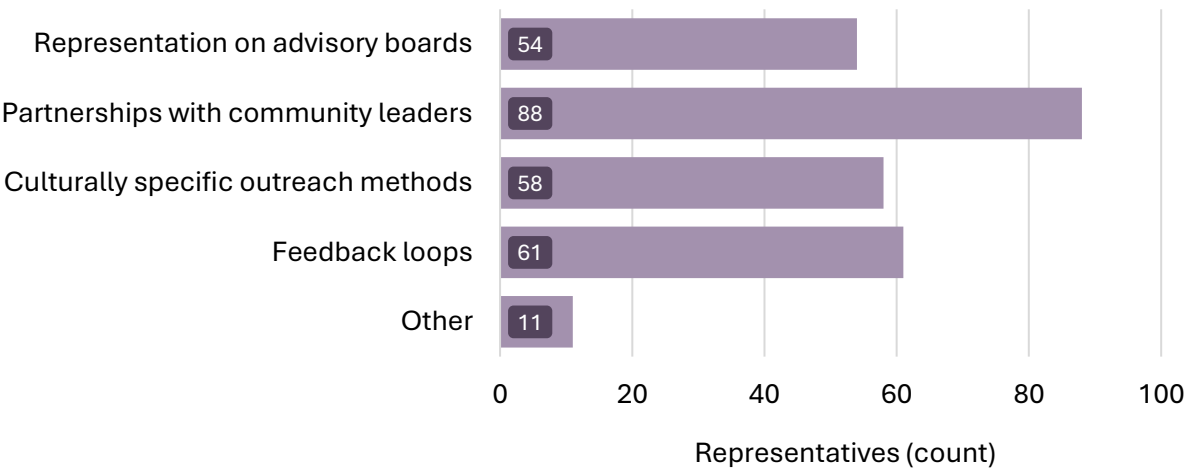
“Representation of the community is serving, community voice, and establishing trust and respectable relationships.”

“Language access, bringing resources to remote areas in the county.”

“Meet them where they are and talk to them using minimal jargon.”



Figure 56: Organizational engagement strategies for underserved populations, reported by representatives



Organizational challenges to community engagement

A comprehensive capacity assessment must also examine the barriers that constrain effective community participation. This reveals systemic obstacles to equity-centered engagement and informs strategic priorities for capacity building and resource allocation. We asked respondents to identify the primary challenges their organizations face in engaging community members.

The distribution of reported barriers reveals significant resources constraints as the predominant obstacle to effective engagement. The vast majority of organizations (n=81) cited lack of resources, including staffing and funding limitations. This indicates capacity deficits represent a fundamental structural barrier to sustained, meaningful community engagement. Difficulty reaching specific populations (n=51) and limited community trust or participation (n=36) were also frequently identified challenges. This suggests even well-resourced engagement efforts encounter obstacles related to access, historical trauma, and relational barriers with marginalized communities. Twenty-three organizations selected “other.”

Limitations

As with all community-based assessments, these findings should be interpreted within the context of methodological limitations. Participation in the CPA was voluntary, which introduced potential self-selection bias. Organizations with existing capacity for external engagement, established relationships with public health entities, or particular interest in collaborative health planning may be overrepresented. Conversely, smaller grassroots organizations with limited capacity may be underrepresented. The two-month survey administration window, while designed to balance thoroughness with efficiency, may have constrained participation among organizations operating with limited staff capacity to respond to external requests.



Additionally, the predefined response categories, while informed by public health frameworks and community input, may not fully capture the range and nuance of organizational activities, assets, or challenges present within Pierce County's health ecosystem. The reliance on organizational self-report introduces potential for social desirability bias, particularly regarding equity-related practices and community engagement approaches. Geographic representation across Pierce County's diverse communities—from urban Tacoma to rural areas—may vary within the sample, potentially affecting the comprehensiveness of identified service gaps and priorities.

A final limitation relates to efforts to balance the influence of large organizational partners with varied interests and levels of investments. To address this, we sampled multiple representatives from larger organizations like Virginia Mason Franciscan Health, City of Tacoma, Pierce County Library System, and Pierce County Human Services for a more comprehensive range of perspectives within them.

Despite these limitations, there are also several methodological strengths that enhance the credibility and utility of the findings. For instance, the mixed methods approach combined quantitative survey data with open-text qualitative data for elaboration and further context. Inclusive recruitment strategies spanning multiple sectors and organizational types captured a range of perspectives. The findings were validated through partner review processes, ensuring interpretations align with the lived experience and knowledge of community-based practitioners.

Conclusion

The CPA findings illustrate patterns that have direct implications for strengthening Pierce County's capacity for equity-centered health improvement. The results reveal strategic assets to leverage and systemic gaps requiring coordinated attention. The ultimate goal of the CPA is to better understand the community partners the Health Department can engage with to move toward community health improvement. As one survey respondent shared:

"If we want to build a stronger public health system, we need to see where partnerships exist and where they don't."

Because the CPA was designed to understand how community partners contribute to public health systems, we expected to see strong alignment with EPHS related to partnership building and community engagement. The finding that 93 representatives identified "strengthen community partnerships" as a current contribution to EPHS, and that 88 reported partnering with community leaders to support inclusive decision-making, confirms this expectation. It also represents a significant asset for community health improvement and provides a foundation upon which we can build equity-focused interventions.

At the same time, the findings highlight persistent challenges in community engagement that are not primarily attributable to individual organizational capacity. Instead, they reflect structural



barriers embedded within systems, policies, and resource distribution patterns. Insufficient funding for engagement may reflect long-standing underinvestment in participatory approaches led by community organizations. Difficulty reaching specific populations may stem from transportation infrastructure inequities, digital access barriers, and service distribution patterns that systematically exclude rural and economically marginalized communities.

This section marks the last of the three assessments within the 2025 CHA and provides a foundation for developing the CHIP. The CPA rounds out the CHA by identifying cross-cutting themes that reflect shared community health priorities. We developed these priority issues through a prioritization analysis, using quantitative evidence to identify urgent health challenges and guide the selection of indicators to monitor progress toward shared community health improvement goals. In this way, the CHA moves from listening to learning to action, ensuring community voices inform the strategies shaping Pierce County's path toward equity and well-being.



Health inequities and disparities

The CHA identified significant health inequities and disparities across Pierce County communities. The assessment integrated residents' lived experiences with quantitative health indicators to provide a comprehensive understanding of community-identified strengths, needs, and priorities. Multiple data sources informed the identification and assessment of inequities, including trend analysis, health outcome measures, and disparity data.

Health inequity indicators

The indicators below demonstrate the greatest disparities and inequities using the methodology and scoring rubric detailed in the following "Identification of inequities and disparities" section.

Adult health outcomes

- Adult obesity.
- Asthma-related emergency department visits.
- Depression.
- Life expectancy.
- Poisoning deaths.
- STIs.
- Unintentional deaths (drug overdose).
- Years of life lost.

Social determinants of health

- Cigarette use.
- Discrimination
- Homelessness

Child and youth health

- Alcohol, marijuana, painkillers, or other illicit drug use.
- Anxiety.
- Depression.
- Inadequate prenatal care.
- Infant mortality.
- Low birth weight.



Identification of inequities and disparities

We developed a standardized scoring rubric to identify indicators and topics demonstrating inequities and disparities in Pierce County.⁶⁷ For indicators coming from datasets that maintained the same methodology throughout the COVID-19 pandemic, we used three criteria. We scored each indicator using these weighted criteria, resulting in a possible score range of 0 to 4:

- Performance worse than Washington average (1 point).
- Evidence of worsening trend over time (1 point).
- Presence of equity gap by race/ethnicity or sex (2 points).

Some datasets experienced methodological or guideline changes during the COVID-19 pandemic, making trend analyses or certain comparisons inadvisable. These included:

- All indicators from the HYS (methodology change).
- Colorectal cancer screening (change in recommendations).
- Discrimination (no historic data available).
- Homelessness (using a data source without explicit comparison to Washington data).
- Childcare and housing cost data (no explicit comparison to Washington data).
- Household vehicle access (no race or sex data available).
- Hospitalizations (change in data availability).

For these indicators, we used only the applicable criteria when scoring.

We then calculated average scores for each indicator. Scores ranged from 0 to 1.33 and were ranked in descending order. Indicators with average scores of 1.0 or higher were considered to demonstrate substantial inequities and disparities. See appendix K for a complete list of indicators and their scores.

Several limitations should be considered when interpreting these findings:

- Indicator selection—The inclusion and exclusion of specific indicators may influence which issues emerge as top disparities.
- Multiple associations—Many indicators are associated with more than one health domain. For example, obesity is linked to chronic disease and has a behavioral health component. For the purposes of this analysis, only primary associations were considered.

As a result, the identified inequities may not fully capture the breadth and complexity of community health needs.

⁶⁷ Note that this methodology is similar—but not identical—to the methods used in the 2022 and 2025 Pierce County Community Health Needs Assessments.



The 2025 CHA reflects the wisdom, experiences, and main concerns of Pierce County residents and the organizations that serve them. Community members consistently emphasized the need to:

- Invest in community-based organizations that address local needs.
- Strengthen cross-sector partnerships to reduce fragmentation and improve coordination.
- Remove policy and systems barriers that perpetuate disparities.
- Ensure people and communities most affected by inequities are meaningfully involved in decisions that affect their lives.

This assessment is not an endpoint. It is a call to action grounded in community voice and empirical evidence. It offers a snapshot of community strengths, challenges, partnerships, and opportunities for improvement. Most importantly, it reinforces that data alone is not enough. Data must inform action and meaningful action requires sustained investment in the people, organizations, and communities who are working to advance health and equity every day.

Alignment with the Health Department's 2025–2029 Strategic Plan

The findings of the CHA provide a strong foundation for implementing the Health Department's 2025–2029 Strategic Plan. Community-identified needs align closely with strategic priorities across multiple focus areas.

For example, in the area equity and community engagement, 90% of partner organizations report using feedback mechanisms to inform their work. Transportation and digital access barriers documented in the assessment echo county priorities around safe routes, broadband access, and mobility solutions. Housing affordability and behavioral health surfaced as critical community concerns, underscoring the importance of county efforts to expand affordable housing and strengthen behavioral health infrastructure.

These findings highlight both the complexity of health inequities in Pierce County and the opportunities for collective action. By aligning community perspectives with strategic priorities, the 2025 CHA provides a clear foundation for collaborative planning and implementation. The next phase of this work will focus on translating these findings into actionable strategies and shared commitments through the CHIP.

Looking ahead

The next phase of this work is the development of the CHIP. The CHIP serves as Pierce County's roadmap for coordinated action to improve community health and advance equity. It identifies a focused set of priority health issues, outlines evidence-informed strategies, and establishes shared accountability for progress. While the Health Department will facilitate the planning process and



use the CHIP to guide departmental priorities, the intent is for community partners, government agencies, healthcare organizations, and residents across Pierce County to use the CHIP as a shared framework for alignment, collaboration, and action. The CHIP supports goal setting, informs grant planning, and helps partners coordinate efforts to improve health outcomes across the county.

The CHA directly informs the CHIP by identifying the conditions, disparities, and structural factors that most significantly influence health in Pierce County. The assessment highlights where needs are greatest, where inequities persist, and where collective action has the greatest potential to create meaningful change. These findings provide the evidence base for establishing CHIP priorities, developing strategies, and strengthening cross-sector collaboration.

Community partners and residents will remain central to the CHIP development process. Their perspectives and lived experiences help ensure that priorities and strategies reflect community needs and assets. Ongoing engagement also strengthens the feasibility, cultural relevance, and responsiveness of proposed actions, ensuring that improvement efforts are grounded in the realities of Pierce County communities.

By moving from assessment to action, Pierce County has an opportunity to strengthen partnerships, address structural inequities, and create the conditions necessary for all people and communities to thrive. We invite continued partnership, reflection, and engagement throughout this process. To collaborate, share insights, or learn more about the CHA and CHIP process, see tpchd.org/data.

Together, we can protect and improve the health of all people and places in Pierce County.



Appendices

The appendices provide supporting materials and technical details that complement the main body of the CHA. These materials are intended to increase transparency, document methods, and provide additional depth for readers who want to explore the data and process more fully.

Appendices include:

- Qualitative coding frameworks and thematic summaries that informed the CCA.
- Facilitation guides for focus groups, interviews, and youth-art submission outreach materials.
- CSA data sources and technical notes.
- CPA survey instrument and participating organizations.
- Facilitation guide for the CPA data walk to support ongoing community validation of findings.
- Partner-identified recommendations and other supplemental content that emerged through engagement activities.
- Acronym definitions and glossary of terms to support clarity and accessibility.

These resources provide additional context for the findings and ensure the CHA process remains rigorous, transparent, and accessible to both technical and community audiences.



Appendix A: Reports included in the systematic review of existing qualitative data

Review phase	Report title	Author organization(s)	Report date
I	CoF Report	Health Department	2022
I	Pierce County CHA	Health Department	2019
I	Pierce County CHIP	Health Department	2020
I	Pierce County CHNA	– Health Department – Virginia Mason Franciscan Health – MultiCare	2022
I	Pierce County COVID-19 Health Equity Assessment	Health Department	2019
I	Policies to Advance Health Equity	– Health Department – University of Washington Department of Psychiatry and Behavioral Sciences	2020
I	Resilient Pierce County Culminating Report	United Way of Pierce County	2020
I	Tacoma Metropolitan Development Council Community Needs Assessment	– Metropolitan Development Council – Pierce County Human Services	2024
I	Youth Focus Groups	Health Department	2020
II	Baby Lounge Post Survey	Health Department	2022–2024
II	City of Tacoma Climate Action Plan 2030	City of Tacoma	2021
II	Disrupting and Healing Trauma Associated with Youth Violence: Root Causes, Service Gaps, and Proven Strategies	Peace Point	2023
II	Family Connects Outcomes	Health Department	2024
II	Family Outcomes Data	Health Department	2024
II	Metro Parks Tacoma Comprehensive Program Plan: Community Input	Metro Parks Tacoma	2019
II	South Sound Housing Affordability Partners Middle Housing Grant Deliverables	South Sound Housing Affordability Partners	2023
II	Springbrook Food Access Survey	Health Department	2024
II	State of Play Tacoma	– Metro Parks Tacoma – Aspen Institute	2024
II	Tacoma Public Libraries Eastside and Hilltop Libraries Feasibility Study	City of Tacoma	2022
II	Your Voice, Your Power	Health Department	2023
II	Youth Focus Groups	Health Department	2019



Appendix B: Community Context Assessment methodological questions

Systematic review of existing qualitative data questions

- What are the health priorities for Pierce County communities as shared in assessments 2020–2024?
- What strengths and assets have been identified in Pierce County communities in assessments 2020–2024?
- What gaps in services, resources, and opportunities were identified by Pierce County communities in assessments 2020–2024?

Focus group and interview questions

- What factors in your community help promote good health?
 - What about physical buildings and public spaces available in your community?
- What is the community doing to improve health outcomes?
 - What solutions have the community identified to improve community health?
- What barriers keep you from being healthy?
- What has occurred recently that might affect your community, what might occur in the future?
 - What forces are occurring locally, regionally, nationally, globally?



Appendix C: Oasis Youth Center creative arts project information form

Participant Information Form

Creative arts partnership with Oasis Youth Center



Tacoma-Pierce County Health Department has partnered with Oasis Youth Center to collect photos, art, and creative writing that reflects on questions about community health. We seek the perspectives of young people who identify as LGBTQIA+, as they often experience higher rates of negative mental health outcomes compared to their straight and/or cis-gender peers. Their input is crucial to help inform public health programs and services.

Participation is voluntary

You can contact us at any point to cancel your submission. All responses are confidential unless you choose to include your name in your artwork or writing. Participation will not affect any service or benefits children or their families receive from the Health Department. If you're under 13 years old, you need a parent or guardian's signature to participate. If you're 14 or older and you don't have a guardian present, you may sign for yourself.

Why we want your creative work

We are conducting a Community Health Needs Assessment. We do this every 3 years in partnership with Virginia Mason Franciscan Health, MultiCare Health Systems, and community-based organizations. The report helps guide public health and hospital systems to better understand the health needs and priorities of community. It helps us identify community resources and strengths that can help support planning and services.

Creative writing, photos, and artwork offer a powerful way to express health needs, strengths, and assets. The report we share with our hospital partners must reflect the community's needs in ways that are meaningful and supportive to those involved.

Your submission should help answer:

- In your community, what supports your health and wellness?
- What makes it hard for you to be healthy?

After you submit your creative work

We will review your submission and will feature some creative works in the report we share with hospital partners and on our website. If we select your submission, we'll contact you to review and approve the final draft. You may choose to remain anonymous or have your name displayed in the report.

Possible risks or discomforts

While we will not ask about specific health-related questions, you are welcome to creatively express or share health concerns that may bring up strong feelings for you. Below, we've provided links to support health services and people you can reach out to if you need to talk to a trusted peer or adult during this project. Your well-being is important to us, and we want to ensure you have the support you need.

- [Trever Project](#)—Info and support for LGBTQIA+ people any hour of any day. Call (866) 488-7386 or text START to 678678.
- [Pierce County Crisis Connections](#)—24-hour crisis line. Confidential support for mental health, domestic violence, grief, recovery, etc. Call (800) 576-7764.
- [Suicide & Crisis Lifeline](#)—Help for people in a suicidal crisis or emotional distress. Call 988 or text 741741.
- [TeenLink](#)—A helpline for teens, by teens. Talk with teen volunteers trained to talk about any issue, 6–10 p.m. (866) 833-6546
- [Tacoma Needle Exchange](#)—Get harm reduction and overdose prevention supplies like Naloxone.



Participant Information Form

Creative arts partnership with Oasis Youth Center



Compensation

We will give **\$100 Amazon gift cards to the first 10 creative arts or writing submissions** we receive by **Jan. 20, 2025**. To be eligible, your submission must address the questions in the submission form and include all required info, including contact details. We will use your contact info solely to communicate about your gift card and let you know if we select your submission to be featured in our report.

Even if your submission is not among the first 10, we may still choose to include it in our report. In that case, you would also receive a \$100 gift card.

Questions or comments?

Contact Leah Fors (she/her) at lford@tpchd.org or (253) 722-3506.

This section is required only if you are under 13 years of age. If you are 13 or older, your parent or guardian doesn't need to sign but please give this info to them.

Printed name of minor _____

Consent

By signing below, I voluntarily consent for my child (under 13) to take part in this program. I understand they will be submitting creative writing, art, or photos in response to questions for a Community Health Needs Assessment that, if selected, may be included in a public report. I understand my child can withdraw their submission ant time, without penalty. I have had a chance to ask questions.

Parent signature

Date

Adolescent signature of assent

Date

Signature of person conducting assent discussion

Date



Appendix D: Creative arts submissions from Oasis Youth Center

Reflection questions

- What in your community supports your health and wellness?
- What makes it hard for you to be healthy?



Selected creative arts submissions

“Space Oil” by Sprout Armstrong





“is Ze real” by Moxie K.

Artist’s description: *the barriers to getting my identity recognized and my hidden disabilities.*

yes ze at least zey thinks ze are but are zey
the world says no ze should not exists but ze does should ze stay or should ze go what if zey
where a mask then ze will exist right the little bird on the branch said to ze to the world you will
only exist to blame but you can exist with us said a voice from a place called the trash

we are all not supposed to be gay said im gay i like men and i am a boy

hi ze i am trans fem and trans masc is my twin we are both not who our anatomy says we are

the bird said everyone in the trash outside of the box is alive but not in the box we are all
together and if you want you can stay ze

ze said i am ze not she or he just ze and that’s all right



“Friendship mummy” by Kel Welsheimer

Artist’s description: A mummy with googly eyes reciting a poem about their support from friends.





“M dawg in the tunnel” by Billy M.

Artist’s description: A painting of my friend in a tunnel that’s in one of the beautiful forests in the pacific northwest.





“You are not alone” by Monty Goff





“Never enough time” by Ray Fitzpatrick

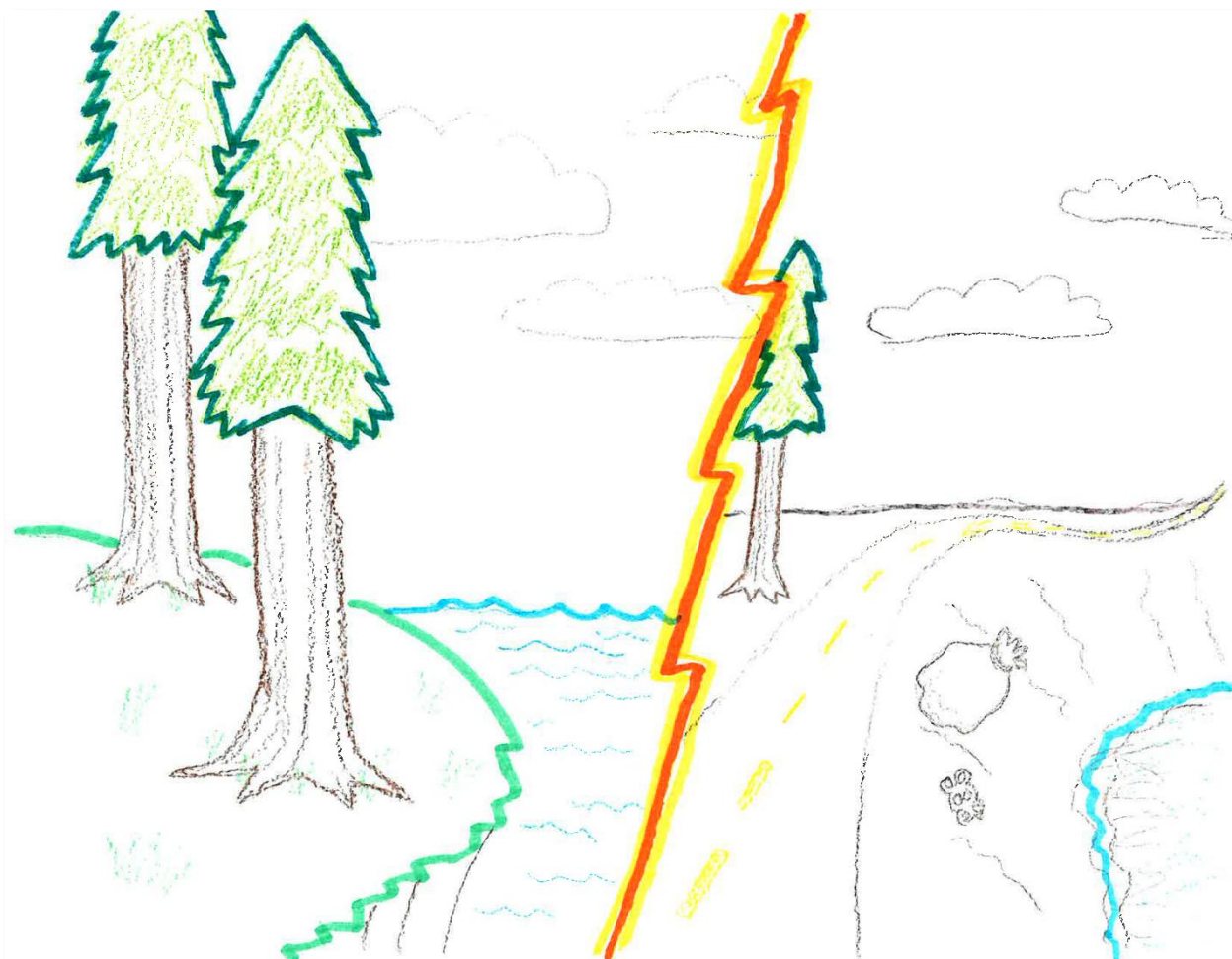
Artist’s description: This piece is about the difficulties of managing your time and how that can be a barrier for taking care of your own health and wellness, when there’s so much to do, work, school, college, socio personal relationships, self-care often comes last.





“Our outdoors” by Tommy Griffith

Artist’s description: *The benefits of walking outside yet the harm of pollution.*





Appendix E: Art-based inquiry analysis methods

Art was sorted and reviewed by medium. Health Department Assessment, Evaluation, and Epidemiology (AEE) analysts and an Oasis Youth Center staff member completed a selection analysis of submission forms to determine eligibility and number of works per medium. All entries were accepted for qualitative analysis. The following table describes the forms of analysis that were included. All analysts used a deductive approach and codebook consistent with focus groups and key informant interviews.

Analysis type	Description
Symbolic	To reduce potential bias, three Health Department analysts and an Oasis Youth Center staff member reviewed visual art works without knowing titles. Analysts coded art by hand individually. The group then collectively reviewed each other’s codes, rationales, and observations while looking at each of the works. One analyst coded the narrative submissions and artist descriptions using ATLAS.ti. ⁶⁸
Form	Analyzed artworks (visual and narrative) as a group through a visual review of how the shapes, forms, composition, and color contribute to overall meaning.
Content	Analyzed artworks and descriptions separately from one another.
Cross-sectional	Reviewed all aspects of the artworks and previous analysis.

⁶⁸ ATLAS.ti Web. (2025). *ATLAS.ti Web* [computer software]. ATLAS.ti Scientific Software Development GmbH.



Appendix F: Codebook for systematic review of existing qualitative data

Codes were generated from existing internal Health Department assessments of common qualitative data themes 2018–2022 and applied to text using a deductive qualitative analysis approach.

Code	Definition	Example(s)	Rationale
Social connections (strength/asset or need)	A sense of belonging to others and to a neighborhood or community. Social connections can give you a support system and a sense of belonging and improve your: • Mental health. • Physical health. • Longevity. • Community’s ability to recover after emergencies.	Need: “As an older family member, I haven’t been able to see my grandkids and it hurts.” –COVID-19 listening session participant Strength/asset: “This is the heart of the community. I don’t even know how else to describe it. It’s the heart like you pass by, people wave at you, people speak to you. My kids love it here.” –Stafford Elementary School parent	The person is/is not feeling a sense of belonging with family and it’s affecting their mental health positively/negatively.
Healthy food affordability and accessibility (strength/asset or need)	Food affordability describes whether people can buy healthy food without straining their income. Food accessibility refers to people’s ability to easily access healthy food options. Lack of healthy food is related to numerous chronic diseases.	“Turn empty lots, closed parks, broken pools into community gardens, gathering places, places to learn and share stories. There is a (natural) place behind a bar where I go to feel calm and peace.” –Lincoln High School student	The person is suggesting a community garden as a food source need as well as a strength/asset where they go to feel better.



Code	Definition	Example(s)	Rationale
Transportation (strength/asset or need)	Accessing basic health needs and services can be challenging without good transportation. Community feedback around transportation improvements or “ways to get around” cover a variety of topics including physical road improvements (fix potholes, road repairs) to more accessible public transportation. Bringing services to those who are home-bound or unhoused has also been a common theme. Policy research/evidence shows transportation can be made more accessible by eliminating public transit costs. Free transportation for riders improves student attendance, reduces contact with the juvenile justice system by reducing citations for bus fare evasions, and improves air quality.	Buses that meet people where they live, learn, work, and shop. “Late bus for after-school activities.”	The student is sharing how buses are important for them to access after-school activities, which supports their health and wellbeing.
Housing affordability and accessibility (strength/asset or need)	Housing affordability and accessibility is the ability to comfortably pay for housing with your existing income. Community members shared the need for safe, reliable and affordable housing. Specifically, there is a need for low-income housing and support for those who have become displaced or homeless because of gentrification or economic hardship.	“Concerned about housing. Still don’t know what’s going to happen. I’ve been able to pay my rent, but I’m concerned. As the (eviction) moratorium expires. Not sure what that looks like.” –COVID-19 listening session participant	The person is referencing an eviction policy that could positively or negatively affect their ability to keep secure housing, due to financial instability from COVID-19.



Code	Definition	Example(s)	Rationale
Safety (strength/asset or need)	In community health, "safety" refers to the state where a community is protected from physical, psychological, and environmental hazards, allowing people to live without fear of harm or injury. It includes access to necessary resources and services to maintain well-being, encompassing aspects like crime prevention, access to quality healthcare, and a supportive social environment. People feel secure in their daily lives and have the ability to thrive.	"The cops never came (we need improved police presence)." –<i>Stafford Elementary School parent</i> "There are A LOT of kids in our district, but so much fast traffic. I'm afraid someone is going to get hurt. We need more crosswalks and streetlights." –<i>Gray Middle School student</i>	Both people are afraid of being harmed and/or unprotected from physical, psychological and environmental hazards, in the forms of firearm violence and traffic.
Youth activities (strength/asset or need)	Describes the community's desire to create more activities and programs that support youth development inside and outside school. Examples include organized youth sports, meditation, computer animation programs, psychological support, cultural & community events, and more libraries and parks within walking distance.	"There should be a place for kids to do other activities like building robots/STEM." –<i>Stafford listening session participant</i> "I saw... a small open space, and the community, they gathered people to help build the park together. There were construction people there too, but the community built it." –<i>Youth health equity project listening session participant</i>	These emphasize a need for a physical space to host STEM activities for kids and reference a strength/asset in a youth-led community construction project to support outdoor space in which young people can play and thrive.
Access to community resources (strength/asset or need)	Access to community resources is vital for community members and their health. Resources can cover things like information, services, activities, and parks. It can also describe the dynamic or unique physical setting of the neighborhood or community.	"Easy access to resources that promote an active lifestyle—parks, trails and local gyms." –<i>2018 Community Health Needs Assessment</i>	This person is sharing how easy access to parks, trails, and local gyms supports physical activity.



Code	Definition	Example(s)	Rationale
Celebrate diversity (strength/asset or need)	Describes an environment where ethnic and cultural diversity is valued. All people are accepted and feel a sense of belonging, and everyone is respected for the value they bring.	“It’s not necessary to leave the community to celebrate my ethnic background.” –2019 CHA Community Workshop participant “We have become more accepting of ethnicity and gender than we used to be.” –2019 CHA community workshop participant	These people are sharing strength in feeling a sense of belonging in their local community, and the community is showing respect and acceptance of different ethnic and gender identities.
Education access (strength/asset or need)	Describes the ability of schools to ensure high quality education and advancement for all students. Strategies include high school completion programs and ending zero tolerance school discipline policies.		
Early child development (strength/asset or need)	Policies support the social, cognitive, emotional, and physical development of children from birth to age 3. Strategies include supporting the sustainability of high-quality childcare and education programs.		
Healthy community planning and built environment (strength/asset or need)	Refers to community-led neighborhood planning processes focused on human-created surroundings. Strategies include green spaces, accessible food, and accessible transportation options.		
Access to healthcare (physical and behavioral) (strength/asset or need)	A community’s ability to easily obtain medical and health services. Strategies include restructuring healthcare to increase access as well as improving social, economic, and environmental conditions of health (housing, employment).	Distrust in providers persists due to racism and trauma historically pervasive within the healthcare system. Providers should concentrate on trust-building and the provision of culturally grounded information.	This presents trust as a barrier to accessing healthcare, due to historic exclusion or marginalization within health systems.



Code	Definition	Example(s)	Rationale
Youth behavioral health (strength/asset or need)	Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral healthcare refers to the prevention, diagnosis and treatment of those conditions.	"(Concerns about the) impact of technology on children's mental health with the increases of technology, children experience issues like social isolation, sleep problems and screen addiction."	Parents are expressing a concern/need regarding their kids' mental health and the potential negative effect of tech/screen addiction.
COVID-19-specific care (strength/asset or need)	Refers to policies that decrease or eliminate the inequitable economic and health impacts of COVID-19 among race/ethnicity groups.	Strengthen existing healthcare systems and COVID-19 vaccine access. Support flexible workplace strategies. Encouraging or requiring local businesses to allow frontline workers to stay at home with pay or with more flexible work hours will minimize the disproportionate exposure to the virus.	These examples reference policies or systems to support people most at risk of experiencing negative health and economic impacts of COVID-19.
Economic stability (strength/asset or need)	Refers to having enough financial resources to afford basic needs. Strategies include employment resources and direct financial assistance.		
Culturally grounded information (strength/asset or need)	Centers the individual's cultural practices, values, and experiences. Within public health and healthcare systems, a lack of culturally grounded information perpetuates distrust and inaccessibility.	"I haven't heard anything specific saying, 'Hey, we realize that like historically medicine impacts you (people of color) differently.' I wish they would be more bold in saying that, because I'm not really trusting the procedures."	Highlights how receiving information acknowledging their experience of historical medical violence would affect their level of trust in public health and healthcare systems.



Code	Definition	Example(s)	Rationale
Environmental health/ climate change (strength/asset or need)	Clean air, stable climate, adequate water, sanitation and hygiene, safe use of chemicals, protection from radiation, healthy and safe workplaces, sound agricultural practices, health-supportive cities, and preserved nature are all prerequisites for good health. “Climate” includes climate-change impacts, climate-related stress, and attempts to address climate change (e.g., recycling or low-emission transportation). “Environment” includes ecology conservation and access to ecology education, green spaces, and environments that connect people to the land, waterways, and ecosystems. It also includes diverse historic and cultural definitions of environments, ecosystems, etc. “Environmental justice” includes addressing policies, procedures and resources that address environment-related health equity and effects of inequitable effects of structural racism. This includes recognizing and respecting Native land sovereignty, stewardship, and leadership/power sharing. In these scenarios, structural racism and other health priorities would be included.	“Lack of public transit options in many places. Increased commute times contributes to CO₂ [carbon dioxide] emissions.” “Reducing greenhouse gas emissions by, for example, electrifying transportation, also reduces pollutants like particulate matter and ozone, which disproportionately affect the health of low-income residents and BIPOC communities who often live closer to major roads.”	Environmental health factors have an impact on communities and people. A safer environment leads to better health outcomes.
Civic engagement (strength/asset or need)	Participating in activities that improve one's community or address wider social issues.	When asked what motivated them to participate in the participatory budgeting process, advisory group members named a range of benefits on both the individual and collective level. The most common motivator was the opportunity to empower their own community through arts and cultural events.	Community members participating in the community builds strength and expands assets throughout the community, providing mutual aid and peer-to-peer support.



Code	Definition	Example(s)	Rationale
Structural racism	Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values and distribution of resources.⁶⁹ The domains of racism are: • Land theft. • Inequitable educational funding and spending. • Voter suppression and disenfranchisement. • Gentrification and displacement. • Housing discrimination and disinvestment. • Low wage jobs. • Inequitable distribution of environmental pollutants. • Exclusion from labor unions. • Employment and wage discrimination. • Inequitable immigration policies. • Direct exclusion from government and social programs. • Mass incarceration and chattel slavery. • Food apartheid. • Racial segregation (residential, educational, occupational, etc.).	“Few people know that medical experimentation took place in the Marshall Islands. No one would expect people who were part of these experiments to have faith in medical providers after this.” “...Since the inception of the 1st Treaty Council, the Medicine Creek Treaty Tribes honorably agreed to the terms... with the understanding that we as first peoples of these lands would continue to have access to our subsistence and ceremonial plants, fish, and animals. To this day, the City of Tacoma continues to dishonor the Medicine Creek Treaty Tribes and Puyallup Tribes sovereignty every time it makes decisions that harm the social-ecological systems within the ceded areas of the Medicine Creek Treaty...”	The first example shows how systemic and individual racism created a barrier to accessing health education, prevention and interventions that supports health and wellbeing. The participant has also self-identified structural racism as a primary cause for poor health for themselves and their community. The second example also demonstrates the intersectionality of impacts from structural racism. Assets would include changes in policies and practices such as renegotiated treaties, institutional or individual cultural norms such as successful community engagement practices or increased hires of BIPOC providers, and BIPOC-defined self-protections such as cultural practices, social connections, relevant programming, civic engagement, etc.

⁶⁹ Bailey Z. D., Krieger, N., Agénor, M., Graves J., Linos, N. & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, 389(10077), 1453–1463.



Code	Definition	Example(s)	Rationale
Legislative environment	Legislative environment refers to the current context of laws, policies, and regulations at the local, state, and federal levels. It also includes how community members experience and perceive these conditions. For example, whether they feel stability or uncertainty, and whether the impacts on health and wellbeing are seen as positive or negative. This keeps the dual emphasis on the systems that shape health and the lived experiences shared in our focus groups.		



Appendix G: Community Status Assessment quantitative data sources and technical notes

This report's quantitative analysis incorporated data from a variety of sources, including those that provide aggregate results for specific populations and those offering raw data. This allowed us to generate our own estimates.

American Community Survey (ACS)

This mailed survey serves as an annual supplement to the ten-year U.S. Census. ACS data determines residence based on census tracts, which are then converted into zip code tabulation areas (ZCTAs) for analysis.

Behavioral Risk Factor Surveillance System (BRFSS)

This is the world's largest continuously conducted telephone health survey, gathering extensive data on health conditions, behaviors, and risk and protective factors among adults. In 2011, a new data-weighting methodology was introduced. It made pre-2011 data unreliable for direct comparison with new data.

Comprehensive Hospitalization Abstract Reporting System (CHARS)

Hospital discharge data includes detailed records of inpatient and observation patient stays, providing valuable insights into hospital utilization, diagnoses, procedures, and patient outcomes.

Community Health Assessment Tool (CHAT)

This web application allows authorized users to generate estimates for various geographies based on different data sources. It consolidates data from a range of sources to provide estimates at the zip code, county, and state levels.

Washington State Department of Social and Human Services

Foster care placement services, foster care support services, and Child Protective Services (CPS) aggregate estimates at the county and school district levels. The detailed, location-specific data is accessible through Washington State Department of Social and Human Services' online reporting system.



Healthy Youth Survey (HYS)

This school-based survey is conducted biennially statewide for public school students in 6th, 8th, 10th, and 12th grades. This report focuses on data for 10th graders. Maternal education level serves as a proxy for SES. Low SES was defined as having a mother with a high school diploma/GED or lower. High SES was having a mother who had at least some college or technical training after high school.

Office of the Superintendent of Public Instruction (OSPI)

Washington OSPI offers data on graduation rates and free or reduced-price meal eligibility through the Comprehensive Education Data and Research System (CEDARS). This online system captures information about student graduation, transfers, and drop-outs. The adjusted cohort method tracks a single group of students over four years, starting from their first year in 9th grade. The cohort is adjusted by adding students who transfer into the school and subtracting those who transfer out.

Social Vulnerability Index (SVI)

CDC initially developed the SVI to help emergency responders prioritize communities for hazard preparedness and response. It uses 15 census-tract-level variables to assess and rank communities across:

- SES.
- Household composition and disability.
- Minority status and language.
- Housing type and transportation.

These variables are then combined into a single overall score. A lower SVI score corresponds to greater resiliency in a community. For this report, we grouped SVI scores into these categories:

- Highly resilient: 0.0–5.9.
- Somewhat resilient: 6.0–7.6.
- Somewhat vulnerable: 7.7–9.3.
- Highly vulnerable: 9.4 or greater.

Birth certificate data

The birth certificate system in Washington includes records for all births occurring within the state and nearly all births to state residents. Information is collected about the mother, father, pregnancy, and child through forms completed by parents or medical staff, as well as from reviews of medical charts. In cases where midwives or family members deliver the baby, they are responsible for



completing the birth certificate and gathering the necessary information from the parent or their records. DOH's CHS compiles this data.

United States Department of Transportation Equitable Transportation Community Explorer

This web application uses 2020 census tracts and data to highlight how the combined cost of transportation disproportionately impacts some communities. It calculates a percentage based on the sum of a household's costs for vehicles (including purchasing and upkeep), travel time, and transit costs, divided by the average household income in that census tract. We accessed the data through the U.S. Department of Transportation Insecurity Analysis Tool.

Washington State Cancer Registry (WSCR)

WSCR tracks cancer incidence in the state to enhance understanding and control and reduce cancer occurrence. We obtained estimates derived from this data through DOH's CHAT.

Washington State Immunization Information System

Washington State Immunization Information System (WSIIS) is a lifetime registry that maintains immunization records for people of all ages. We gathered estimates from WSIIS, with specific immunization reports focusing on children 19–35 months old.

Washington Tracking Network

Washington Tracking Network (WTN) is a comprehensive collection of environmental public health data. It aggregates estimates from various data sources, providing a centralized location for accessing measures that impact environmental public health.

Quantitative Methods

Estimates are generated for both Washington and Pierce County. In most instances, we used Statistical Software Suite (SAS) 9.4 software data analysis. However, in some cases, estimates are sourced externally. We also produced subpopulation estimates and included maps when relevant. For clarity, here's how we defined some important terms.

Rates

A standardized proportion (or ratio) expressed as the number of events (e.g., live births) that occurred with respect to a standard population within a defined time period (usually one year). Rates help compare disease risk between groups while controlling differences in population size. The size of the standard population used can vary depending on whether the events are common or



rare. For example, since HIV is rare in Washington, HIV incidence rates are expressed as new cases per 100,000. Crude rates are calculated for a total population, while age-specific rates are calculated for specific age groups.

Age adjustment

All age-adjusted mortality and disease rates in this report are standardized to the United States population in 2000. 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 death and disease rates. To control for differences in the age compositions of the communities being compared, death and certain disease rates are age-adjusted. This helps us compare populations.

Averages

We used multiyear average estimates to increase sample sizes and minimize widely fluctuating frequencies from year to year.

Confidence intervals

We calculated county comparisons to Washington and comparisons among subpopulations 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. Confidence intervals help determine if differences among groups are statistically significant. If the confidence intervals of two different estimates do not overlap, we most often can conclude that the difference is statistically significant and not due to chance.

Standard error

Standard errors are used to determine significance between groups in the analysis. Unless noted, these are based on 95% confidence intervals, or an alpha of 0.05. Relative standard error (RSE) is used to determine what statistics are reported. If the RSE is greater than 30% and/or the sample size is too limited to have confidence in these estimates, then we excluded them. If the RSE is greater than 30%, but the estimates may still be reliable, then we marked them with “!” to draw attention to this concern.

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 or gender. We used the following terms to describe race/ethnicity:

- White (non-Hispanic).
- Black (non-Hispanic).



- Hispanic (Hispanic as race).
- Asian (non-Hispanic).
- American Indian/Alaska Native (AI/AN) (non-Hispanic).
- Native Hawaiian/Pacific Islander (NH/PI) (non-Hispanic).
- Multiracial (more than one race).

For some indicators, these stratification levels may not have a sample size adequate to draw reliable conclusions about that population, so we left them out. Groups are typically not combined due to concerns about over-generalizations made based on those results.



Appendix H: Community Partner Assessment methods

This appendix describes the full methodology we used for the CPA. It includes survey design, recruitment, key informant interviews, partner mapping, and data analysis. The CPA employed a mixed-methods design that combined document review, interviews, surveys, and a participatory mapping activity.

Document review

Staff reviewed internal records, partnership maps, and engagement logs to validate existing relationships and identify underrepresented or disconnected organizations. We incorporated notes from 2025 key informant interviews where relevant. We used lessons learned from the previous CHA process, including feedback on past surveys and interviews, to refine methods and strengthen inclusivity. These steps ensured the CPA design was community-informed, accessible, and equity-grounded.

Key informant interviews

We conducted 30-minute semi-structured interviews with representatives from healthcare, education, housing, grassroots, cultural, and faith-based organizations. These conversations provided insights into partnership experiences, perceived barriers, and recommendations for strengthening equity-focused work. For accessibility, some participants chose to complete the interview questions in survey format. These responses followed the same structure and were integrated into the dataset. Interviews were conducted during the same data collection window as the survey (Feb. 1–March 31, 2025).

Participant selection and recruitment

Recruitment prioritized organizations serving communities experiencing disproportionate health outcomes and systemic barriers, based on local quantitative data and CHA/CHNA findings. We engaged partners through word of mouth at community events and public meetings, targeted outreach to organizations serving CoF zip codes, and direct contact with grassroots leaders, coalition partners, and agencies.

Survey instrument

103 representatives from 83 organizations completed the CPA survey. The instrument included Likert-scale, multiple-choice, and open-ended questions, organized into 3 sections:



- Organization descriptors.
- Organizational engagement efforts.
- Organizational insights.

To reduce barriers, some participants completed the survey through one-on-one interviews using the same question set.

Limitations

As with all community-based research, you should interpret findings with attention to limitations. Participation was voluntary, introducing potential self-selection bias. Smaller organizations and those with limited capacity may be underrepresented. The survey window was two months, which may have constrained participation for some partners. Despite these limitations, the mixed-methods approach, inclusive recruitment, and partner validation strategies strengthen the credibility and relevance of the findings.

Survey participant recruitment

Participation in the CPA survey was voluntary, with respondents self-selecting from within recruited organizations. This approach was designed to reduce barriers to entry and encourage broad-based input from organizations embedded in and accountable to the communities they serve.

We shared invitations through multiple channels including email, virtual meetings, and personalized outreach by Health Department staff. Recruitment was informed by a stakeholder mapping exercise conducted early in the MAPP 2.0 planning phase, which helped identify a diverse range of partner organizations.

The structured mixed-methods survey was fielded Feb. 1–March 31, 2025. It included Likert-scale, multiple-choice, and open-ended questions to capture both baseline measures and richer contextual insights. To enhance clarity and reduce respondent burden, the instrument adapted the standard MAPP 2.0 survey tool, incorporating lessons from prior engagement efforts and partner feedback.

The recruitment strategy intentionally prioritized organizations that:

- Represent historically marginalized communities.
- Represent those newly engaged or previously under-engaged.
- Work across a wide range of geographic areas and service sectors.

Survey design drew on MAPP 2.0 guidance, peer-reviewed instruments from other local health departments, and tools we've used in the past. Using a community-participatory approach, we invited partners to review, test, and refine the survey to ensure accessibility, cultural responsiveness, and alignment with local priorities.



Consistent with our commitment to equity and transparency, the survey also included questions about the CoF program. These items sought to capture organizational perspectives on the reach and effectiveness of CoF within designated zip codes and in related equity-focused work. This input strengthens our understanding of how community-serving organizations perceive our work and offers critical feedback for aligning strategies, partnerships, and investments with community priorities.

Qualitative data analysis

To assess patterns across sectors and surface opportunities for collaboration, we created a partner map to visualize cross-sector strengths and highlight opportunities for deeper collaboration. We analyzed quantitative survey data using descriptive statistics to identify trends in organizational readiness, leadership capacity, and alignment with public health goals.

We analyzed open-text responses to both structured and qualitative questions using grounded theory methods, allowing themes to emerge organically from the data. We coded key informant interview responses using the same grounded theory framework as the open-text survey responses. This helped ensure consistency in thematic interpretation across all data sources. We coded responses using the same thematic framework applied to other qualitative components of the CHA, ensuring consistency in identifying barriers, gaps, and insights.

We compiled results from the community partner mapping activity into the engagement matrix, highlighting existing partnerships and uncovering geographic or sectoral gaps. We reviewed preliminary findings with partners through a feedback session. This served to validate interpretations, provide additional context, and collaboratively shape next steps. This feedback loop was essential to ensure accuracy, integrity, and shared ownership of the findings.



Appendix I: Community Partner Assessment survey instrument

We adapted this survey tool from the MAPP 2.0 framework and used it for both online and interview-based data collection.

Community Partner Assessment for Pierce County CHA

Thank you for contributing to Tacoma-Pierce County Health Department's Community Health Assessment (CHA). Your valuable input will help us identify community strengths, challenges, and opportunities to promote health and well-being throughout Pierce County. All responses will remain confidential and will be used solely for assessment and planning purposes.

About your organization

1. What is the full name of your organization?
2. Please enter the zip code of where your organization is located?
3. Which zip codes does your organization primarily serve? (List all that apply)
4. Which communities or populations does your organization primarily serve? (Select all that apply.)
 - ☐ Black/African American
 - ☐ Indigenous/Native American
 - ☐ Hispanic/Latinx
 - ☐ Asian/Pacific Islander
 - ☐ LGBTQIA+
 - ☐ Immigrants/refugees
 - ☐ People with disabilities
 - ☐ Unhoused
 - ☐ Rural
5. What are your organization's top 3 focus areas? (Select up to 3.) Please select 3 options.
 - ☐ Housing
 - ☐ Education
 - ☐ Behavioral health
 - ☐ Physical health
 - ☐ Economic development
 - ☐ Substance use services



6. Which areas of the 10 Essential Public Health Services does your organization currently support? (Select all that apply.)
- ☐ Assess and monitor community health
 - ☐ Investigate health problems and hazards
 - ☐ Communicate effectively about health issues
 - ☐ Strengthen community partnerships
 - ☐ Develop public health policies
 - ☐ Enforce public health laws
 - ☐ Provide equitable access to care
 - ☐ Build a diverse and skilled workforce.
 - ☐ Improve public health functions through evaluation and research.
7. What strengths or resources does your organization bring to improving community health? (Select all that apply.)
- ☐ Staff expertise in health equity
 - ☐ Existing community partnerships
 - ☐ Advocacy or policy experience
 - ☐ Data collection and analysis capabilities
8. What areas would your organization like to strengthen to better support community health improvement? (Select all that apply.)
- ☐ Community engagement
 - ☐ Data collection/analysis
 - ☐ Equity-focused practices
 - ☐ Policy/advocacy
9. What engagement strategies does your organization use? (Select all that apply.)
- ☐ Focus groups
 - ☐ Surveys
 - ☐ Town halls/community meetings
 - ☐ Social media outreach
10. How does your organization ensure the voices of underserved populations are included in decision-making? (Select all that apply.)
- ☐ Representation on advisory boards
 - ☐ Partnerships with community leaders
 - ☐ Culturally specific outreach methods
 - ☐ Feedback loops (e.g., follow-up surveys or meetings)



11. What challenges does your organization face in engaging the community?

- ☐ Lack of resources (staff, funding)
- ☐ Difficulty reaching specific populations
- ☐ Limited community trust or participation

12. What strategies have been most effective in engaging the community?

13. What are the most significant gaps in services or resources for the communities you serve?

- ☐ Affordable housing
- ☐ Health education
- ☐ Childcare
- ☐ Transportation barriers
- ☐ Access to behavioral health services
- ☐ Access to substance use services

14. Who else should be involved in community health improvement efforts?

- ☐ Faith-based organizations
- ☐ Local businesses
- ☐ School districts
- ☐ Healthcare providers
- ☐ Community members

15. What specific policies or systems changes could address the gaps identified in your community?



Appendix J: Organizations that responded to the Community Partner Assessment survey

- Asia Pacific Cultural Center
- Associated Ministries
- Associated Ministries of Tacoma Pierce County
- Bamford Foundation
- Behavior Bridges
- Boys & Girls Clubs of South Puget Sound
- BySMITHS Consulting
- Carelon Behavioral Health
- City of Buckley Parks & Recreation
- City of Tacoma
- City of Tacoma Environmental Services Department Stormwater Management Program
- City of Tacoma Neighborhood Planning Program
- Columbia Crest School
- Comprehensive Life Resources
- Eastside Tacoma Community Leaders
- Eatonville Area Council dba Eatonville Family Agency
- Elevate Health
- Evergreen Produce Connection
- Family Connects
- First 5 Fundamentals
- Forever Green Trails
- Franklin Pierce Schools
- Franklin Pierce Youth First
- Gig Harbor & Key Peninsula Housing & Homeless Coalition
- Golden Bamboo Walking Groups
- Huckleberry Club
- Key Center Pierce County Library
- Key Peninsula Healthy Community
- Key Peninsula Metropolitan Parks District
- Kris Dowling
- Lakewood's CHOICE
- Leaders in Women's Health
- Living Access Support Alliance
- Mary Bridge Children's Advocacy Center of Pierce County
- Mercy Housing



- MultiCare Tacoma General Hospital Adolescent Behavioral Health Unit
- Multicultural Child and Family Hope Center
- Mustard Seed Project
- North Pierce County Community Coalition
- Oasis Youth Center
- Office of Culture and Engagement
- On the Road with Partner Cafe
- Parkland Community Association
- Parkland Youth Wellness Zone
- Pho Bac Cafe
- Pierce County Human Services
- Pierce County Library System
- Pierce County Oral Health Coalition
- Pierce County Project Access
- Pierce County Sustainable Resources division
- Pierce Transit
- Prairie Ridge Community Coalition
- Prosperity Wellness Center
- Puget Sound Asthma Coalition
- Puget Sound Clean Air Agency
- Puget Sound Educational Service District
- Puget Sound Educational Service District
- Rebuilding Together South Sound
- Red Barn Youth Center
- Safe Streets Campaign
- Salishan Association
- Serene Services
- St Vincent de Paul
- Sumner-Bonney Lake School District & Communities for Families Coalition
- Tacoma Fire Department
- Tacoma Healing Awareness Community
- Tacoma Tree Foundation
- Tacoma–Pierce County Health Department
- Telecare Corporation
- The Farm at Franklin Pierce Schools
- The Mustard Seed Project of Key Peninsula
- The Red Barn Association
- Tillicum Woodbrook Community Center
- Trinity Lutheran Food Pantry



- University of Washington Tacoma School of Nursing & Healthcare Leadership
- University of Washinton Action Mapping Project
- Virginia Mason Franciscan Health
- Washington State Patrol
- White River Family Resource Center
- Workforce Central



Appendix K: Health indicator average inequity scores

Indicator	Average inequity score	Indicators with average scores of 1.0 or higher were considered to demonstrate substantial inequities and disparities.
Adult obesity	1.33	
Inadequate prenatal care	1.33	
Life expectancy	1.33	
Poisoning deaths	1.33	
Unintentional deaths	1.33	
Years of life lost	1.33	
Adult cigarette use	1.00	
Adult depression	1.00	
Asthma-related ED visits	1.00	
Discrimination	1.00	
Homelessness	1.00	
Infant mortality	1.00	
Low birth weight	1.00	
STI incidence/prevalence	1.00	
Youth alcohol, marijuana, painkillers, or other illicit drug use	1.00	
Youth anxiety	1.00	
Youth depression	1.00	
Adult cardiovascular disease prevalence	0.67	
Adult hypertension prevalence	0.67	
Adult health insurance coverage	0.67	
Child abuse and neglect	0.67	
Cold weather-related ED visits	0.67	
Colorectal cancer incidence	0.67	
Congenital syphilis incidence	0.67	
Disability	0.67	
Heat-related ED visits	0.67	
Kindergarten readiness	0.67	
Poverty	0.67	
Suicide deaths	0.67	
Transportation cost burden	0.67	
Adults who met colorectal cancer screening guidelines	0.50	
ACEs	0.50	
Attempted suicide hospitalization rate	0.50	
Fall-related hospitalization rate	0.50	
Respiratory disease incidence	0.50	
Youth asthma prevalence	0.50	
Youth dental checkup in the past year	0.50	



Indicator	Average inequity score
Youth who met physical activity recommendations	0.50
Youth obesity	0.50
Youth who planned for suicide	0.50
Youth vape use	0.50
Adult diabetes prevalence	0.33
Adult flu vaccination	0.33
Adults who skipped healthcare due to cost	0.33
Adults experiencing nervousness or anxiety	0.33
Adults who met breast cancer screening guidelines	0.33
Adults with social support	0.33
Breast cancer incidence	0.33
Recommended childhood vaccination	0.33
Unemployment	0.33
Adults who met physical activity recommendations	0.00
Adults with a dental checkup in the past year	0.00
Childcare cost burden	0.00
Households without access to a motor vehicle	0.00
Housing cost burden	0.00
Wildfire smoke ED visits	0.00
Youth cigarette use	0.00
Youth who felt safe at school	0.00
Youth screen time	0.00



Appendix L: Acronym definitions

Acronym	Definition
ABI	Art-based inquiry
ACS	American Community Survey
AEE	Assessment, Evaluation, and Epidemiology
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian/Alaska Native
BIPOC	Black, Indigenous, or person of color
BMI	Body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CBPR	Community-based participatory research
CCA	Community Context Assessment
CCS	Clinical Classifications Software
CDC	Centers for Disease Control and Prevention
CEDARS	Comprehensive Education Data and Research System
CFR	Code of Federal Regulations
CHA	Community Health Assessment
CHARS	Comprehensive Hospitalization Abstract Reporting System
CHAT	Community Health Assessment Tool
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHS	Center for Health Statistics
CHW	Community health worker
CoF	Communities of Focus
COPD	Chronic obstructive pulmonary disease
CPA	Community Partner Assessment
CPS	Child Protective Services
CSA	Community Status Assessment
DOH	Washington State Department of Health
DSL	Digital subscriber line
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
ED	Emergency department
eHARS	Enhanced HIV/AIDS Reporting System
EPHS	Essential public health services
ESRI	Environmental Systems Research Institute
ESSENCE	Electronic Surveillance System for the Early Notification of Community-Based Epidemics
FQHC	Federally Qualified Health Center
GED	General Educational Development
HYS	Healthy Youth Survey



Acronym	Definition
ICD	International Classification of Diseases
IHI	Indigenous Health Indicators
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and more
MAPP	Mobilizing for Action through Planning and Partnership
ME/NA	Middle Eastern/North African
MSM	Men who have sex with men
NH/PI	Native Hawaiian/Pacific Islander
NSSP	National Syndromic Surveillance Program
OFM	Washington State Office of Fiscal Management
OSPI	Office of the Superintendent of Public Instruction
PHIMS-STD	Public Health Issue Management System–Sexually Transmitted Disease
RSE	Relative standard error
RSV	Respiratory syncytial virus
SAS	Statistical Software Suite
SDOH	Social determinants of health
SES	Socioeconomic status
SME	Subject matter expert
STI	Sexually transmitted infection
SVI	Social Vulnerability Index
USCB	U.S. Census Bureau
WSCR	Washington State Cancer Registry
WSIIS	Washington State Immunization Information System
WTN	Washington Tracking Network
ZCTA	Zip code tabulation area