

2021

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Alaska Medical Center and St. Elias Specialty Hospital

Anchorage, Alaska



To provide feedback on this CHNA or obtain a printed copy free of charge, please email Nathan Johnson at Nathan.Johnson@Providence.org

Photo Attribution: By Frank K. from Anchorage, AK—Anchorage looking nice on an April evening



CONTENTS

| | |
|--|----|
| Executive Summary..... | 4 |
| Understanding and Responding to Community Needs | 4 |
| Gathering Community Health Data and Community Input | 4 |
| Identifying Top Health Priorities | 4 |
| Measuring Our Success: Results from the 2021 CHNA and 2022-2024 CHIP | 5 |
| Introduction | 7 |
| Who We Are..... | 7 |
| Our Commitment to Community..... | 8 |
| Health Equity..... | 9 |
| Our Community..... | 11 |
| Hospital Service Area and Community Served | 11 |
| Providence Need Index | 13 |
| Community Demographics | 14 |
| Health Professional Shortage Area | 20 |
| Overview of CHNA Framework and Process..... | 21 |
| Data Limitations and Information Gaps..... | 21 |
| Process for Gathering Comments on Previous CHNA and Summary of Comments Received | 22 |
| Health Indicators..... | 23 |
| Hospital Utilization Data | 23 |
| Community Input | 25 |
| Community Strengths | 25 |
| Community Needs..... | 26 |
| Community Survey..... | 28 |
| Challenges in Obtaining Community Input | 28 |
| Significant Health Needs | 29 |
| Prioritization Process and Criteria | 29 |
| 2021 Priority Needs | 29 |
| Potential Resources Available to Address Significant Health Needs | 30 |
| Evaluation of 2019-2021 CHIP Impact | 31 |

Addressing Identified Needs 34

2021 CHNA Governance Approval 36

Appendices..... 37

 Appendix 1: Quantitative Data 37

 Appendix 2: Community Input..... 50

 Appendix 3: Community Resources Available to Address Significant Health Needs..... 64

 Appendix 4: Process Governance and Oversight 67

 Appendix 5: CHNA Community Health Survey..... 69

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Alaska Medical Center (PAMC) and St. Elias Specialty Hospital (SESH) to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, especially our neighbors who are most economically poor and vulnerable.

The 2021 CHNA was approved by the Providence Alaska Region Board on November 16, 2021 and made publicly available by December 28, 2021.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, information was collected from the following sources: local community health survey responses, state and national public health data, qualitative data from stakeholder interviews, and hospital utilization data. Stakeholder interviews were conducted with representatives from organizations that serve people who have chronic conditions, are from diverse communities, have low incomes, and/or are medically underserved.

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

Identifying Top Health Priorities

As part of the CHNA process, a CHNA advisory group was established to inform and guide the CHNA process and to identify the top health priorities for the community based on CHNA community health data. The committee was comprised of local community leaders and health-related experts that represent the broad interests and demographics of the community. The CHNA advisory committee engaged in a facilitated process to identify the top health priorities. The process started with the findings of the key stakeholder interview qualitative analysis. These findings were used to frame the discussion of top health needs. A review of the quantitative data (community-wide Health and Wellbeing Monitor survey and healthcare utilization data) was conducted to validate and enrich the discussion of the key stakeholder interview key findings. Through the facilitated discussion of the qualitative and quantitative data, the CHNA advisory group identified the priorities below.

PRIORITY A: BASIC NEEDS / ECONOMIC SECURITY

There is substantial and increasing evidence that socio-economic factors, also known as the “social determinants of health,” are just as important to an individual's health as genetics or certain health behaviors. Economic or financial insecurity is chief amongst those factors that have a tremendous impact on health. With economic insecurity comes an increased risk of food insecurity, homelessness, and inability to meet basic needs. Education, job security and availability of affordable childcare are also significant factors in ensuring economic stability.

PRIORITY B: BEHAVIORAL HEALTH (mental health and substance use disorders)

Behavioral health is foundational to quality of life, physical health and the health of the community and includes our emotional, psychological, and social well-being. Substance misuse and mental health disorders such as depression and anxiety are closely linked. Alcohol and drugs are often used to self-medicate the symptoms of mental health problems. Poor mental health and substance misuse have significant health and social impacts on the well-being of individuals and the community.

PRIORITY C: HEALTHY BEHAVIORS / PHYSICAL HEALTH

Roughly thirty percent of factors affecting an individual's health are related to their behaviors and lifestyle choices, with socioeconomic, environmental, and healthcare related factors making up the remaining seventy percent. Creating an environment that favors the adoption of healthy behaviors related to preventive dental hygiene, physical activity, nutrition, sleep, and stress management can prevent the onset of costly chronic diseases, reduce the need for healthcare services, and substantially improve quality of life and longevity. In addition to healthy behaviors, access to preventive and acute care has an impact on individuals' ability to maintain good health.

PRIORITY D: CULTURAL AND SOCIAL COMMUNITY WELLBEING

There is an established link between health outcomes and social relationships. The quantity and quality of an individual's connections to their community and culture has a significant impact on their health and wellbeing. This can be demonstrated not only by the positive outcomes associated with a strong support-network and cultural connection, but also by the negative health outcomes that result from the impacts of discrimination and social injustice.

PAMC will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2022-2024 CHIP will be approved and made publicly available no later than May 15, 2022.

Measuring Our Success: Results from the 2021 CHNA and 2022-2024 CHIP

This report evaluates the impact of the 2019-2021 CHIP. PSMC responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, written comments were solicited on the 2018 CHNA and 2019-2021 CHIP, which were made widely available to the public. No written comments were received on the 2018 CHNA and 2019-2021 CHIP. A few of the key outcomes from the previous CHIP are listed below:

- Initiated Healthcare and Homelessness Pilot: Selected as one of five cities in the nation to engage in a healthcare and homelessness pilot in collaboration with Community Solutions and the Institute for Healthcare Improvement.

- Established on-site healthcare clinic for 400-person emergency homeless shelter in response to COVID-19 shelter expansion needs and providing behavioral health and medication assisted treatment (MAT) services onsite.
- Increased remote and out-of-clinic access to care by adding tele-psychiatry to Providence Alaska Medical Center Emergency room in Anchorage, Providence Valdez Medical Center, Providence Seward Medical Center, Seward Mountain Haven long term care facility, Providence Transitional Care Center, and Providence Extended Care Center.

INTRODUCTION

Who We Are

Our Mission As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence continues its Mission of service by providing Alaskans with healthcare offered nowhere else in the state. Providence Health & Services Alaska (PHSA) as a region serves the health needs of all people across the vast state of Alaska (population of over 730,000). PHSA has 16 ministries. The majority of facilities are located in the Anchorage area, but PHSA also has a presence in four other Alaska communities. Additionally, services are expanded to communities in Alaska and Oregon via connecting technologies (e.g., telestroke and eICU services).

Providence Alaska Medical Center (PAMC) is a 401-bed acute-care hospital located in Anchorage, Alaska. PAMC is the state’s largest hospital, a nationally recognized trauma center, and the only comprehensive tertiary referral center serving all Alaskans. PAMC features the Children’s Hospital at Providence (the only one of its kind in Alaska), the state’s only Level III NICU, Heart and Cancer Centers, the state’s largest adult and pediatric Emergency Department, full diagnostic, rehabilitation, and surgical services, as well as both inpatient and outpatient mental health and substance use disorder services for adults and children.

St. Elias Specialty Hospital, also located in Anchorage, has 59 beds and is the only long-term acute care hospital in Alaska. The hospital provides customized, physician-driven services for patients requiring longer stays in an acute-care environment due to multiple or complex conditions.

Providence’s family practice residency program and primary care and specialty clinics serve the primary care, behavioral health, specialty, and subspecialty needs of Anchorage and Alaska residents. Additionally, Providence’s service to the community is strengthened by a continuum of senior and community services ranging from primary care at Providence Medical Group Senior Care to long-term skilled nursing care at Providence Extended Care. PHSA also partners to provide additional services through four joint ventures including: Providence Imaging Center, Imaging Associates, LifeMed Alaska (a medical transport/air ambulance service), and Creekside Surgery Center.

PHSA manages three critical access hospitals located in the remote communities of Kodiak, Seward and Valdez, all co-located with skilled nursing facilities. Community mental health centers are operated in Kodiak and Valdez.

Our Commitment to Community

Providence Health and Services Alaska (PHSA), including PAMC and St. Elias, dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2020, PHSA provided \$70 Million in Community Benefit¹ to respond to unmet needs and improve the health and well-being of those we serve in the Alaska region. PAMC further demonstrates organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs.

The PAMC hospital administrator is responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for community leaders, PHSA Region Community Ministry Board, internal hospital Executive Management Team members, physicians, and other staff to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

Figure 1. Providence Total Benefit to Our Communities in 2020

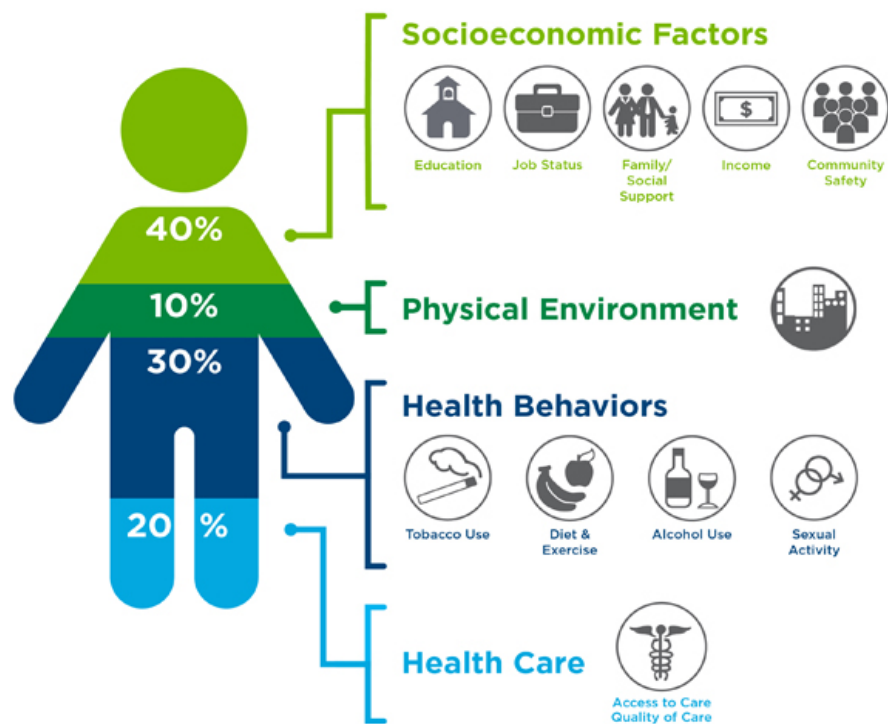


¹ Per federal reporting and guidelines from the Catholic Health Association.

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1²).

What Goes Into Your Health?



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The Bridgespan Group

Figure 2. Factors contributing to overall health and well-being

² Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms³). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive healthcare, and more.

Health Equity

A principle meaning that “everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.” (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

Figure 3. Definitions of key terms

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:



Approach

- Explicitly name our commitment to equity
- Take an asset-based approach, highlighting community strengths
- Use people first and non-stigmatizing language



Community Engagement

- Actively seek input from the communities we serve using multiple methods
- Implement equitable practices for community participation
- Report findings back to communities



Quantitative Data

- Report data at the block group level to address masking of needs at county level
- Disaggregate data when responsible and appropriate
- Acknowledge inherent bias in data and screening tools

³ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

OUR COMMUNITY

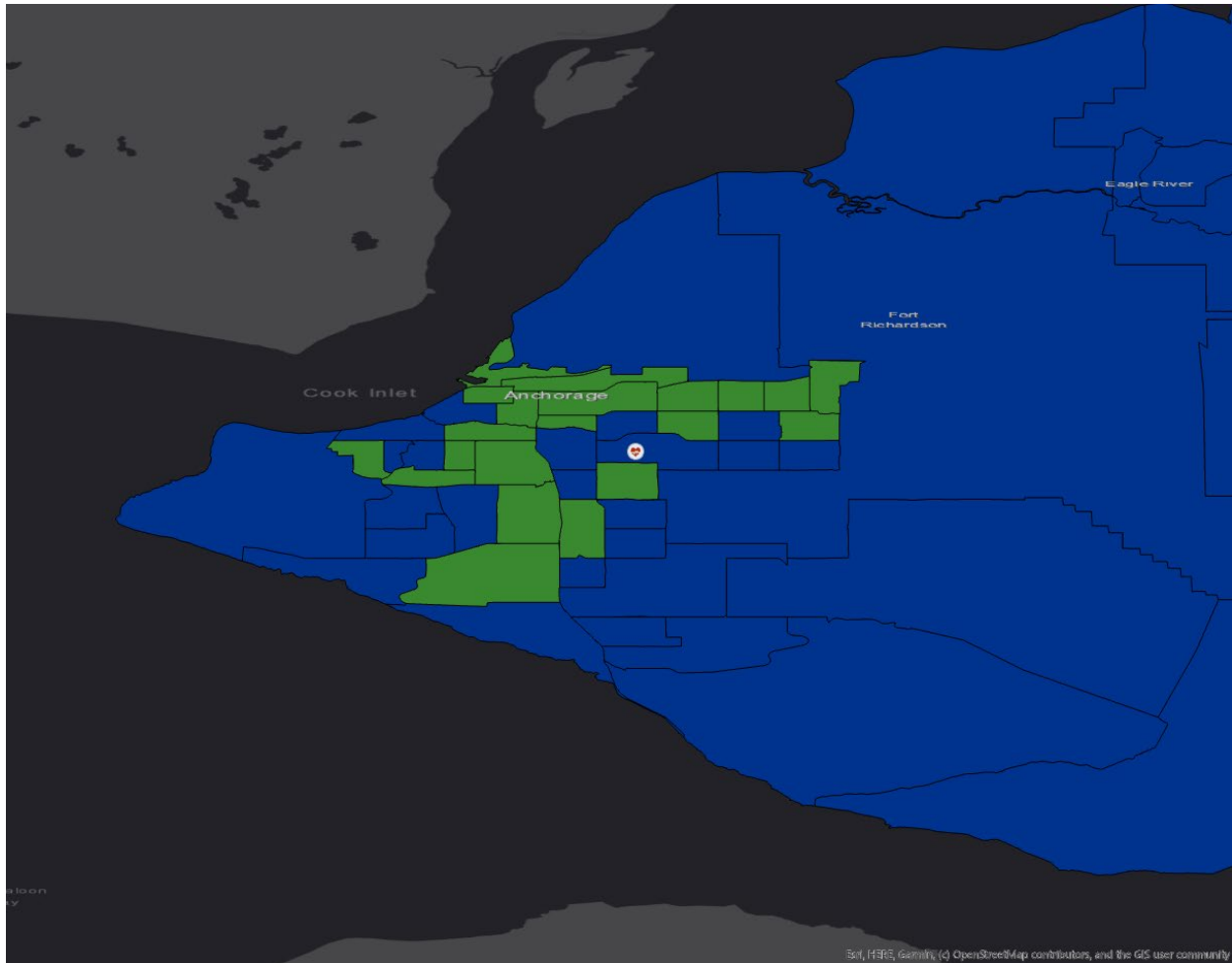
Hospital Service Area and Community Served

The service area of Providence Alaska Medical Center (PAMC) and St. Elias Specialty Hospital is the Municipality of Anchorage, the largest community in the state of Alaska, where the majority of patients seeking services reside. As the largest and most comprehensive acute care hospital and health system in Alaska, PAMC, St. Elias, and Providence Health and Services Alaska see patients from the entire state of Alaska, although for the purposes of this CHNA, the hospital service area is the Municipality of Anchorage.

Anchorage is located in Southcentral Alaska along Cook Inlet. It sits in a bowl with Cook Inlet on one side and Chugach State Park on the other. Home to nearly half the state's residents, Anchorage has a population of approximately 299,100 people and includes the communities of Anchorage, Chugiak, Eagle River, Girdwood, and Joint Base Elmendorf-Richardson. It is the hub of Alaska's infrastructure and business community.

Based on available data, geographic access to facilities and primary care, and other hospitals in neighboring counties, Anchorage serves as the boundary for the hospital service area. See the map below for further detail, including communities identified as higher need. There are 21 census tracts in the high need service area and 34 in the broader service area.

Figure 5. Zoomed-in View of PAMC Service Area



Providence Need Index

Within a medical center's service area is a high need service area that is based on social determinants of health related to the inhabitants of that census tract. Based on work done by the Public Health Alliance of Southern California and their [Healthy Places Index \(HPI\)](#) tool, the following variables were used in the calculation of a high need census tract:

- Population Below 200% the Federal Poverty Level (2019, American Community Survey)
- Percent of Population with at least a high school education (2019, American Community Survey)
- Percent of population Age 5 Years and over in [Limited English Households](#) (2020, American Community Survey)
- Life Expectancy at Birth (Estimates based on 2010-2015 data, CDC)

For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households, and a lower life expectancy at

birth were identified as “high need.” All variables were weighted equally, and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth. Ultimately, a census tract was given a score between 0 and 1, where 0 represents the “best” performing census tract and 1 represents the “worst” performing census tract according to the criteria.

Census tracts that scored higher than the average were classified as high need service areas and are depicted in green. In the Municipality of Anchorage service area, **21 of 55 census tracts** scored above the **average of 0.30** on the Providence Need Index.

Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. The high need area includes census tracts identified based upon lower life expectancy at birth, a lower percent of the population with at least a high school diploma, more households which are linguistically isolated, and more households at or below 200% of the Federal Poverty Level (FPL) compared to county averages. For reference, in 2019, 200% FPL represents an annual household income of \$51,500 or less for a family of four.

For the socioeconomic indicators, the broader service area and high need service area values are calculated based on the average of the census tracts within each service area classification.

Providence has developed a dashboard that maps each CHNA indicator at the census tract level, which can be found here:

<https://psjh.maps.arcgis.com/apps/MapSeries/index.html?appid=c4fb822899d0461fb7089747c24f8279>

POPULATION AND AGE DEMOGRAPHICS

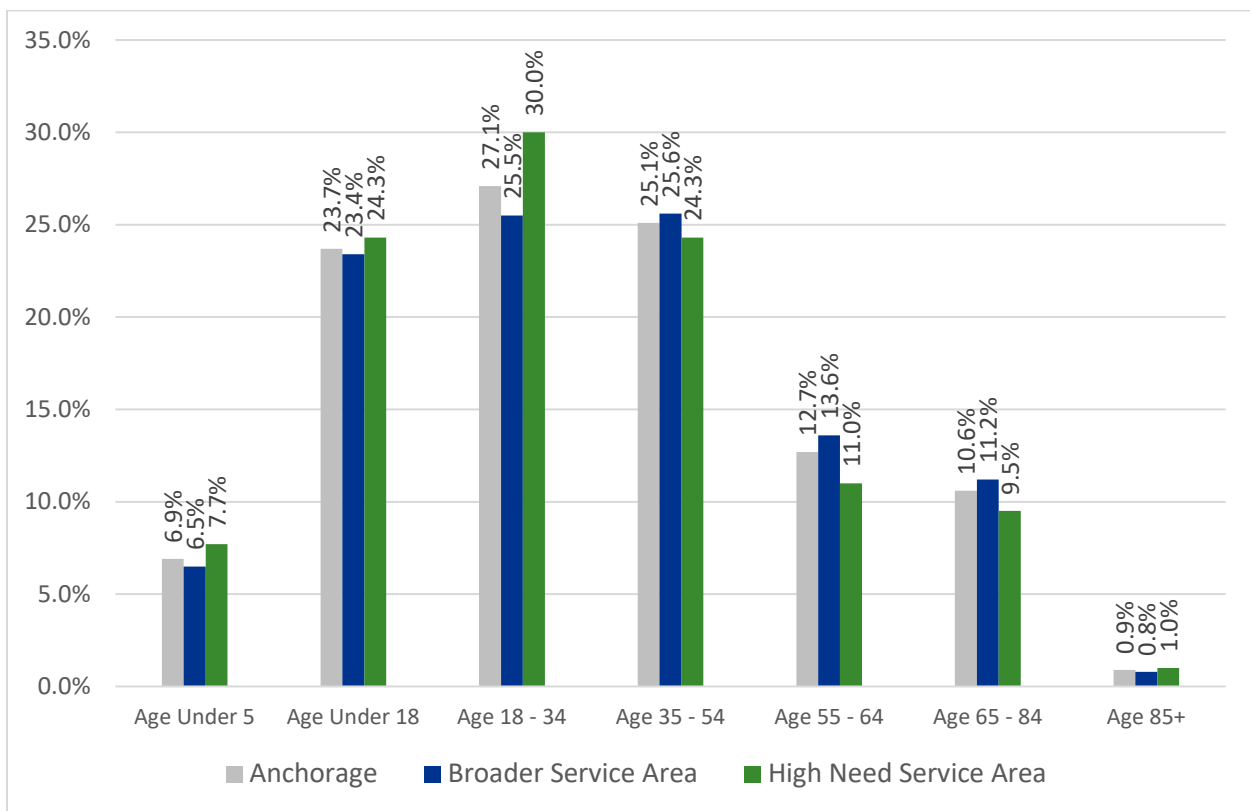
Table 1. Population Demographics for PAMC Service Area

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|-----------------------|-----------------|----------------------|------------------------|
| 2019 Total Population | 299,100 | 192,994 | 106,106 |
| Female Population | 147,592 (49.4%) | 95,642 (49.6%) | 51,950 (49.0%) |
| Male Population | 151,508 (50.7%) | 97,352 (50.4%) | 54,146 (51.0%) |

Table 2. Population by Age Groups in PAMC Service Area

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|-------------------------|-----------------|----------------------|------------------------|
| Population Age Under 5 | 20,718 (6.9%) | 12,553 (6.5%) | 8,165 (7.7%) |
| Population Age Under 18 | 70,859 (23.69%) | 45,093 (23.4%) | 25,766 (24.3%) |
| Population Age 18 - 34 | 81,068 (27.1%) | 49,275 (25.5%) | 31,793 (30%) |
| Population Age 35 - 54 | 75,109 (25.1%) | 49,304 (25.6%) | 25,805 (24.3%) |
| Population Age 55 - 64 | 37,856 (12.7%) | 26,183 (13.6%) | 11,673 (11%) |
| Population Age 65 - 84 | 31,617 (10.6%) | 21,559 (11.2%) | 10,058 (9.5%) |
| Population Age 85+ | 2,591 (0.9%) | 1,580 (0.8%) | 1,011 (1%) |

Figure 6. Population by Age Groups in PAMC Service Area



In 2019, the total population of Anchorage was 299,100 residents, with 192,994 residents in the broader service area and 106,106 residents in the high need service area. The majority of residents in the Anchorage, broader, and high need areas were between the age of 18-54. In Anchorage, 52.2% of the

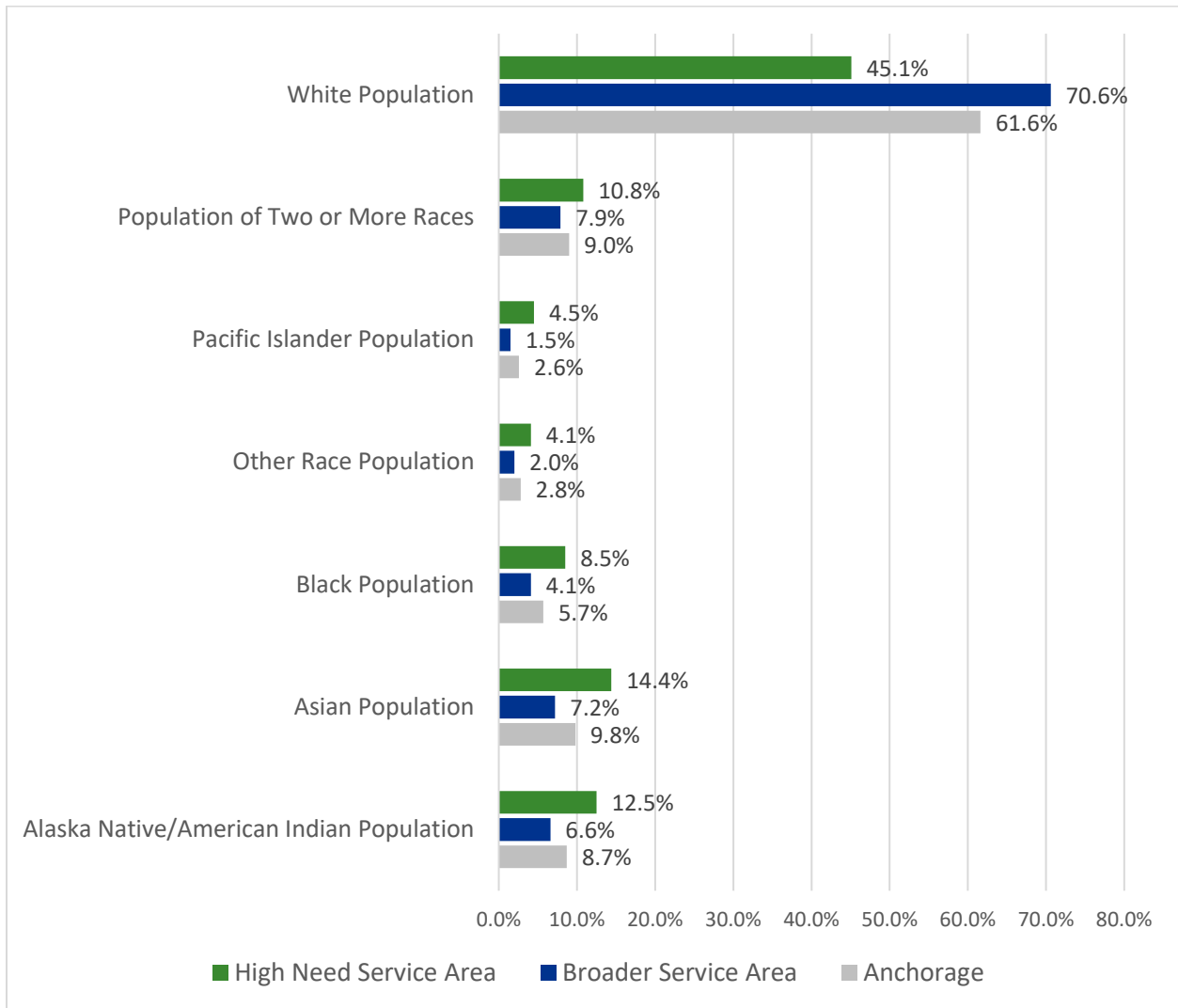
population is aged between 18-54 years, compared to 51.1% in the broader service area and 54.1% in the high need service area.

POPULATION BY RACE AND ETHNICITY

Table 3. Population by Race

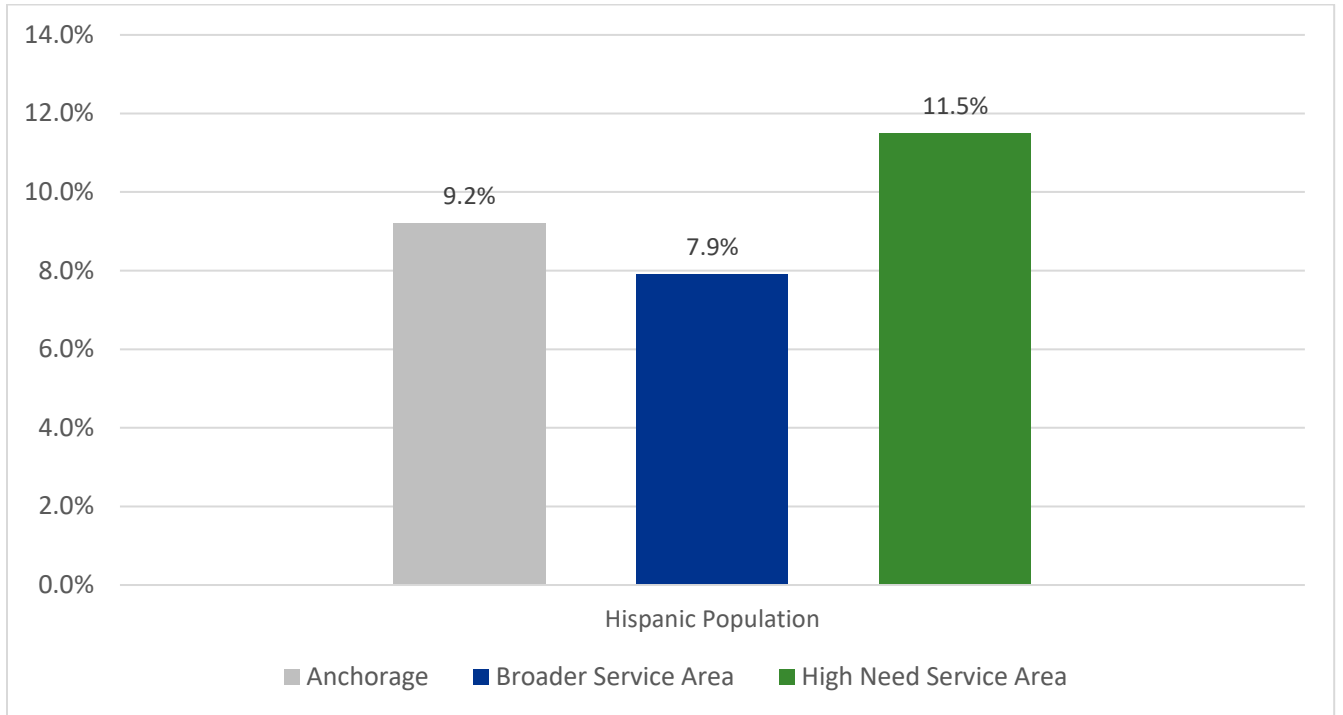
| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|-----------------|----------------------|------------------------|
| Alaska Native/American Indian Population | 26,034 (8.7%) | 12,786 (6.6%) | 13,248 (12.5%) |
| Asian Population | 29,168 (9.8%) | 13,881 (7.2%) | 15,287 (14.4%) |
| Black Population | 16,973 (5.7%) | 7,927(4.1%) | 9,046 (8.5%) |
| Other Race Population | 8,247 (2.8%) | 3,886 (2%) | 4,361(4.1%) |
| Pacific Islander Population | 7,746 (2.59%) | 2,953 (1.5%) | 4,793 (4.5%) |
| Population of Two or More Races | 26,803 (9%) | 15,318 (7.9%) | 11,485 (10.8%) |
| White Population | 184,129 (61.6%) | 136, 243 (70.6%) | 47,886 (45.1%) |

Figure 7. Population by Race



Within the Anchorage service area, the three largest racial groups included White (61.6%), Asian (9.8%) and Alaska Native/American Indian (8.7%). In the broader service area, 70.6% of the population identified as White, 7.2% identified as Asian, and 6.6% identified as Alaska Native/American Indian. Comparatively, in the high need service area, 45.1% of the population identified as White, 14.4% identified as Asian, and 12.5% identified as Alaska Native/American Indian. The Pacific Islander, “other race,” Black, Asian, Alaska Native/American Indian, and Hispanic populations were overrepresented in the high need service area compared to the broader service area, while the White population was underrepresented in the high need service area.

Figure 8. Hispanic Population in PAMC Service Area



MEDIAN INCOME

Table 4. Median Income in Anchorage Service Area

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Median Household Income Data Source: American Community Survey Year: 2019 | \$82,716 | \$100,241 | \$59,795 |

The median household income in Anchorage was \$82,716 in 2019. The broader service area had a median household income \$17,525 higher than Anchorage, while the high need service area had a median household income \$22,921 lower than Anchorage.

SEVERE HOUSING COST BURDEN

Table 5. Severe Housing Cost Burden in Anchorage Service Area

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data | 19.9% | 16.7% | 20.4% |

Severe housing cost burden is defined as households spending 50% or more of their income on housing costs. Within Anchorage, 19.9% of the population experiences severe housing cost burden, compared to 16.7% of the population in the broader service area and 20.4% in the high need service area.

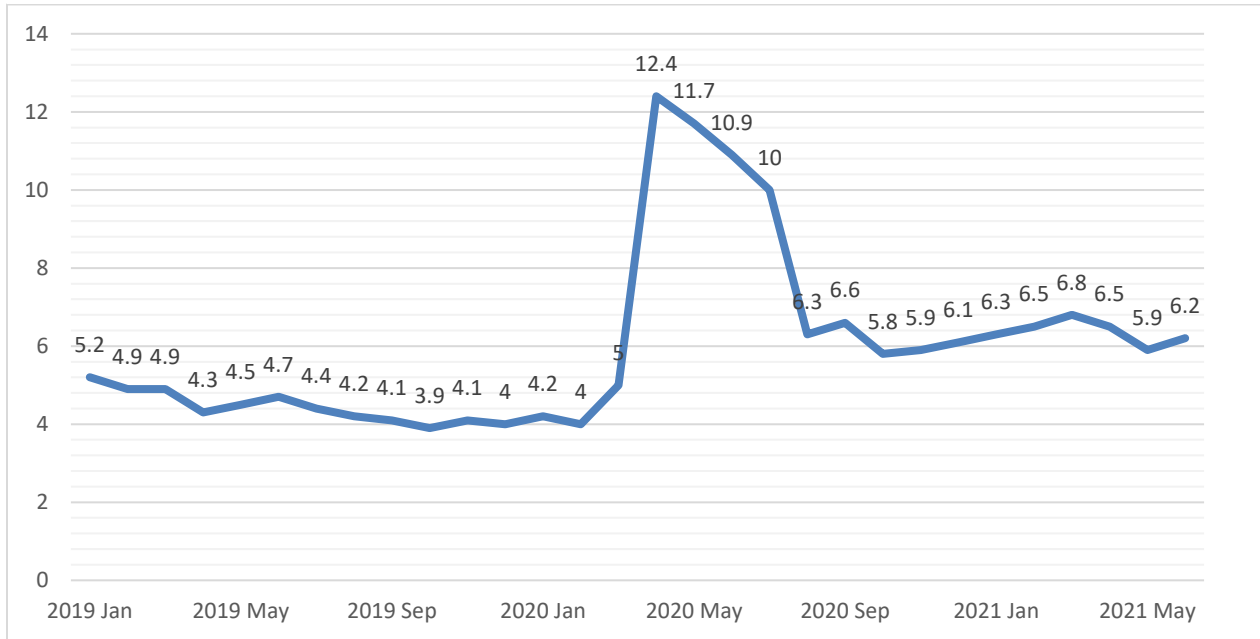
PERCENT OF LABOR FORCE UNEMPLOYED

Table 6. Percent of Labor Force Unemployed in Anchorage Service Area

| Indicator | Anchorage | Alaska | United States |
|---|-----------|--------|---------------|
| Percent of Labor Force Unemployed Data Source: U.S Bureau of Labor Statistics Year: April 2021 | 5.9% | 6.7% | 6.1% |

Anchorage has a lower percent of labor force unemployed, 5.9%, than the state of Alaska, 6.7% and the United States, 6.1%.

Figure 9. Anchorage Unemployment Rate, Jan. 2019- June 2021



Health Professional Shortage Area

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. There are three types of HPSAs:

- Geographic HPSA: a shortage of providers for an entire group of people within a defined geographic area.
- Population HPSA: a shortage of providers for a specific group of people within a defined geographic area.
- Facility HPSA: These include correctional facilities, state/county mental hospitals, Federally Qualified Health Centers, Indian Health Facilities, IHS and Tribal Hospitals, and others.

More information can be found on the [HRSA website](#). The Anchorage Borough is designated as a primary care, dental health, and mental health area HPSA.

See [Appendix 1](#) for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital, not only were the health conditions of the population examined, but also socioeconomic factors, the physical environment, and health behaviors. Additionally, key stakeholders were invited to provide additional context to the quantitative data through qualitative data in the form of interviews. We sought input from community members through a community-based survey. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

There are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

Data were reviewed from the American Community Survey and local public health authorities. In addition, hospital utilization data was used to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- As not all desired data were readily available, sometimes it was necessary to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not an accurate reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, data were disaggregated by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2018 CHNA and 2019-2021 CHIP reports, which were made widely available to the public via posting on the internet in December 2018 (CHNA) and May 2019 (CHIP), as well as through various channels with our community-based organization partners.

To date, no public comments have been received.

HEALTH INDICATORS

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Anchorage. We were particularly interested in studying potentially Avoidable Emergency Department (AED) visits and Prevention Quality Indicators. AED use is reported as a percentage of all Emergency Department visits over a given time period, which are identified based on an algorithm developed by Providence’s Population Health Care Management team based on NYU and Medi-Cal’s definitions.

The Prevention Quality Indicators (PQIs) are similar, although they are based on in-patient admissions. Both PQIs and AED use serve as proxies for inadequate access to or engagement in primary care. When possible, data were examined for total utilization, frequency of diagnosis, demographics, and payor to identify disparities.

Table 7. Avoidable Emergency Department Visits for Providence Alaska Ministries, 2020

| Facility | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|----------------|------------|-----------------|-------|
| Providence Seward Medical Center | 1,082 | 437 | 1,519 | 28.8% |
| Providence Valdez Medical Center | 716 | 273 | 989 | 27.6% |
| Providence Kodiak Island Medical Center | 1,847 | 665 | 2,512 | 26.5% |
| Providence Alaska Medical Center | 28,561 | 13,052 | 41,613 | 31.4% |
| Region Total | 32,206 | 14,427 | 46,633 | 30.9% |

Across Providence Alaska’s footprint, PAMC had an above average percentage of potentially avoidable ED utilization in 2020, with the highest percentage of AED visits of the four Alaska hospitals. Although, please note PAMC sees a much higher volume of patients in the ED compared to the other hospitals. The three ZIP Codes with the highest percentage of AED visits at PAMC were 99508, 99504, and 99507.

Table 8. Avoidable Emergency Department Visits by Ministry and Patient Zip Code, 2020

| Encounters by Patient Zip Code | Non-AED Visits | AED Visit | Total ED Visits | AED % |
|---|----------------|---------------|-----------------|--------------|
| PROVIDENCE ALASKA MEDICAL CENTER | 28,561 | 13,052 | 41,613 | 31.4% |
| 99508 | 4,103 | 2,136 | 6,239 | 34.2% |
| 99504 | 4,083 | 1,840 | 5,923 | 31.1% |
| 99507 | 3,538 | 1,596 | 5,134 | 31.1% |
| 99501 | 2,547 | 1,470 | 4,017 | 36.6% |
| 99503 | 1,994 | 1,012 | 3,006 | 33.7% |
| 99502 | 1,884 | 778 | 2,662 | 29.2% |
| 99515 | 1,671 | 626 | 2,297 | 27.3% |
| 99517 | 1,293 | 598 | 1,891 | 31.6% |
| 99577 | 1,166 | 433 | 1,599 | 27.1% |
| 99516 | 1,108 | 330 | 1,438 | 22.9% |

See [Appendix 1: Quantitative Data](#) for more information on PQIs and AEDs

COMMUNITY INPUT

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives of Providence Alaska Medical Center and St. Elias Specialty Hospital conducted 8 stakeholder interviews from August 18 to September 13, 2021. Below is a high-level summary of the findings from these sessions; full details on the protocols, findings, and attendees are available in Appendix 2.

Community Strengths

While a CHNA is primarily used to identify gaps in services and challenges in the community, it is important to highlight and leverage the community strengths that already exist, including the following:

COMMUNITY PARTNERS

As a key strength, stakeholders noted the many nonprofits, businesses, and community organizations that are willing to work together and are committed to making Anchorage a healthier place. They recommended leveraging this strength through more cross-sector collaboration and building local capacity by bringing together partners to ensure community plans are implemented in a coordinated way.

RELATIONSHIPS AND CONNECTEDNESS OF THE COMMUNITY

Stakeholders discussed how community members are willing to help their neighbors, volunteer, and start programs to meet community needs. They noted a strong sense of community and engagement, with people coming together to support projects and movements.

DIVERSITY AND RICH COMMUNITY KNOWLEDGE

Anchorage is rich in traditions and cultures, with many Alaska Native tribes represented and languages spoken. To leverage the diversity and wisdom of the people living in Anchorage, stakeholders discussed the importance of listening to the community and involving people with lived experience in decision making.

Community Needs

The following findings represent the **high-priority health-related needs**, based on community input:

Behavioral health challenges (includes both mental health and substance use disorders)

Stakeholders identified behavioral health challenges as an upstream cause of violence and abuse. They emphasized the need to normalize healing and break cycles of behavioral health challenges in families. Stakeholders discussed a lack of system capacity to meet patient demand, noting long wait lists and a need for more behavioral health clinicians. They identified a need for better coordination between primary care and mental health services, describing a disjointed system with gaps in care. They noted that particular populations may have more barriers to accessing care, including young people, the Alaska Native population, people whose primary language is not English, and people experiencing homelessness. Stakeholders named racism and discrimination as a cause of trauma and harm done to Alaska Native communities, which can contribute to mental health challenges and substance use disorders. The COVID-19 pandemic has worsened mental health challenges for many, causing increased stress and fear. They shared that social-emotional well-being is tied to community connection, and people are feeling less connected and more alone. It has also made accessing behavioral health services more challenging. Stakeholders noted particular concern for young people and providers who may be experiencing burnout.

Homelessness/lack of safe, affordable housing

Stakeholders shared affordable housing is an enormous need in the community, noting housing is connected to health and stability. They shared the high cost of housing and lack of low-income and affordable rentals makes finding stable, good-quality housing challenging. Additionally, differing community perspectives on how best to address homelessness have provided challenges in meeting community needs. Stakeholders identified people with low incomes, people living with disabilities, and the Alaska Native population as disproportionately affected by housing instability. They shared the importance of honoring the whole person when addressing homelessness, including integrating cultural programming for Native communities into shelter spaces to ensure people feel seen and welcome. They also noted the importance of supporting easier access to coordinated services, including health care services, for people experiencing homelessness. Students experiencing homelessness also need increased support. The COVID-19 pandemic has exacerbated housing challenges with an increase in people seeking shelter, although rental assistance programs have helped keep people in their homes.

The following findings represent the **medium-priority health-related needs**, based on community input:

Obesity and chronic conditions

Stakeholders shared a concern for a lack of primary and preventive care contributing to unmanaged chronic conditions. They noted the COVID-19 pandemic has highlighted systemic inequities contributing to poorer health; people with chronic conditions and obesity have higher risk for poor outcomes from COVID-19 and are also the people who are often underserved. The pandemic has led to people delaying preventive care with some people not accessing chronic disease management care. While telehealth is helpful, it does not allow for measuring A1C or blood pressure. Additionally, stakeholders spoke to the importance of primary care homes and viewing health holistically, rather than only through specialized care. There was particular concern for people experiencing homelessness who may have increased barriers to managing their chronic conditions, including affording medication and accessing care.

Access to health care services

Stakeholders identified the following challenges related to access to care: workforce challenges due to difficulty recruiting staff, particularly specialists; long wait times for emergency care and overuse of the Emergency Department for non-emergent conditions; high cost of care for patients who are uninsured or underinsured; and a lack of coordinated care. Accessing welcoming, culturally responsive, and linguistically appropriate care may be more challenging for Black, Brown, and Indigenous Persons of Color (BBIPOC), particularly Alaska Native communities, as well as people whose primary language is not English and people experiencing homelessness. Additionally, having robust data and strong community partners to serve the Pacific Islander and Asian communities effectively can be challenging. Stakeholders spoke to a need for more providers that are culturally aware and respectful of patients that may have been disenfranchised by health care systems due to racism and discrimination. During the COVID-19 pandemic, some patients delayed or were unable to access care. Stakeholders shared telehealth services improved access for some patients, but not for others. Stakeholders shared seeing an increase in people seeking support to maintain their health insurance after a job loss. The pandemic has also placed increased strain on health care providers and systems, made more challenging by staffing shortages.

Economic insecurity

Stakeholders discussed economic insecurity, including unemployment and lack of living wage jobs, as a challenge connected to many other needs, including housing. Employment is connected to insurance and the ability to afford health care services, including medications. Populations of particular concern include families slightly above 200% of the Federal Poverty Level that do not qualify for many financial support services. This “benefits cliff” means benefits taper off quickly as income increases, leading families to vulnerable situations where they may not have enough money to navigate a crisis. The COVID-19 pandemic has affected many families' financial security, with more families having to make spending tradeoffs, meaning choosing between necessities like medication and food. This has been especially true for people working in lower wage jobs, such as the hospitality sector. Stakeholders identified BBIPOC and immigrant communities as disproportionately affected by economic insecurity.

Community Survey

Due to the limited data available for Anchorage through state and federal sources, Providence fielded a survey from June 15 through June 30, 2021. A total of 604 responses were received: 251 online and 353 phone responses. Providence reached people by phone, mobile phone, direct mail, and online, as well as through utilizing registered voter lists and other specialized lists. Every effort was made to ensure the survey responses represented the diversity of the community and captured input from those with low incomes and those otherwise underserved in the community.

The survey leveraged the questions from the Health and Well-being Monitor™ developed by the Providence Institute for a Healthier Community to more holistically assess community strengths and indicators of well-being. The report groups findings into six dimensions of well-being: connections and relationships; physical health; mental/emotional and spiritual health; security and basic needs; neighborhood and environment; and work, learning, and growth.

See [Appendix 5: CHNA Community Health Survey](#) for full methodology and findings from the survey

Challenges in Obtaining Community Input

Due to the COVID-19 pandemic, stakeholder interviews were conducted virtually. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews. Reaching community members was also a challenge. While efforts were made to distribute the survey through community partners and community health workers, limited capacity, COVID-related closures, and survey fatigue may have affected distribution and willingness to participate.

See [Appendix 2: Community Input](#)

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

As part of the CHNA, a CHNA advisory group was established to inform and guide the process and identify the top health priorities for the community based on review of the data. The committee was comprised of local community leaders and health-related experts who represent the broad interests and demographics of the community. The CHNA advisory committee engaged in a facilitated process to identify the top health priorities. The process started with the findings of the key stakeholder interview qualitative analysis. These findings were used to frame the discussion of the top health issues facing the community. A review of the quantitative data (community-wide Health and Wellbeing Monitor survey and healthcare utilization data) was conducted to validate and enrich the discussion of the key stakeholder interview key findings. Through the facilitated discussion of the qualitative and quantitative data, the CHNA advisory group identified the priorities below.

The following criteria were considered in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need

2021 Priority Needs

The list below summarizes the significant health needs identified through the 2021 Community Health Needs Assessment process. Note that the needs were not prioritized relative to one another and are listed in no particular order:

PRIORITY A: BASIC NEEDS / ECONOMIC SECURITY

There is substantial and increasing evidence that socio-economic factors, also known as the “social determinants of health,” are just as important to an individual’s health as genetics or certain health behaviors. Economic or financial insecurity is chief amongst those factors that have a tremendous impact on health. With economic insecurity comes an increased risk of food insecurity, homelessness, and inability to meet basic needs. Education, job security and availability of affordable childcare are also significant factors in ensuring economic stability.

PRIORITY B: BEHAVIORAL HEALTH (mental health and substance use disorders)

Behavioral health is foundational to quality of life, physical health and the health of the community and includes our emotional, psychological, and social well-being. Substance misuse and mental health disorders such as depression and anxiety are closely linked. Alcohol and drugs are often used to self-

medicate the symptoms of mental health problems. Poor mental health and substance misuse have significant health and social impacts on the well-being of individuals and the community.

PRIORITY C: HEALTHY BEHAVIORS / PHYSICAL HEALTH

Roughly thirty percent of factors affecting an individual's health are related to their behaviors and lifestyle choices, with socioeconomic, environmental, and healthcare related factors making up the remaining seventy percent. Creating an environment that favors the adoption of healthy behaviors related to preventive dental hygiene, physical activity, nutrition, sleep, and stress management can prevent the onset of costly chronic diseases, reduce the need for healthcare services, and substantially improve quality of life and longevity. In addition to healthy behaviors, access to preventive and acute care has an impact on individuals' ability to maintain good health.

PRIORITY D: CULTURAL AND SOCIAL COMMUNITY WELLBEING

There is an established link between health outcomes and social relationships. The quantity and quality of an individual's connections to their community and culture has a significant impact on their health and wellbeing. This can be demonstrated not only by the positive outcomes associated with a strong support-network and cultural connection, but also by the negative health outcomes that result from the impacts of discrimination and social injustice.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized healthcare delivery system includes the Department of Public Health, Alaska Native Medical Center, Alaska Psychiatric Institute, Alaska Regional Hospital, North Star Hospital, and St. Elias. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see Appendix 3.

[Appendix 3: Resources potentially available to address the significant health needs identified through the CHNA](#)

EVALUATION OF 2019-2021 CHIP IMPACT

This report evaluates the impact of the 2019-2021 Community Health Improvement Plan (CHIP). The 2018 CHNA prioritized poverty/ social determinants of health, mental health, healthy behaviors, substance misuse, and access to healthcare. PAMC responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

The COVID-19 pandemic has had a significant impact on Providence’s capacity over the past two years. Despite this, meaningful progress and efforts were made in addressing needs identified in the prior CHNA.

| Priority Need | Focus | Programs/Results/Outcomes |
|---|---------------------------------|--|
| 1. Poverty/ Social Determinants of Health | Homelessness | <ul style="list-style-type: none"> • Providence continued 5-year, \$15M commitment to \$3M annual investment in the homeless response system • Initiated Healthcare and Homelessness Pilot: Selected as 1 of 5 cities in the nation to engage in a healthcare and homelessness pilot in collaboration with Community Solutions and the Institute for Healthcare Improvement. • Established on-site healthcare clinic for 400-person emergency homeless shelter in response to COVID-19 shelter expansion needs and providing behavioral health and MAT services onsite. • Delivered dinner meal service 365 days of the year to Brother Francis Homeless Shelter and Clare House emergency shelter for women and children prepared by Providence Alaska Medical Center food service. • Continued partnership and funding support with Alaska Native Medical Center, Alaska Regional Hospital, and Catholic Social Services to maintain the 10-bed respite program at the Brother Francis Shelter to improve the health of patients experiencing homelessness (post-hospital discharge) and increase their chances of obtaining and maintaining stable housing once they have sufficiently healed. |
| 2. Mental Health | Mental Health/ Psychiatric care | <ul style="list-style-type: none"> • Maintained the only 24/7 psychiatric emergency department in Anchorage. |

| | | |
|----------------------------|---|---|
| | | <ul style="list-style-type: none"> • Maintained only inpatient psychiatric unit (12 bed) with medical treatment that provides a comprehensive form of milieu therapy. • Maintained inpatient adolescent psychiatric unit (15 bed) for adolescents (ages 13-18) in need of intensive crisis intervention, stabilization, and behavioral health treatment. • Compass Program: 8-bed, 24-hour crisis intervention program that serves to stabilize the acute psychiatric symptoms of adult patients in crisis. • Continued the Directions Program: 8-bed, 24-hour early intervention program for adolescents (ages 13-18), providing residential individual, group, and family therapy. • Residential Treatment Program: (10-bed, 24-hour) serving girls ages 12-18 with one prior admission who are unable to be stabilized and maintained in an outpatient setting requiring long-term residential treatment. • Significantly expanded telehealth capacity to address increasing behavioral health needs through COVID-19. |
| <p>3. Health Behaviors</p> | <p>Health promotion and healthy behaviors</p> | <ul style="list-style-type: none"> • Faith Community Nursing: Providence provided a nurse coordinator, educator, and resource person for parishes and churches to increase health literacy and promote healthy behaviors at the community level. • Health Ministry Outreach: Increased health literacy of English learners, specifically immigrants and refugees. Trained in-community leaders in health literacy to improve understanding of health issues, healthy behaviors, and access to care for English learners. • Safe Kids Alaska Injury Prevention: Program engaged in community outreach and education, which included a wide array of areas such as pedestrian safety, bike safety, smoke and carbon monoxide detector education, water safety, and car seat fitting and inspection. • Nurse Family Partnership (NFP) program: In accordance with NFP evidence-based practice, provided in-home intensive family services to first-time mothers with low incomes in the Municipality of Anchorage to improve pregnancy health and outcomes, child health and |

| | | |
|-------------------------|--------|--|
| | | <p>development, and maternal outcomes from pregnancy through the child’s second year.</p> <ul style="list-style-type: none"> • Medicaid Coordinated Care Demonstration Project: Patient Centered Medical Home model of care delivery utilized an Integrated Direct Care Team (IDCT) comprised of behavioral health, social work, nurse case management, home visits, and pharmacy services coordinated with the patient’s primary care physician to increase access, decrease inappropriate utilization, and improve patient outcomes. |
| 4. Substance Misuse | | <ul style="list-style-type: none"> • Established on-site healthcare clinic for 400-person emergency homeless shelter in response to COVID-19 shelter expansion needs, providing primary care, behavioral health, and MAT services onsite. • Continued to collaborate with and financially support Recover Alaska to increase substance misuse prevention and awareness efforts in the community, advocate for effective substance use-related policy, and increase access to substance use disorder (SUD) services. • Increased remote and out-of-clinic access to care by adding tele-psychiatry to Providence Alaska Medical Center emergency department in Anchorage, Providence Valdez Medical Center, Providence Seward Medical Center, Seward Mountain Haven long term care facility, Providence Transitional Care Center, and Providence Extended Care Center. • Added psychiatrist to the Crisis Recovery Center and received a designation to provide ambulatory detox to expand capacity to meet community need. • Breakthrough Program: Expanded SUD services to treat pregnant mothers and adolescents and offer free pre-treatment for people waiting for an assessment. |
| 5. Access to Healthcare | Access | <ul style="list-style-type: none"> • Established on-site healthcare clinic for 400-person emergency homeless shelter in response to COVID-19 shelter expansion needs and providing behavioral health and MAT services onsite. • Increased remote and out-of-clinic access to care by adding tele-psychiatry to Providence Alaska Medical |

| | | |
|--|--|---|
| | | <p>Center emergency department in Anchorage, Providence Valdez Medical Center, Providence Seward Medical Center, Seward Mountain Haven long term care facility, Providence Transitional Care Center, and Providence Extended Care Center.</p> <ul style="list-style-type: none"> • Added psychiatrist to the Crisis Recovery Center and received a designation to provide ambulatory detox to expand capacity to meet community need. • Subsidized pediatric subspecialty clinics not otherwise available in Alaska to meet the specialized medical service needs of children in the community. • Continued partnership and funding support with Alaska Native Medical Center, Alaska Regional Hospital, and Catholic Social Services to maintain the 10-bed respite program at the Brother Francis Shelter to improve the health of patients experiencing homelessness (post-hospital discharge) and increase their chances of obtaining and maintaining stable housing once they have sufficiently healed. • Nursing and non-nursing clinical preceptorships: Offered these preceptorships to provide practical and clinical nursing and non-nursing clinical training for students or novices under the supervision of a preceptor to help build the necessary workforce to meet community need. • Alaska Family Medicine Residency (AFMR): Provided primary care services on a sliding fee scale to remove cost as a barrier to needed care; provided student residents (roughly 36 at any given time) with the necessary experience and training to become family physicians. The retention within Alaska of graduating physician residents exceeds 80 percent, which helps fill the need for primary care physicians within Anchorage and across Alaska. |
|--|--|---|

Addressing Identified Needs

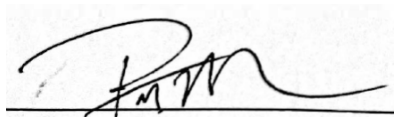
The Community Health Improvement Plan developed for the Anchorage service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how PAMC plans to address health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will

not only describe the actions PAMC intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between PAMC and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2022.

2021 CHNA GOVERNANCE APPROVAL

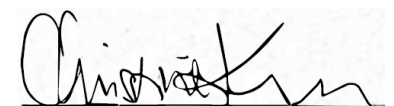
This Community Health Needs Assessment was adopted by the Providence Alaska Region Board⁴ of the hospital on November 16, 2021. The final report was made widely available by December 28, 2021.



11-16-2021

Preston M. Simmons, DSc, MHA, FACHE
Chief Executive, Alaska Providence St. Joseph Health

Date



11-16-2021

Christine Kramer, ANP
Chair, Providence Alaska Region Board, Providence Health and Services Alaska

Date



12-17-2021

Justin Crowe
Senior Vice President, Community Partnerships, Providence

Date

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

⁴ See [Appendix 4: Process Governance and Oversight](#)

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Population Below 200% Federal Poverty Level

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Percent of Population Below 200% Federal Poverty Level Data Source: American Community Survey Year: 2019 | 20.6% | 13.9% | 33.5% |

Across the Anchorage service area, 20.6% of the population was below 200% Federal Poverty Level. Within the Broader Service Area, 13.9% of the population was below the 200% Federal Poverty Level, compared to 33.5% of the population in the high need service area.

Language Proficiency

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|-----------|----------------------|------------------------|
| Percent of Population Age 5+ Who Do Not Speak English Very Well Data Source: American Community Survey Year: 2019 | 2.1% | 0.86% | 4.2% |

Across the Anchorage service area, 2.1% of the population reported that they do not speak English very well. The percentage of the population who did not speak English very well was substantially higher in the high need service area (4.2%) compared to the percentage of the population who did not speak English very well in the broader service area (0.86%).

Percent of Population with A High School Education

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Percent of Population Age 25+ With A High School Diploma Data Source: American Community Survey Year: 2019 | 92.7% | 95.2% | 87.7% |

Across the Anchorage service area, 92.7% of the population over 25 had a high school diploma. The percentage of the population with a high school diploma was higher in the broader service area (95.2%) compared to the percentage of the population with a high school diploma in the high need service area (87.7%)

Percent of Households Receiving SNAP Benefits

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Percent of Households Receiving SNAP Benefits Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data | 8.2% | 4.3% | 15.7% |

Over 8% of households across the Anchorage service area reported receiving SNAP benefits. The percentage of households receiving SNAP benefits was substantially higher in the high need service area (15.7%) compared to the percentage households receiving SNAP benefits in the broader service area (4.3%).

Asthma Prevalence in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Current Asthma Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Year: 2018 | 9% | 8.9% | 9.9% |

The crude prevalence of asthma in the Anchorage service area, 9%, was similar to that of the broader service area, 8.9%. The high need service area had a slightly higher prevalence at 9.9%.

Obesity Prevalence in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|-----------|----------------------|------------------------|
| Current Obesity Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Year: 2018 | 27.7% | 26.7% | 30.3% |

Obesity is defined as having a Body Mass Index above 30. The crude prevalence of obesity across the Anchorage service area was 27.7%. Within the broader service area, obesity crude prevalence was 26.7%, while, within the high need service area, obesity crude prevalence was 30.3%.

Tobacco Use in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|-----------|----------------------|------------------------|
| Current Smoking Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Year: 2018 | 17.3% | 15.9% | 21.6% |

Within the Anchorage service area, the crude prevalence of smoking was 17.3%. The crude prevalence of smoking within the high need service area (21.6%) was higher than the crude prevalence of smoking in the broader service area (15.9%).

Alcohol Consumption in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Binge Drinking Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Year: 2018 | 16.2% | 18.1% | 16.7% |

Binge drinking in males is defined as having five or more drinks on one occasion, and in females is defined having four or more drinks on one occasion. Binge drinking crude prevalence across the Anchorage service area was 16.2%. Within the broader service area, the crude prevalence of binge drinking was 18.1% while in the high need service area the crude prevalence of binge drinking was 16.7%.

Physical Inactivity in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|-----------|----------------------|------------------------|
| Physical Inactivity Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Year: 2018 | 18.6% | 16.2% | 22% |

Physical inactivity is defined as participating in no leisure-time physical activity within the past month. Across the Anchorage service area, the crude prevalence of physical inactivity was 18.6%. The crude prevalence of physical inactivity was higher in the high need service area (22%) than the broader service area (16.2%).

Diabetes Prevalence in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Current Diabetes Crude Prevalence Data Source: Behavioral Risk Factor Surveillance System Year: 2018 | 8.9% | 7.3% | 9.7% |

Across the Anchorage service area, the crude prevalence of diabetes was 8.9%. In the broader service area, the crude prevalence of diabetes was 7.3%, while in the high need service area the crude prevalence of diabetes was 9.7%.

Life Expectancy at Birth in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|------------|----------------------|------------------------|
| Life Expectancy at Birth Data Source: CDC/National Center for Health Statistics Year: 2010-2015 | 79.3 years | 79.8 years | 75.2 years |

The life expectancy at birth across the anchorage service area was 79.3 years. the life expectancy at birth was lower in the high need service area (75.2 years), compared to the broader service area (79.8 years).

Percentage of Veterans in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|--|-----------|----------------------|------------------------|
| Population 18+ who are Veterans Data Source: American Community Survey Year: 2019 | 12.6% | 13.3% | 11.4% |

Across the Anchorage service area 12.6% of the population identify as veterans. Within the broader service area, 13.3% of the population identify as veterans and in the high need service area 11.4% of people identify as veterans.

Households without Internet Access in Anchorage

| Indicator | Anchorage | Broader Service Area | High Need Service Area |
|---|-----------|----------------------|------------------------|
| Households without Internet Access Data Source: American Community Survey Year: 2019 | 7.5% | 4.9% | 13.1% |

Within the Anchorage service area 7.5% of households are without internet access. The percentage of households without internet access in the high need service area (13.1%) is substantially higher than the percentage of households without internet access in the broader service area (4.9%).

HOSPITAL LEVEL DATA

Avoidable Emergency Department (AED) Visits

Emergency department discharges for the year 2020 were coded as “avoidable” per the Providence definition for Providence Alaska Medical Center and nearby Providence hospitals. Avoidable Emergency Department (AED) visits are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Table 9. Avoidable Emergency Department Visits by Providence Hospital in Alaska

| Facility | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|----------------|---------------|-----------------|--------------|
| Providence Seward Medical Center | 1,082 | 437 | 1,519 | 28.8% |
| Providence Valdez Medical Center | 716 | 273 | 989 | 27.6% |
| Providence Kodiak Island Medical Center | 1,847 | 665 | 2,512 | 26.5% |
| Providence Alaska Medical Center | 28,561 | 13,052 | 41,613 | 31.4% |
| Region Total | 32,206 | 14,427 | 46,633 | 30.9% |

Table 10. Avoidable Emergency Department Visits by Race at Providence Alaska Medical Center

| Facility and Race | Non-AED Visits | AED Visit | Total ED Visits | AED % |
|---|----------------|---------------|-----------------|--------------|
| PROVIDENCE ALASKA MEDICAL CENTER | 28,561 | 13,052 | 41,613 | 31.4% |
| Alaska Native/American Indian | 1,972 | 1,390 | 3,362 | 41.3% |
| Asian | 2,221 | 960 | 3,181 | 30.2% |
| Black or African American | 2,730 | 1,383 | 4,113 | 33.6% |
| Native Hawaiian or Other Pacific Islander | 2,957 | 1,475 | 4,432 | 33.3% |
| Other | 1,088 | 537 | 1,625 | 33.0% |
| Patient Refused | 60 | 22 | 82 | 26.8% |
| Unknown | 301 | 97 | 398 | 24.4% |
| White or Caucasian | 17,225 | 7,176 | 24,401 | 29.4% |
| (Blank) | 7 | 12 | 19 | 63.2% |

Table 11. Avoidable Emergency Department Visits by Ethnicity at Providence Alaska Medical Center

| Facility and Ethnicity | Non-AED Visits | AED Visit | Total ED Visits | AED % |
|---|----------------|---------------|-----------------|--------------|
| PROVIDENCE ALASKA MEDICAL CENTER | 28,561 | 13,052 | 41,613 | 31.4% |
| American | 622 | 213 | 835 | 25.5% |
| Filipino | 24 | 19 | 43 | 44.2% |
| Hispanic Or Latino | 2164 | 1039 | 3203 | 32.4% |
| Not Hispanic Or Latino | 25103 | 11532 | 36635 | 31.5% |
| Patient Refused | 62 | 16 | 78 | 20.5% |
| Samoaan | 35 | 17 | 52 | 32.7% |
| Self-identified ethnicities with counts under 10* | 63 | 29 | 92 | 31.5% |
| Unknown | 473 | 167 | 640 | 26.1% |
| (Blank) | 15 | 20 | 35 | 57.1% |

*Ethnicities with any column including fewer than 10 counts were combined into one category

Table 12. Avoidable Emergency Department Visits by ZIP Code at Providence Alaska Medical Center

| Encounters by Patient Zip Code | Non-AED Visits | AED Visit | Total ED Visits | AED % |
|---|----------------|---------------|-----------------|--------------|
| PROVIDENCE ALASKA MEDICAL CENTER | 28,561 | 13,052 | 41,613 | 31.4% |
| 99508 | 4,103 | 2,136 | 6,239 | 34.2% |
| 99504 | 4,083 | 1,840 | 5,923 | 31.1% |
| 99507 | 3,538 | 1,596 | 5,134 | 31.1% |
| 99501 | 2,547 | 1,470 | 4,017 | 36.6% |
| 99503 | 1,994 | 1,012 | 3,006 | 33.7% |

Table 13. Top 5 Diagnosis Groups for Avoidable Emergency Department Visits at Providence Alaska Medical Center

| Top 5 Diagnosis Groups for AED Visits | Avoidable Visits | Percent of Total Avoidable Visits |
|--|------------------|-----------------------------------|
| PROVIDENCE ALASKA MEDICAL CENTER | 13,052 | - |
| Skin Infection | 1,181 | 9.0% |
| Urinary Tract Infection | 963 | 7.4% |
| Bronchitis and Other Upper Respiratory Disease | 957 | 7.3% |
| Substance Use Disorders | 896 | 6.9% |
| Nonspecific Back and Neck Pain | 762 | 5.8% |

Prevention Quality Indicators

Prevention Quality Indicators were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCs are conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications.

More info on PQIs can be found on the following link:

https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx

PQIs were calculated using inpatient admission data for the year 2020.

PQI 90 Description: Prevention Quality Indicators (PQIs) overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications,

diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

PQI 90 Numerator: Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

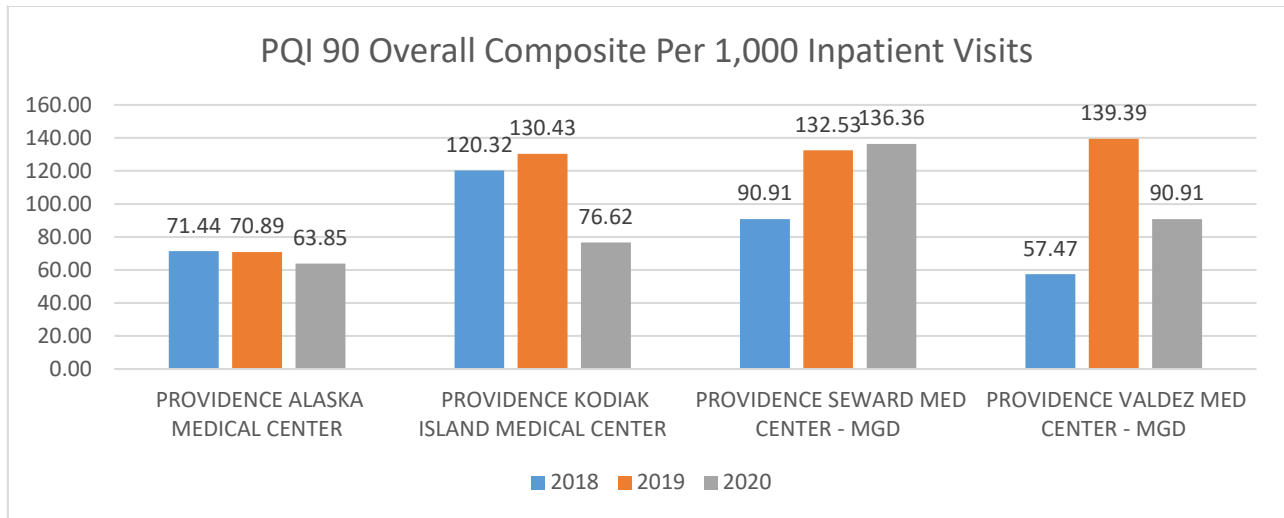
- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI#11 Community-Acquired Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

PQI 90 Denominator: Discharges, for patients ages 18 years and older, at a hospital.

Table 14. Prevention Quality Composite Rates for Providence Alaska Hospitals, 2018-2020

| Hospital | PQI 90 | 2018 | 2019 | 2020 |
|--|------------------------------|---------------|---------------|---------------|
| PROVIDENCE ALASKA MEDICAL CENTER | Numerator | 985 | 961 | 805 |
| PROVIDENCE ALASKA MEDICAL CENTER | Denominator | 13,788 | 13,557 | 12,608 |
| PROVIDENCE ALASKA MEDICAL CENTER | Rate per 1,000 Visits | 71.44 | 70.89 | 63.85 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Numerator | 61 | 63 | 39 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Denominator | 507 | 483 | 509 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Rate per 1,000 Visits | 120.32 | 130.43 | 76.62 |
| PROVIDENCE SEWARD MED CENTER - MGD | Numerator | 10 | 11 | 9 |
| PROVIDENCE SEWARD MED CENTER - MGD | Denominator | 110 | 83 | 66 |
| PROVIDENCE SEWARD MED CENTER - MGD | Rate per 1,000 Visits | 90.91 | 132.53 | 136.36 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Numerator | 10 | 23 | 11 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Denominator | 174 | 165 | 121 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Rate per 1,000 Visits | 57.47 | 139.39 | 90.91 |

Figure 10. PQI 90 Overall Composite Per 1,000 Inpatient Visits, 2018-2020



PQI 91 Description: Prevention Quality Indicators (PQI) composite of acute conditions per 100,000 population, ages 18 years and older. Includes admissions with a principal diagnosis of one of the following conditions: bacterial pneumonia or urinary tract infection.

PQI 91 Numerator: Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #11 Community-Acquired Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate

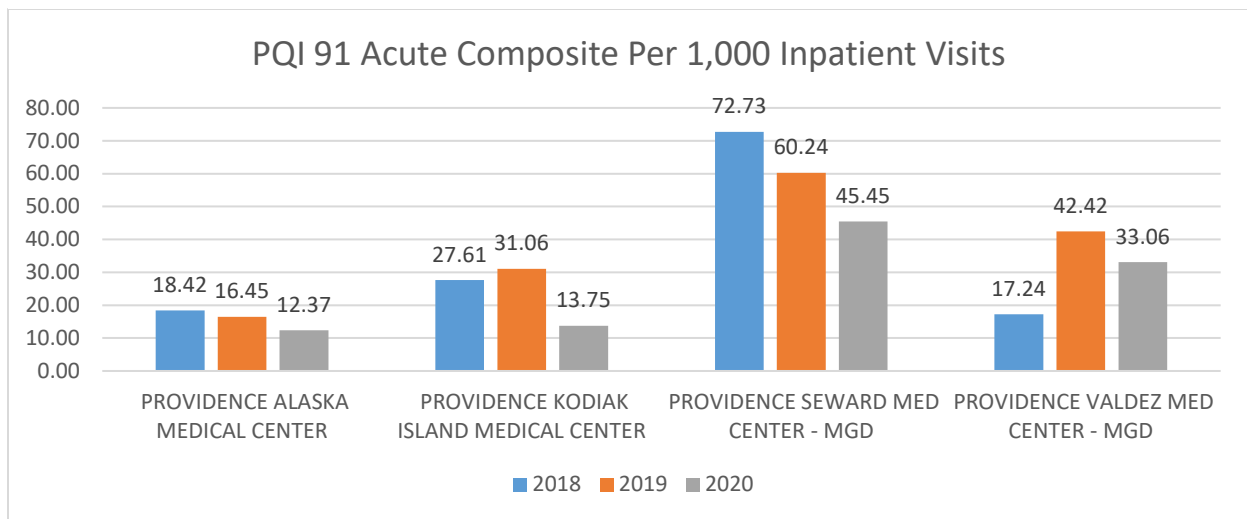
PQI 91 Denominator: Discharges, for patients ages 18 years and older, at a hospital.

Table 15. Prevention Quality Acute Composite Rates for Providence Alaska Hospitals, 2018-2020

| Hospital | PQI 91 | 2018 | 2019 | 2020 |
|--|------------------------------|--------------|--------------|--------------|
| PROVIDENCE ALASKA MEDICAL CENTER | Numerator | 254 | 223 | 156 |
| PROVIDENCE ALASKA MEDICAL CENTER | Denominator | 13,788 | 13,557 | 12,608 |
| PROVIDENCE ALASKA MEDICAL CENTER | Rate per 1,000 Visits | 18.42 | 16.45 | 12.37 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Numerator | 14 | 15 | 7 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Denominator | 507 | 483 | 509 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Rate per 1,000 Visits | 27.61 | 31.06 | 13.75 |
| PROVIDENCE SEWARD MED CENTER - MGD | Numerator | 8 | 5 | 3 |
| PROVIDENCE SEWARD MED CENTER - MGD | Denominator | 110 | 83 | 66 |
| PROVIDENCE SEWARD MED CENTER - MGD | Rate per 1,000 Visits | 72.73 | 60.24 | 45.45 |

| | | | | |
|---|------------------------------|--------------|--------------|--------------|
| PROVIDENCE VALDEZ MED CENTER - MGD | Numerator | 3 | 7 | 4 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Denominator | 174 | 165 | 121 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Rate per 1,000 Visits | 17.24 | 42.42 | 33.06 |

Figure 11. PQI 91 Acute Composite Per 1,000 Inpatient Visits, 2018-2020



PQI 92 Description: Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.

PQI 92 Numerator: Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

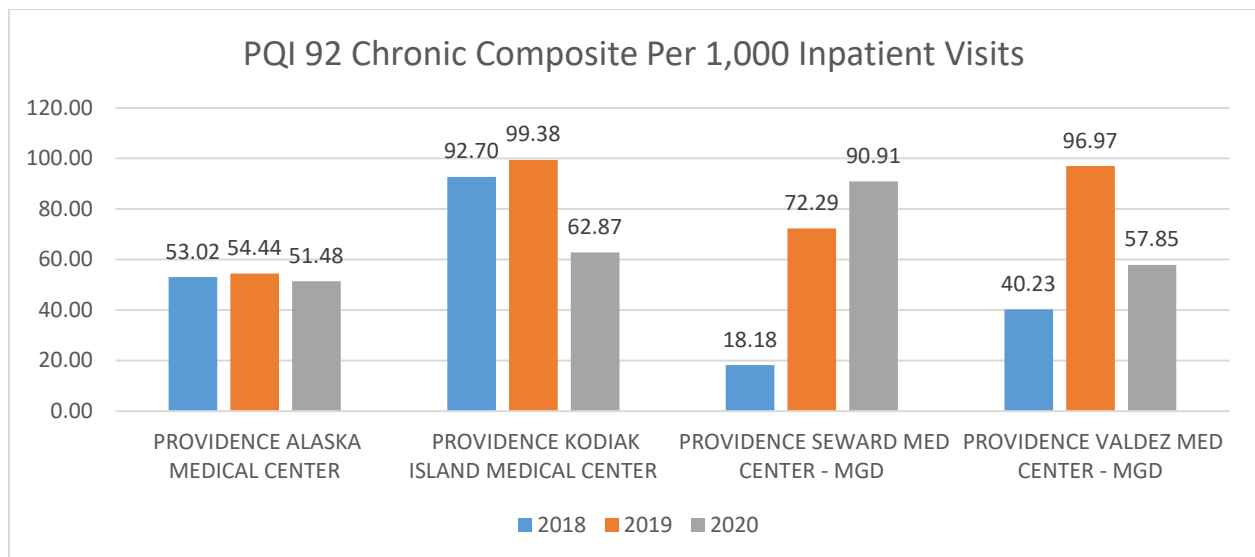
- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

PQI 92 Denominator: Discharges, for patients ages 18 years and older, at a hospital.

Table 16. Prevention Quality Chronic Composite Rates for Providence Alaska Hospitals, 2018-2020

| Hospital | PQI 92 | 2018 | 2019 | 2020 |
|--|------------------------------|--------------|--------------|--------------|
| PROVIDENCE ALASKA MEDICAL CENTER | Numerator | 731 | 738 | 649 |
| PROVIDENCE ALASKA MEDICAL CENTER | Denominator | 13,788 | 13,557 | 12,608 |
| PROVIDENCE ALASKA MEDICAL CENTER | Rate per 1,000 Visits | 53.02 | 54.44 | 51.48 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Numerator | 47 | 48 | 32 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Denominator | 507 | 483 | 509 |
| PROVIDENCE KODIAK ISLAND MEDICAL CENTER | Rate per 1,000 Visits | 92.70 | 99.38 | 62.87 |
| PROVIDENCE SEWARD MED CENTER - MGD | Numerator | 2 | 6 | 6 |
| PROVIDENCE SEWARD MED CENTER - MGD | Denominator | 110 | 83 | 66 |
| PROVIDENCE SEWARD MED CENTER - MGD | Rate per 1,000 Visits | 18.18 | 72.29 | 90.91 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Numerator | 7 | 16 | 7 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Denominator | 174 | 165 | 121 |
| PROVIDENCE VALDEZ MED CENTER - MGD | Rate per 1,000 Visits | 40.23 | 96.97 | 57.85 |

Figure 12. PQI 92 Chronic Composite Per 1,000 Inpatient Visits, 2018-2020



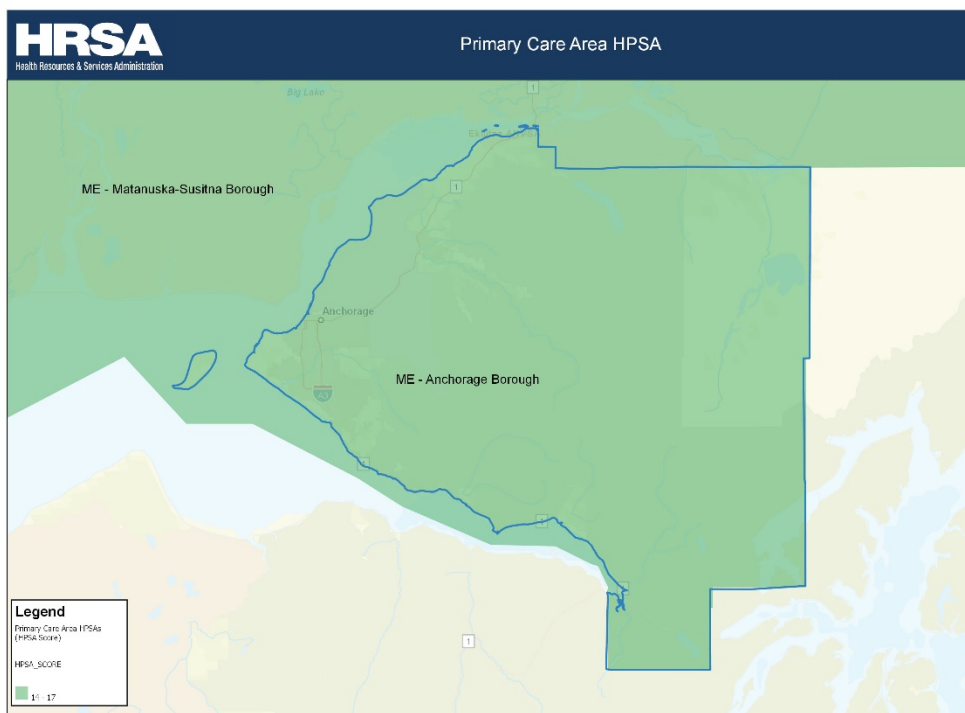
HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. There are three types of HPSAs:

- Geographic HPSA: a shortage of providers for an entire group of people within a defined geographic area.
- Population HPSA: a shortage of providers for a specific group of people within a defined geographic area.
- Facility HPSA: These include correctional facilities, state/county mental hospitals, Federally Qualified Health Centers, Indian Health Facilities, IHS and Tribal Hospitals, and others.

More information can be found on the [HRSA website](#). The Anchorage Borough is designated as a primary care, dental health, and mental health area HPSA. The maps below depict these shortage areas.

Figure 13. Primary Care Area HPSA in Anchorage Borough



data.HRSA.gov

Prepared by:
Division of Data and Information Services
Office of Information Technology
Health Resources and Services Administration
Created on: 12/10/2021

Figure 14. Dental Health Area HPSA in Anchorage Borough

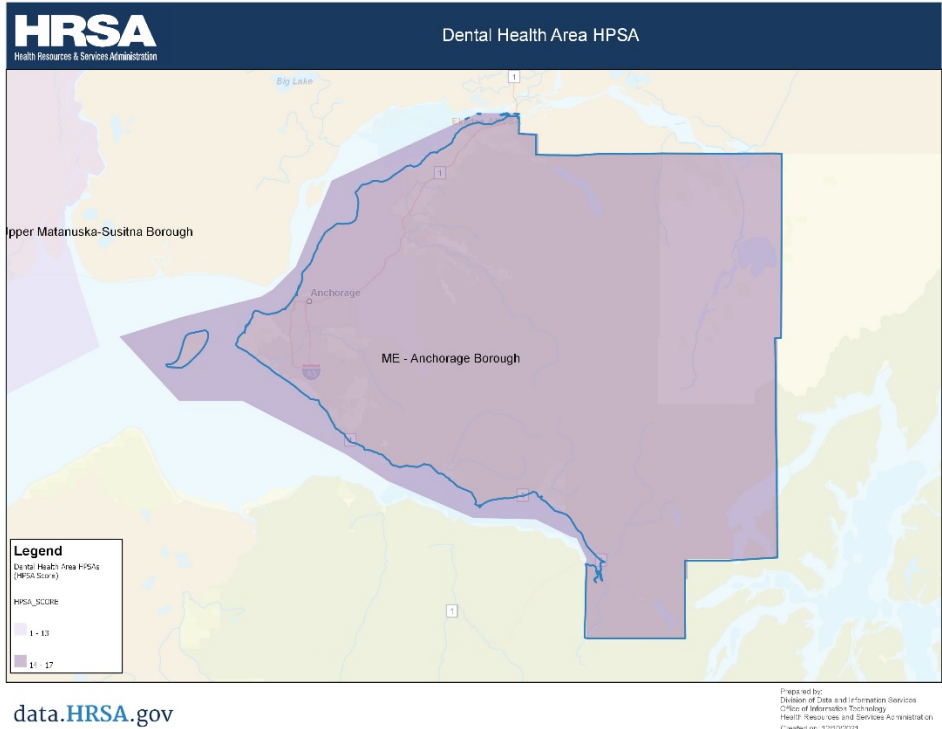
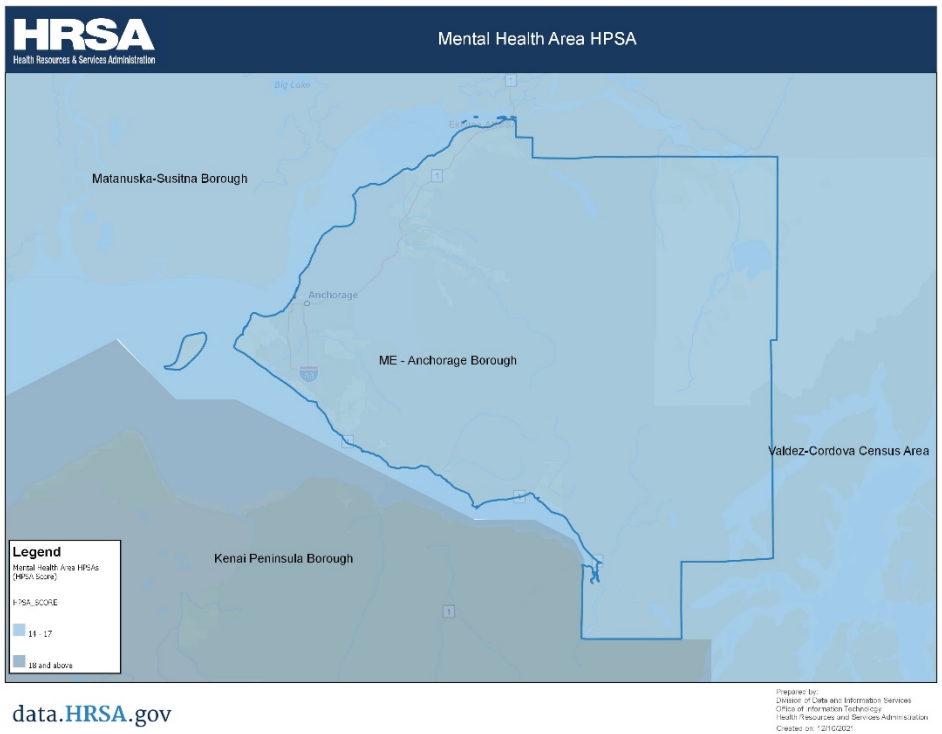


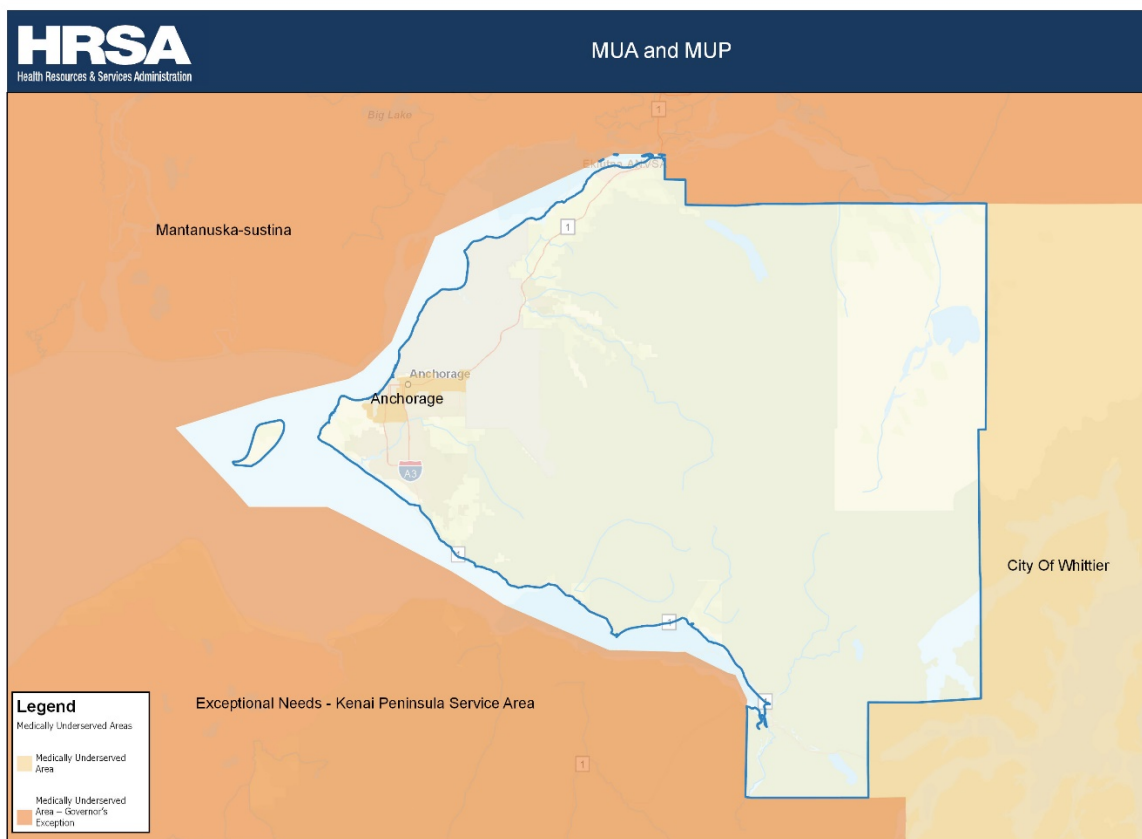
Figure 15. Mental Health Area HPSA in Anchorage Borough



MEDICALLY UNDERSERVED AREA / MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary. Certain census tracts within the Anchorage Borough are designated as a Medically Underserved Area, as depicted in Figure 13.

Figure 16. Medically Underserved Area in Anchorage Borough



data.HRSA.gov

Prepared by:
Division of Data and Information Services
Office of Information Technology
Health Resources and Services Administration
Created on: 12/10/2021

Appendix 2: Community Input

INTRODUCTION

Providence Alaska Medical Center (PAMC) conducted 8 stakeholder interviews with people who are invested in the wellbeing of the community and have first-hand knowledge of community needs and strengths. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA. The goal of the interviews was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

Representatives from PAMC conducted 8 stakeholder interviews from August 18 to September 13, 2021. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. PAMC aimed to engage stakeholders from social service agencies, healthcare, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Human Services Manager from the Anchorage Health Department, the Deputy Director from the Alaska Division of Public Health, and the Director of Public Health from the Department of Health and Social Services.

Table_Apx 1. Key Community Stakeholder Participants

| Organization | Name | Title | Sector |
|--|----------------|--|--|
| Anchorage Health Department | Nicole Lebo | Human Services Division Manager | Public health |
| Alaska Native Heritage Center | Emily Edenshaw | President and CEO | Alaska Native cultural programming and education |
| Anchorage Neighborhood Health Center | Shannon Savage | Chief Communications and Development Officer | Healthcare |
| Catholic Social Services | Lisa Aquino | CEO | Social services, homelessness |
| Department of Health and Social Services | Heidi Hedberg | Director of Public Health | Public health, social services |

| | | | |
|----------------------------------|-----------------|-----------------|--|
| Alaska Division of Public Health | Tari O'Connor | Deputy Director | Public health |
| Rasmuson Foundation | Michele Brown | Senior Fellow | Social services, housing, arts and culture |
| United Way | Clark Halvorson | President | Social services, economic security, homelessness |

Facilitation Guide

Providence developed a facilitation guide that was used across all hospitals completing their 2021 CHNAs (see [Stakeholder Interview Questions](#) for the full list of questions):

- The community served by the stakeholder’s organization
- The community strengths
- Prioritization of unmet health-related needs in the community, including social determinants of health
- The COVID-19 pandemic’s effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Training

The facilitation guide provided instructions on how to conduct a stakeholder interview, including basic language on framing the purpose of the interview. Each facilitator participated in a training on how to successfully facilitate a stakeholder interview and was provided a list of questions to ask the stakeholder.

Data Collection

The facilitator conducted all interviews using the Microsoft Teams platforms and recorded the interviews with participants’ permission.

Analysis

Qualitative data analysis of stakeholder interviews was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned

a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded nine domains relating to the topics of the questions: 1) name, title, and organization of stakeholder; 2) population served by organization; 3) greatest community strength; 4) unmet health-related needs; 5) disproportionately affected population; 6) effects of COVID-19; 7) opportunities to leverage community strengths; 8) successful programs and initiatives; and 9) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as “other,” and similar codes were grouped together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code “food insecurity” can occur often with the code “economic insecurity.” Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Community Strengths

The interviewer asked stakeholders to share one of the strengths they see in the community and discuss how community strengths can be leveraged to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, it is important to highlight and leverage the community strengths that already exist. Stakeholders primarily spoke to two main strengths in the community:

Community partners

Stakeholders spoke to the many nonprofits, businesses, and community organizations that are willing to work together and are committed to making Anchorage a healthier place. They spoke to the COVID-19 pandemic as highlighting the partners’ willingness to address large community issues through systems planning.

“I think that Anchorage, one of its strengths is having a lot of partners and resources, who are interested in making Anchorage a healthier place.” – Community Stakeholder

Stakeholders recommended leveraging this strength through more cross-sector collaboration, bringing together service providers that serve people along the spectrum of life. They also suggested building

local capacity by convening the many partners in the community, ensuring community plans are implemented in a coordinated way. This would reinforce the expertise of partners is leveraged.

“We have a lot of people doing some really amazing work, but it's not always coordinated and it's not always in synergy. I think there's times of competition... If we could be on the same page of what those few north stars are...if we can identify those things, so we take politics out of them, if we can identify who in our community is best to make those investments in to build those resources and do that work, I think that's a huge thing.” – Community Stakeholder

Relationships and connectedness of the community

Stakeholders discussed how community members are willing to help their neighbors, volunteer, and start programs to meet community needs. They noted a strong sense of community and engagement, with people coming together to support projects and movements.

“We're far away from other places, and so we really need to depend on each other in Alaska. I feel like that's a special thing about living up here.” – Community Stakeholder

“I think the community that we work with has that really strong sense of community, they see their neighbors. They want to help, they want to be engaged.” – Community Stakeholder

Diversity and rich community knowledge

Anchorage is rich in traditions and cultures. The Alaska Native community has many tribes represented and many languages are spoken in Anchorage. Culture connects people to who they are, and knowledge passed through generations is a source of strength.

“Our culture, our way of life, our knowledge system, what makes us Indigenous, who we are as people. That's our greatest strength.” – Community Stakeholder

Anchorage is rich in traditions and cultures, with many Alaska Native tribes represented and languages spoken. To leverage the diversity and wisdom of the people living in Anchorage, stakeholders discussed the importance of listening to the community and involving people with lived experience in decision making.

“Leading doesn't always mean you're going to lead something and create something, leading also means you're supporting others doing important work. I would say that, in the context of this conversation, and how to really meet those unmet needs, is to ensure that those solutions are coming from the community that they serve not people in a boardroom who don't have an understanding of what it really means to be homeless, or what it really means to lose your son to suicide, or your daughter to suicide, or these people who are making these decision that these solutions are truly coming from the communities that you serve.” – Community Stakeholder

High Priority Unmet Health-Related Needs

Stakeholders were asked to identify their top five health-related needs in the community. Two needs were frequently prioritized and were categorized as high priority. Three additional needs were categorized as medium priority. The effects of the COVID-19 pandemic are woven throughout the following sections on health-related needs.

Stakeholders were most concerned about the following health-related needs:

1. Behavioral health challenges (includes both mental health and substance use disorders)
2. Homelessness/lack of safe, affordable housing

Behavioral health challenges (includes both mental health and substance use disorders)

Stakeholders identified behavioral health challenges as an upstream cause of violence and abuse. They were particularly concerned about high rates of suicide in Alaska and repeating cycles of substance use disorders, depression, and abuse. They emphasized the need to normalize healing and break cycles of behavioral health challenges in families.

Stakeholders discussed a lack of system capacity to meet patient demand, noting long wait lists, particularly for people with Medicaid or those uninsured or underinsured.

“It’s not that we don’t have [behavioral health services]. They’re just overwhelmed in terms of capacity.” – Community Stakeholder

There is a need for more qualified behavioral health clinicians, although recruitment of qualified applicants is a challenge.

“I think Alaska has this bigger challenge of being able to recruit and hire qualified staff here. We are way north, and we don’t have that same market for some of those individuals.” – Community Stakeholder

They also noted a need for better coordination between primary care and mental health services, describing a disjointed system with gaps in care. Integrating mental health assessments into primary care, or even into schools or childcare, may support identifying behavioral health needs before an acute need.

They noted particular populations may have more barriers to accessing care:

- **Young people:** Challenges with identity, bullying, and social media can contribute to mental health needs for young people. Stakeholders spoke to needing more engaged adults to support young people and to be aware of unsafe situations, abuse, and mental health challenges.

“I’ve seen it time and time again, where there just needs to be more services, more safe places for youth.” – Community Stakeholder

- **Alaska Native population:** There are a lack of substance use disorder (SUD) recovery programs that incorporate cultural practices for Alaska Native people. While the Alaska Native community is disproportionately affected by SUD, they do not have access to many resources that are

culturally specific and responsive. Stakeholders spoke to the importance of programming that incorporates cultural practices and the whole person for healing.

“I would say that the number one thing that I would see is not only A) safe places for Native people to reconcile or to find healing, but B) more of those programs that are really geared towards making sure that people can become more whole.” – Community Stakeholder (3:7)

Stakeholders named racism as a cause of trauma and harm done to Alaska Native communities, including forced sterilization, boarding schools, and more. This racism and trauma, which has not been fully acknowledged nor healed, contributes to mental health challenges, SUD, and homelessness.

“The current systems in place are not designed for [Native American and Alaska Native] people to succeed, and to heal and to become our whole.” – Community Stakeholder

- **People whose primary language is not English**
- **People experiencing homelessness:** Stakeholders spoke to the connection between trauma, mental health challenges, and homelessness.

The COVID-19 pandemic has worsened mental health challenges, causing increased stress and fear. Stakeholders shared social-emotional wellbeing is tied to community connection; yet people are feeling less connected and more alone. It has also made accessing behavioral health services more challenging and not everyone has been able to receive the support they need. Stakeholders noted particular concern for young people and providers who may be experiencing burnout.

Homelessness/lack of safe, affordable housing

Stakeholders shared affordable housing is an enormous need in the community, noting housing is connected to health and stability. Homelessness negatively affects people’s health.

“Really mental health and housing and homelessness are the two things that just, I feel would bring such a measure of stability to our patients' lives.” – Community Stakeholder

They shared the high cost of housing and lack of low-income and affordable rentals make finding stable, good-quality housing challenging. There is a need for more affordable rentals in the community so that people can find stable housing.

“I just say from the perspective of the work that we do, housing and homelessness is an enormous need in our community. We don't have enough affordable housing. That's a real challenge and homelessness is an issue of health.” – Community Stakeholder

“The housing stock here is very expensive. There's very little low-income housing and so making sure people can be in stable housing has been a big challenge for us across the state and specifically in Anchorage.” – Community Stakeholder

Differing community perspectives on how best to address homelessness have provided challenges in meeting community needs.

Stakeholders identified the following populations as disproportionately affected by housing insecurity:

- **People with low incomes:** Housing instability is connected to economic instability. Families living slightly above 200% of the Federal Poverty Level do not qualify for many financial support programs, yet may not have enough income to meet their needs. Therefore, these families may be making spending tradeoffs.
- **The Alaska Native population:** Homelessness is tied to discrimination.
- **People living with disabilities**

They shared the importance of honoring the whole person when addressing homelessness, including integrating cultural programming for Native communities into shelter spaces to ensure people feel seen and welcome.

“There's no space in town where people who are on the street feel like they can come and be seen and see themselves reflected. There's no community day center... The truth is, we need to have a day center for Native people who are on the street grounded in arts and culture.” – Community Stakeholder

They also noted the importance of supporting easier access to coordinated services, including healthcare services, for people experiencing homelessness. Improved coordination may alleviate the burden of people having to transport themselves between different services.

Students experiencing homelessness also need increased support. With remote schooling, there were students who did not have access to light at night or internet, meaning they could not access education.

“Before the pandemic, it wasn't easy to be homeless and go to school, but during the pandemic it was impossible.” – Community Stakeholder

The COVID-19 pandemic has exacerbated housing challenges, with an increase in people seeking shelter, although rental assistance programs have helped keep people in their homes. The pandemic also highlighted the importance of moving people out of shelters into safe, stable housing to prevent the spread of COVID-19 and promote people’s stability.

Medium Priority Unmet Health-Related Needs

Three additional needs were often prioritized by stakeholders:

3. Obesity and chronic conditions
4. Access to health care services
5. Economic insecurity

Obesity and chronic conditions

Stakeholders shared a concern for a lack of primary and preventive care contributing to unmanaged chronic conditions. They noted the COVID-19 pandemic has highlighted systemic inequities contributing to poorer health; people with chronic conditions and obesity have higher risk for poor outcomes from COVID-19 and are also the people who are often underserved. The pandemic has led to people delaying

preventive care with some people not accessing chronic disease management care. Additionally, competing resources to address urgent needs rather than preventive care may have caused some delays.

“I would say that treatments are delayed because of the competing resources. The workforce is exhausted. It's taking longer to provide care and treatment to those that normally would receive it in a more expeditious manner.” – Community Stakeholder

While telehealth is helpful, it does not allow for measuring A1C or blood pressure like in person. Additionally, stakeholders emphasized the importance of primary care homes and viewing health holistically, rather than only through specialized care.

There was particular concern for people experiencing homelessness who may be affected by increased barriers to managing their chronic conditions, including affording medication and accessing care.

Access to healthcare services

Stakeholders identified the following challenges related to access to care:

- **Workforce challenges due to difficulty recruiting staff, particularly specialists:** Healthcare systems continue to experience staffing challenges, making meeting patient demands difficult. There are insufficient medical providers, particularly specialists, and recruiting staff is a challenge.
- **Long wait times for emergency care and overuse of the ED for non-emergent conditions:** Patients without health insurance may use the Emergency Department as their primary source of care. A lack of medical homes for people with barriers to care, including people experiencing homelessness and those without insurance, contributes to the use of the ED for non-emergency needs.
- **High cost of care for patients that are uninsured or underinsured:** Accessing affordable healthcare services continues to be a challenge for patients, particularly those who are uninsured. Some patients may seek financial assistance for an ED visit rather than going to an urgent care facility because of the cost of care.
- **A lack of coordinated care:** While there are many healthcare resources in Anchorage, they are not always coordinated.

Accessing welcoming, culturally responsive, and linguistically appropriate care may be more challenging for the following communities:

- **Black, Brown, Indigenous, and Persons of Color (BBIPOC):** BBIPOC communities are disproportionately affected by economic insecurity and racism, affecting their well-being and access to opportunities. For Pacific Islander, Asian, and Black communities, a lack of robust data can make understanding the unique barriers and needs of these communities more difficult. This has been more apparent during the COVID-19 pandemic.

- **Alaska Native communities:** The Alaska Native community may lack access to information in their native language and healthcare that honors their culture. Providers may not have a lot of knowledge about or awareness of Native culture and history.

“Our service providers need to find ways to empathize with [Alaska Native] people. For them to even understand what collectively our people have gone through, I think that would just set it up for a different type of relationship and the way that they would view Native people.” – Community Stakeholder

- **People whose primary language is not English:** A variety of languages are spoken in Anchorage. Patients whose primary language is not English may have more difficulty navigating the healthcare system, asking for help, and receiving care in their native language.

“Thinking about Anchorage and then about statewide, we have a lot of individuals from other countries that don't know how to access [help] or don't know how to ask for help. English is not their first language.” – Community Stakeholder

- **People experiencing homelessness:** People who have been treated poorly in healthcare or felt shamed for their SUD may be more reluctant to reengage with services.

“Especially those who are experiencing homelessness who might have some of those health or substance misuse issues that I spoke about earlier and/or, might be disenfranchised from all systems, just engaging with healthcare actually is a gigantic event.” – Community Stakeholder

Stakeholders spoke to a need for more providers who are culturally aware and respectful of patients who may have been disenfranchised by healthcare systems. Racism and discrimination are barriers to patients feeling safe engaging with the healthcare system. More cultural programming and training for providers may help with this.

During the COVID-19 pandemic, some patients delayed or were unable to access care. Deferred primary care may have led to worsened health and unmanaged chronic conditions for some patients. COVID-19 highlighted the importance of linking people to a primary care home, as those without one may have had more challenges getting the care they needed.

“Additionally, one of the impacts we've seen, of course, is people who avoided coming in or reaching care. Obviously, this has gone in a little bit of waves. It's not that this has been consistent the entire time, but that feeling that it's not fully safe to come out and about in the community then, of course, means people are not coming in to get their A1C checked for their diabetes or these other things.” – Community Stakeholder

Stakeholders shared telehealth services improved access for some patients, but not for others. Some limitations of telehealth include not being able to take A1C or blood pressure during the appointment. Telehealth appointments may be more challenging for patients needing an interpreter.

Stakeholders shared they had seen an increase in people seeking support to maintain their health insurance after a job loss.

“I highlighted the number of people that we had calling for healthcare referrals. I think that was a highlight of people that lost their jobs. I think we saw a huge impact from folks that were losing their jobs, that were unemployed, that didn't understand how to maintain health coverage and what that would look like.” – Community Stakeholder

The pandemic has also placed increased strain on healthcare providers and systems, made more challenging by staffing shortages. Stakeholders spoke to seeing increased staff burnout. The COVID-19 pandemic has highlighted the importance of data and information sharing related to community health to ensure that schools, organizations, and healthcare providers have up-to-date information for decision making.

Economic insecurity

Stakeholders discussed economic insecurity, including unemployment and lack of living wage jobs, as a challenge connected to many other needs, including housing. Employment is connected to insurance and the ability to afford healthcare services, including medications. Stakeholders were also concerned about income inequality.

Stakeholders identified BBPOC and immigrant communities as disproportionately affected by economic insecurity. They also identified families slightly above 200% of the Federal Poverty Level that do not qualify for many financial support services. This “benefits cliff” means benefits taper off quickly as income increases, leading families to vulnerable situations where they may not have enough money to navigate a crisis. These families may be underemployed, meaning they must work multiple jobs, but do not have sufficient income to thrive.

“Individuals who are just outside of the various economic barriers that would allow them access to discounts, that would allow them access to services but whom realistically are just barely able to pay their bills and who are oftentimes just a short jump away from economic catastrophe. That's something we always worry about, particularly in a pandemic circumstance where that often is that jolt that puts people into that unstable situation that they'd just been barely avoiding.” – Community Stakeholder

The COVID-19 pandemic has affected many families’ financial security, with more families having to make spending tradeoffs, meaning choosing between necessities like medication and food.

“We have seen a real shift in people who are unemployed or financially strapped. And what we've seen is this pandemic has massively impacted people's economic security. The patients who before were still patients of ours, but there was never a point where they had to try and decide which medications that they were going to fill because of the disparity between being able to pay for medicine and being able to pay for food.” – Community Stakeholder

This has been especially true for people working in lower wage jobs, such as the hospitality sector. These workers may have lost their job or hours, affecting their ability to pay for housing. They may have also lost their health insurance.

“I think the people that were hit the hardest, that had the greatest loss of income were those lowest on our income scale. I think we saw them really negatively impacted from it.” – Community Stakeholder

Community Stakeholder Identified Assets

Stakeholders were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs. Their responses are included in the following table:

| Community Need | Program/Initiative |
|--------------------------------------|--|
| Access to healthcare services | Providence Community Health Workers: Especially beneficial was their support connecting the community to COVID-19 related information and services. |
| | <p>The Sullivan Arena clinic operated by Southcentral Foundation, Providence, and Anchorage Neighborhood Health Center: Offers acute and chronic medical care for people experiencing homelessness. Behavioral health services are also provided.</p> <p><i>“We’re bringing everybody to a single point so that we’ve got a lot of services. The fact that all of these different service agencies came together, all of these different healthcare agencies came together to try and create a space where all of us are on the same page, where you don’t have transportation issues or people not getting connected to the next step in their resource support chain. I think that has been phenomenal.” – Community Stakeholder</i></p> |
| Basic needs | Alaska 211 with United Way: A central location for anyone in Alaska to call and gain access to resources. |
| Economic insecurity | <p>Cook Inlet Tribal Council’s Chanlyut program: An eight-month residential work-training program that provides employment, peer-to-peer support, and education and job training. Especially beneficial is this program’s commitment to meeting people where they are.</p> <p><i>“All of the characteristics that make those programs effective or that they’re meeting people where they’re at, whether that’s coming out of incarceration or struggling with like an addiction disorder, it is meeting them where they’re at.” – Community Stakeholder</i></p> |
| Educational opportunities | 90% by 2020: A community collaboration to increase and sustain Anchorage graduation rates, led by United Way of Anchorage. |
| Homelessness and housing instability | The Anchorage Coalition to End Homelessness: A convener of community members, businesses, and providers in Anchorage working towards making homelessness rare, brief, and one-time. |
| | Healthcare and Homelessness Partnership: A collaboration between Catholic Social Services, Providence, Alaska Native Tribal Health Consortium, Alaska Regional Hospital, southcentral Foundation, Anchorage Neighborhood Health Center, and the Municipality of Anchorage. |

| | |
|--|---|
| | Particularly beneficial is the Medical Respite program, which supports recuperation after discharge from a medical facility ,and the Caring Clinic program, which provides preventative medical care. |
| | Inupihany program: A partnership between Alaska Native Heritage Center and Alaska Art Alliance that focuses on reconnecting Alaska Natives experiencing homelessness to art and culture. |

Opportunities to Work Together

Participants were asked, “What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?” Stakeholders shared the following suggestions:

- **Bring together local leaders with healthcare to align priorities:** Stakeholders spoke to the importance of shared goals and priorities across the community. One way to identify these shared goals is to look at the identified needs of other organizations in the community.

“I think really finding ways for us to come together, find those common north stars that we want to work towards that we can come together and make some change.” – Community Stakeholder

- **Partner more with entities already doing the work and engaging the community:** Stakeholders spoke to the importance of strategic memoranda of understanding (MOUs) with organizations that are already engaged in improving community well-being and have established trusted relationships. This includes partnering with Alaska Native organizations that have cultural programming and pathways for receiving input from the community. This is also a way to meet communities where they are.
- **Improve data sharing:** Stakeholders spoke to the importance of integrated data systems that would allow better access to timely information. One opportunity for cross-sector data sharing is between homeless providers and healthcare systems.

LIMITATIONS

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. Due to COVID-19, not all stakeholders invited to participate in interviews were available.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst’s unique identities and experiences.

STAKEHOLDER INTERVIEW QUESTIONS

1. How would you define the community that your organization serves?
2. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization services.
3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.
4. Using the table, please identify the five most important “issues” that need to be addressed to make your community healthy (1 being most important). [see table below]
5. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
6. What suggestions do you have for how we can leverage community strengths to address these community needs?
7. Please identify one or two community health initiatives or programs you see currently meeting the needs of the community.
8. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
9. Is there anything else you would like to share?

Question 4: Using the table below, please identify the five most important “issues” that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.

| | | | |
|--|--|--|---|
| | Access to healthcare services | | Few community-building events (e.g., arts and cultural events) |
| | Access to dental care | | Food insecurity |
| | Access to safe, reliable, affordable transportation | | Gun violence |
| | Affordable childcare and preschools | | HIV/AIDS |
| | Aging problems | | Homelessness/lack of safe, affordable housing |
| | Behavioral health challenges and access to care (includes both mental health and substance use disorder) | | Job skills training |
| | Bullying in schools | | Lack of community involvement and engagement |
| | Community violence; lack of feeling of safety | | Obesity and chronic conditions |
| | Disability inclusion | | Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools) |
| | Domestic violence, child abuse/neglect | | Racism and discrimination |
| | Economic insecurity (lack of living wage jobs and unemployment) | | Safe and accessible parks/recreation |
| | Environmental concerns (e.g. climate change, fires/smoke, pollution) | | Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits) |
| | | | Other: |

Appendix 3: Community Resources Available to Address Significant Health Needs

PAMC and St. Elias cannot address all significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 2. Community Resources Available to Address Significant Health Needs

| Organization or Program | Description of services offered | Significant Health Need Addressed |
|---|---|---|
| Akeela House | Substance use disorder and mental health treatment services. | Behavioral health |
| Alaska Behavioral Health | Serves children and adults who experience a wide range of mental health issues, including children who experience severe emotional disturbance and adults with severe mental illness, with or without co-occurring substance use. | Behavioral health |
| Alaska Dental Society | Provides free dental care to low-income members of the community. | Access to care |
| Alaska Native Medical Center | 167-bed acute care hospital | Access to care |
| Alaska Psychiatric Institute | 80-bed psychiatric acute care hospital | Access to care |
| Alaska Regional Hospital (HCA) | 250-bed acute care hospital | Access to care |
| Alaska School Activities Association | Educates school youth about substance misuse and better choices and health through school activities. | Behavioral health |
| Anchorage Department of Health and Human Services | Promotes good physical and mental health, preventing illness and injury, protecting the environment, and providing helping services to people in need. | Poverty, Healthy behaviors, Behavioral health, Access to care |

| | | |
|--------------------------------------|--|---|
| Anchorage Neighborhood Health Center | Provides primary care, dental, behavioral health, and lab services to low-income populations. | Poverty, Healthy behaviors, Behavioral health, Access to care |
| Anchorage Project Access | Coordinates a volunteer network of healthcare providers to deliver healthcare to those who would not otherwise be able to access care in our community. | Access to care |
| Anchorage Running Club | Provides coordination and support for healthy community running events for all ages. | Healthy Behaviors |
| Anchorage School District | Provides school-based clinics in two diverse, neighborhood schools with low incomes – both focus on health with one specializing in behavioral health. | Access to care, Behavioral Health |
| Catholic Social Services | Serves the poor and those in need, strengthens individuals and families, and advocates for social justice. Services include Clare House, Brother Francis Shelter, and St. Francis House. | Poverty, Behavioral health, Access to care |
| Covenant House | Provides comprehensive services for homeless teens, including housing and a basic care clinic and mental health services. | Poverty, Access to care |
| Ernie Turner Center | Detox and inpatient substance use disorder treatment. | Behavioral health |
| Food Bank of Alaska | Provides food to low-income individuals and families. | Poverty |
| Healthy Futures Program | Provides programs to increase healthy behavior and activities of school aged children. | Healthy Behaviors |
| Lutheran Social Services | Provides aid to low-income individuals and families. | Poverty |
| Neighborworks | Dedicated to improving the quality of life for families and individuals by preserving homes, creating new housing opportunities, and strengthening neighborhoods. | Poverty |

| | | |
|---------------------------------------|--|---|
| North Star Hospital | 140 psychiatric acute care beds (3 locations) | Access to care |
| Providence Alaska Medical Center | 401-bed acute care hospital | Access to care |
| Providence Health and Services Alaska | Addresses community need through programs and services across the continuum, including Nurse Family Partnership, health ministry outreach, health promotion activities, behavioral health services, pediatric specialty services, senior services, family medicine residency program, and community investments. | Poverty, Healthy behaviors, Behavioral health, Access to care |
| Recover Alaska | Works collaboratively with community partners to reduce harm caused by excessive alcohol consumption in Alaska focusing on systems, policy, statutory and practice changes. | Behavioral health |
| St. Elias Specialty Hospital | 59-bed long term acute care hospital | Access to care |
| Stone Soup Group | Provides information, support, training, and resources to assist families caring for children with special needs. | Poverty, Access to care |
| United Way of Anchorage | Combines efforts with partners to ensure Anchorage has strong families, successful kids, healthy kids and adults, workforce affordable housing, and connecting people through a statewide referral system for health and human services information. | Poverty, Healthy behaviors, Access to affordable care |
| University of Alaska | Provides education through their nursing school and the Center for Community Engagement. | Access to care |
| YWCA | Committed to empower women and eliminate racism. Programs include Economic Empowerment, Women's Wellness, Youth Empowerment, Women's Empowerment, and Social Justice. | Poverty, Healthy Behaviors |

Appendix 4: Process Governance and Oversight

2021/2022 PROVIDENCE ALASKA REGION BOARD

Providence Health & Services Alaska

| | |
|--|--|
| <p>CHRISTINE (Potter) KRAMER, DNP, chair Anchorage, AK</p> | <p>JOE N. FAULHABER Fairbanks, AK</p> |
| <p>STEPHANIE KESLER, vice chair Anchorage, AK</p> | <p>SCOTT T. HABBERSTAD Anchorage, AK</p> |
| <p>DONNA LOGAN, secretary VP-Anchorage Operations McDowell Group Anchorage, AK</p> | <p>Kristen Solana-Walkinshaw, MD PAMC – Chief of Staff Family Medicine Residency Medical Director Anchorage, AK</p> |
| <p>PAMELA SHIRRELL, RN Valdez, AK</p> | <p>TANYA KIRK Anchorage, AK</p> |
| <p>LISA D.H. AQUINO, MHS Anchorage, AK</p> | <p>WALTER WILLIAMS, IV Anchorage, AK</p> |
| <p>SARAH BARTON Palmer, AK</p> | <p>STEVE SMITH, MD Providence Kodiak, Chief of Staff Kodiak, AK</p> |
| <p>PAT BRANSON Chair, PKIMC Advisory Board Kodiak, AK</p> | <p>SCOTT WELLMAN Anchorage, AK</p> |
| <p>MARTIN PARSONS Anchorage, AK</p> | <p>KAREN KING Anchorage, AK</p> |
| <p>KIM REITMEIER Anchorage, AK</p> | |
| <p>PRESTON SIMMONS, DSC, FACHE Ex officio member CEO, Providence Health & Services Alaska Anchorage, AK</p> | |

2021 ANCHORAGE CHNA ADVISORY COUNCIL MEMBERS

| Organization | POC/Org. Leader |
|--------------------------------------|--|
| Catholic Social Services | <ul style="list-style-type: none"> • Lisa Aquino, CEO |
| United Way | <ul style="list-style-type: none"> • Sue Brogan • Clark Halverson, CEO |
| Anchorage Neighborhood Health Center | <ul style="list-style-type: none"> • Shannon Savage, Chief Coms/Dev Officer • Tammy Green, CEO |
| Anchorage Community Land Trust | <ul style="list-style-type: none"> • Radhika Krishna Director of Operations • Kirk Rose, CEO |
| Anchorage Health Department | <ul style="list-style-type: none"> • Nicole Lebo, Division Manager |
| Anchorage Literacy Program | <ul style="list-style-type: none"> • Lori Pickett, CEO |
| Alaska Native Heritage Center | <ul style="list-style-type: none"> • Emily Edenshaw, CEO |
| Providence Alaska | <ul style="list-style-type: none"> • Nathan Johnson, Regional Director Community Health Investment |

Appendix 5: CHNA Community Health Survey

Welcome.

Congratulations on taking this next step on the journey to assess and enhance the health and well-being of the Anchorage community! Your 2021 Anchorage Health & Well-being Monitor™ provides a snapshot of your community's health and well-being – perceptions, satisfaction, and behaviors, related to Six Dimensions of Health™ that resonate with your community because they were affirmed by your community.

Having this survey data reveals health and well-being strengths, along with opportunities for improvement. Accompanying countywide 2021 benchmarks throughout your report add preliminary context to your HWBM results.

Most importantly, the Providence Institute for a Healthier Community is honored to join you on your journey to better community health. It is our greatest hope that this report supports your efforts to set community health improvement priorities that enhance the overall health and well-being of your community.

At A Glance

Your Community Health & Well-being Monitor™ Report provides:

1. A snapshot of your community's overall health and well-being
2. Preliminary benchmark data to contextualize your results
3. Insights into focus areas for improvement
4. A way to monitor progress over time, with subsequent Health & Well-being Monitor studies and reports.



A Letter from the Executive Director

On behalf of the entire Institute team, thank you for your commitment to the health and well-being of our communities. You join a broad array of organizations building this work together over more than a half-decade. This report, along with all the work of the Providence Institute for a Healthier Community, is organized around Six Dimensions of Health™ and well-being, based on foundational work of the institute in community-based participatory research in 2015, listening to and learning how communities define health and well-being.

The original research drew on insights from 130 community members from organizations as diverse as Familias Unidas, Native peoples, the NAACP, Minority Achievers Program alumni, low-income housing residents, university students, YMCA members, faith leaders; street interviews; and conventional focus groups of different ages, income and geography. The question was simple: how do you define health and well-being? In that qualitative work, combined with literature review, 24 common attributes emerged. We tested the model in a regional January 2016 survey fielded by Elway Research, augmented by nationally validated questions. Factor analysis of those 24 attributes revealed natural groupings into Six Dimensions of Health™ faithful to the voice of the community.

Since 2016, over 10,000 people have participated in the institute's regional and Community Health & Well-being Monitor studies, yielding a growing body of research data including under-represented populations unlikely to be included in conventional research, along with innovations in community-based fielding techniques.

Your Anchorage 2021 survey

Your 2021 Health & Well-being Monitor relies on a robust probability sample of 604 randomly selected residents of Anchorage. This is the first such comprehensive, community-based study of well-being in Anchorage history. Our work has demonstrated that when communities review the survey results together, they can become a reliable barometer for planning and prioritizing. These results will serve as a baseline for more targeted community studies (including some underway currently) and future measures of change. In this round we have provided preliminary benchmark results based on a sample of Snohomish County, Washington residents during the same time period (June 2021). In the future, your Anchorage 2021 results will serve as a better benchmark. In the meantime, we believe your data provides powerful insights for planning and prioritizing.

Our entire institute team thanks you for your commitment to community well-being. Now, let's get to your results.

In good health,

Scott Forslund

Providence Institute for a Healthier Community

How Your Results are Organized

Your results for Anchorage 2021 are organized into three parts:

1.Part I: Summary Results & Six Dimensions Roadmap

2.Part II: Key Findings

- Your Core4™ Well-being Index Score
- Your HWBM Composite Measure™ (the “Speedo”)
- “One More Thing”: Your Respondents’ Wishes for Health
- Your Cantril’s Ladder well-being score

3.Part III: Detailed Results

- Charts, graphs and highlights for each indicator, organized into Six Dimensions of Health
- Index to Results of your Tailored Questions (reported in the relevant Six Dimensions section.)

Appendices: Here you will find a summary of the Survey

Methodology. Verbatims of open-ended questions available upon request.



Table of Contents

| | |
|--|-----------|
| Things to Keep in Mind | 4 |
| | |
| PART 1: Summary Results | 5 |
| | |
| Dashboard | 6 |
| | |
| Six Dimensions Roadmap | 7 |
| | |
| PART 2: Key Findings | 8 |
| | |
| Your Core4™ Well-being Index Score | 10 |
| | |
| Your HWBM Composite Measure™ (the “Speedo”) | 12 |
| | |
| “One More Thing”: Respondents’ Wishes for Health | 13 |
| | |
| Individual and Community Level Can-DO™ | 14 |
| | |
| Your Cantril’s Ladder Well-being Score | 17 |
| | |
| PART 3: DETAILED RESULTS | 19 |
| | |
| APPENDICES | 62 |
| | |
| | |

Things to Keep in Mind

- **It All Matters:** look at the data, but remember a start anywhere is a step towards better overall health and well-being.
- **Tune In to Heart & Soul:** what are your communities' interests, priorities, and values? They matter.
- **Start Small:** Is there an easy 'win'? Build confidence and self-efficacy - 'We Can Do This.'
- **Assess Resources:** Have enough people, time, money or other supports? Supports ensure your success.

The 'health' of each area influences, impacts, & contributes to other areas and overall well-being. Well-being is dynamic.



Six Dimensions of Health

Well-being is broad definition addressing many attributes—happiness, health, stability, purpose and meaning. Health is multi-dimensional. Your HWBM Report represents six dimensions of well-being that resonated with communities like yours. A spirit of learning, and growing in each of these dimensions is important if we are to feel fulfilled and whole as individuals and communities, both in the absence and presence of disease!



Relationships & Social Connections



Mental, Emotional & Spiritual Health



Neighborhood & Environment



Work, Learning & Growth



Security and Basic Needs



Physical Health



Isolation is fatal, according to psychiatrists Jacqueline Olds and Richard Schwartz. Their decades of research support the idea that a lack of relationships can cause multiple problems with physical, emotional, and spiritual health.

Summary Results and Six Dimensions of Health Roadmap





Anchorage, Alaska 2021 Dashboard

Key

Above Benchmark
At Benchmark
Below Benchmark

Your Engagement Results

SAMPLE FRAME: Municipality of Anchorage, Adults 18+
SAMPLE SIZE: 604 phone, direct mail/online
POPULATION: TOTAL: ~290,000 | ADULTS 18+: ~220,000

Core4 Well-being Index

1 metric, linked to Core4™ measures, with benchmarks
See page 10

7.31

Anchorage, Alaska
2021
"C"

7.28

Benchmark
Snohomish County WA 2021
"C"

CORE4™ Well-being Scores

Satisfaction Indicators
A catalyst for change
See page 11

7.3

Life Satisfaction
Benchmark: 7.2

7.0

Physical Health Satisfaction
Benchmark: 6.8

7.4

Mental Health Satisfaction
Benchmark: 7.4

7.5

Overall Health Satisfaction
Benchmark: 7.6

HWBM Composite™

The distribution of your community's well-being
See page 12

13%

Struggling
Benchmark: 11%

33%

Mixed
Benchmark: 46%

40%

Doing Well
Benchmark: 35%

14%

Flourishing
Benchmark: 9%

Your CAN-DO™ Scores

Capacity & Motivation to improve:
Individual and your community
See page 14

68%

Individual Capacity
Benchmark: 70%

46%

Individual Low Motivation
Benchmark: 46%

22%

Individual High Motivation
Benchmark: 24%

24%

Community Efficacy
Benchmark: 18%

Six Dimensions Of Health™

See page 19



Relationships & Social Connections



Mental, Emotional Spiritual



Neighborhood & Environment



Work, Learning & Growth



Security & Basic Needs



Physical Health

The Six Dimensions Roadmap

Key: Green: Above benchmark | Blue: At benchmark | Red: Below benchmark | Black: Tailored questions/no benchmark available

Work, Learning and Growth

Your work/job rating (6d)
Opps for learning/growth rating (6h)
Sense of purpose & meaning (7b)
Educational/training gap - living wage (9f)
Job insecurity/unemployed (9e)

Physical Health

Physical health satisfaction (4)
Physical health current state (6b)
Medical/health condition (18)
Poor physical health days/mo (11)
Debilitating health days/mo (13)
Behavior: days fruit & veggies (14a)
Behavior: days exercise >30 mins (14c)
Behavior: days sleep 7+ hrs (14d)

Neighborhood and Environment

Neighborhood quality rating (6a)
Behavior: days fruit & veggies (14a)
Behavior: days exercise >30 mins (14c)
Feel Safe in my Community (q7f) **T**
Community as a place to raise children (q7g) **T**
Community as a place to grow old (q7h) **T**

Mental, Emotional & Spiritual Health

Mental/emotional wellbeing satisfaction (5)
Emotional wellbeing rating (6e)
Religion/spirituality importance (7a)
Sense of purpose & meaning (7b)
Poor mental health days/month (12)
Debilitating health days/month (13)
Need for Mental Health/Substance Use Tx (a106) **T**
Ability to get MH/Substance Use Tx (a107) **T**
Barriers to get MH/Substance Use Tx (a108) **T**
Suicidal Ideation (a109) **T**

Additional Tailored Questions (T)

Includes 8 black-colored questions (designated with a "T") in Six Dimensions sections plus the following 8 questions:

Covid-19 Personal Impacts (a2) **T**
Covid Vaccination Status (a3) **T**
Reasons to avoid Covid vaccine (a4) **T**
Binge Drinking (a104) **T**
Alcohol consumption vs. pre-Covid (a105) **T**
Smoking/Vaping (a112) **T**
Confidence Achieving Best Health (a110) **T**

Security & Basic Needs

Future financial security rating (7d)
Ability to meet basic needs (6f)
Behavior: frequency skip meal lack of \$ (14e)
Access to health care insurance (17)
Access to health care & info (6c)
healthcare visits past 12 mo (15)
SDOH: TotalHEALTH 7
Food insecurity (9a)
Transpo lack/worries (9b)
Homeless/unstable housing (9c)
Trouble paying utility bills (9d)
Job loss/insecurity (9e)
Education/training gap - living wage (9f)
Intimate violence/unsafe at home (9g)

Relationships & Connections

Relationship rating (6g)
Sense of community belonging (7e)
Community efficacy (7c)
Getting together with friends (14f)
Talking with neighbors (14b)
Discrimination (8)
Help with Chores if Sick (a111) **T**

Key Findings

Core4™ Well-being Index Score

HWBM Composite Measure™

“One More Thing”: Respondents’ Wish for Health

Individual & Community Can-DO™

Cantril’s Ladder Score



Key Findings

Core4™ Well-being Index

HWBM Composite Measure

'One More Thing': Respondents' Wish for Health

Cantril's Ladder Score

»» At A Glance

The Core4™ Index is linked to:

- Poor health days
- Eating fruits and vegetables
- Talking more with neighbors
- Exercising more regularly
- Getting a good night's sleep
- Getting together with family & friends
- Neighborhood health
- Physical health
- Access to medical care and health information
- Work or job ratings
- Mental & emotional well-being
- Ability to meet basic need
- Satisfaction with relationships
- Educations, learning and growth
- Faith and spirituality
- Purpose and meaning
- Ability to influence my community
- Financial security
- Community belonging

KEY FINDINGS

- The Anchorage 2021 Core4 Well-being Index Score was 7.31 or a "C" (similar to the HWBM Snohomish County WA 2021 Benchmark, provided temporarily since Anchorage has no direct benchmark).
- Health is unevenly distributed in the community. Key opportunities in each of the Six Dimensions of Health are highlighted here; details follow, along with insights on which priorities explain the greatest differences in overall community well-being.
- *Equity and Discrimination is an issue in Anchorage and across the country. This survey has an insufficient sample size of BIPOC residents to provide a reliable picture of impacts in Anchorage. We are fielding a separate community-based survey now.*

Security & Basic Needs:

- 37% of residents do not feel secure about their financial futures
- 1 in 4 are challenged meeting basic needs, and 28% are lacking at least one key need area such as insecure food (10.9%), housing (10.4%), transportation, job, and unsafe personal relationships (5%).

Mental & Emotional Well-being

- On average, residents reported 6.3 days per month of poor mental health days, and 4.3 days of debilitating health days, unable to carry out their usual activities.
- 1 in 5 needed mental health services or substance use treatment, but nearly half of whom were unsuccessful securing services.
- Nearly 7% of residents -- 14,000 people -- seriously contemplated suicide in the past 12 months. 34% sought but were unsuccessful accessing mental health services.

Relationships & Social Connections

- 44% do not feel part of the community; 30% do not feel confident they can get help if they are ill; and 23% report active discrimination (*see comment above*).

Work, Learning & Growth

- 10% were unemployed, 15% job insecure, and 21% lack training necessary to maintain a living wage. Over 1 in 4 lack opportunities for learning and growth.

Physical Health

- Residents average nearly a week (6.1 days) per month of poor physical health days.
- 37% report medical conditions requiring special treatment, with 55% reporting difficulties accessing needed health care and health information.

Neighborhood & Environment

- Only 4 in 10 feel strongly that they are safe in their community, or that Anchorage is a good place to raise children and to grow old.

Tailored Questions

- Covid-19 has had a significant impact on community health.
- 16% of respondents are drinking more, and 14% report binge drinking.

CORE4™ WELL-BEING INDEX SCORE

AVERAGES (0-10)



*NOTE: For most key well-being measures we display your overall community average, along with the averages for residents who are "**STRUGGLING**" and "**FLOURISHING**" (see HWBM Composite Measure description on page 11).*

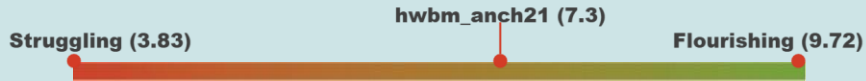
Key Findings

- Anchorage has a Core4 Well-being Index Score of 7.31 (a 'C').
 - Among 13% who are STRUGGLING, the score was 3.65 (F).
 - Among 14% who are FLOURISHING, the score was 9.7 (High A).
- This is the first study for Anchorage and as such forms a baseline.
- It was marginally above a preliminary 2021 benchmark mean score of 7.28 (for Snohomish County, Washington). In future, Anchorage will have its own past benchmarks for comparison.
- Overall, Core4 scores were higher among men, people over 55, employed, incomes > \$75K. Your Core4 Well-being Index scores were most strongly correlated with:
 - Perceived neighborhood quality (.74)
 - Emotional well-being (.65)
 - Sense of purpose and meaning (.64)
 - Security about financial future (.63)
 - Current financial ability to meet basic needs (.56)
 - Physical health rating (.59)
 - Opportunities for learning and growth (.59) Number of poor mental health days / month (-.58)
 - Relationships with other people (.54)
 - Work or job rating (.54)
 - Quality of relationships (.54)
 - Sense of belonging and community connection (.54)
 - Access to healthcare and health info (.51)
 - Debilitating health days/month (-.50)
- Well-being was moderately correlated with perceptions of community safety, and perceptions of Anchorage as a good place for elders and to raise children (.40-.47).
- Overall well-being was weakly associated with health behaviors:
 - Frequency of eating fruits & veggies (.28)
 - Days with 30+ minutes of walking/exercise (.27)
 - Nights with 7+ sleep hours (.21)

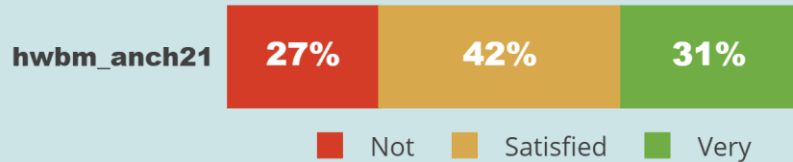
CORE4™ WELL-BEING COMPONENT SCORES

Thinking about your overall life, are you satisfied or dissatisfied with the way things are in your life these days? (2)

AVERAGES (0-10)



DISTRIBUTION

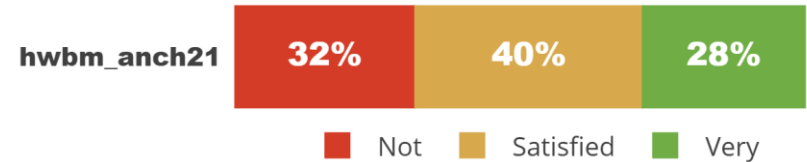


Thinking about your physical health, are you satisfied or dissatisfied with the current state of your physical health? (4)

AVERAGES (0-10)



DISTRIBUTION

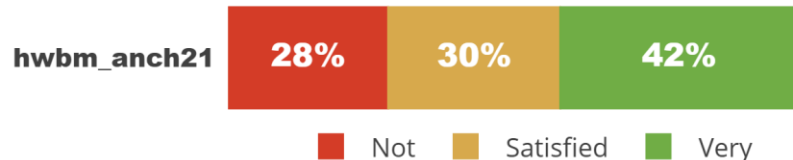


Thinking about your mental or emotional well-being, how satisfied or dissatisfied are you with the state of your mental or emotional well-being? (5)

AVERAGES (0-10)

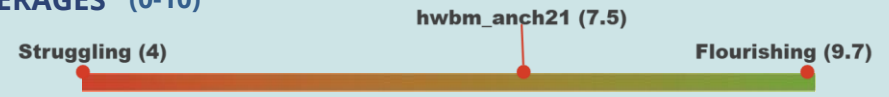


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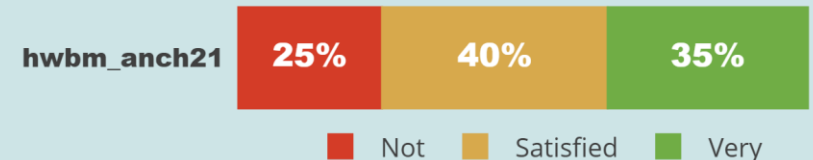


Taking everything into account, how satisfied are you with your overall well-being? (10)

AVERAGES (0-10)



DISTRIBUTION



HWBM Composite Measure™

The Core4™ Index Score provides a single measure of well-being based on four key aspects – overall life, physical, mental/emotional/spiritual, and overall well-being.

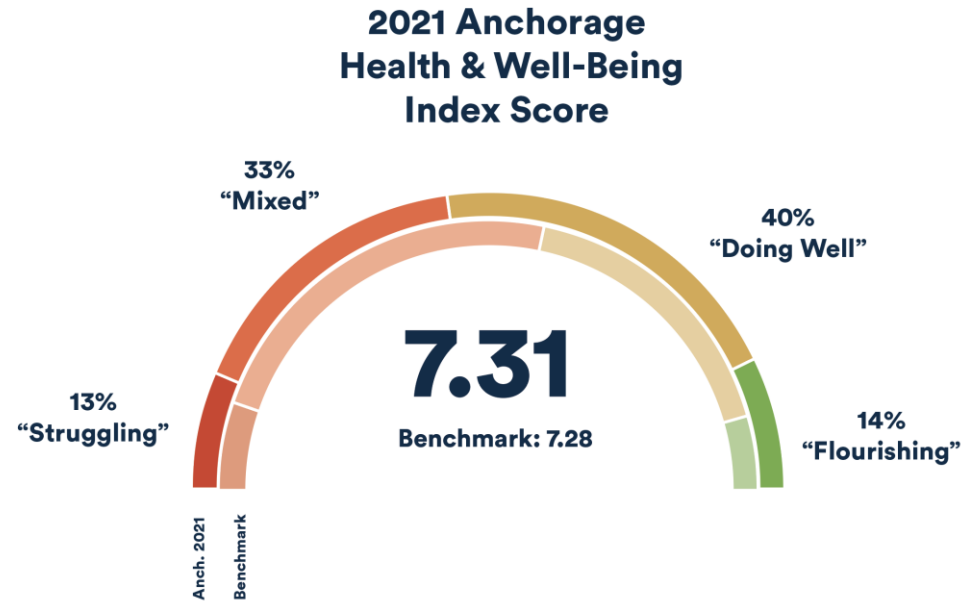
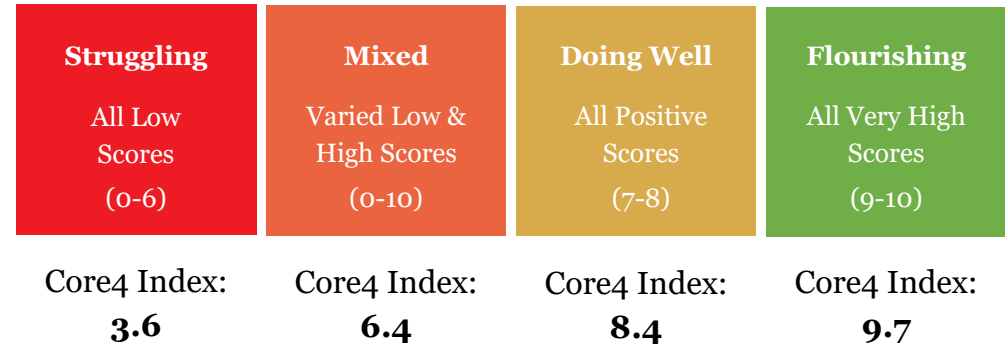
However, a calculated average does not tell the whole story. Six years of research with over 10,000 respondents has shown that many things must go well for well-being to flourish.

The HWBM Composite Measure™ is a picture of how each member of your community is doing across all four Core4 measures.

- People who are scoring highest (9-10) on all four are FLOURISHING
- Those whose scores are all positive (7-10) are DOING WELL.
- People with a mix of lower and higher scores (0-10) are MIXED.
- People whose scores are all low (0-6) are STRUGGLING.

Your community's Composite Measure is displayed on an arc (we call The Speedo), compared to a broader community benchmark – in this case, all of Snohomish County, Washington, in 2021.

The Composite Measure categories strongly link to the Core4 Index scores as the chart at right shows.



Individual & Community Level Can-Do™



Why It Matters

We are humans becoming—always on a journey. As life continually changes, our beliefs and what we think is important changes. In this continual ebb and flow, a sense of self-efficacy* can play a major role in how one approaches goals, tasks, and challenges, and either takes action or doesn't take action in cultivating well-being. Moving towards a greater sense of self-efficacy makes a difference in improving and, more importantly, sustaining overall well-being.

Your Can-Do™ score gives insights into your community's current CAPACITY to improve well-being and MOTIVATION to change. Capacity is the % of respondents who say they can be doing more to improve their health. Motivation is indexed by the percentage who say they can do "a little more" or "a lot more." You can compare your community profile to a larger community benchmark – and to your own baseline when you run a follow-up Monitor™ in the future.

INDIVIDUAL vs. COMMUNITY EFFICACY. We provide you with insights into your respondents' capacity to improve their INDIVIDUAL well-being, as well as your community's belief that it can influence well-being on a community-level.



What this Community Can Do

Create experiences for mastery using small achievable goals and cooperative learning strategies. Progress creates positive cycle of success. Reflect on accomplishments, and recognize strengths you already have to achieve new goals.

Highlight stories of people similar to your community who have succeeded and sustained their efforts. People learn by observing others, especially role models. Influential people make a difference—parents, leaders, teachers, etc. Hearing 'we can do it' strengthens our beliefs that we have what it takes.

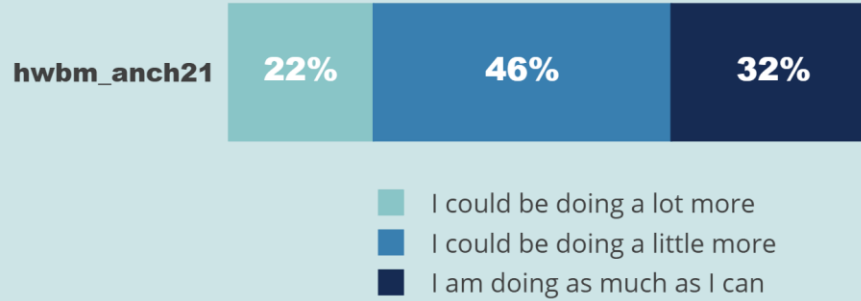
Create nurturing environments—emotions influence self-efficacy. Stress, anxiety, and depression have a 'negative' interpretation from society. Recognize emotions as normal and okay, while also working to address anxiety, depression and negative perceptions.

Create vision boards or other visual imagery, to influence self-efficacy through 'imagination experiences'.

**Self-efficacy beliefs determine how people feel, think, motivate themselves and behave -a sense of mastery over yourself, confidence to affect life's challenges, and abilities to control your environment. Self-efficacy has been linked to well-being and strengths processes, such as resilience, in past studies and is considered a basic human need.*

When it comes to maintaining or improving your health, which of these statements best describes you. I could be doing: (16)

DISTRIBUTION

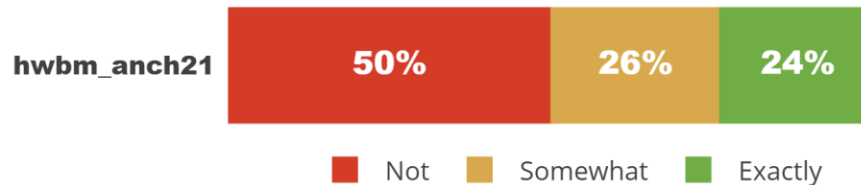


Key Findings

- 68% say they can do more; 32% are doing all they can.
- 51% with high ratings are DOING WELL/FLOURISHING; 42% with low ratings are STRUGGLING/MIXED
- Higher motivation among seekers of healthcare in general and mental health especially.
- Lower motivation among couples w/o children, people over age 75, less than HS education, and reporting transportation barriers.

If I made up my mind to try, I could have a significant influence on decisions being made in my community (7c)

DISTRIBUTION



Key Findings

- Average rating: 6.2/10.
- 74% with high ratings are DOING WELL/FLOURISHING; 60% with low ratings are STRUGGLING/MIXED
- High scores: age over 55, strong ratings of relationships, job, physical & emotional health, purpose & meaning, financial security, community belonging, and views of Anchorage as safe, and a good place for children and elders.
- Lowest scores for age 18-24, nonwhites, those reporting poor healthcare access.

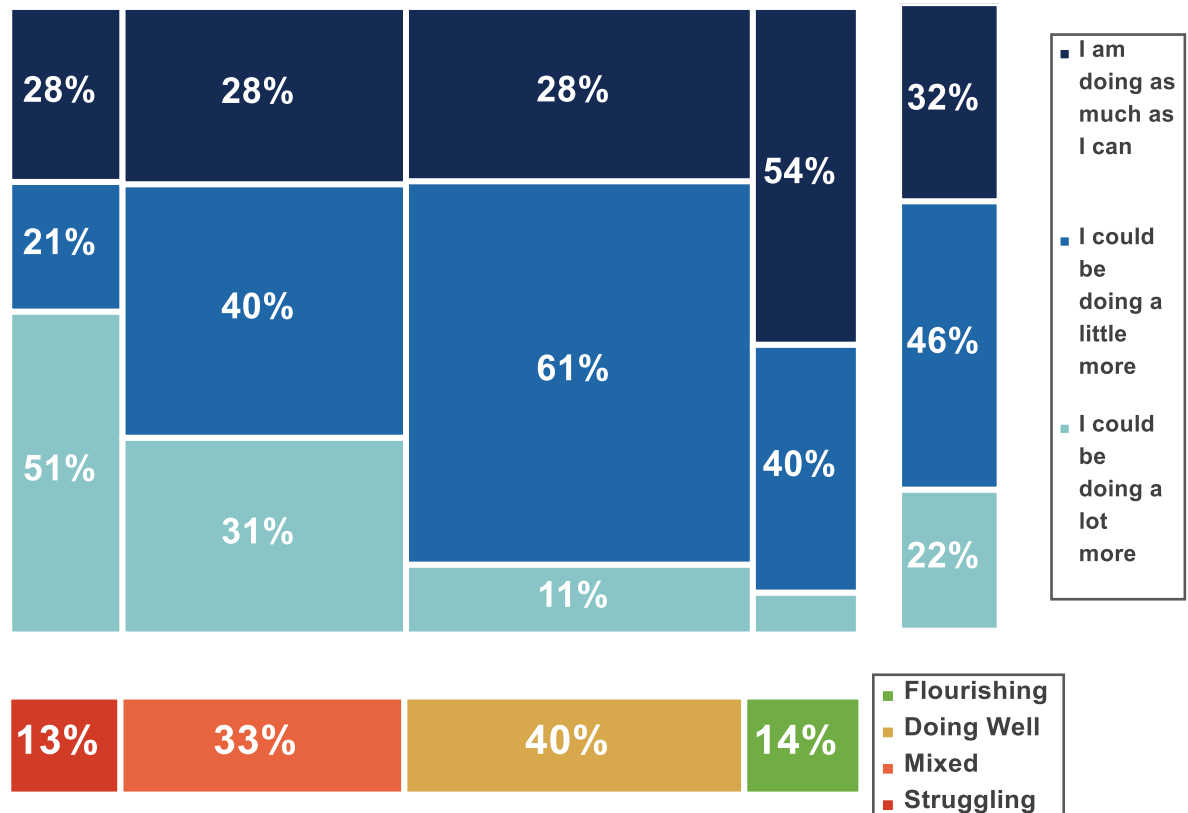
Can-Do™ By Well-being Level

The Can-Do Grid™ reveals a capacity and motivation of Anchorage community members to improve their health at every level of well-being, from STRUGGLING to FLOURISHING.



This grid presents a promising picture relative to the benchmark community. Anchorage residents report:

- Capacity to improve consistent for all but FLOURISHING.
- Motivation to do a LOT more is distributed where it can make the greatest difference: among those classified as “STRUGGLING” and “MIXED.” Higher than benchmark communities.
- Especially given the outsized focus on health in a Coronavirus era, this is a community at an inflection point.



Cantril's Ladder

The Cantril Self-Anchoring Scale, developed by pioneering social researcher Dr. Hadley Cantril in 1965, is a well validated and widely used measure of general well-being, including Gallup's World Poll of more than 150 countries, representing more than 98% of the world's population, and Gallup's in-depth daily poll of America's well-being (Gallup-Sharecare Well-Being Index; Harter & Gurley, 2008).

- The “Cantril’s Ladder” questions correlate with multiple indicators of well-being on this survey.
- Compared to the HWBM Core4™ Index, Cantril’s Ladder scores generally are not as strongly correlated with a range of health and well-being indicators.
- Inclusion of the Cantril’s results adds a comparative, independent measure to your results and serves to further validate the strength of the Health & Well-being Monitor Core4™ Well-being Index and survey.
- **Based on Gallup groupings, your residents are most likely to fall at the low margin of the “THRIVING” category.**

Further description of the Cantril’s Ladder Scale from Gallup follows here:

Analyses of data from different regions of the world make it clear that the general tendency is for respondents to provide more optimistic views of the next five years than the present. This is the case for respondents in most countries, with a few exceptions. Based on statistical studies of the ladder-present and ladder future scale and how each relates to other items and dimensions as outlined above, Gallup formed three distinct (and independent) groups, for summary purposes:

THRIVING: Well-being that is strong, consistent, and progressing. These respondents have positive views of their present life situation (7+) and have positive views of the next five years (8+). They report significantly fewer health problems, fewer sick days, less worry, stress, sadness, anger, and more happiness, enjoyment, interest, and respect.

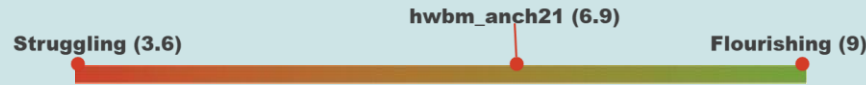
[NOTE: Because a score of 7 is typically below the average score for communities, in this analysis we break out THRIVING further, into THRIVING/LOW (7-8 ratings) and THRIVING/HIGH (9-10 ratings).]

STRUGGLING: Well-being that is moderate or inconsistent. These respondents have moderate views of their present life situation OR moderate OR negative views of their future. They are either struggling in the present, or expect to struggle in the future. They report more daily stress and worry about money than the “thriving” respondents, and more than double the amount of sick days. They are more likely to smoke, and are less likely to eat healthy.

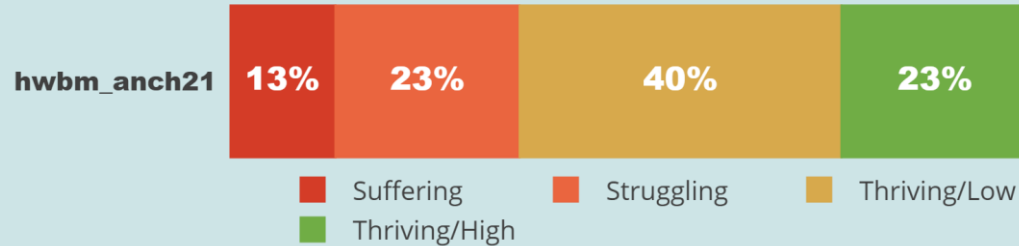
SUFFERING: Well-being that is at high risk. These respondents have poor ratings of their current life situation (4 and below) AND negative views of the next five years (4 and below). They are more likely to report lacking the basics of food and shelter, more likely to have physical pain, a lot of stress, worry, sadness, and anger. They have less access to health insurance and care, and more than double the disease burden, in comparison to “thriving” respondents.

Imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you. (C1)

AVERAGE (0-10)



DISTRIBUTION



Key Findings

Average score: 6.9.

- 85% with high ratings are DOING WELL/FLOURISHING;
- 84% with low ratings are STRUGGLING/MIXED

Higher scores:

- over age 55,
- HH income over \$75K
- Mental healthcare seekers reporting good access to care
- high neighborhood ratings; views Anchorage as safe and good for children and elders
- good physical health, access to healthcare, work/job, emotional wellbeing, relationships
- financially secure, opps for learning & growth, spirituality important, strong sense of purpose & meaning, ability to influence community.

Lower scores:

- Self-defined gender
- ages 18-24
- jobless and students
- HH income under \$50K
- HS or less education
- Singles living with other adults
- Non-whites
- Those needing but not able to access mental health services
- Insecure or lacking basic needs including food, transpo, housing, job, personal safety.



Dimension 1

Relationships & Social Connections

Healthy relationships are vital to health. Strong family ties, friendships, and partnerships can increase our sense of security, self-esteem, and belonging and provide a buffer against stress, anxiety, and depression. Low social connection is linked to declines in physical health, healing and mental health.

Overall Scores



- **86% above benchmark**
- **14% at benchmark**
- **0% below benchmark**

What This Community Can Do

Advocate for the time and energy needed to build relationships, foster trust, civic engagement and support equity and fairness where people can share their interests, connect and empathize with one another.

KEY FINDINGS

Among 7 key indicators, Anchorage was above benchmark on 6 (86%).

- However, there are significant opportunities for improvement based on the gap in Anchorage between community-wide averages and those who are FLOURISHING.

HWBM Composite Indicators are strong guides for action:

- 54% to 74% of respondents with high Relationship ratings are DOING WELL/FLOURISHING
- 55% to 89% with low Relationship ratings are STRUGGLING

Indicators in this dimension are correlated with:

- Your Core4 Well-being Index scores, higher overall life satisfaction, and other indicators including mental/emotional health ratings, satisfaction with overall well-being, purpose and meaning, financial security, and community belonging.

Respondents with higher ratings share these attributes in higher proportions:

- Ages 55+
- Higher emotional wellbeing, financial security, community belonging
- Views of Anchorage as a safe community and a good place for children and elders

Respondents with lower ratings share these attributes in higher proportions:

- Ages 18-34
- Women and self-defined gender
- Lower education levels
- Seekers of mental health services
- Household incomes under \$49,000 per year
- Unemployed

Key Driver Analysis of your data suggests 4 strategies* to increase overall Core4 Well-being Index scores:

- **Strengthen personal relationships**
- **Foster a greater sense of community belonging**
- **Reduce presence of discrimination**
- **Increase confidence that someone is there to help when in need**

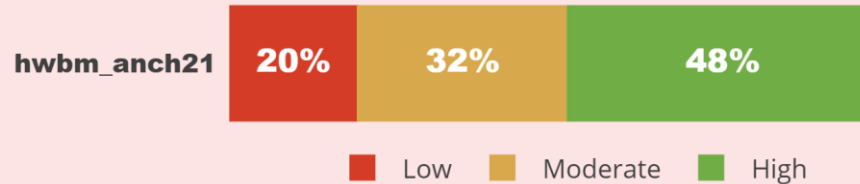
*Differences in these wellbeing factors explain 56% of the variation in your Core4 Well-being Index score. (R-squared value: .5593.)

How satisfied are you with your relationships with other people? (6g)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 8.0 (strong)

- 72% with high ratings are DOING WELL/FLOURISHING; 89% with low ratings are STRUGGLING/MIXED

Higher scores:

- Over age 55, retired, high ratings on emotional wellbeing, opps for learning & growth, financial security

Lower scores:

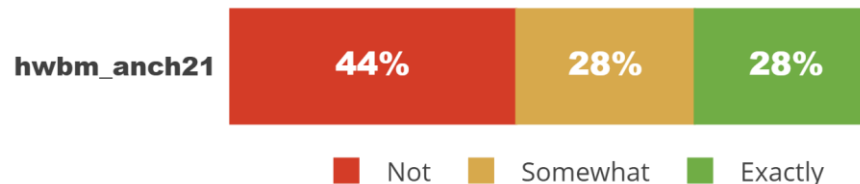
- Self-defined gender, age 18-24, jobless, HH income <\$50K, HS education or less, singles
- Poor access to needed mental health services
- Insecure on 7 of 7 basic needs, esp food, housing, personal safety

I feel like I am part of a community / sense of belonging. (7e)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Avg score: 6.5

- 68% with high ratings are DOING WELL/FLOURISHING; 67% with low ratings are STRUGGLING/MIXED

Higher scores:

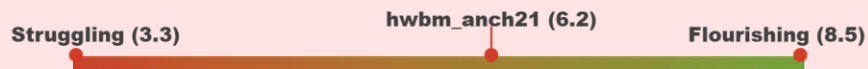
- Age 75+, strong ratings for neighborhood & views Anchorage as safe & good for children & elders,
- good relationships, physical & emotional health, healthcare access, job, opps for learning & growth, sense of purpose, community efficacy, financial security

Lower scores:

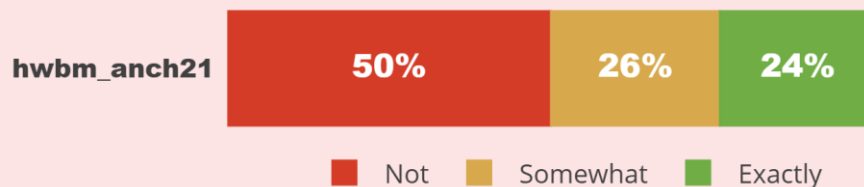
- Age 18-24, jobless, HH income <\$25K, non-white, low feelings of safety (personal & community)

If I made up my mind to try, I could have a significant influence on decisions being made in my community. (7c)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

- Average score: 6.2
- 74% with high ratings are DOING WELL/FLOURISHING; 60% with low ratings are STRUGGLING/MIXED

Higher scores:

- Over age 55, fully employed or retired, ratings on physical & emotional health, job, relationships, learning & growth opps, spirituality, financial security, community belonging, view of Anchorage as safe & a good place for children / elders.

Lower scores:

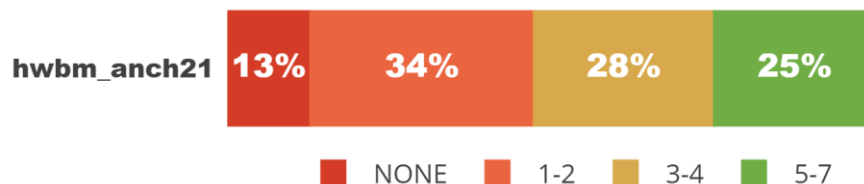
- Self-defined gender, age 18-24, non-white, healthcare access, sense of purpose, financial security

In the last week, how many days did you: Get together with family and friends? (14f)

AVERAGES (Days/week)



DISTRIBUTION



Key Findings

Average: 3.1 days/week

- 66% with high 5-7 days are DOING WELL/FLOURISHING; 75% with 0 days are STRUGGLING/MIXED

Higher scores:

- Age 55+, nonwhite

Lower scores:

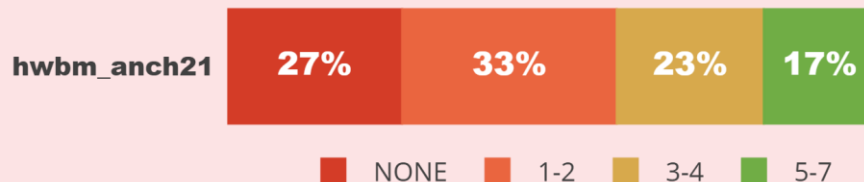
- Self-defined gender, jobless, HH income <\$75K, HH's with children, mental health service seekers,
- Lacking basic needs especially food, transpo, housing, personal safety/domestic violence
- Lower rating of neighborhood, healthcare access, job, access to basic needs, relationships, views of Anchorage as good for elders

In the last week, how many days did you talk with your neighbors? (14b)

AVERAGES (Days/week)



DISTRIBUTION



Key Findings

Average: 2.3 days/week

- 54% with high ratings are DOING WELL/FLOURISHING; 55% with low ratings are STRUGGLING/MIXED

Higher scores:

- Over age 55, PT job or jobless, less than HS education, transportation barriers, good emotional health, relationships, belief in ability to influence community, financially secure, community belonging,

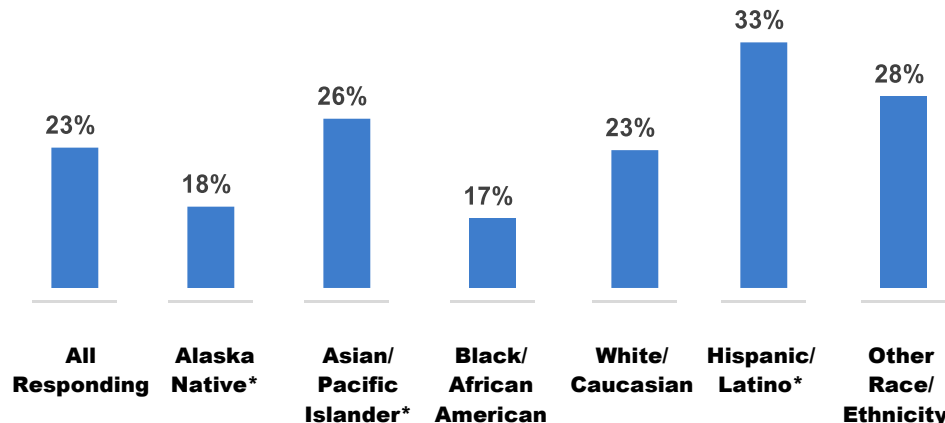
Lower scores:

- Self-defined gender, age 18-24, single with children, mental health service seekers, homeless, relationships, sense of purpose

During the past 12 months, have you personally experienced discrimination or been treated unfairly for any reason including your race, ethnic background, gender, or sexual orientation? (8a)

**Note: sample size small. Deeper community survey underway. Meanwhile, use caution interpreting subset results.*

| | | | |
|--------|----|--------------------|----|
| Race | 9% | Sexual Orientation | 6% |
| Gender | 9% | Other | 5% |



Key Findings

Average: 23% experienced discrimination

- 41% among DOING WELL/FLOURISHING; 59% among STRUGGLING/MIXED

Discrimination linked to higher rates of:

- Mental health service seekers

Lower ratings on:

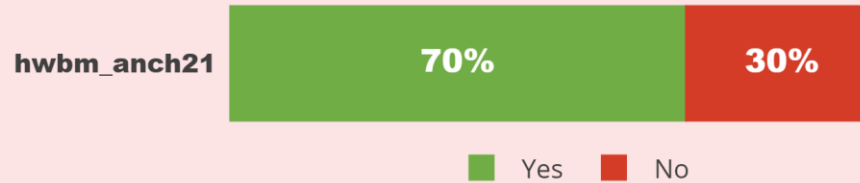
- Access to basic needs, especially healthcare, food & housing insecurity, transportation barriers, joblessness, education gaps, personal safety/domestic violence
- Work/job, emotional well-being, relationships, learning/growth opps, sense of purpose & meaning, safety of community for them & children.

If you were sick, could you easily find someone to help you with household chores? (a111)

AVERAGES

Not available for this question

DISTRIBUTION



Key Findings

- 70% report they can find help easily
- 66% who can find help are DOING WELL/FLOURISHING; 75% who cannot find help are STRUGGLING/MIXED

Able to find help:

- Tended to rise with age, especially after 55
- Linked to good ability to find mental health services

Unable to find help:

- Highest among STRUGGLING
- Higher among self-defined gender, under age 25, unemployed, HH income under \$75K
- Higher for single adults (with/without children)
- Higher among mental health service seekers unable to find mental health services
- Linked to poor access to basic needs especially food and housing insecurity, transportation barriers, joblessness and personal safety/domestic violence
- Linked to low ratings on access to healthcare, work/job, ability to meet basic needs, relationships, learning/growth opps, purpose & meaning, financial security, sense of community belonging
- Linked to higher views that Anchorage is not a safe community, and not a good place for children and elders



Dimension 2

Mental, Emotional & Spiritual Health

Recognizing your own and others' emotions and responding appropriately makes a difference. It is the ability to cultivate positive thoughts, practice self-compassion, express emotions and consciously choose your responses; including, engaging in support systems to help cope. A strong sense of spirituality provides important benefits to health. It is linked with a sense of meaning and purpose which offers a sense of direction, shapes goals, influences behavior, and provides comfort during life's challenges.

Overall Scores



- 30% above benchmark
- 50% at benchmark
- 20% below benchmark

What This Community Can Do

Facilitate warm connections with others and encourage opportunities to express gratitude, self-compassion, mindfulness. **Expand resources** to support healthy coping skills, recovery and resiliency.

KEY FINDINGS

On 10 key indicators, Anchorage was above or at benchmark on 8 (80%).

- HWBM Composite Indicators are strong guides for action:
- 64% to 87% with high ratings are DOING WELL/FLOURISHING
- 55% to 100% with low ratings are classified as STRUGGLING/MIXED

Indicators on this dimension are correlated with:

- Core4 Well-being Index scores; poor physical health days; quality of relationships; overall life satisfaction; overall well-being satisfaction; poor mental health days; debilitating health days; opportunities for learning & growth; physical health ratings; and community belonging.

Respondents with low ratings tend to share these attributes in higher proportions:

- Lower HH incomes
- Younger ages (age 18-24)
- Mental health service seekers
- Unemployed
- Lower education levels
- Difficulty meeting basic needs
- **1 in 5 residents (about 40,000) needed mental health & substance abuse services. Nearly half didn't get them.**
- **6.6% of respondents - an estimated 14,000 adults-- seriously contemplated suicide in the past 12 months.**

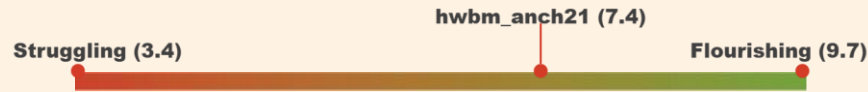
Key Driver Analysis of your data suggests 5 strategies* to increase overall Core4 Well-being Index scores:

- Improve ratings of mental/emotional health
- Improve levels of satisfaction with mental & emotional well-being
- Instill a greater sense of purpose and meaning
- Reduce the number of poor mental health days and debilitating health days
- Reduce suicidal ideation

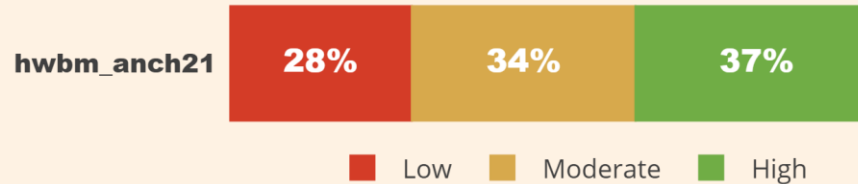
*Differences in these wellbeing factors explain 88% of the variation in your Core4 Well-being Index score. (R-squared value: .8827.)

Rate your emotional well-being. (6e)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.4

- 87% with high ratings are DOING WELL/FLOURISHING; 99% with low ratings are STRUGGLING/MIXED

Higher scores:

- >age 55, HH income >\$75K, whites
- Higher ratings on neighborhood, physical health, job, financial security, relationships, learning/growth opps, belonging, view that Anchorage is safe / good for children

Lower scores:

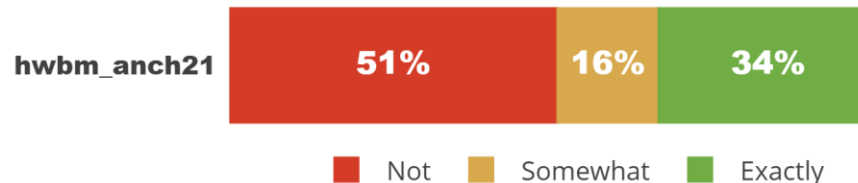
- Self-defined gender, age 18-24, jobless, HH income <\$25K, <HS education
- Mental health service seekers, food & housing insecurity, transpo barriers

Religion or spirituality is important to me. (7a)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Avg score: 5.9

- Over half of residents do not believe this is personally important.
- 64% with high ratings are DOING WELL/FLOURISHING; 55% with low ratings are STRUGGLING/MIXED

Higher scores:

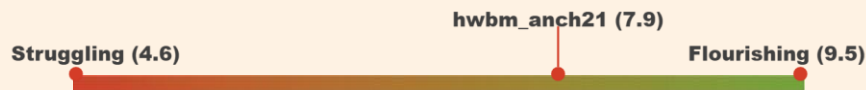
- HH's with children, Asian/Pacific Islanders, Latinos
- Linked to higher sense of purpose & meaning, community efficacy & belonging, view that Anchorage is a good place for elders

Lower scores:

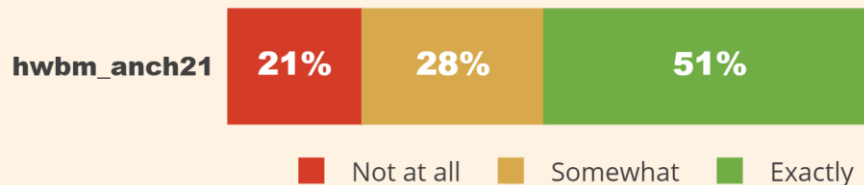
- Students, mental health service seekers; linked to low sense of purpose & meaning

I have a sense of purpose and meaning in my life (7b)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.9

- 71% with high ratings are DOING WELL/FLOURISHING; 93% with low ratings are STRUGGLING/MIXED

High scores:

- Higher ratings on work/job, emotional health, learning/growth, spirituality, belonging & efficacy

Lower scores:

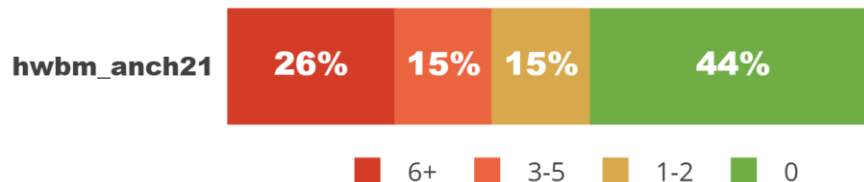
- Self-defined gender, age 18-24, jobless, HH income <\$50K, Singles, access to care & mental health services; food, housing & job insecurity; personal safety
- Lower ratings on neighborhood, work, relationships; view that Anchorage not safe or good for children & elders

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good. (12)

AVERAGES (Poor health days/month)



DISTRIBUTION



Key Findings

Average: 6.3 days/month

- 74% with 0 days are DOING WELL/FLOURISHING; 83% with 6+ days are STRUGGLING/MIXED

0 poor health days:

- Males, age 55+
- Good access to mental health svcs
- High job ratings, emotional wellbeing

6+ poor health days:

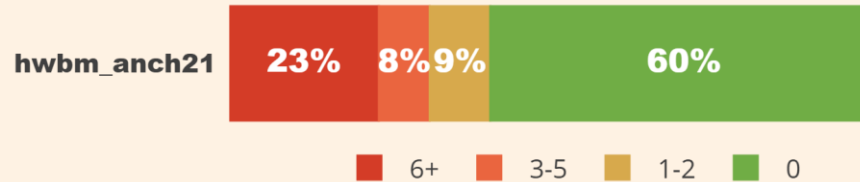
- Self-defined gender, jobless, HH's with >3 children & income <\$75K
- Insecure food, housing, personal safety
- Mental health service seekers with poor healthcare access
- Lower rating of neighborhood, job, relationships; views of Anchorage as unsafe & not good for elders

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (13)

AVERAGES (Days/month)



DISTRIBUTION



Key Findings

Average: 4.3 days/month

- 70% with 0 days are DOING WELL/FLOURISHING; 79% with 6+ days are STRUGGLING/MIXED

0 debilitating health days:

- No clear patterns/correlations

6+ poor health days:

- Self-defined gender; age 18-24; jobless or students; HH income <\$25K, HS or less education; singles; HH's with >3 children; non-whites;
- Financial insecurity & lack of basic needs including Insecure housing, transportation, access to healthcare
- Lower ratings on neighborhood, physical & emotional health, job, relationships; learning/growth opps; sense of purpose & meaning; community belonging;
- Lower feelings of personal and community safety

In the last 12 months, do you feel like you needed mental health services or substance abuse treatment? (a106)

AVERAGES

Not available for this question

DISTRIBUTION



Key Findings

Nearly 1 in 5 adults -- ~40,000 -- needed mental health or substance abuse treatment.

- 62% who don't need services are DOING WELL/FLOURISHING; 82% needing services are STRUGGLING/MIXED

Among those who do not need services:

- No clear patterns/correlations

Among those needing services:

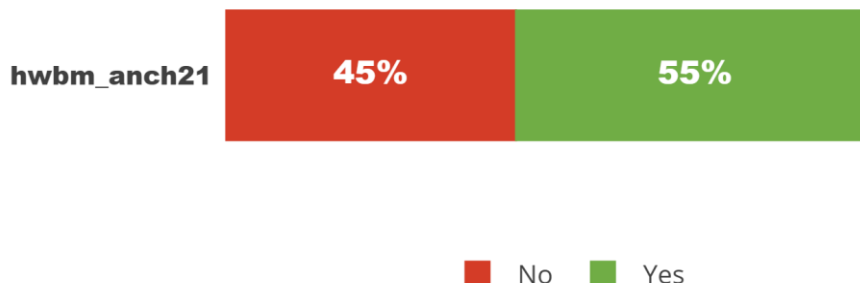
- Self-defined gender, under age 25, jobless, HH income <\$50K, AK Natives
- **45% unable to access needed services**
- Insecure finances, food & housing
- Lower ratings on neighborhood, physical & mental health, healthcare access, job, relationships, purpose & meaning, community belonging; 49% view city as unsafe for themselves or for children

Were you able to get the services you need? (a107)

NOTE: This is among the 19% of Anchorage respondents who reported needing mental health services or substance abuse treatment.

AVERAGES

Not available for this question



Key Findings

Overall, nearly 1 in 10 Anchorage residents were unable to access the mental health services or substance use treatment they needed in the past 12 months.

- 45% who needed mental health/substance use services were unable to get them.
- 23% able to access services are DOING WELL/FLOURISHING, vs. 11% unable.
- 78% able to access services are STRUGGLING/MIXED, vs. 89% unable.

Ability to access needed services higher among:

- Students, HH income >\$125K; post-graduate education

Inability to access services higher among:

- Unemployed, < HS education, people of color

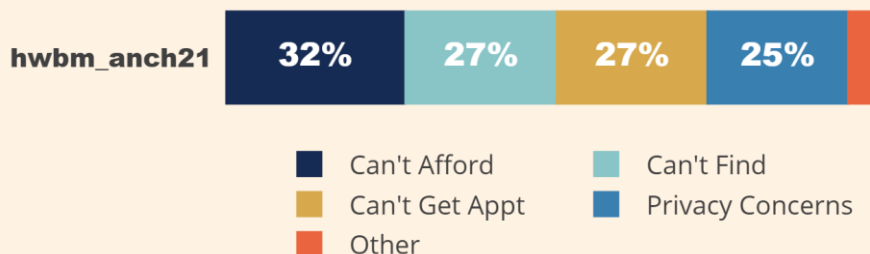
Why were you not able to get the services you needed? (a108)

NOTE: This is among the 45% of Anchorage respondents (about 1 in 10 residents overall) who reported they were unable to access needed mental health services or substance abuse treatment.

AVERAGES

Not available for this question

DISTRIBUTION



Key Findings

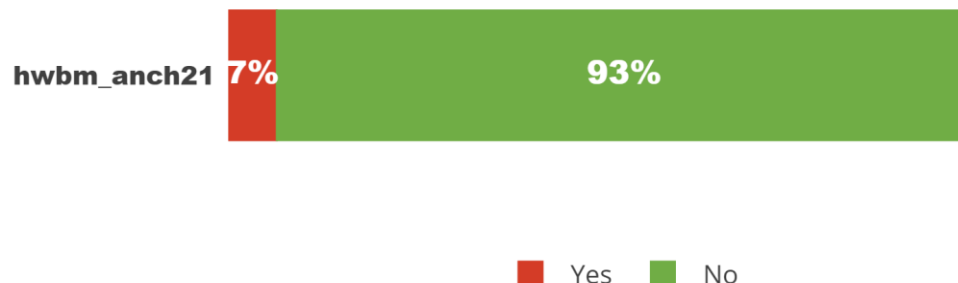
Nearly 1 in 5 residents needed mental health or substance abuse treatment.

- **Affordability** (32%) was a bigger barrier for women, HH's with income under \$25K, HS or lower education, singles
- **Inability to find services** (27%) was a bigger barrier for people under age 25, seniors, and HH's with incomes over \$200K
- **Inability to get an appointment** (27%) was a bigger barrier for jobless, singles with children, and people in unsafe personal relationships
- **Privacy concerns** (25%) were a bigger barrier for people under age 24 and over 55; HH's with income >\$200K, and families with children

During the past 12 months, did you ever seriously consider attempting suicide? (a109)

AVERAGES

Not available for this question



Key Findings

6.6% of Anchorage adult residents -- an estimated 14,000 people -- seriously considered taking their own lives last year.

- 100% contemplating suicide (vs. 35% of those who did not) are STRUGGLING/MIXED

Among those who reported seriously considering suicide:

- 93% were female
- 46% were aged 18-24
- 50% were couples with children
- 47% were people of color
- 34% were unable to access needed mental health services; and 91% had poor healthcare access in general
- 95% were financially insecure and 85% had difficulty meeting basic needs
- 91% did not feel part of the community



Dimension 3

Neighborhood & Environment

In important ways, your location defines your health. Safe, connected, walkable neighborhoods with access to nutritional food, good education for children, and human services make it easier to enjoy well-being. Being in nature not only makes you feel better emotionally, it contributes to your physical well-being. It soothes, restores and connects. People who live near parks and natural areas are more physically active, live longer, and these open spaces draw people together, enhancing social connections.

Overall Scores



- **33% above benchmark**
- **50% at benchmark**
- **17% below benchmark**

What This Community Can Do

Encourage stewardship of our natural environment in our homes, workplaces, communities, and society. As individuals, nurture time spent outdoors – connecting with the mystery of the larger world, bringing perceptive beauty and positive mood.

KEY FINDINGS

Anchorage was above or at benchmark on 5 of 6 indicators (83%).

HWBM Composite Indicators are strong guides for action:

- 59% to 74% with high ratings on these indicators are classified as **DOING WELL/FLOURISHING**
- 51% to 79% with low ratings (including homelessness worries) are classified as **STRUGGLING**

Indicators in this dimension are correlated with:

- Core4 Well-being Index; emotional health rating; opportunities for learning and growth; relationship ratings; physical health satisfaction; and debilitating health days

Respondents with low ratings share these attributes at higher levels:

- Self-defined gender,
- age 18-24,
- jobless,
- HH income <\$50K,
- HS education or less,
- Financial security / insecure housing, food, transportation, unsafe personal relationships
- Lower ratings of community belonging

Key Driver Analysis of your data suggests 3 strategies* to increase overall Core4 Well-being Index scores:

- Invest in efforts to improve perceived neighborhood quality
- Improve perceptions of Anchorage as a safe community
- Increase community value of Anchorage as a good place for children to grow up



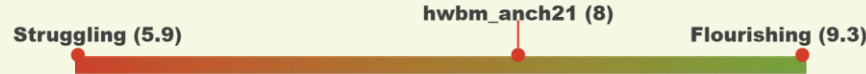
ENVIRONMENT AND WELL-BEING. A healthy physical environment – with access to clean water and air - is crucial to good health and well-being.

Increasingly, the threat of global climate change may dwarf all other dimensions of health in the future – threatening our social and political stability, economies, food supply, the viability of life and civilization on earth as we know it.

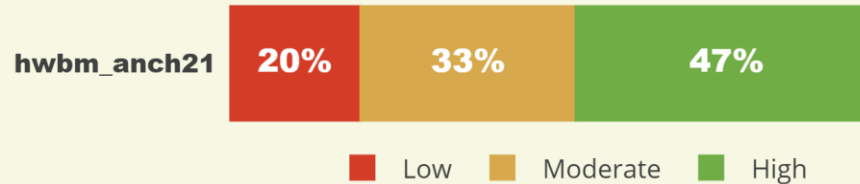
*Differences in these wellbeing factors explain 44% of the variation in your Core4 Well-being Index score. (R-squared value: .4387.)

Rate the neighborhood you live in. (6a)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 8.0 (strong)

- 72% with high ratings are DOING WELL/FLOURISHING; 89% with low ratings are STRUGGLING/MIXED

Higher scores:

- Students, higher ratings on mental/emotional health, belonging, cmtly safety, qual for children / elders

Lower scores:

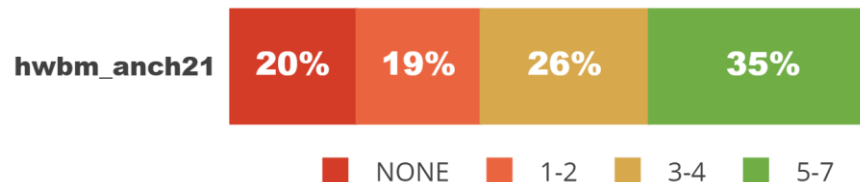
- Self-defined gender, age 18-24, jobless, HH income <\$50K, HS education or less, singles alone
- Financially insecure including food, transpo, housing, job, personal safety
- Mental health service seekers
- Lower ratings physical & mental health, care access, learning/growth opps, life purpose, cmtly belonging, cmtly safety, quality for kids/elders

How many days do you eat 5 servings of fresh vegetables & fruit, past week? (14a)

AVERAGES (Days/week)



DISTRIBUTION



Key Findings

Average: 3.4 days/week

- FLOURISHING (average 4.2 days) are below CDC guidelines
- 59% with high 5-7 days are DOING WELL/FLOURISHING; 61% with 0 days are STRUGGLING/MIXED

Higher scores:

- Age 55+, HH income>\$200K, Couples

Lower scores:

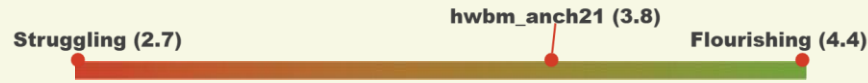
- Self-defined gender, students,
- Financially insecure and lacking basic needs -- food, transpo, housing, job, education
- Lower ratings on physical health

CDC Recommendations:
Adults: 1.5-2 cup equivalents of fruits and 2-3 cup equivalents of vegetables per day.

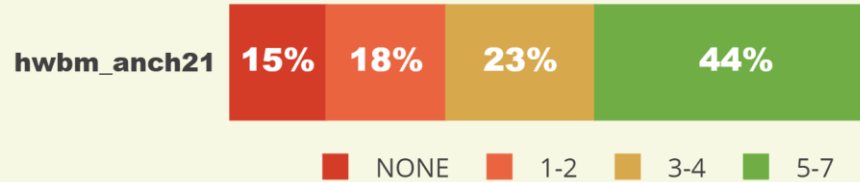
In the past week, how many days did you walk or exercise 30 minutes or more? (14c)

CDC Recommendations: 30 minutes or more, at least 5 days per week.

AVERAGES (Days/week)



DISTRIBUTION



Key Findings

Average: 3.8 days/week

- FLOURISHING (average 4.4 days) are below CDC guidelines of 5+ days
- 62% with high 5-7 days are DOING WELL/FLOURISHING; 63% with 0 days are STRUGGLING/MIXED

Higher scores:

- No consistent patterns

Lower scores:

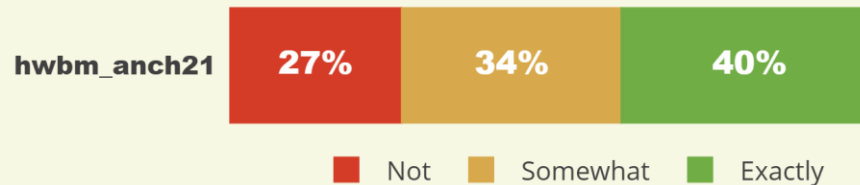
- Housing insecurity, education gap to meet basic needs
- Lower ratings on physical health, sense of purpose & meaning

I feel safe in my community. (7f)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.5 (STRUGGLING nearly 6.0)

- 74% with high ratings are DOING WELL/FLOURISHING; 80% with low ratings are STRUGGLING/MIXED

High scores:

- Students
- Higher ratings on neighborhood, physical & mental health, job, cmtly belonging & efficacy, financial security, Anchorage as good for children /elders

Lower scores:

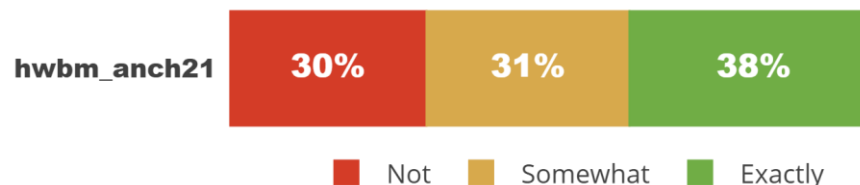
- Self-defined gender, age 18-24, jobless, HH income <\$75K, singles, mental health service seekers, low healthcare access
- Lower financial security & basic needs-- food, transo, housing, unsafe personal relationships,
- Lower ratings mirror high ratings above.

My community is a good place to raise children. (7g)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.2 (STRUGGLING 5.0)

- 73% with high ratings are DOING WELL/FLOURISHING; 76% with low ratings are STRUGGLING/MIXED

High scores:

- Students
- Higher ratings on neighborhood, physical / mental health, job, financial security, cmtly safety & belonging, quality for elders

Lower scores:

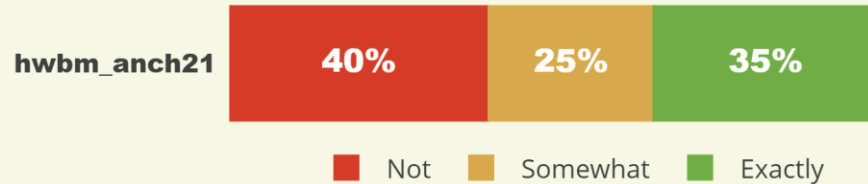
- Self-defined gender, age 18-24, jobless
- Mental health svc seekers & low access
- Insecure food, transpo, housing, safety
- Lower ratings on health, basic needs, relationships, learning/growth opps, cmtly belonging, quality for elders

My community is a good place to grow old. (7h)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 6.7 (weak)

- 73% with high ratings are DOING WELL/FLOURISHING; 76% with low ratings are STRUGGLING/MIXED

High scores:

- Students, HH with 3+ children,
- Higher ratings on neighborhood, health, job, cmtly belonging & efficacy, financial security, safety, views as good place for children

Lower scores:

- Self-defined gender, age 18-24, jobless,
- Mental health service seekers, barriers to healthcare access
- Lower financial security including fod, transportation, housing, unsafe personal relationships
- Lower ratings on job, relationships, learning & growth opps, sense of purpose, cmtly safety & belonging, views of city as not a good place for kids



Dimension 4

Work, Learning & Growth

Employment, education and opportunities for personal growth are bedrocks of well-being.

Using available resources to develop and create opportunities that resonate with your unique gifts, skills, and talents contributes to meaning and purpose, and helps you remain active and involved throughout life.

Education is deeply connected with well-being. Opportunities for ongoing growth brings a sense of purpose and meaning. A work life or career consistent with your personal values, interests, beliefs and balances both work and can contribute greatly to all six dimensions of well-being.

Overall Scores



- 0% above benchmark
- 0% at benchmark
- 100% below benchmark



What This Community Can Do

Facilitate equitable access to life-long learning at home, in schools, at work and community/society. Seek and offer education and growth opportunities in work and life. Boost confidence, purpose, skills and connect with others.

KEY FINDINGS

Anchorage was below benchmark on 5 of 5 indicators (100%).

HWBM Composite Indicators are strong guides for action:

- 73% to 77% with high ratings on these indicators are DOING WELL/FLOURISHING
- 66% to 98% with low ratings are STRUGGLING/MIXED

Indicators in this dimension are correlated with:

- Core4 Well-being Index; emotional health rating; opportunities for learning and growth; relationship ratings; physical health satisfaction; and debilitating health days

Respondents with low ratings share these attributes at higher levels:

- HH income under \$49K/year
- Younger ages (18-34)
- HS or less education
- BIPOC
- Housing insecurity

Key Driver Analysis of your data suggests 4 strategies* to increase overall Core4 Well-being Index scores:

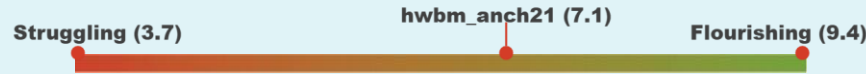
- Invest in efforts to improve job access, quality & conditions especially for lower-income and marginalized residents
- Improve opportunities for learning & growth in Anchorage
- Design & promote initiatives that connect to residents' sense of purpose & meaning
- Increase access to job-related education & training especially for lower-income and marginalized residents

*Differences in these wellbeing factors explain 88% of the variation in your Core4 Well-being Index score. (R-squared value: .6803.)

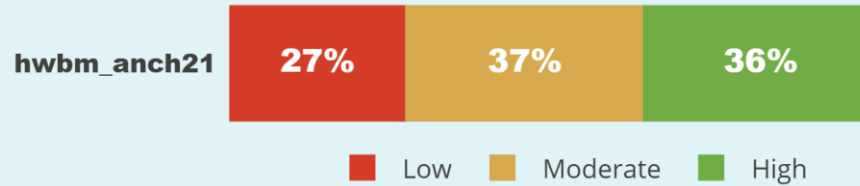


Rate your work or job (poor-excellent). (6d)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.1

- 73% with high ratings are DOING WELL/FLOURISHING; 89% with low ratings are STRUGGLING/MIXED

Higher scores:

- >age 55, HH income >\$75K, whites
- Higher ratings on health, healthcare access, relationships, learning/growth opps, sense of purpose, belonging & efficacy, cmtly safety, & views that Anchorage is good for children / elders.

Lower scores:

- Women, self-defined gender, age 18-24, jobless, HH income <\$25K, singles+kids
- Mental health service seekers
- Insecure food, housing, job, pers safety
- Lower ratings for the "ratings" list above.

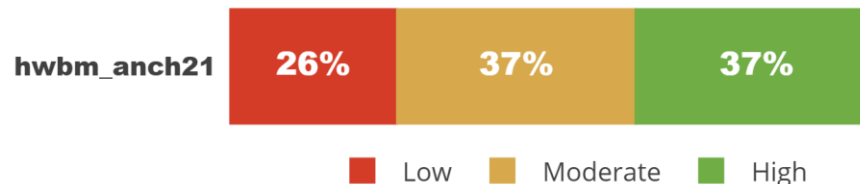


Rate your opportunities for learning and growth (poor-excellent). (6h)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.5

- 77% with high ratings are DOING WELL/FLOURISHING; 90% with low ratings are STRUGGLING/MIXED

Higher scores:

- >age 55; Higher ratings on health, healthcare access, job, financial security, relationships, sense of purpose, belonging & efficacy,

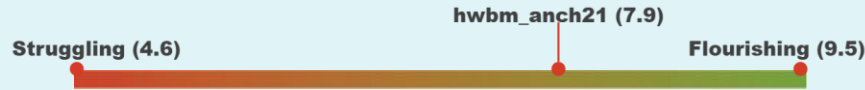
Lower scores:

- Women, self-defined gender, jobless, 18-24, jobless, HH income <\$50K, HH's with >3 children,
- Mental health service seekers
- Insecure food, housing, job, pers safety
- Lower ratings for the "ratings" list above plus low quality of Anchorage for elders.

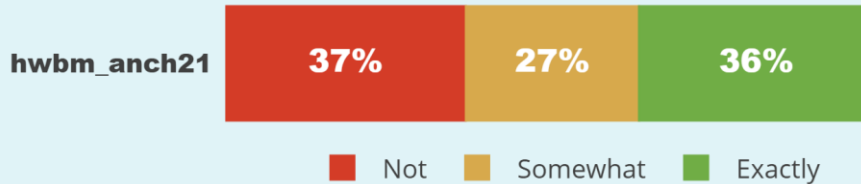


I have a sense of purpose and meaning in my life. (7b)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.9

- 71% with high ratings are DOING WELL/FLOURISHING; 93% with low ratings are STRUGGLING/MIXED

High scores:

- Higher ratings on work/job, emotional health, learning/growth, spirituality, belonging & efficacy

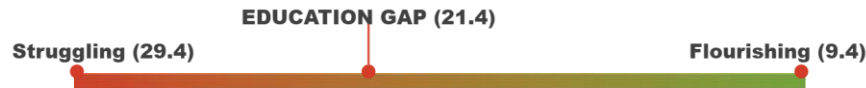
Lower scores:

- Self-defined gender, age 18-24, jobless, HH income <\$50K, Singles, access to care & mental health services; food, housing & job insecurity; personal safety
- Lower ratings on neighborhood, work, relationships; view that Anchorage not safe or good for children & elders

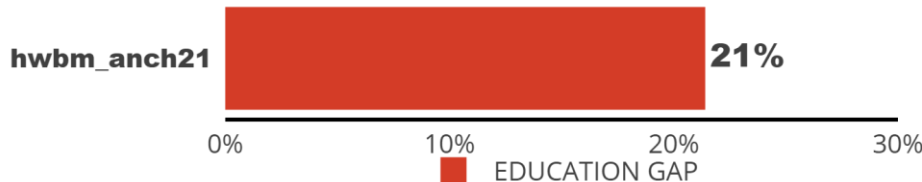


Do you need additional education or training to get the job and income you need? (9f)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 21% of residents (estimated 44,000) are jobless or job insecure.
- 18% are not currently employed.
- Among this group, 34% are DOING WELL/FLOURISHING; 66% are STRUGGLING/MIXED

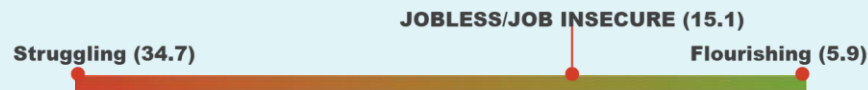
Higher among

- Women and gender self-defined
- < age 35; HH income <\$75K; HS education
- Single with children at home
- All non-white race/ethnicities
- 38% are Mental health svc seekers; 46% unable to get needed services
- Highly correlated with all TotalHealth7 needs
- 37% report unsafe relationships at home
- Low ratings on most HWBM indicators

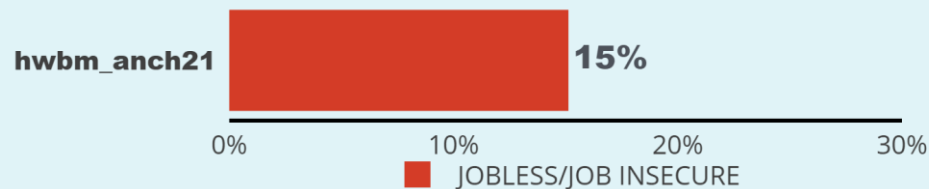


Are you without a stable job, or do you need help getting a better job? (9e)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 5% above 2020 benchmark; 98282 is 4% above, and 98292 is 6% below
- 76% with high ratings are DOING WELL/FLOURISHING; 98% with low ratings are STRUGGLING/MIXED
 - Very strongly correlated with Core4 Well-being Index (.76)
 - Strong correlation with quality of relationships (.60); opportunities for learning & growth (.56); physical health (.53); work/job (.44)
- Lower scores linked to HH income; age; No. of children at home; unemployment



Dimension 5

Security & Basic Needs

Having enough, and freedom from worry. We need enough money for food, rent or mortgage, health care, medical bills and basic expenses of daily living. Lack of access to basic needs and personal safety are linked at all stages of life to physical and mental illness, post-traumatic stress, shorter lifespans and poorer quality of life.

The experience of others affects you. 2019 Monitor™ research found that overall community well-being was measurably lower for ALL where rates of homelessness are higher. Research shows that ‘extras’ don’t really contribute to our well-being-unless it is for fun activities and friends, or expenses that match our values.

Overall Scores



- 0% above benchmark
- 8% at benchmark
- 92% below benchmark

KEY FINDINGS

Economic insecurity -- including food, housing, job -- affects nearly 60,000 Anchorage residents and has a significant impact on overall wellbeing.

Anchorage was at or below benchmark on 13 of 13 key indicators, including the "TotalHEALTH 7" set of basic needs.

- HWBM Composite Indicators are strong guides for action:
 - Up to 72% with high ratings on these indicators are classified as DOING WELL/FLOURISHING
 - 78% to 81% with low ratings are classified as STRUGGLING

Indicators in this dimension are moderately correlated with:

- Core4 Well-being Index; emotional health rating; opportunities for learning and growth; relationship ratings; physical health satisfaction; and debilitating health days

Affected respondents share these attributes at higher levels:

- HH income under \$49K/year; younger ages (18-34); HS or less education; BIPOC; unstably housed or unsheltered

Key Driver Analysis of your data suggests 4 strategies* to increase overall Core4 Well-being Index scores:

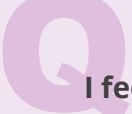
- Increase access to mental health services
- Promote efforts to increase residents' financial security
- Improve access to basic needs
- Improve access to health care and health information (beyond mental health services)

Key Driver Analysis of your TotalHEALTH7 data suggests 3 targeted strategies** to increase overall Core4 Well-being Index scores (see p. 44):

- Reduce housing insecurity
- Reduce food insecurity
- Invest in training and education to support living wage incomes

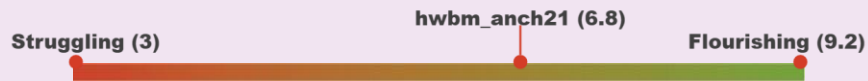
*Differences in these wellbeing factors explain 57% of the variation in your Core4 Well-being Index score. (R-squared value: .5709.)

**Differences in these wellbeing factors explain 43% of the variation in your Core4 Well-being Index score. (R-squared value: .4333.)

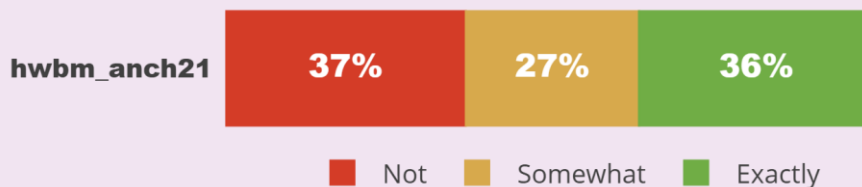


I feel secure about my financial future. (7d)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 6.8

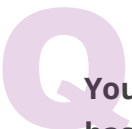
- 78% with high ratings are DOING WELL/FLOURISHING; 78% with low ratings are STRUGGLING/MIXED

Higher scores:

- Men, age 55+, HH income >\$75K,
- Higher ratings on health, healthcare access, job, meeting basic needs, learning/growth opps, cmtty belonging, views city as safe, good for kids/ elders

Lower scores:

- Self-defined gender, age 18-24, jobless/student, HH income <\$50K, HS or less education, Single with children, BIPOC, 19% mental health service seekers; 45% unable to secure.
- High rates of basic needs insecurities
- Rate most wellbeing indicators lower

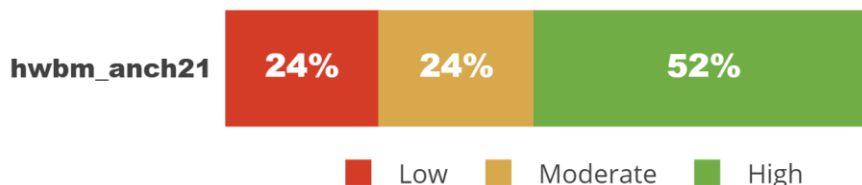


Your ability to meet your basic needs - like food, housing, transportation, safety. (6f)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.8 (generally a strength)

- 72% with high ratings are DOING WELL/FLOURISHING; 89% with low ratings are STRUGGLING/MIXED

Higher scores:

- Men, age 65+, HH income >\$75K, BA+ education, couples w/o kids, Whites, learning & growth opps, financially secure

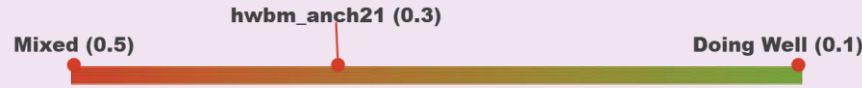
Lower scores:

- Self-defined gender, age 18-24, jobless, HH income <\$50K, HS or less education, Single living with other adults,
- with children, BIPOC, 38% mental health service seekers; 60% unable to secure.
- High rates of basic needs insecurities
- Rate most wellbeing indicators lower

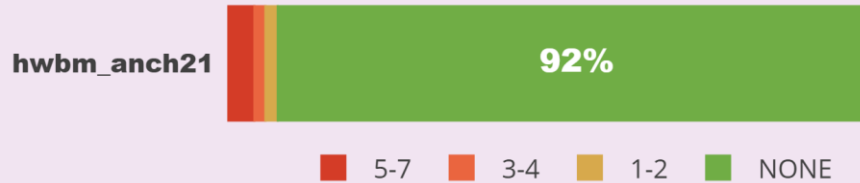


In the past week, how often did you go without a meal due to lack of money? (14e)

AVERAGES



DISTRIBUTION



Key Findings

Average: 8% (about 17,000 adults) skipped one or more meals in the past week for lack of money.

- 44% who skipped meals 0 times are FLOURISHING; 62% with high 5-7 days are DOING WELL/FLOURISHING; 44% with 5-7 days are STRUGGLING/MIXED

Among those reporting 0 skipped meal days:

- No consistent patterns in the data

Among those reporting 5-7 skipped meal days:

- Unemployed, < HS education,
- 70% Single (17% with children, 54% living with other adults)
- High rates of basic needs insecurity including 85% difficulty paying power/water bill.
- Low ratings of purpose/meaning, safe community, mental wellbeing.

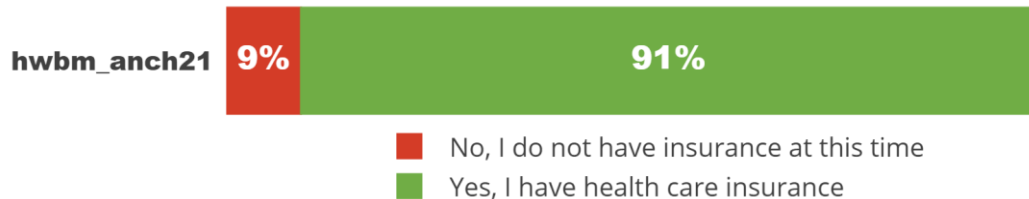


The next questions are about health care insurance. (17)

AVERAGES

Not available for this question

DISTRIBUTION



Key Findings

Average: 9% (about 19,000 adults) lack health insurance.

- 44% who skipped meals 0 times are FLOURISHING; 62% with high 5-7 days are DOING WELL/FLOURISHING; 44% with 5-7 days are STRUGGLING/MIXED

Among those with health insurance:

- No consistent patterns in the data

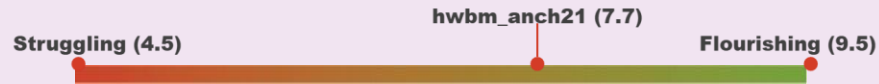
Among those without coverage, higher rates of:

- Part-time or Unemployed, HH incomes <\$75K, singles and singles with children,
- Food, transpo, housing, job insecurity
- Lower healthcare access
- 25% needed mental health services and 74% did not secure them
- Lower views of Anchorage as safe, and a good place for children

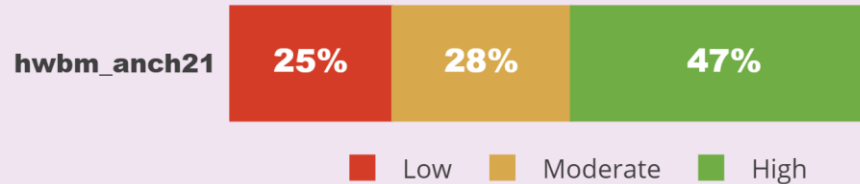


Rate your ability to get medical care & health info. (6c)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.7

- 72% with high ratings are DOING WELL/FLOURISHING; 81% with low ratings are STRUGGLING/MIXED

Higher scores among:

- >age 65, HH income >\$75K, whites
- Higher ratings on work, mental emotional wellbeing, financial security, feeling part of a community

Lower scores among:

- Women and self-defined gender, age 18-24, jobless or part time, HH income \$25K-49K, HS education, singles living with other adults
- Higher rates of food, housing, transpo, job, education, personal safety insecurities
- Lower ratings on physical and mental health
- 37% mental health service seekers (of whom 49% didn't secure needed care)

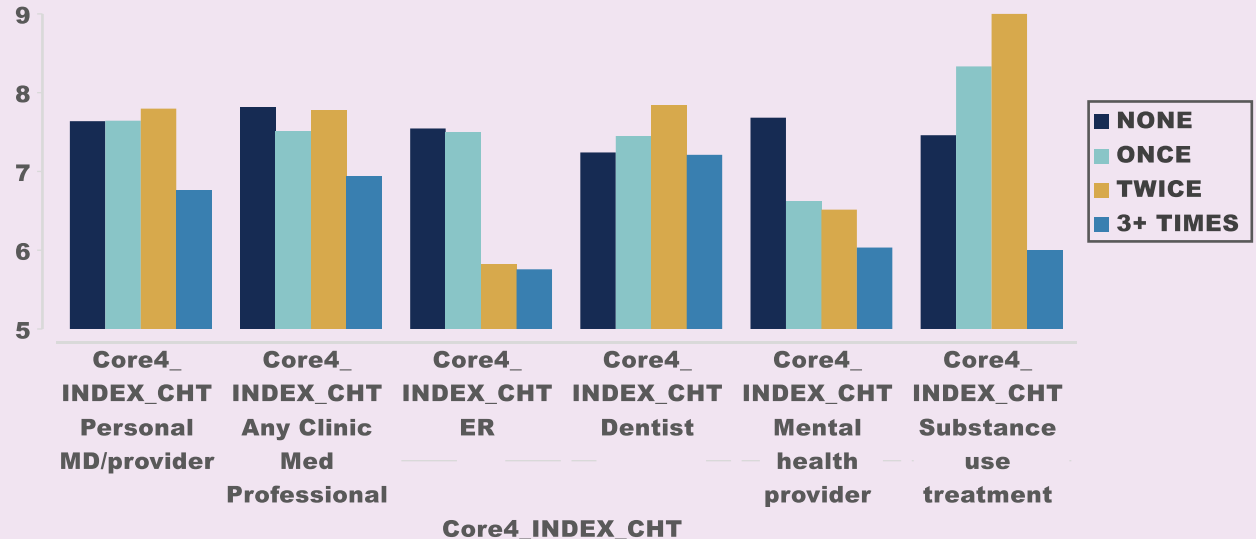
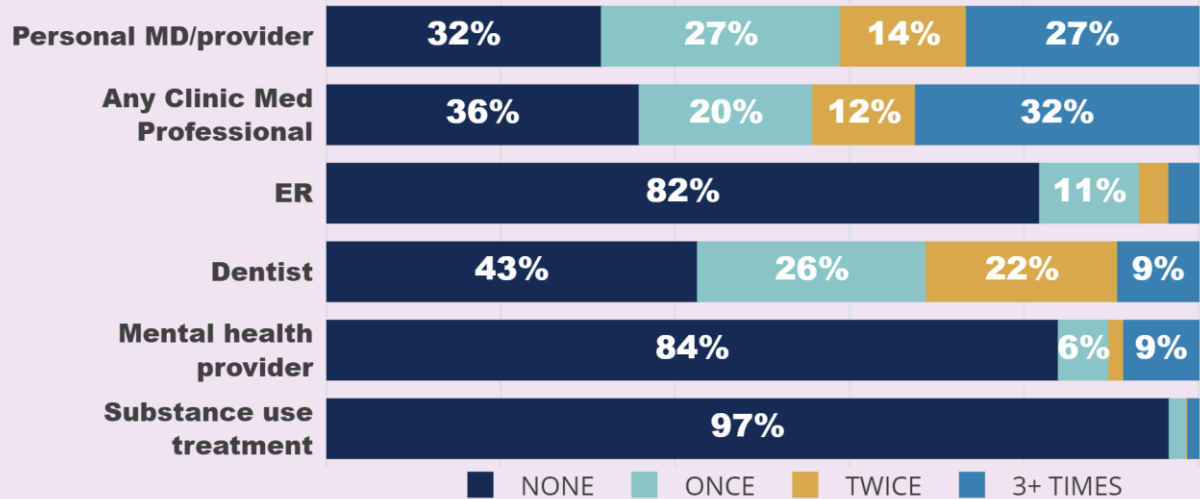


About how many times in the last year- if any - have you visited a healthcare professional? (15)

Key Findings

- Anch21 average of 1.3 clinician visits, 1.5 other clinic clinician visits, .3 mental health visits
- For every category, except mental health, wellbeing was higher among those who had seen a health professional at least once, and was lower among those who saw a provider more than twice.

DISTRIBUTION

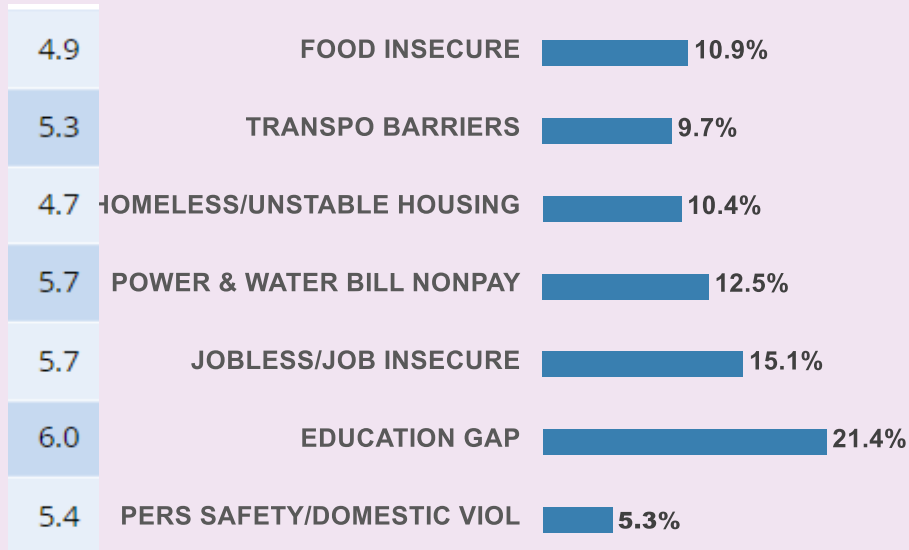


TotalHealth7™ Basic Needs Panel

TotalHEALTH7™ is a panel of questions tied to key security and basic needs issues.

- While Anchorage residents generally fare better than the 2020 benchmark community, over 1 in 4 local residents (28%) report they are currently experiencing or worried about one or more of these basic needs.
- Core4 Well-being Index scores are 16% to 36% lower than average among residents reporting gaps in basic needs.

Core4 Well-being Index Score



KEY FINDINGS

Anchorage was higher (worse) than benchmark on 7 of 7 key indicators (100%).

- HWBM Composite Indicators are strong guides for action: Among those expressing needs aside from education/training, 74%-92% were STRUGGLING/MIXED, while only 8%-26% were DOING WELL/FLOURISHING.

28% of adult residents reported at least one unmet need:

- 118% higher food insecurity (vs. benchmark level)
- 39% higher transportation barriers
- 30% higher housing insecurity
- 108% higher power/water bill payment issues
- 8% higher housing insecurity
- 13% higher training/education gaps
- 6% higher reports of unsafe personal relationships

Indicators in this dimension are correlated with:

- Core4 Index (.50); overall wellbeing satisfaction (.52), and moderately correlated with community belonging; opportunities for learning and growth; ability to get medical care and health information; relationships; mental-emotional health satisfaction; and sense of purpose & meaning.

Respondents with unmet needs share these attributes in higher proportions:

- HH incomes under \$50K
- Ages 45-64 HS or less education
- Singles living with other adults
- Singles with children
- Unemployed

Key Driver Analysis of your data suggests 3 strategies* to increase overall Core4 Well-being Index scores:

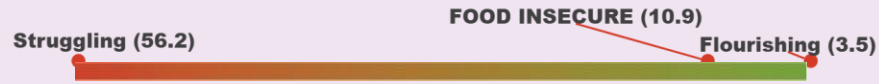
- Reduce housing insecurity
- Reduce food insecurity
- Invest in training and education to support living wage incomes

*Differences in these wellbeing factors explain 43% of the variation in your Core4 Well-being Index score. (R-squared value: .4333.)

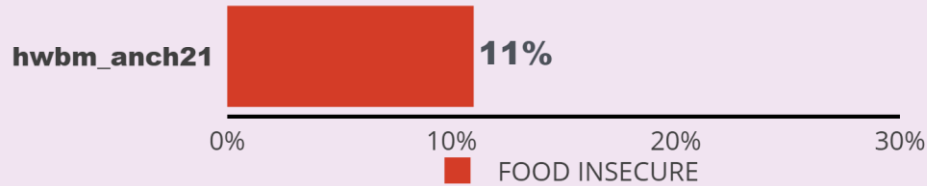


Are you worried that you or others in your home will not have enough food to eat? (9a)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 11% of residents (estimated 23,000 adults) are food insecure
- Among food insecure, 16% DOING WELL/FLOURISHING; 84% are STRUGGLING/MIXED

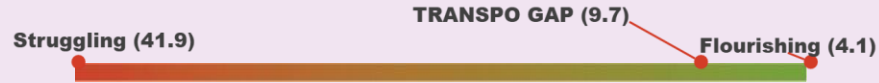
Higher among:

- women and gender self-defined
- Higher among those < age 45,
- part-time or unemployed,
- HH incomes <\$50K
- HS education
- Single HH with children
- Mental health svc seekers; 61% of food insecure people seeking services were to get needed services
- Highly correlated with all other TotalHealth7 needs
- Lower ratings on every HWBM indicator

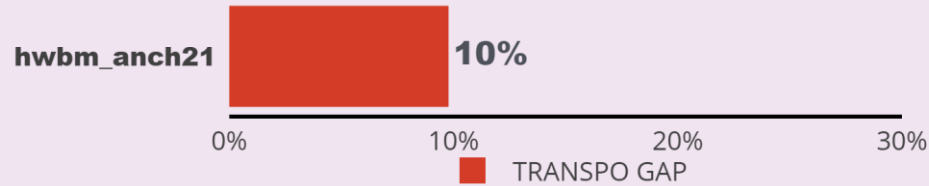


Are you worried about getting to work, school, groceries or appointments because you don't have a way to get there? (9b)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 10% of residents (estimated 21,000 adults) are food insecure
- Among food insecure, 11% DOING WELL/FLOURISHING; 89% are STRUGGLING/MIXED

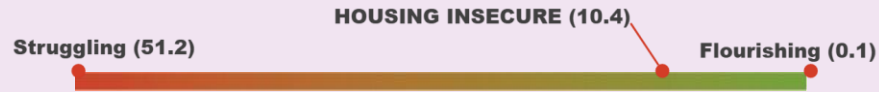
Higher among

- women and gender self-defined
- < age 25,
- unemployed,
- HH incomes <\$25K
- HS education or less
- Single HH living with other adults
- Mental health svc seekers; 56% unable to get needed services
- Highly correlated with all other TotalHealth7 needs
- Lower ratings on every HWBM indicator

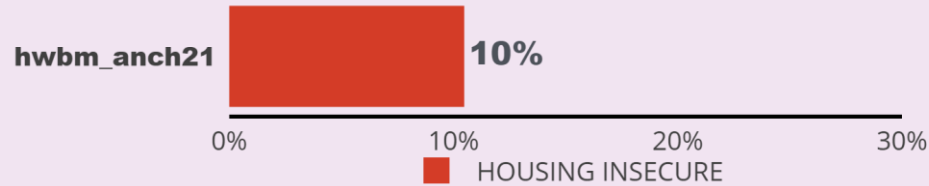


Are you living without stable housing, currently homeless or worried about losing your housing? (9c)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 10% of residents (estimated 21,000) are homeless or housing insecure
- Among food insecure, 15% DOING WELL/FLOURISHING; 85% are STRUGGLING/MIXED

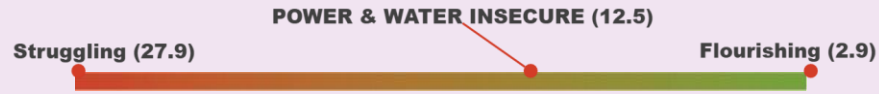
Higher among

- women and gender self-defined
- < age 25,
- part time or unemployed,
- HH incomes <\$75K
- HS education or less
- Single living alone or with other adults
- 51% are Mental health svc seekers; 66% unable to get needed services
- Highly correlated with all other TotalHealth7 needs
- Lower ratings on every HWBM indicator

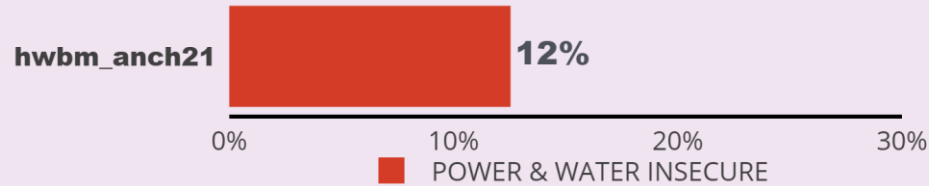


POWER & WATER: Are you worried about paying your water and/or power bills? (9d)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 12% of residents (estimated 25,000) are unable/worried about paying power & water bills
- Among this group, 19% are DOING WELL/FLOURISHING; 81% are STRUGGLING/MIXED

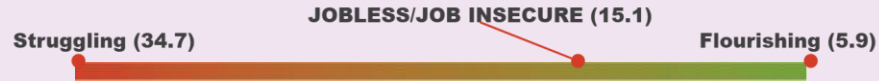
Higher among

- women and gender self-defined
- < age 25,
- unemployed
- HH incomes <\$50K
- HS education or less
- Single with ~1-2 children at home
- 21% are Mental health svc seekers; 65% unable to get needed services
- Highly correlated with all other TotalHealth7 needs
- 57% report unsafe relationships at home
- Lower ratings on every HWBM indicator

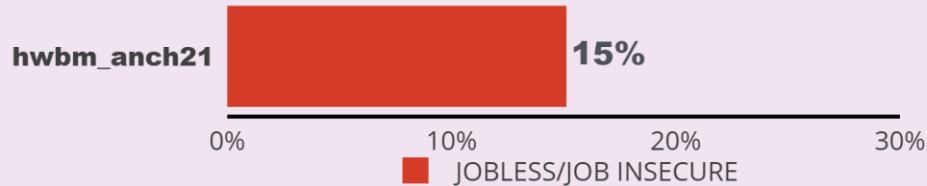


Are you without a stable job, or do you need help getting a better job? (9e)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 15% of residents (estimated 32,000) are jobless or job insecure.
- 41% are not currently employed.
- Among this group, 26% are DOING WELL/FLOURISHING; 74% are STRUGGLING/MIXED

Higher among

- women and gender self-defined
- < age 25, 45-54
- HH incomes <\$75K
- HS education
- Single with children at home
- Asian/Pacific Islanders, Black/African Americans and Latinos
- 39% are Mental health svc seekers; 71% unable to get needed services
- Highly correlated with all other TotalHealth7 needs
- 37% report unsafe relationships at home
- Lower ratings on virtually every HWBM indicator

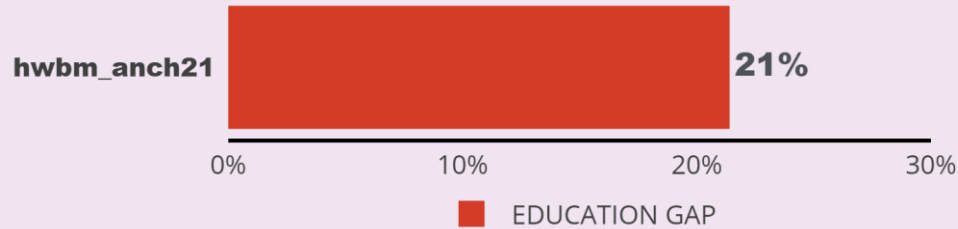


Do you need additional education or training to get the job and income you need? (9f)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 21% of residents (estimated 44,000) are jobless or job insecure.
- 18% are not currently employed.
- Among this group, 34% are DOING WELL/FLOURISHING; 66% are STRUGGLING/MIXED

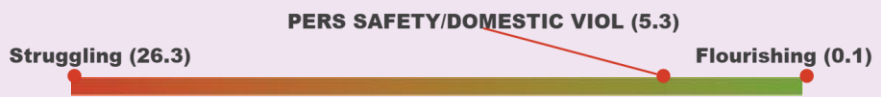
Higher among

- Women and gender self-defined
- < age 35; HH incomes <\$75K
- HS education
- Single with children at home
- All non-white race/ethnicities
- 38% are Mental health svc seekers; 46% unable to get needed services
- Highly correlated with all TotalHealth7 needs
- 37% report unsafe relationships at home
- Lower ratings on virtually every HWBM indicator

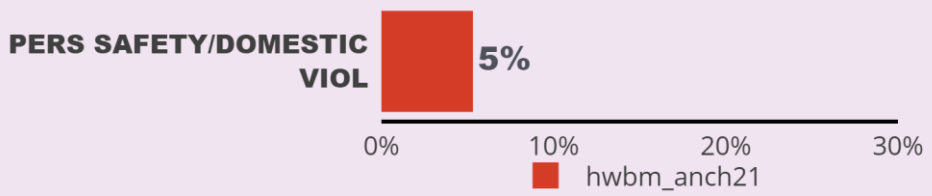


Do you ever feel unsafe in your relationship or at home? (9g)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 5% of residents (estimated 11,000) report unsafe relationships at home.
- Among this group, 8% are DOING WELL/FLOURISHING; 92% are STRUGGLING/MIXED

Higher among

- women and gender self-defined
- < age 25, and 55-64 age groups
- 28% unemployed outside the home
- 27% HH incomes <\$25K; 14% over \$200K
- 45% Voc-tech or some college
- 41% Single/living alone
- 23% Hispanic/Latino, 12% Native Alaskan
- 38% are Mental health svc seekers; 41% unable to get needed services
- Highly correlated with all other TotalHealth7 needs
- 70% are housing insecure
- Lower ratings on virtually every HWBM indicator
 - 65% difficulty meeting basic needs
 - 53% low life purpose & meaning
 - 81% do not feel that they are part of the community
 - 83% disagree that Anchorage is a good place for children to grow up
 - 94% disagree that Anchorage is a good place to grow old



Dimension 6

Physical Health

Physical health is both a state of being and a practice. Behaviors such as diet, exercise, sleep and stress have a profound effect on disease conditions and well-being. Physical health is also directly linked to hygiene routines, use of tobacco, alcohol and other drugs, the use of personal protective equipment, workplace safety and following safety guidelines, not taking unnecessary risks and the wise use of healthcare resources, including regular checkups and recommended screenings.

Overall Scores



- **88% above benchmark**
- **0% at benchmark**
- **12% below benchmark**

What This Community Can Do

Be a role model and self-care advocate. One of the most important things communities can do is to provide access to information, resources and built environments that support safety and health – helping individuals maintain an independent, productive and social life. And remember to “put on your own oxygen mask first.”

KEY FINDINGS

On 8 key indicators, Anchorage was above benchmark on 7 (88%).

- However, this is a low bar. Key indicators of physical health are below CDC guidelines.

HWBM Composite Indicators are strong guides for action:

- 55% to 92% with high ratings are DOING WELL/FLOURISHING
- 61% to 99% with low ratings are classified as STRUGGLING/MIXED

Indicators in the Physical Health dimension are correlated with:

- emotional well-being; poor mental health days; rating of current mental-emotional health

Respondents with low ratings share these attributes in higher proportions:

- HH income under \$50K
- HS or less education
- Singles with children, especially 3 or more children
- Mental health service seekers

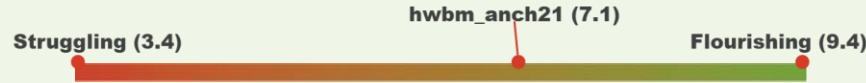
Key Driver Analysis of your data suggests 3 strategies* to increase overall Core4 Well-being Index scores:

- Improve physical health as defined by residents
- Invest in actions that reduce the number of debilitating health days by Anchorage residents
- Reduce prevalence of medical conditions and chronic illness

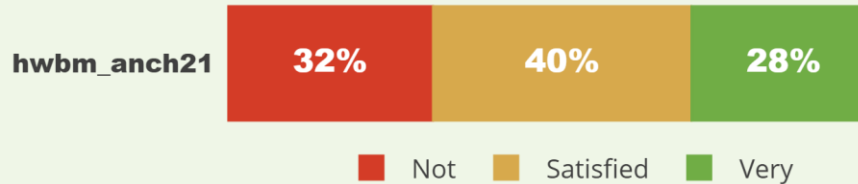
*Differences in these wellbeing factors explain 68% of the variation in your Core4 Well-being Index score. (R-squared value: .6858.)

Rate the current state of your physical health. (6b)

AVERAGES (0-10)



DISTRIBUTION



Key Findings

Average score: 7.1

- 92% with high ratings are DOING WELL/FLOURISHING; 99% with low ratings are STRUGGLING/MIXED

High scores (green):

- Men, Students, >age 55, HH income >\$75K, whites
- Higher ratings on financial security, learning/growth opps, belonging, view that Anchorage is safe / good for children & elders

Low scores (red):

- Jobless, HH income <\$25K, <HS education, single HH with children
- Mental health service seekers
- Insecurity on all TotalHealth 7 needs

Do you have a medical or health condition that requires treatment or special care? (18)

AVERAGES (%)



DISTRIBUTION



Key Findings

- 37% of residents (estimated 78,000 adults) have medical conditions
- 44.3% of MIXED have med conditions, driving mean higher than STRUGGLING
- 70% of "NO" are DOING WELL/FLOURISHING; 69% with "YES" are STRUGGLING/MIXED

"YES" (red) is higher among:

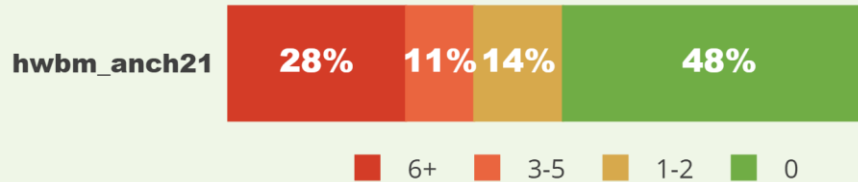
- women and gender self-defined; Age 55+; Jobless or retired; HH incomes <\$25K and over \$200K; Singles+kids
- Mental health svc seekers; 41% unable to get needed services
- Food, transpo, housing, safety insecurity
- Lower ratings on physical health, job, basic needs, relationships, learning/growth opps

Poor physical health days/month: Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (11)

AVERAGES (Days/month)



DISTRIBUTION



Key Findings

Average: 6.1 days/month

- 69% with 0 days are DOING WELL/FLOURISHING; 67% with 6+ days are STRUGGLING/MIXED

0 poor health days:

- Males

6+ poor health days:

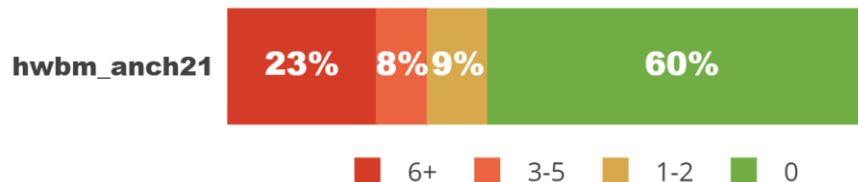
- Females, self-defined gender, students, HH income <\$25K; HS education; singles;
- Insecure housing, transpo, unsafe relationships
- Mental health service seekers (of whom 38% could not get services)
- Lower ratings on physical health, job, learning/growth opps, view of Anchorage as a safe community

Debilitating health days/month: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (13)

AVERAGES (Days/month)



DISTRIBUTION



Key Findings

Average: 4.3 days/month

- 70% with 0 days are DOING WELL/FLOURISHING; 79% with 6+ days are STRUGGLING/MIXED

0 debilitating health days:

- No clear patterns/correlations

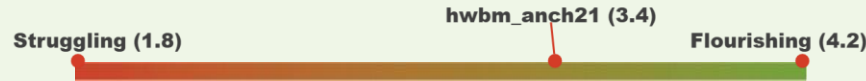
6+ poor health days:

- Self-defined gender; age 18-24; BIPOC; jobless or students; HH income <\$25K, HS or less education; singles; HH's with >3 children;
- Financial insecurity & lack of basic needs including Insecure housing, transportation, access to healthcare
- Lower ratings on virtually all key indicators
- Lower feelings of community safety

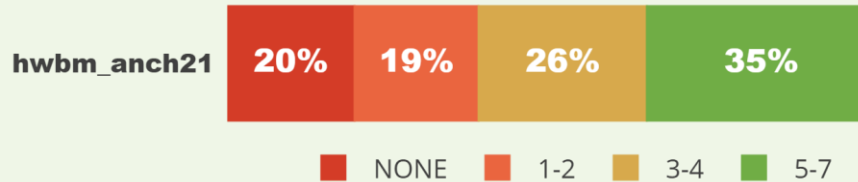
In the last week, how many days did you eat 5 servings of fresh vegetables & fruit? (14a)

CDC Recommendations:
Adults: 1.5-2 cup equivalents of fruits and 2-3 cup equivalents of vegetables per day.

AVERAGES (Days)



DISTRIBUTION



Key Findings

Average: 3.4 days/week

- FLOURISHING (average 4.2 days) are below CDC guidelines
- 59% with high 5-7 days are DOING WELL/FLOURISHING; 61% with 0 days are STRUGGLING/MIXED

Higher scores:

- Age 55+, HH income > \$200K, Couples

Lower scores:

- Self-defined gender, students,
- Financially insecure and lacking basic needs -- food, transpo, housing, job, education
- Lower ratings on physical health

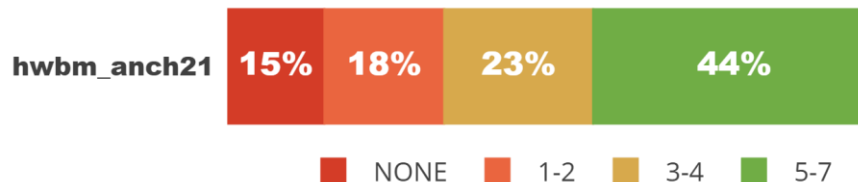
How many days in the past week did you walk or exercise 30 minutes or more? (14c)

CDC Recommendations:
at least 30 minutes, five or more days per week.

AVERAGES (Days)



DISTRIBUTION



Key Findings

Average: 3.8 days/week

- FLOURISHING (average 4.4 days) are below CDC guidelines of 5+ days
- 62% with high 5-7 days are DOING WELL/FLOURISHING; 63% with 0 days are STRUGGLING/MIXED

Higher scores:

- No consistent patterns

Lower scores:

- Housing insecurity, education gap to meet basic needs
- Lower ratings on physical health, sense of purpose & meaning



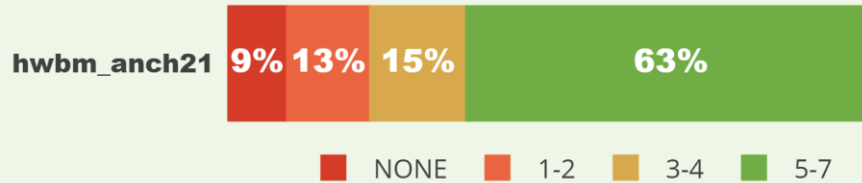
In the last week, how many days did you sleep at least 7 hours? (14d)

CDC Recommendations:
7+ hours every night

AVERAGES (Days/week)



DISTRIBUTION



Key Findings

Average: 4.8 days/week

- FLOURISHING (average 6 days) are below CDC guidelines
- 55% with high 5-7 days are DOING WELL/FLOURISHING; 67% with 0 days are STRUGGLING/MIXED

Higher scores (5-7 days):

- No consistent patterns; good sleep distributed evenly in population

Lower scores (0 days):

- Age 75+; HH income <\$50K; Retired;
- Less than HS education;
- HH with >2 children (accounts for 43% of the "0 nights" segment)
- 17.8% are mental health service seekers, but 81% of these are unable to secure services
- Lower ratings on ability to meet basic needs (40% -- nearly double the overall population)
- Higher insecurity on food, transportation, housing, bill-pay, education and personal safety
- Lower physical health ratings
- Lower ratings on opps for learning/growth

Tailored Questions

INDEX TO TAILORED QUESTIONS

The Health & Well-being Monitor is designed to incorporate a comprehensive set of well-being indicators, along with tailored questions that are relevant at the local level.

This survey includes 15 tailored questions -- 8 incorporated into their most relevant Dimensions of Health section, and 7 on the following pages.

See this section

- Covid-19 Personal Impacts (a2) **T**
- Covid Vaccination Status (a3) **T**
- Reasons to avoid Covid vaccine (a4) **T**
- Binge Drinking (a104) **T**
- Alcohol consumption vs. pre-Covid (a105) **T**
- Smoking/Vaping (a112) **T**
- Confidence Achieving Best Health (a110) **T**

Mental, Emotional & Spiritual Health section

- Need for Mental Health/Substance Use Tx (a106) **T**
- Ability to get MH/Substance Use Tx (a107) **T**
- Barriers to get MH/Substance Use Tx (a108) **T**
- Suicidal Ideation (a109) **T**

Security & Basic Needs section

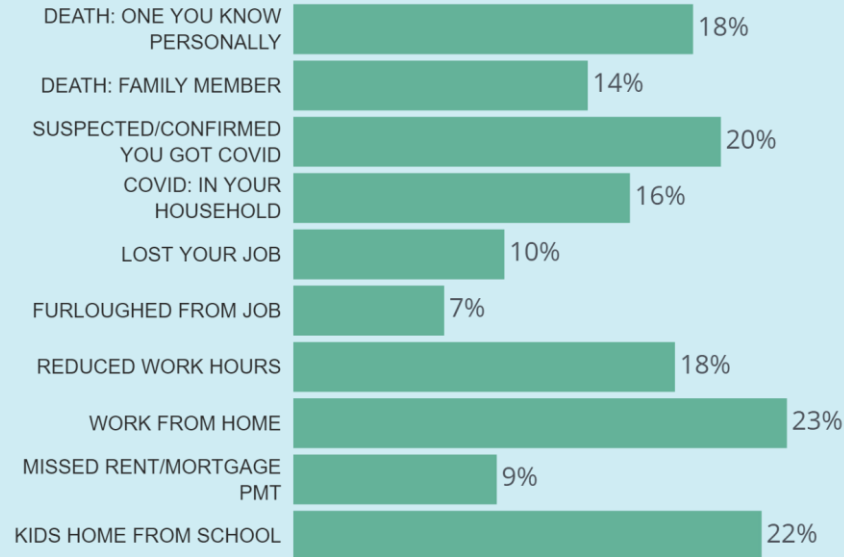
- Help with Chores if Sick (a111) **T**

Neighborhood & Environment section

- Feel Safe in my Community (q7f) **T**
- Community as a place to raise children (q7g) **T**
- Community as a place to grow old (q7h) **T**

These next questions are about the Coronavirus pandemic. Which of the following have you personally experienced since the beginning of the outbreak? (a2)

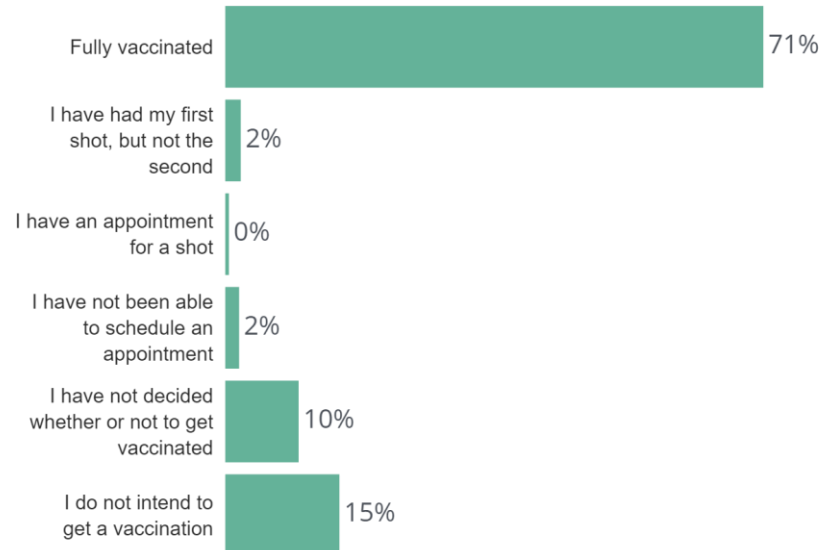
DISTRIBUTION



Key Findings

- Personal impacts of Covid-19 have had a measurable impact on overall wellbeing of Anchorage adults.
- 73% of respondents experienced at least one of the listed impacts below
- Core4 Wellbeing Index score fell to 12 points to 6.1 (a low "D") for those with covid personally or in their households
- Job impacts reduced wellbeing an average of 7 points, to 6.6 (a "D")
- Impact of children home for school had a smaller impact (7.0; C-)
- Greatest impact was from economic damage: among the 9% who missed a rent or mortgage payment due to Covid-19 related effects, measured wellbeing fell to 5.4 (an F).

When it comes to coronavirus vaccination, which of these best describes you: (a3)



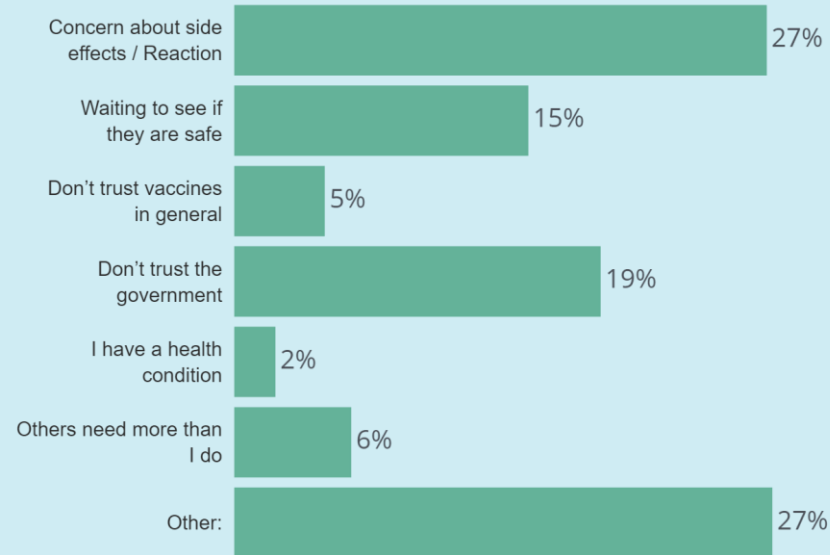
Key Findings

- 71% of respondents are vaccinated
- Vaccinated are evenly distributed in terms of wellbeing levels.
- Those choosing not to be vaccinated are more likely to be:
 - Jobless (23.3% of population, vs 10.4% overall)
 - Did not finish high school (13% vs. 5.2% of population)
 - Single with children at home
 - Food insecure, transportation barriers
- More detailed analysis available on request



What is the main reason you will not or may not get vaccinated? (a4)

DISTRIBUTION



Key Findings

- Among the 25% undecided or deciding not to be vaccinated, about 4 in 10 (42%) cite concerns about safety or side effects.
- Another 19% cite mistrust of government.
- Only 2% cite a health condition.
- Of interest, levels of concern about safety and side effects did not differ between people who have medical conditions and those who do not.
- More detailed analysis available on request

During the past 30 days, about how often did you have 5 or more drinks containing any kind of alcohol within a two-hour period? (a104)

This is the CDC definition of binge drinking.

DISTRIBUTION



Key Findings

On average, respondents binge drink about 1.2 times per month.

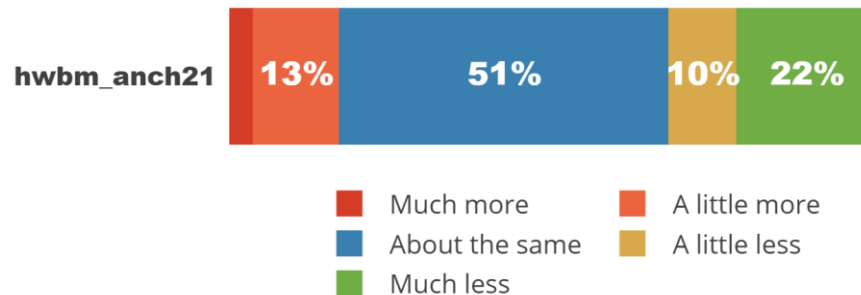
- Binge drinkers are twice as likely to be STRUGGLING
- 62% binge drinking 1+/month are STRUGGLING/MIXED
- Very strongly correlated with Core4 Well-being Index (.76)
 - Strong correlation with quality of relationships (.60); opportunities for learning & growth (.56); physical health (.53); work/job (.44)
- CDC/BRFSS reports 17.8% of Anchorage residents binge drinking 1+ times in past 30 days in 2015 (the most recent published data).

In Anchorage in 2021, 14% of respondents binge drink 1+ times/month

- More likely female, ages 25-34; HH income <\$25K, < HS education; unemployed (1 in 4; 58% above average); singles with children at home; Hispanic/Latinos; persons unable to access mental health services
- Nearly twice as likely to need MH services and 70% more likely to not receive needed MH services
- Basic needs: Over 1 in 3 are food insecure or unable to pay power/water bills; over 1 in 4 housing insecure; 87% higher rate of not meeting basic needs overall
- Low reported mental/emotional wellbeing; low sense of purpose and meaning;

Compared to before COVID-19, are you consuming more or less alcohol this year? (a105)

DISTRIBUTION



Key Findings

16% (33,600 adults) were drinking more; 32% drinking less

Profile of 13% Drinking More (& 3% Drinking Much More)

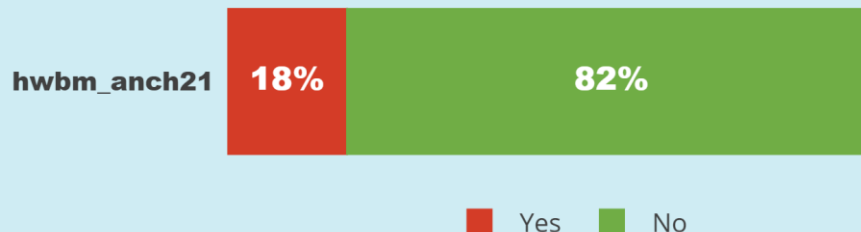
- 35-44 (age 35-54)
- students (enemployed)
- <\$25K HH income (<\$50K; >\$200K)
- <HS education (HS & below)
- Singles with children (Singles alone)
- 30% Mental service Seekers (39%)
- 30% didn't secure MH services (73%)
- Insecure job (Insecure job, food, transportation, housing, power/water)

Ratings:

- Drinking **More**: No strong differences
- Drinking **Much More**: Lower ratings on job, physical & mental health, basic needs, relationships, learning/growth,

Do you smoke tobacco products, e-cigarettes or use smokeless tobacco? (a112)

DISTRIBUTION



Key Findings

18% (38,000 adults) smoked/vaped/chewed.

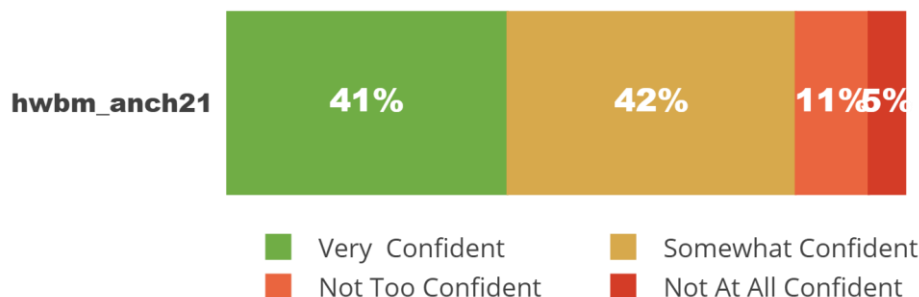
- Spread evenly across wellbeing levels
- Smokers had slightly lower measured Core4 well-being levels (7.1 vs. 7.3)

Profile of smokers disproportionately represented compared the overall population:

- Under age 55
- Students, jobless
- HH income <\$25K
- Less than HS education
- AK Natives, Black/African American
- Insecure transportation, housing, unsafe relationships

How confident are you that you can achieve or maintain the level of health that is best for you? (a110)

DISTRIBUTION



Key Findings

83% of respondents --the vast majority of Anchorage -- were "somewhat" or "very confident."

There were no patterns in the data for the top two tiers...these groups are evenly distributed throughout the community.

As a diagnostic or differentiator, the "Not too confident and Not at all confident" segment is linked to measures of financial security, lacking basic needs, safety and sense of purpose.

This question is poorly correlated with overall measures such as the Core4Wellbeing Index and Cantril's ladder, and other HWBM indicators questions correlate as well or better with financial security and basic needs.

Appendix





APPENDIX A: Anchorage 2021 Health & Well-being Monitor™ survey methods and data

This study had two primary purposes: as a comprehensive baseline measure of well-being for the Anchorage community, and to provide insights for the community advisory council overseeing the work of the Providence Alaska Medical Center 2021 Community Health Needs Assessment (CHNA). The results of this and other research will be used to set priorities for an upcoming three-year Community Health Improvement Plan which PAMC is required by law to produce every three years. This survey is being run in conjunction with a community-based convenience sample survey that will provide greater predictive power for marginalized populations including Black and Indigenous People of Color living in Anchorage.

The survey of Anchorage residents began in June 2020. The Monitor™ was conducted online from June 15 through June 30, 2021.

DATA COLLECTION. We employed a probability sample reaching phone, mobile phone, direct mail and online, utilizing registered voter lists and other specialized lists.

SURVEY RESPONSES. A total of 604 responses were received: 251 online, and 353 phone responses.

BENCHMARK RESULTS. To date, more than 10,000 people have taken the PIHC Health & Wellbeing Monitor. A hallmark of the HWBM™ is providing our clients with the most recent available community-wide benchmarks for comparison. Selected results of the annual Snohomish County Health & Well-being Monitor fielded in June 2021, commensurate with the Anchorage data collection, are included here to provide *preliminary context*. In the future, Anchorage Health & Well-being Monitor reports will use this survey as a community baseline.

DATASET USED TO DEVELOP THIS REPORT. The data were weighted based on age, gender, income and education as per the most recent available U.S. Census Bureau American Communities Survey to align the data closer to known demographic parameters. Based on raw data, the Core4 Well-being Index score is 7.459, vs. 7.314, the result published here after harmonizing the data with population parameters noted above.



APPENDIX B: Anchorage 2021 Demographic Profile

SAMPLE WEIGHTING: USCB American Communities Survey

Your Engagement Results

SAMPLE FRAME: Municipality of Anchorage, Adults 18+
SAMPLE SIZE: 604 phone, direct mail/online
POPULATION: TOTAL:~290,000 | ADULTS 18+: ~220,000

| | % | Count | Weighted Count |
|---------------|------|-------|----------------|
| Male | 49% | 232 | 300 |
| Female | 49% | 357 | 296 |
| Self-describe | 2% | 9 | 12 |
| NET | 100% | 598 | 608 |

q28 GENDER SUMMARY

| | % | Count | Weighted Count |
|-------|------|-------|----------------|
| 18-24 | 13% | 22 | 81 |
| 25-34 | 23% | 98 | 138 |
| 35-44 | 18% | 124 | 107 |
| 45-54 | 16% | 97 | 98 |
| 55-64 | 16% | 91 | 101 |
| 65-74 | 10% | 113 | 60 |
| 75+ | 5% | 56 | 28 |
| NET | 100% | 601 | 613 |

q21 AGE SUMMARY

| | % | Count | Weighted Count |
|--------------|------|-------|----------------|
| < \$25K | 11% | 45 | 67 |
| \$25-\$49K | 17% | 61 | 101 |
| \$50-\$74K | 18% | 102 | 106 |
| \$75-\$124K | 23% | 133 | 142 |
| \$125-\$149K | 10% | 51 | 62 |
| \$150-\$199K | 11% | 52 | 65 |
| \$200K+ | 10% | 50 | 62 |
| NET | 100% | 494 | 604 |

q27_INCOME SUMMARY

| | % | Count | Weighted Count |
|-------------------------------|------|-------|----------------|
| Did not finish High School | 5% | 12 | 30 |
| High School Diploma / GED | 25% | 61 | 152 |
| Vocational / Technical School | 0% | 35 | 1 |
| Some College (Including A.A.) | 33% | 147 | 202 |
| Bachelor's Degree | 22% | 184 | 134 |
| Graduate School | 15% | 158 | 88 |
| NET | 100% | 597 | 607 |

q22 EDUC SUMMARY

| | % | Count | Weighted Count |
|------------------------|------|-------|----------------|
| Employed Full Time | 57% | 303 | 347 |
| Employed Part Time | 10% | 58 | 58 |
| Not Currently Employed | 10% | 48 | 60 |
| Student | 3% | 8 | 19 |
| Retired | 20% | 177 | 123 |
| NET | 100% | 594 | 607 |

q24 EMP STAT SUMMARY

| | % | Count | Weighted Count |
|----------------------------------|-----|-------|----------------|
| Alaska Native, Eskimo, Am Indian | 9% | 36 | 55 |
| Asian or Pacific Islander | 6% | 27 | 36 |
| Black or African American | 5% | 18 | 33 |
| White or Caucasian | 74% | 464 | 453 |
| Hispanic or Latino | 8% | 29 | 51 |
| Other | 2% | 17 | 13 |
| NET | 96% | 560 | 592 |

q25: X- What is your race and/or ethnicity SUMMARY

| | % | Count | Weighted Count |
|----------------------|------|-------|----------------|
| Couple+Child(ren) | 29% | 157 | 172 |
| Couple/No Child | 29% | 202 | 173 |
| Single+Child(ren) | 5% | 30 | 28 |
| Single, Living Alone | 19% | 125 | 112 |
| Single+Other Adults | 19% | 71 | 114 |
| NET | 100% | 585 | 600 |

q23 HH TYPE SUMMARY

| | % | Count | Weighted Count |
|-------------------|------|-------|----------------|
| Couple+Child(ren) | 86% | 157 | 172 |
| Single+Child(ren) | 14% | 30 | 28 |
| NET | 100% | 187 | 201 |

q23_3 HH TYPE 2 HH with Kids SUMMARY

| | % | Count | Weighted Count |
|-----|------|-------|----------------|
| 0 | 13% | 27 | 27 |
| 1 | 47% | 82 | 93 |
| 2 | 27% | 51 | 54 |
| 3 | 11% | 18 | 22 |
| 4 | 1% | 4 | 2 |
| 5 | 0% | 1 | 1 |
| 7 | 0% | 1 | 0 |
| NET | 100% | 184 | 200 |

q231: # Children < 18 SUMMARY

Thank You

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