2024

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Alaska Medical Center and St. Elias Specialty Hospital

Anchorage, AK

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

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EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Alaska Medical Center (PAMC) and Providence St. Elias Specialty Hospital 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.

This report is a joint CHNA and reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community and the community strengths. The hospitals participating in this joint CHNA share a service area and community served. The 2024 CHNA was approved by the Providence Alaska Region Board on November 9, 2024, and made publicly available by December 28, 2024.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, and public health data regarding health behaviors; morbidity and mortality, and hospital-level data.

To actively engage the community, we conducted 9 key informant interviews with representatives from organizations that serve diverse populations, specifically seeking to gain deeper understanding of community strengths and opportunities.

We also conducted an online community survey of 600 local respondents, the Health & Well-Being Monitor™. Survey participants were asked questions six dimensions of health: relationships and social connections; mental and emotional health; neighborhood and environment; physical health; work, learning and growth; and security and basic needs. During analysis, 2024 survey responses were compared with 2021 responses for benchmark trend results.

The following provides key findings from the Community Health and Well-being Monitor™:

Basic Needs / Economic Security

- Those reporting their financial security as "high" decreased from 36 percent in 2021 to 31 percent in 2024.
- Food insecurity remained at nearly 1 in 10 from 2021 to 2024.
- In 2021 Power and Water was identified as a top need by 13 percent of respondents and increased to 17 percent of respondents in 2024.

Mental Health

- In 2021 and 2024, roughly 1 in 5 community members report that they or a family member needed mental health services in the past year.
- Nearly 1 in 14 respondents in both 2021 and 2024 report having had thoughts of suicide in the prior 12 months.
- One in four reported having "low" satisfaction with their mental or emotional wellbeing in 2024.

Substance Use/Misuse

- Almost 1 in 3 respondents (31%) report having engaged in binge drinking during the prior 30 days.
- One in twenty respondents report having sought substance use treatment in the past year.

Healthy Behaviors / Physical Health

- Nearly 1 in 3 respondents rate the state of their physical health as "low."
- In 2024, more than 1 in 4 reported having a chronic disease such as congestive heart failure, diabetes, asthma, etc.
- Nearly 1 in 4 respondents reported using tobacco related products.

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

The Anchorage CHNA Committee reviewed a summary of all quantitative data collected from key informant interviews, as well as relevant quantitative data regarding identified community health-related need areas.

After this in-depth data review, the Committee prioritized the need areas based on the following criteria:

- **Size and Scope**: What is the significance of the health issue in terms of the number/percent of people affected?
- **Severity:** How serious are the negative impacts of this issue on individuals, families, and the community?
- **Ability to Impact:** What is the probability that the community could succeed in addressing this health issue? (They took into consideration factors such as community resources, whether there are known interventions, and community commitment to addressing the need.)

Listed in order of priority, they selected the following as the most significant health needs in the PAMC service area:

PRIORITY 1: BASIC NEEDS / ECONOMIC SECURITY

There is substantial and increasing evidence that socio-economic factors, also known as social determinants of health, are just as important to an individual's health as genetics or certain health behaviors. Financial security is chief amongst the factors that impact an individual's health, wellbeing, and longevity. Individuals that lack economic security experience an increased risk of food insecurity, homelessness, and inability to meet basic needs. These basic needs include education, job security, economic opportunity, transportation, and availability of affordable childcare. The persistence of racial and gender income gaps continues to demonstrate the importance of social justice and equity in the health and wellbeing of the community and each individual's ability to access the resources necessary to meet their basic needs.

PRIORITY 2A: MENTAL HEALTH

Mental health is foundational to quality of life, physical health, and the health of the community and includes our emotional, psychological, and social wellbeing. Individuals experiencing social inequities such as discrimination, cultural barriers, poverty, limited access to quality education and socio-economic opportunities often experience higher levels chronic stress which can lead to a higher incidence of mental health challenges. Poor mental health has significant health and social impacts on the well-being of individuals and the community as a whole. The community conditions that support resilience, social connection, equity and justice, along with timely access to behavioral health care and services are fundamental to healthy individuals and a healthy community.

PRIORITY 2B: SUBSTANCE USE/MISUSE

Alcohol and substance misuse has significant health and social impacts both for individuals and the community. 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 unaddressed mental health issues. The challenges of substance use disorders (SUD) have compounding physical, mental, and economic impacts on individuals, families, and the greater community. Social, economic, racial, and gender inequities along with cultural beliefs and social stigma are factors influencing the incidence of SUD in the community and as well as issues related to access to treatment.

PRIORITY 3: PHYSICAL HEALTH *(HEALTHY BEHAVIORS, CHRONIC CONDITIONS, AND OVERALL HEALTH)*

Roughly thirty percent of factors affecting an individual's health are related to their behaviors and lifestyle choices, with socio-economic, 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. Barriers to achieving physical health and wellbeing track with those of the other needs categories and include culture, language, social and economic inequities, transportation, education, systemic and historical issues related to trust in health systems.

PRIORITY 4: ACCESS TO HEALTH CARE *(PRIMARY, SPECIALTY, ACUTE, AND DENTAL CARE)*

Appropriate access to preventive and acute care has an impact on individuals' ability to maintain good health. Appropriate healthcare access means receiving the right care at the right time and in the right place or setting - the timely use of personal health services to achieve the best outcomes. Barriers to

achieving that include the lack of locally available and accessible primary, acute and specialty care and dental services including Medicare providers for seniors in the community, the complex siloed nature of our health systems, lack of means to pay or being uninsured, and include cultural, language and even transportation challenges.

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 2025-2027 CHIP will be approved and made publicly available no later than May 15, 2025.

Results from the 2021 CHNA and 2022-2024 CHIP

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. In addition, we invited written comments on the 2021 CHNA and 2022-2024 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the 2021 CHNA and 2022-2024 CHIP. The 2021 CHNA and 2022-2024 CHIP priorities were the following:

- Basic Needs / Economic Security
- Behavioral Health (includes mental health and substance use/misuse)
- Healthy Behaviors / Physical Health
- Cultural and Social Community Wellbeing

A few of the key outcomes from the previous CHIP are listed below:

- Opening of 51-unit permanent supportive housing facility in 2024 for elders 55 years and older experiencing homelessness and disabling health conditions.
- Finalization of Healthcare and Homelessness Pilot with Institute for Healthcare Improvement and Community Solutions, establishing a community-based healthcare and homelessness liaison at the Anchorage Coalition to End Homelessness.

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.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

Joint CHNA Report

This is a "joint CHNA report," within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Anchorage Medical Center and St. Elias Specialty Hospital. This report reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community as well the community strengths. The hospitals participating in this joint CHNA share a service area and community served. This CHNA engaged with and sought input from that community.

SECTION I: CHNA FRAMEWORK AND PROCESS

Equity Framework

Our vision, Health for a Better World, is driven by a belief that health is a human right. Every person deserves the chance to live their healthiest life. At Providence, we recognize that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion or socioeconomic status. Our health equity statement can be found online: https://www.providence.org/about/health-equity.

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. 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 health care, and more.

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 census tract level to address masking of needs at county level

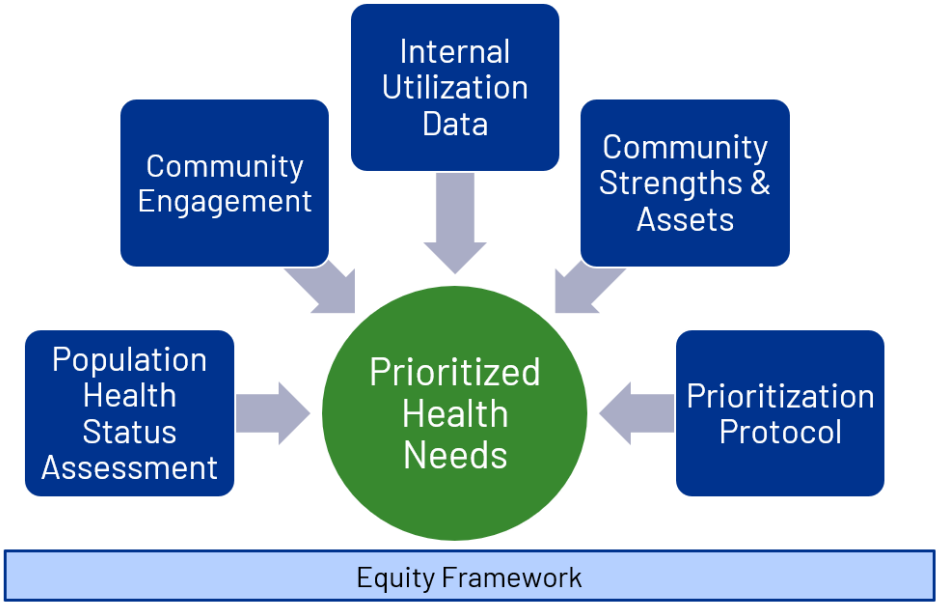
Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed-methods

Figure 1. CHNA Framework



*modified MAPP Framework

approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.

Data Sources

In gathering information on the communities served by the Providence Alaska Medical Center and St. Elias Specialty Hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at 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.

We reviewed data from the following sources:

Primary Data Sources	Secondary Data Sources
• Key informant interviews (including Anchorage Health Department) • Internal hospital utilization data • Community Health & Well-Being Monitor™	• American Community Survey from the U.S. Census Bureau • Behavioral Risk Factor Surveillance System (BRFSS) • CDC Places • Environmental Justice Index • U.S. Health Resources and Services Administration

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:

- Not all desired data were readily available, so sometimes we had 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 a good reflection of the current state.
- Reporting data at the borough or municipality 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, we disaggregated the data 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

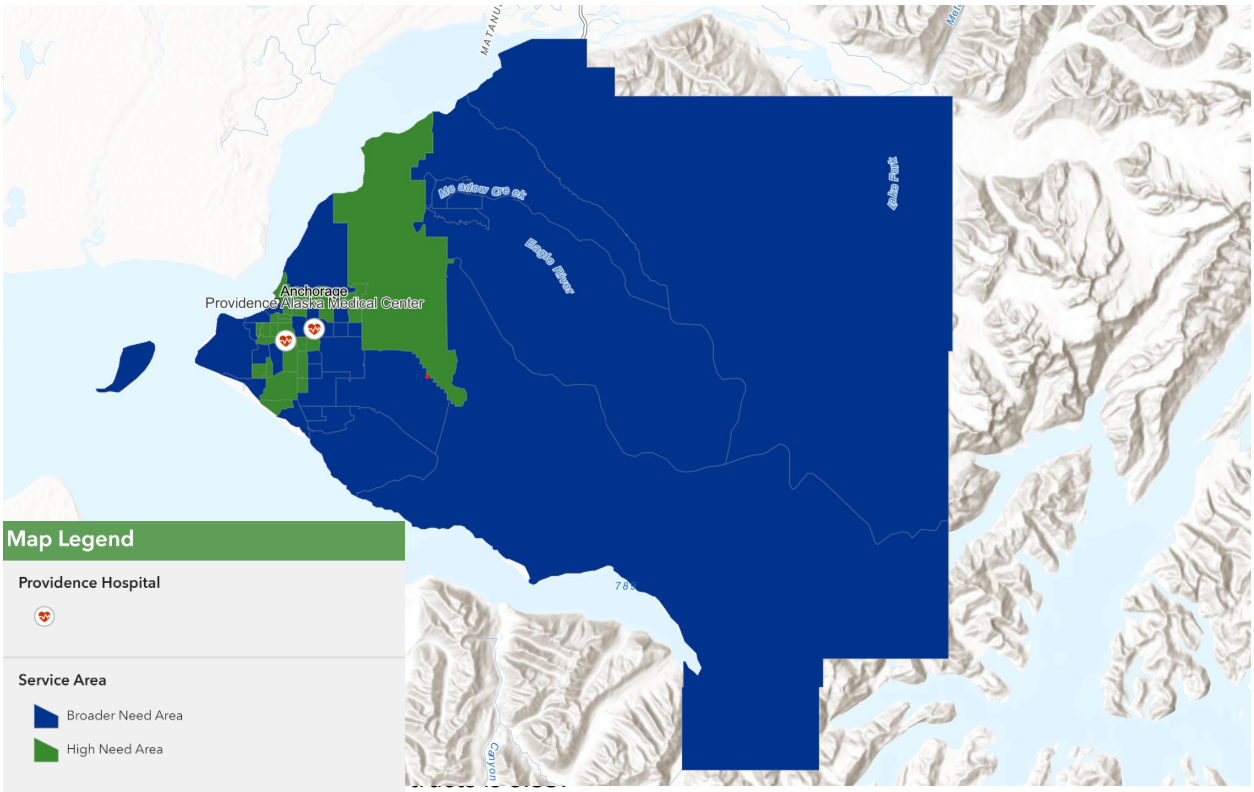
Written comments were solicited on the 2021 CHNA and 2022-2024 CHIP reports, which were made widely available to the public via posting on the internet in December 2021 (CHNA) and May 2022 (CHIP), as well as through various channels with our community-based organization partners. No comments were received.

SECTION II: DESCRIPTION OF COMMUNITY

CHNA Service Area

Based on the availability of data, geographic access to the facility, and other hospitals in neighboring boroughs, the Municipality of Anchorage serves as the boundary for the hospital service area.

Figure 2. CHNA Service Area for PAMC and St. Elias Specialty Hospital—Municipality of Anchorage



Community Demographics

The tables and graphs below provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a data hub that maps each CHNA indicator at the census tract level: [Anchorage 2024 CHNA Dashboard (arcgis.com)]

POPULATION AND AGE DEMOGRAPHICS

Table 1. Total Population and Population Sex for Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area
Total Population	290,674	154,713	135,961
Female Population	48.7% (141,530)	49.1% (75,903)	48.3% (65,627)
Male Population	51.3% (149,144)	50.9% (78,810)	51.7% (70,334)

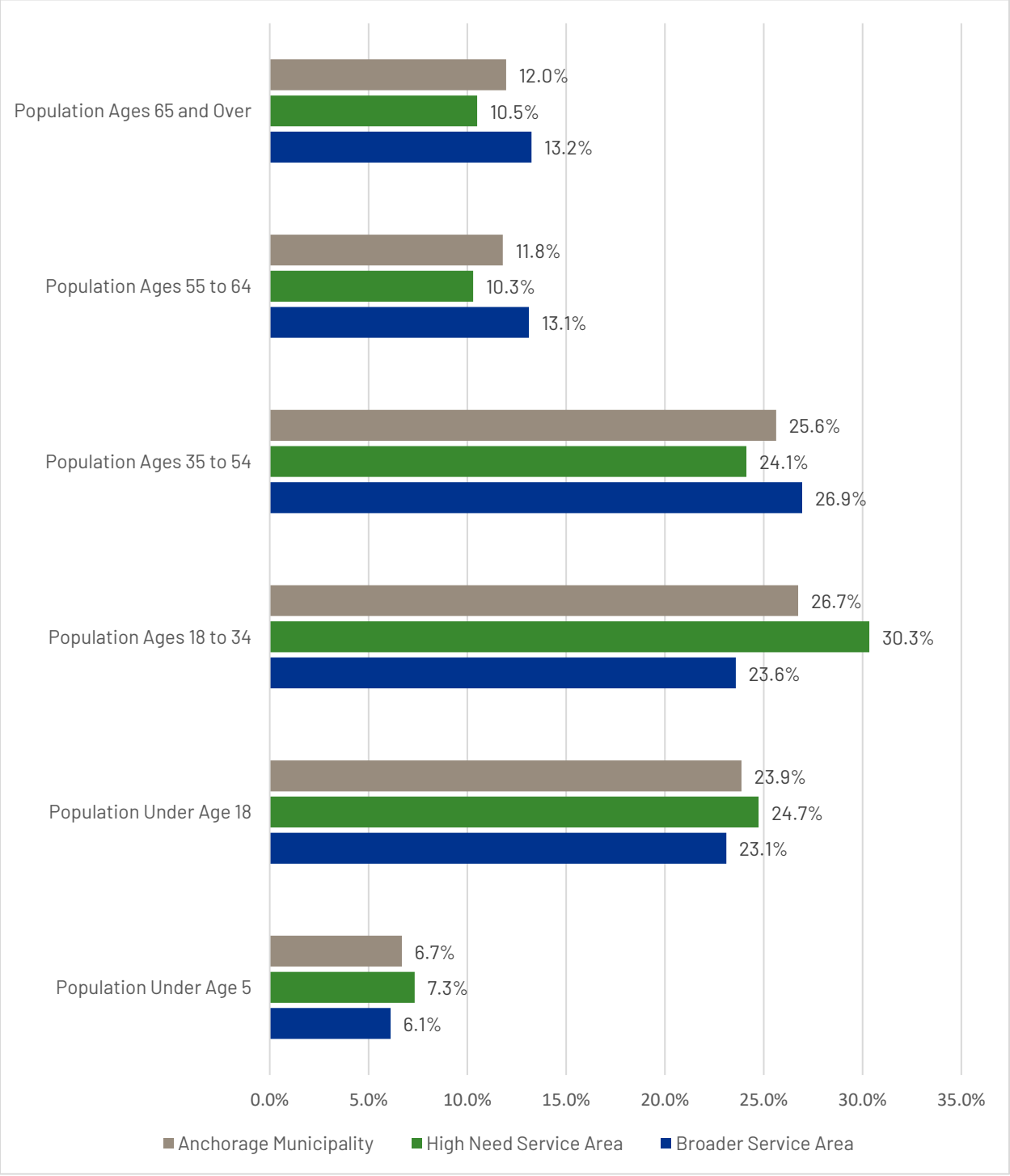
Source: 2022 American Community Survey 5-Year Estimates

Table 2. Population by Age Group for Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area
Population Age Under 5	6.7% (19,434)	6.1% (9,459)	7.3% (9,975)
Population Age Under 18	23.9% (69,388)	23.1% (35,752)	24.7% (33,636)
Population Age 18 to 34	26.7% (77,738)	23.6% (36,486)	30.3% (41,252)
Population Age 35 to 54	25.6% (74,494)	26.9% (41,692)	24.1% (32,802)
Population Age 55 to 64	11.8% (34,286)	13.1% (20,290)	10.3% (13,996)
Population Age 65 and Over	12.0% (34,768)	13.2% (20,493)	10.5% (14,275)

Source: 2022 American Community Survey 5-Year Estimates

Figure 3. Population by Age Group for Anchorage Municipality Service Area



Source: 2022 American Community Survey 5-Year Estimates

People ages 18 to 34 are more likely to live in the high need service area compared to the broader service area and Anchorage Municipality overall. In contrast, the Broader Service Area has a slightly older demographic, with a larger proportion of individuals aged 35 and above.

Population by Race and Ethnicity

Table 3. Population by Race for Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area
Alaska Native/American Indian Population	7.4% (21,507)	5.2% (7,975)	10.0% (13,532)
Asian Population	9.8% (28,440)	7.3% (11,349)	12.6% (17,091)
Black Population	5.3% (15,469)	2.8% (4,313)	8.2% (11,156)
Other Race Population	2.9% (8,563)	0.8% (1,227)	5.4% (7,336)
Pacific Islander Population	2.7% (7,728)	2.2% (3,421)	3.2% (4,307)
Population of Two or More Races	12.7% (36,963)	12.7% (19,609)	12.8% (17,354)
White Population	59.2% (172,004)	69.0% (106,819)	47.9% (65,185)

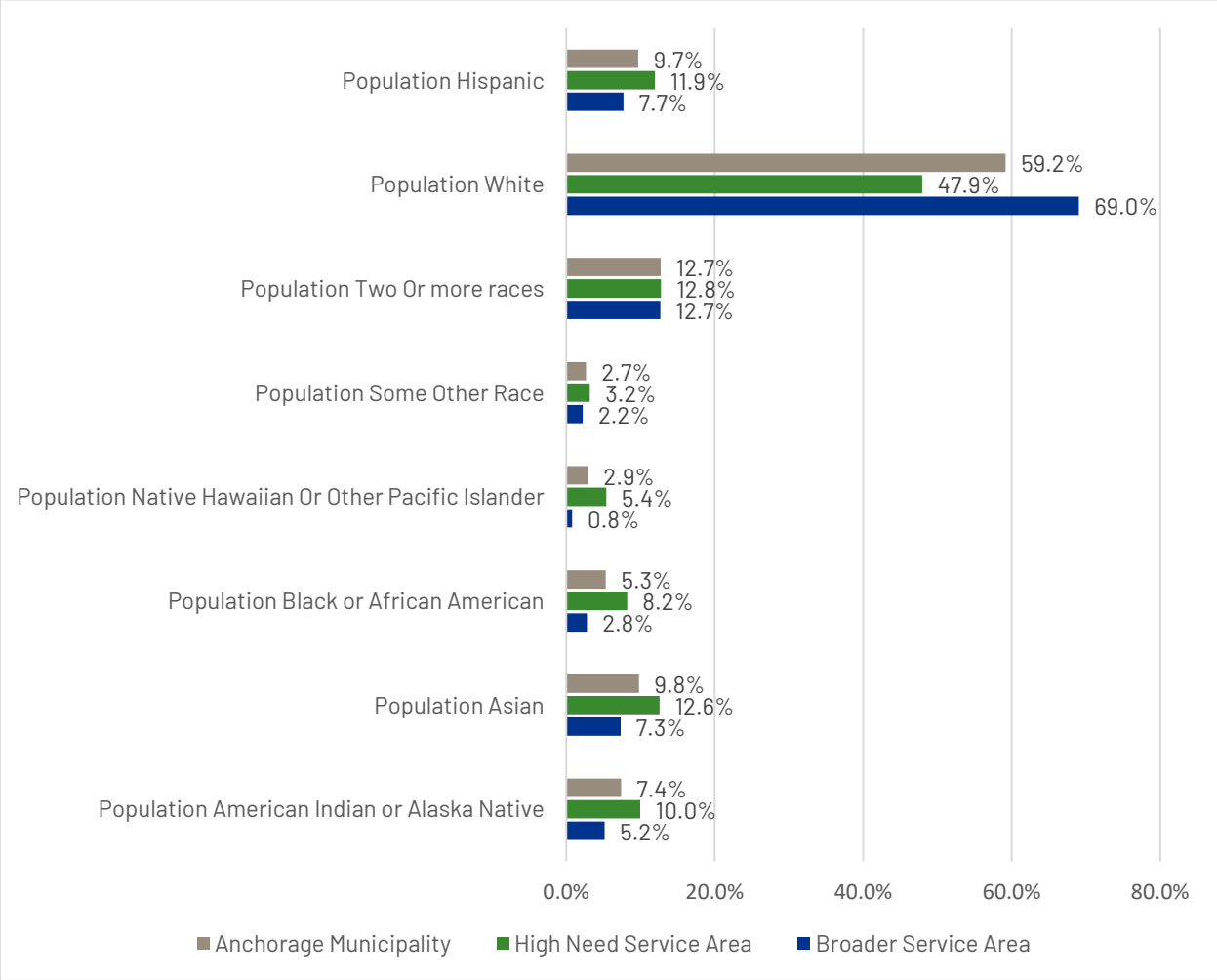
Source. 2022 American Community Survey, 5-Year Estimates

Table 4. Population by Ethnicity for Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area
Hispanic Population	9.7% (28,162)	7.7% (11,923)	11.9% (16,239)

Source: 2022 American Community Survey 5-Year Estimates

Figure 4. Population by Race and Ethnicity for Anchorage Municipality Service Area



Source: 2022 American Community Survey 5-Year Estimates

The High Need Service Area has a more racially and ethnically diverse population compared to the Broader Service Area and the Anchorage Municipality overall. The High Need Service Area has higher proportions of Hispanic (11.9%), Black or African American (8.2%), and Native Hawaiian or Other Pacific Islander (5.4%) populations. In contrast, the Broader Service Area is predominantly White (69%).

Table 5. Median Income in Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area	Alaska
Median Household Income Data Source: 2022 American Community Survey 5-Year Estimates	$95,731	$124,083	$75,091	$86,370

The High Need Service Area has the lowest median household income at $75,091, which is substantially lower than both the Broader Service Area ($124,083) and Anchorage Municipality as a whole ($95,731). However, it is still slightly higher than the median for Alaska overall ($86,370).

Table 6. Severe Housing Cost Burden for Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area	Alaska
Percent of Households Experiencing Severe Housing Cost Burden Data Source: 2022 American Community Survey, 5-Year Estimates	12.5% (13,427 households)	10.4% (5,771 households)	15.9% (7,656 households)	11.3% (29,776 households)

Severe housing cost burden is defined as households spending 50% or more of their income on housing costs. The High Need Service Area has the highest percentage of households experiencing severe housing cost burden at 15.9%, compared to 12.5% in Anchorage Municipality, 10.4% in the Broader Service Area, and 11.3% statewide in Alaska. This indicates that households in the High Need Service Area face greater financial strain related to housing costs than households in other parts of Anchorage or Alaska as a whole.

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. The Anchorage Municipality is designated as a primary care, dental health, and mental health HPSA for the Medicaid Eligible Population.

See Appendix 1 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

SECTION III: HEALTH-RELATED INDICATORS

Please refer to the Anchorage Data Hub 2024 to review each of the following health indicators mapped at the census tract level: https://experience.arcgis.com/experience/8d4c9fe8721a49208ee2b5f7b4064cbe/.

The hub provides data on each indicator in the Anchorage Municipality, high need and broader need service areas, and Alaska, as well as information about the importance of each indicator.

Table 7. Households receiving SNAP Benefits in Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area	Alaska
Households Receiving SNAP Benefits Data Source: 2022 American Community Survey, 5-Year Estimates	8.9% (9,533 households)	3.3% (1,867 households)	15.8% (7,666 households)	10.5% (27,659 households)

Households receiving SNAP is used as a proxy measure to identify households that may be experiencing food insecurity. The High Need Service Area has a significantly higher percentage of households receiving SNAP benefits at 15.8% (7,666 households) compared to 3.3% (1,867 households) in the Broader Service Area.

Table 8. Population below 200% FPL in Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area	Alaska
Population Below 200% Federal Poverty Level (FPL) Data Source: 2022 American Community Survey, 5-Year Estimates	22.3% (63,378 individuals)	13.9% (20,571 individuals)	33.2% (42,807 individuals)	24.7% (177,333 individuals)

In 2022, 200% Federal Poverty Level was equivalent to an annual household income of $55,500 or less for a family of four in the contiguous United States and $69,380 in the state of Alaska. The High Need Service Area has a substantially higher proportion of its population living below 200% of the Federal Poverty Level (FPL) at 33.2% (42,807 individuals), compared to 13.9% (20,571 individuals) in the Broader Service Area.

Table 9. Population Unemployed in Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area	Alaska
Population Unemployed Data Source: 2022 American Community Survey, 5-Year Estimates	5.2% (7,747 individuals)	4.6% (3,636 individuals)	6.1% (4,111 individuals)	6.4% (23,035 individuals)

The High Need Service Area has a higher unemployment rate at 6.1% (4,111 individuals) compared to 5.2% (7,747 individuals) in Anchorage Municipality overall and 4.6% (3,636 individuals) in the Broader Service Area. This aligns with statewide unemployment levels in Alaska at 6.4%, indicating greater economic challenges in the High Need Service Area compared to the rest of Anchorage, but somewhat comparable to the state.

Table 10. Population Uninsured in Anchorage Municipality Service Area

Indicator	Anchorage Municipality	Broader Service Area	High Need Service Area	Alaska
Population without Health Insurance Data Source: 2022 American Community Survey, 5-Year Estimates	10.5% (29,277 individuals)	7.8% (11,755 individuals)	13.3% (17,522 individuals)	11.7% (82,562 individuals)

People who had no reported health coverage, or those whose only health coverage was Indian Health Service, were considered without health insurance. The High Need Service Area has the highest percentage of uninsured individuals at 13.3% (17,522 people), compared to 10.5% (29,277 people) in Anchorage Municipality overall, 7.8% (11,755 people) in the Broader Service Area, and 11.7% (82,562 people) statewide in Alaska. This indicates that residents in the High Need Service Area face greater challenges in accessing health insurance coverage compared to other parts of Anchorage and Alaska.

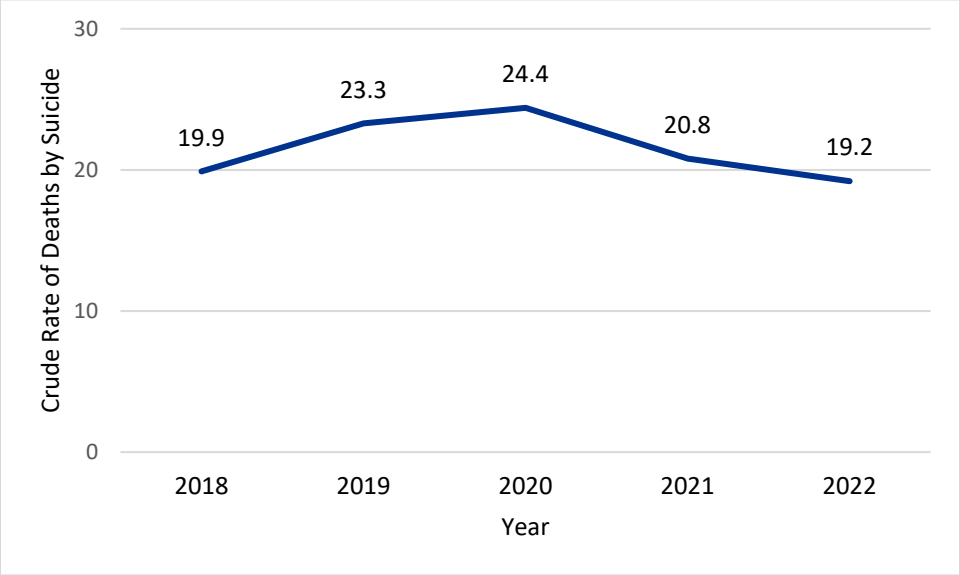
Table 11. Leading Causes of Death in Anchorage Municipality (Crude Rates per 100,000 population)

Cause of Death	Anchorage Municipality	Alaska
1. Malignant neoplasms (cancer)	137.7	141.6
2. Diseases of heart	123.8	125.4
3. Accidents (unintentional injuries)	61.7	66.8
4. COVID-19	34.5	34.3
5. Cerebrovascular diseases	27.9	30.4

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022

Table 11 highlights the top 5 leading causes of death in Anchorage Municipality compared to Alaska statewide. The crude rate represents deaths per 100,000 population without adjusting for age distribution. Malignant neoplasms or cancer (137.7) and diseases of the heart (123.8) are the leading causes, closely mirroring statewide trends but slightly lower than Alaska's overall rates. Accidents (61.7) rank third, with a lower rate than the statewide rate (66.8). COVID-19 (34.5) ranks fourth, with nearly identical rates between Anchorage and Alaska. Cerebrovascular diseases (27.9) rank fifth, with Anchorage's rate slightly lower than Alaska's (30.4).

Figure 5. Deaths by Suicide per 100,000 in Anchorage Municipality between 2018-2022 (Crude Rates)



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022

Figure 5 shows the crude rate of deaths by suicide per 100,000 population in Anchorage Municipality from 2018 to 2022. Following are key findings:

- 2018 to 2020: The rate of deaths by suicide increased from 19.9 in 2018 to its peak of 24.4 in 2020.
- 2020 to 2022: After 2020, the rate steadily decreased, dropping to 19.2 in 2022.
- Overall, the 2022 rate is slightly lower than in 2018, reflecting a decrease of 0.7 over the five years.

See Appendix 1 for additional Population Health Data

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships.

In 2023, our data showed the following key insights for Providence Anchorage Medical Center:

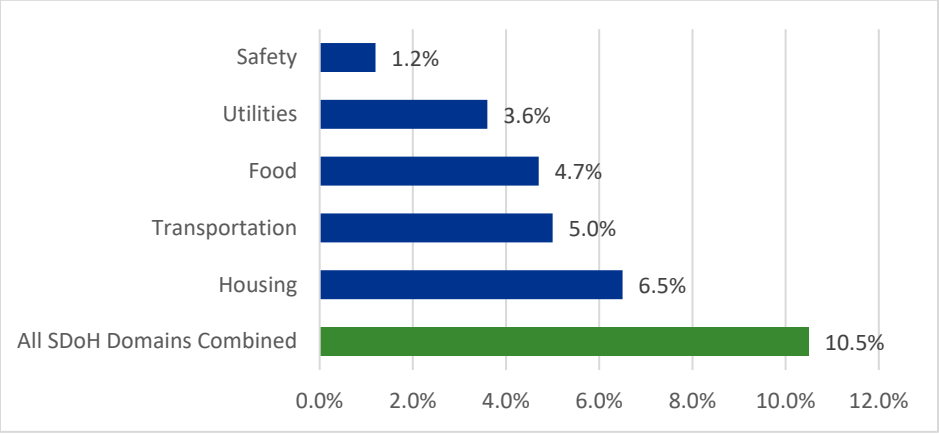
- 29.9% of all ED visits are considered potentially avoidable.
- The ZIP Codes 99508, 99501, 99503 had the highest percentages of visits considered potentially avoidable compared to other ZIP Codes.
- American Indian or Alaska Native patients had the highest percentage of visits considered potentially avoidable, 39.4%, compared to other races and ethnicities, as well as the patient population overall at 29.9%.
- Patients with Medicaid (incl. HMO) have the highest percentage of visits considered potentially avoidable (35.4%) and account for 42.8% of the total AED cases. Patients with a payor of Self-Pay have higher rates (34.6%) of avoidable visits, but low volume, 8.7% of total AED cases.
- The most common diagnoses groupings for all avoidable visits during this time were urinary tract infections, skin infections, and bronchitis and other upper respiratory diseases.
- In 2023, Behavioral Health cases accounted for 5.8% of total ED cases.
- Patients ages 18 to 39 made up half of the total behavioral health ED cases, and 8.9% of the ED cases for this age group were related to behavioral health.

For additional information regarding these findings, please contact nathan.johnson@providence.org.

Hospital Social Determinant Health Screening Data

To better understand and respond to patients' Social Determinant of Health (SDOH) needs, each inpatient over the age of 18 is asked about support needs related to housing, transportation, food, utilities, and safety. From October 1, 2023- June 30, 2024, at PAMC, 10.5% of patients screened positive for at least one need. Housing was the greatest need reported, with 6.5% of patients screening positive. A greater percentage of patients identifying as Alaska Native/ Indigenous American reported at least one SDOH need (31.2%) compared to patients identifying as Black/ African American (17.3%) and as White (9.5%).

Figure 6. Percent of PAMC Inpatients Screening Positive for SDOH Needs



Source: CPH Population Trends, inpatients, 18+years, discharged between 10/1/23-6/30/24

SECTION IV: COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence conducted 9 key informant interviews with representatives from 9 community-based organizations, including the Anchorage Health Department. During these interviews, community members and nonprofit and government key informants discussed the issues and opportunities of the diverse people, neighborhoods, and cities of the service area. All community input was collected between June and August 2024. Below is a high-level summary of the findings of these sessions.

COMMUNITY-DEFINED HEALTH AND STRENGTHS

Key informants were asked to describe their vision of a healthy community and highlight community strengths. These questions are important for understanding what matters to community members and leveraging what is already working:

Vision for a Healthy Community	Community Strengths
•Abundant oppurtunities for growth •Diverse and inclusive •Easy access to health and preventative services •Priotizes social and emotional well-being •Healing and Addressing Trauma	•Collaborative Spirit and Partnerships •Cultural Heritage and Indigenous Knowledge •Commitment to health and well being •Resilience and Optimism

COMMUNITY NEEDS

High Priority Unmet Health-Related Needs

Affordable Housing and Homelessness	Key informants identified affordable housing and homelessness as a major challenge in Anchorage, with rising housing costs making sustainable living increasingly difficult even for employed individuals. There is a shortage of affordable housing options. Eviction rates have surged, and many available housing options are of poor quality. Homelessness is closely linked to trauma and mental health, underscoring the need for lower-barrier housing and more inpatient and outpatient treatment connected to transitional housing. Efforts to address homelessness, such as encampment abatements only shift the problem without solving it. Key informants critiqued the social service system for focusing on temporary housing solutions without addressing root causes such as trauma and economic insecurity. They emphasized the need for long-term shelter solutions and programs that build skills and foster self-sufficiency. Certain populations are especially impacted, including low-income families, individuals with chronic

	medical conditions, people needing assistance with daily living, older adults, and Alaska Natives. These groups face additional barriers, such as high medical costs and lack of services for those needing assistance with daily living. Programs that integrate cultural practices and skill-building could help heal historical trauma and create economic opportunities, aiding transitions out of homelessness.
Behavioral health challenges and access to care (mental health and substance use/misuse)	Key informants identified behavioral health as a critical concern in the community, highlighting systemic gaps in services, cultural misalignments, and insufficient infrastructure, funding, and workforce support. The demand for behavioral health services is rising, particularly for young people, and has been exacerbated by the lingering effects of the COVID-19 pandemic, such as strained relationships, financial hardships, and workplace pressures. There is a strong call to integrate behavioral health into primary care for holistic, whole-person treatment, addressing not only physical but also emotional and cultural needs. Many health issues, like substance use and suicide, are rooted in historical trauma and marginalization, requiring a comprehensive approach. Key populations disproportionately affected include youth, older adults, individuals with low income, people with substance use disorders, BBIPOC communities including Alaska Natives, and trauma survivors. Barriers to accessing behavioral health services include high costs, long wait times, complex service navigation, transportation challenges, and gaps in infrastructure such as crisis stabilization centers and transitional housing options.
Access to Healthcare Services	Key informants highlighted significant systemic and logistical barriers to healthcare access in the community, particularly affecting Alaska Natives, seniors, individuals experiencing poverty, and those with chronic conditions. These challenges stem from a lack of cultural competency, language support, high healthcare costs, and inadequate transportation. Many healthcare programs rely on Western models that fail to address the spiritual and cultural needs of Alaska Natives, resulting in inadequate care. Additionally, healthcare providers often lack knowledge of the historical traumas experienced by these communities, further exacerbating disparities. The rising cost of care, especially for those not yet eligible for Medicare or Medicaid, limits access for low-income individuals, and the closure of local pharmacies makes managing chronic conditions increasingly difficult. Gaps in pediatric, maternal, and complex care services, along with unreliable public transportation, worsen these issues. To address these disparities, there is a need for more community health workers, culturally relevant services, and systemic reforms that account for the diverse needs of populations such as BBIPOC, immigrants, and people experiencing homelessness.

Medium Priority Unmet Health-Related Needs

Economic Insecurity	Key informants identified economic insecurity as a critical issue affecting health outcomes in the community, with long-term economic instability compounding challenges like housing, healthcare access, and adverse childhood experiences (ACEs). The rising cost of living, stagnant wages, and unaffordable childcare make it difficult for residents to meet basic needs. Economic insecurity also contributes to workforce shortages in essential services such as nursing and policing. There is a need for strength-based approaches that emphasize cultural healing, skill-building, and resilience to help people thrive. Programs that incorporate cultural practices and provide clear employment pathways can support economic security and transition people out of homelessness. However, inadequate transportation infrastructure and broken organizational systems, particularly in securing equitable funding for smaller organizations, further hinder access to economic opportunities and services. Economic insecurity remains a major driver of health disparities within the community.
Access to Childcare and Preschools	The availability and cost of childcare are significant barriers for families. In Anchorage, childcare services are affected by low wages for providers, supply shortages, and high costs for families. High costs and a lack of available childcare force families to choose between working or staying home and receiving subsidies. Quality of care is also a concern, with insufficient funding to meet required standards. There is a mismatch between supply and demand for childcare, leaving many families unable to access age-appropriate care, which forces children into developmentally inappropriate environments.

See Appendix 2 for methodology and participant details

Community Health and Well-Being Monitor™

Due to the limited data available for Anchorage through state and federal sources, Providence fielded a survey from May through June of 2024. A total of 600 responses were received. 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: relationships and social connections; mental and emotional health; neighborhood and environment; physical health; work, learning and growth; and security and basic needs.

The following provides key findings from the Community Health and Well-being Monitor™:

Basic Needs / Economic Security

- Those reporting their financial security as "high" decreased from 36 percent in 2021 to 31 percent in 2024.
- Food insecurity remained at nearly 1 in 10 from 2021 to 2024.
- In 2021 Power and Water was identified as a top need by 13 percent of respondents and increased to 17 percent of respondents in 2024.

Mental Health

- In 2021 and 2024, roughly 1 in 5 community members report that they or a family member needed mental health services in the past year.
- Nearly 1 in 14 respondents in both 2021 and 2024 report having had thoughts of suicide in the prior 12 months.
- One in four reported having "low" satisfaction with their mental or emotional wellbeing in 2024.

Substance Use/Misuse

- Almost 1 in 3 respondents (31%) report having engaged in binge drinking during the prior 30 days.
- One in twenty respondents report having sought substance use treatment in the past year.

Healthy Behaviors / Physical Health

- Nearly 1 in 3 respondents rate the state of their physical health as "low."
- In 2024, more than 1 in 4 reported having a chronic disease such as congestive heart failure, diabetes, asthma, etc.
- Nearly 1 in 4 respondents reported using tobacco related products.

See Appendix 5 for detailed findings

Challenges in Obtaining Community Input

Key stakeholder and community leader engagement and participation has remained high in support of qualitative interviews and analysis of community need. While sufficient community survey participation was achieved, response rates have been in decline throughout and in the wake of COVID and was negatively impacted by the increase in political outreach and polling fatigue typical of a Presidential election year.

SECTION V: SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by interview participants through a weighted ranking process and by community members through discussion and theming of the data. Additionally, needs were identified after review of the quantitative data.

Identification and Prioritization of Significant Health Needs

The Anchorage CHNA Committee reviewed the data collected for each of the following community health-related needs:

- Healthy Behaviors / Physical Health
- Basic Needs / Economic Security
- Mental Health
- Substance Use / Misuse
- Access to Healthcare

After this in-depth data review, the Committee prioritized the need areas based on the following criteria:

- **Size and Scope**: What is the significance of the health issue in terms of the number/percent of people affected?
- **Severity:** How serious are the negative impacts of this issue on individuals, families, and the community?
- **Ability to Impact:** What is the probability that the community could succeed in addressing this health issue? (They took into consideration factors such as community resources, whether there are known interventions, and community commitment to addressing the need.)

2024 Priority Needs

Listed in order of priority, they selected the following as the most significant health needs in the PAMC service area:

PRIORITY 1: BASIC NEEDS / ECONOMIC SECURITY

There is substantial and increasing evidence that socio-economic factors, also known as social determinants of health, are just as important to an individual's health as genetics or certain health behaviors. Financial security is chief amongst the factors that impact an individual's health, wellbeing, and longevity. Individuals that lack economic security experience an increased risk of food insecurity, homelessness, and inability to meet basic needs. These basic needs include education, job security, economic opportunity, transportation, and availability of affordable childcare. The persistence of racial and gender income gaps continue to demonstrate the importance of social justice and equity in the

health and wellbeing of the community and each individual's ability to access the resources necessary to meet their basic needs.

PRIORITY 2A: MENTAL HEALTH

Mental health is foundational to quality of life, physical health, and the health of the community and includes our emotional, psychological, and social wellbeing. Individuals experiencing social inequities such as discrimination, cultural barriers, poverty, limited access to quality education and socio-economic opportunities often experience higher levels chronic stress which can lead to a higher incidence of mental health challenges. Poor mental health has significant health and social impacts on the well-being of individuals and the community as a whole. The community conditions that support resilience, social connection, equity and justice, along with timely access to behavioral health care and services are fundamental to healthy individuals and a healthy community.

PRIORITY 2B: SUBSTANCE USE/MISUSE

Alcohol and substance misuse has significant health and social impacts both for individuals and the community. 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 unaddressed mental health issues. The challenges of substance use disorders (SUD) have compounding physical, mental, and economic impacts on individuals, families, and the greater community. Social, economic, racial, and gender inequities along with cultural beliefs and social stigma are factors influencing the incidence of SUD in the community and as well as issues related to access to treatment.

PRIORITY 3: PHYSICAL HEALTH *(HEALTHY BEHAVIORS, CHRONIC CONDITIONS, AND OVERALL HEALTH)*

Roughly thirty percent of factors affecting an individual's health are related to their behaviors and lifestyle choices, with socio-economic, 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. Barriers to achieving physical health and wellbeing track with those of the other needs categories and include culture, language, social and economic inequities, transportation, education, systemic and historical issues related to trust in health systems.

PRIORITY 4: ACCESS TO HEALTH CARE *(PRIMARY, SPECIALTY, ACUTE, AND DENTAL CARE)*

Appropriate access to preventive and acute care has an impact on individuals' ability to maintain good health. Appropriate healthcare access means receiving the right care at the right time and in the right place or setting - the timely use of personal health services to achieve the best outcomes. Barriers to achieving that include the lack of locally available and accessible primary, acute and specialty care and dental services including Medicare providers for seniors in the community, the complex siloed nature of our health systems, lack of means to pay or being uninsured, and include cultural, language and even transportation challenges.

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.

See Appendix 3 for a full list of resources potentially available to address the significant health needs

SECTION VI: EVALUATION OF 2022-2024 CHIP

The 2021 CHNA and 2022-2024 CHIP priorities were the following:

- Basic Needs / Economic Security
- Behavioral Health (includes mental health and substance use disorders)
- Healthy Behaviors / Physical Health
- Cultural and Social Community Wellbeing

This report evaluates the impact of the 2022-2024 Community Health Improvement Plan (CHIP). PAMC and St. Elias Specialty Hospital 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.

PRIORITY A: BASIC NEEDS / ECONOMIC SECURITY

Table 12. Outcomes from the 2022-2024 PAMC and St. Elias Specialty Hospital CHIP In Response to Basic Needs/ Economic Security

Strategies Related to Basic Needs/ Economic Security	Activities/Progress/Outcomes/#s Served Description
1. Refugee and Immigrant Services Trainee (RAIS) Program collaboration with Catholic Social Services	The Providence RAIS Trainee program provides 4–6-month employment and job training within Providence Alaska Medical Center departments for up to six incoming refugees to the Anchorage community at a time. The program has seen upwards of 50 percent of the trainees hired full time by the departments within which they received their training.
2. Project SEARCH – ASD school business partnership internships for students with developmental disabilities	Project SEARCH is an innovative one-year employment program for students at Providence Alaska Medical Center with the objective of helping graduating youth who experience intellectual and developmental disabilities secure competitive employment by the end of the one-year internship program. The program has enjoyed 70-100% success rate with students achieving competitive employment by the end of their internship.
3. Community Health Worker Program to address health disparities in underserved and BIPOC populations	Between 2022 and 2024 the CHW program enrolled 3,423 Neighbors. 80% of these have been screened monthly for SDoH gaps while enrolled, and 92% have had their blood pressure taken at every visit with communication to PCP if meeting high-risk criteria. Over this time there has been a 49% reduction in ED use in the Neighbor cohort, with ED costs to these patients being reduced by 30% and inpatient admit costs being reduced by 41%.
4. Build and operate 51 bed Permanent Supportive Housing facility	In July of 2024 Providence finished construction on and opened a 51-unit permanent supportive housing facility in 2024 for elders

	55 years and older experiencing homelessness and disabling health conditions.
5. $3M annual investment commitment to address homelessness	Providence provided $3M annually in community partnership grants to roughly ten non-profit homeless service providers and partners to address the needs of those experiencing homelessness in Anchorage.
6. Healthcare and Homelessness Pilot with Community Solutions and Institute for Healthcare Improvement	Finalized Healthcare and Homelessness Pilot with Institute for Healthcare Improvement and Community Solutions, establishing a community-based healthcare and homelessness liaison at the Anchorage Coalition to End Homelessness.
7. Homeless Respite Partnership – Providence, Alaska Regional Hospital, Alaska Native Medical Center and Catholic Social Services	Providence funded 10-bed homeless respite program at Brother Francis shelter to provide a healing space for homeless patients being discharged from area hospitals. The program serves roughly 135 individuals annually and provides nearly 3,000 bed nights annually to individuals experiencing homelessness who need a place to heal after discharge.
8. Daily Meal Service 365 days/year for Brother Francis Emergency Homeless Shelter guests	Providence Food and Nutrition Services prepared and delivered roughly 90,000 meals to the Brother Francis and Claire House emergency homeless shelters from 2022-2024 to help meet the nutritional needs of those experiencing homelessness in Anchorage.

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

Table 13. Outcomes from the 2022-2024 PAMC and St. Elias Specialty Hospital CHIP In Response to Behavioral Health

Strategies Related to Behavioral Health	Activities/Progress/Outcomes/#s Served Description
1. Chemical Dependency Services	Breakthrough program provided Intensive Outpatient Programming (IOP), Outpatient Programming (OP) and Medication Assisted Therapy (MAT) to roughly 550 individual a year who suffer significant substance use disorders and have few options for treatment in Anchorage or Alaska.
2. Establish Crisis Stabilization Center – 'no wrong door' Crisis Now model	Providence broke ground in 2024 on a new mental health crisis stabilization center in Anchorage. The center will have space for 24 people who need mental health or substance-use stabilization to offer a diversion site for less acute cases to provide preventive care and reduce impact on the ED. Continuance of the project is pending State of Alaska regulation.

3. Establish Behavioral Health Integration in Schools Program - crisis services for youth (ASD, KISD, and Volunteers of America)	In partnership with the Anchorage and Kodiak Island Borough School Districts, Providence Alaska and VOA Alaska offer school-based mental health services in 18 schools to meet the growing mental health needs of children in Anchorage.
4. Behavioral Health Clinics in Anchorage and Matsu	There is a significant shortage of behavioral health service providers and services in Anchorage and Alaska which has severely limited timely access to mental health services. To address that lack of services and meet community need, Providence Behavioral Health Clinic continued to provide subsidized outpatient mental health services for children, adolescents, and adults. Outpatient mental health services include diagnostic evaluations, medication management, perinatal mental health, neuropsychological and psychological testing, individual and group therapy services.

PRIORITY C: HEALTHY BEHAVIORS / PHYSICAL HEALTH

Table 14. Outcomes from the 2022-2024 PAMC and St. Elias Specialty Hospital CHIP In Response to Healthy Behaviors/ Physical Health

Strategies Related to Healthy Behaviors/ Physical Health	Activities/Progress/Outcomes/#s Served Description
1. Providence Alaska CARES program – Child Advocacy Center addressing child neglect and abuse	Alaska CARES is a custom-designed center owned and operated by Providence that houses detectives from the Anchorage Police Department Crimes Against Children Unit and Special Victims Unit; an investigative unit from the Alaska State Troopers; Office of Children Services; Alaska CARES; and Forensic Nursing to provide access to wrap around services to Alaska's children that experience child abuse and neglect and served roughly 2,200 children from 2022-2024.
2. Forensic Nursing Program – serving adults who have experienced sexual violence, neglect, or intentional psychological injury.	Providence, from 2022-2024, provided forensic services and referrals for roughly 1,100 individuals who experienced physical or sexual violence, neglect or intentional psychological injury.
3. Alaska Family Medicine Residency (AFMR) program (~36 Residents)	Providence continued the Alaska Family Medicine Residency to help residents become physicians to address the ongoing shortage of primary care physicians and help improve access to primary care in Alaska.
4. Injury Prevention Program (bike helmet, car seat, ice cleat and community education program)	Providence Injury Prevention and Outreach provided Stop the Bleed training to roughly 688 participants, 243 child car seat checks, 94 car seats, training for 34 new child passenger safety certified technicians, 505 child bike helmet fittings, and provided

	over 500 ice cleats to community members vulnerable to slips and falls to aid in the prevention of injury in the community.
5. Senior (Primary) Care Center	Providence continued to provide primary care to the senior community, being one of the few and largest Medicare primary care providers in Anchorage to help address the needs of the aging population in Alaska.

PRIORITY D: CULTURAL AND SOCIAL COMMUNITY WELLBEING

Table 15. Outcomes from the 2022-2024 PAMC and St. Elias Specialty Hospital CHIP In Response to Cultural and Social Community Wellbeing

Strategies Related to Cultural and Social Community Wellbeing	Activities/Progress/Outcomes/#s Served Description
1. Refugee and Immigrant Services Trainee (RAIS) Program collaboration with Catholic Social Services	The Providence RAIS Trainee program provides 4–6-month employment and job training within Providence Alaska Medical Center departments for up to six incoming refugees to the Anchorage community at a time. The program has seen upwards of 50 percent of the trainees hired full time by the departments within which they received their training.
2. Project SEARCH – ASD school business partnership internships for students with developmental disabilities.	Project SEARCH is an innovative one-year employment program for students at Providence Alaska Medical Center with the objective of helping graduating youth who experience intellectual and developmental disabilities secure competitive employment by the end of the one-year internship program. The program has enjoyed 70-100% success rate with students achieving competitive employment by the end of their internship.
3. Community Health Worker Program to address health disparities in underserved and BIPOC populations	Between 2022 and 2024 the CHW program enrolled 3,423 Neighbors. 80% of these have been screened monthly for SDoH gaps while enrolled, and 92% have had their blood pressure taken at every visit with communication to PCP if meeting high-risk criteria. Over this time there has been a 49% reduction in ED use in the Neighbor cohort, with ED costs to these patients being reduced by 30% and inpatient admit costs being reduced by 41%.

Addressing Identified Needs

The Community Health Improvement Plan developed for the PAMC 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 the 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, 2025.

2024 CHNA GOVERNANCE APPROVAL

2024 Anchorage CHNA Governance Approval

This Community Health Needs Assessment was adopted by the Providence Alaska Region Board[1] on November 19, 2024. The final report was made widely available by December 28, 2024.

DocuSigned by: Ella Goss — 11/26/2024

Ella Goss, MSN, RN — Date
Alaska Region Chief Executive
Providence

DocuSigned by: Scott Wellmann — 11/25/2024

Scott Wellmann, MD — Date
Chair, Providence Alaska Region Board

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

[1] **See Appendix 4:** Providence Alaska Region Board of Directors

APPENDICES

Appendix 1: Quantitative Data

ADDITIONAL SECONDARY DATA

Table_Apx 1. Social Determinants of Health Indicators

Indicator	High Need Area	Broader Area	Anchorage County	Alaska
Median Household Income	$75,091	$124,083	$95,731	$86,370
Households Receiving SNAP Benefits	15.8% (7,666)	3.3% (1,867)	8.9% (9,533)	10.5% (27,659)
Population Below 200% Federal Poverty Level (FPL)	33.2% (42,807)	13.9% (20,571)	22.3% (63,378)	24.7% (177,333)
Households with Severe Housing Cost Burden	15.9% (7,656)	10.4% (5,771)	12.5% (13,427)	11.3% (29,776)
Limited English Households	4.9% (2,542)	1.0% (0,642)	3.0% (3,184)	2.2% (5,720)
Population Unemployed	6.1% (4,111)	4.6% (3,636)	5.2% (7,747)	6.4% (23,035)
Population with at Least a High School Diploma	91.4% (80,279)	96.5% (100,973)	94.2% (181,252)	93.5% (454,182)
Population Uninsured	13.3% (17,522)	7.8% (11,755)	10.5% (29,277)	11.7% (82,562)
Households without Internet	7.0% (3,362)	3.4% (1,761)	4.8% (5,123)	8.3% (21,866)

Source: US Census Bureau, American Community Survey 5-Year Estimates, 2018 - 2022

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers).

The Anchorage Municipality, in which Providence Alaska Medical Center and St. Elias Specialty Hospital are located, is designated as a partially rural HPSA as follows:

Table_Apx 2. Health Professional Shortage Area

Discipline	HPSA Name	Designation Type	HPSA FTE Short*
Primary Care	ME - Anchorage Borough	Medicaid Eligible Population HPSA	21.31
Dental Health	ME - Anchorage Borough	Medicaid Eligible Population HPSA	16.53
Mental Health	ME - Anchorage Borough	Medicaid Eligible Population HPSA	5.18

Data Source: U.S. Department of Health & Human Services, Health Resources & Services Administration, https://data.hrsa.gov/tools/shortage-area/hpsa-find
** This attribute represents the number of full-time equivalent (FTE) practitioners needed in the HPSA so that it will achieve the population to practitioner target ratio.*

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 health care 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.

The Anchorage Service Area is designated as a non-rural, Medically Underserved Area for primary care. *(Data Source: U.S. Department of Health & Human Services, Health Resources & Services Administration, https://data.hrsa.gov/tools/shortage-area/mua-find)*

Appendix 2: Community Input

METHODOLOGY

Participants

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence conducted 9 key informant interviews with representatives from community-based organizations. Included in the community engagement was representation from the Anchorage Health Department. All community input was collected between June and August 2024.

Table_Apx 3: Key Community Key Informant Participants

Organization	Name	Title	Sector
Alaska Literacy Program	Lori Pickett	Executive Director	Nonprofit Community Services
Alaska Native Heritage Center	Emily Edenshaw	President and CEO	Alaska Native Cultural Center
All Alaska Pediatric Partnership	Carmen Wenger	Director of Programs	Health Care
Anchorage Neighborhood Health Center	Lisa Aquino	CEO	Federally Qualified Health Center
Anchorage Health Department	Kimberly Rash	Acting Director	Local Public Health
Catholic Social Services	Robin Dempsey	CEO	Nonprofit Community Services
Providence Alaska Medical Center	Sarah Skeel	Chief Administrative Officer	Health Care
The Alaska Community Foundation	Alexandra Kim McKay	President and CEO	Philanthropy
United Way of Anchorage and Alaska 211	Sue A. Brogan	Chief Operating Officer	Nonprofit Community Services

Facilitation Guides

For the key informant interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2024 CHNAs:

- The community served by the key informant's organization
- The community strengths
- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

Training

The facilitation guides provided instructions on how to conduct a key informant interview, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a key informant interview and were provided question guides.

Data Collection

Key informant interviews were conducted virtually, and information was collected in one of two ways: 1) recorded with the participant's permission or 2) a note taker documented the conversation. Two note takers documented the conversations.

Analysis

Qualitative data analysis 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.

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant 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 used a standard list of codes, or common topics that are 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 eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) 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 groups 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. 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.

Limitations

While key informants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Key informant interviews were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

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

FINDINGS FROM KEY INFORMANT INTERVIEWS

Vision of a Healthy Community

Key informants were asked to share their vision of a healthy community. The following themes emerged:

Abundant Opportunities for Growth: A healthy community provides ample opportunities for people to thrive. Young people should want to return, knowing they have access to good jobs, recreational activities, and can live without constant worry about basic needs such as food, housing, or financial stability.

> *"An ideal community is where people don't worry about the basic needs... They're not worried about housing, food, or jobs."- Key Informant*

Diverse and Inclusive: A healthy community embraces diversity, supporting multiple perspectives and cultures. Services should be provided by individuals reflecting the community's diversity, ensuring all members feel safe and supported in their identity.

Easy Access to Health and Preventive Services: Access to quality healthcare, including mental health services and preventive care, is critical. Barriers such as financial constraints and language issues must be removed, and resources such as mobile clinics and primary care should be available in underserved areas.

Prioritizes Social and Emotional Well-Being: A healthy community fosters social connections and emotional well-being. It supports individuals throughout their lives, particularly children and seniors, and addresses social determinants of health early to prevent crises like homelessness.

Healing and Addressing Trauma: Acknowledging and addressing historical and intergenerational trauma, especially related to Indian boarding schools, is vital. Family-centered healing, education, and programs that break cycles of trauma promote community-wide healing.

Community Strengths

The interviewer asked key informants to share one of the strengths they see in the community and discuss how we can leverage these community strengths 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, we also want to ensure that we highlight and leverage the community strengths that already exist.

Key informants highlighted several strengths within the community. Anchorage's strengths are rooted in its ability to collaborate, innovate, and draw from its cultural heritage. The community's resilience, optimism, and adaptability enable it to overcome challenges and grow stronger. Additionally, its deep cultural roots and indigenous knowledge offer a unique foundation of wisdom and strength, enriching the community's identity and ability to flourish. These include a sense of community and communal perspective, cultural preservation efforts, unity, responsiveness, diverse population, and resilience. Leveraging existing relationships, partnerships, and community support is crucial for further collaboration and addressing mental health needs.

Collaborative Spirit and Partnerships: Anchorage has strong partnerships across public and private sectors, healthcare, and local organizations. These collaborations break down silos and enable collective action to improve services, particularly in the post-COVID era. Key initiatives like the Alaska Coalition to End Homelessness demonstrate the power of this collaboration.

Commitment to Health and Well-Being: Despite its remoteness, Anchorage offers exceptional healthcare services, including top-ranked facilities like a children's hospital and a cancer center. There is a strong commitment to keeping care local, which minimizes disruptions for families.

Cultural Heritage and Indigenous Knowledge: The community draws strength from its rich cultural traditions and indigenous knowledge systems, which provide resilience and a deep connection to history. Informants suggested that reducing political barriers and policies hindering best practices could strengthen collaboration and inclusivity.

> *"Our greatest strength is our culture, our knowledge. Our indigenous knowledge system, our beautiful cultures and traditions." – Key Informant*

Resilience and Optimism: The community has demonstrated resilience and optimism, particularly in the face of challenges such as the pandemic. Informants emphasized maintaining long-term solutions that unite public and private resources.

"We are able to focus on the common community identity and maximize its capacity to unite." – Key Informant

Key informants discussed how leveraging community strengths to meet the needs in their community and improve health equity involves collaboration among all organizations within the community and sharing common goals. The community's strengths in collaboration, resilience, and integrated service provision can be leveraged by fostering partnerships across sectors, such as healthcare, education, and nonprofits. By enhancing knowledge sharing and reducing political and policy barriers, the community can ensure more seamless and effective services. Education and stronger connections between different systems will further empower the community to meet complex needs while maintaining its focus on inclusivity and long-term well-being.

High Priority Unmet Health-Related Needs

Key informants were asked to identify their top five health-related needs in the community. Three needs were prioritized by most key informants and with high priority. Two additional needs were categorized as medium priority. Key informants were most concerned about the following health-related needs:

1. Affordable Housing and Homelessness
2. Behavioral health challenges and access to care (mental health and substance use/misuse)
3. Access to Healthcare Services

Affordable Housing and Homelessness

Most key informants identified affordable housing and homelessness as significant challenges in Anchorage, noting them as the primary need. They emphasized that affordable housing is difficult to access, even for those with employment. Rising housing costs have made sustainable living increasingly challenging. Eviction rates have surged, and housing options are often of poor quality and sometimes unlivable. Homelessness and trauma are closely linked with mental health concerns, highlighting the need for lower-barrier living options for this population. These gaps are further exacerbated by a lack of inpatient and outpatient treatment services connected to transitional housing. Housing instability and homelessness are tied to economic insecurity, and the community would benefit from more skill-building programs.

Although efforts are being made to address homelessness, key informants noted that abatement of encampments merely shifts the problem without solving it. There is a push for stronger housing codes and long-term, year-round shelter solutions. One key informant likened addressing affordable housing to "whack-a-mole," where large investments in one area only lead to the issue surfacing elsewhere.

Key informants critiqued the social service system for focusing on housing people without addressing the root causes of homelessness and related issues. They stressed that housing programs should also focus on healing trauma, rather than offering only temporary solutions like shelters. Current systems are not designed to foster long-term success and need to be restructured to take a strength-based approach, focusing on people's potential rather than their deficits.

"It's not just about housing, it's about healing. You have to look at the spirit of the person or the soul wounds of the person." – Key Informant

A growing population of unhoused individuals also have high medical needs, particularly chronic conditions such as diabetes and hypertension, as well as mobility issues. High medical costs contribute to housing instability and homelessness. Many people experiencing homelessness who need assistance with daily activities fall outside the capacity of available services, leaving them with nowhere to go.

> *"One significant medical event can trigger housing instability very quickly... the holes in the safety net are getting bigger, and the net pieces are farther and farther in between." – Key Informant*

Key informants shared certain populations have been especially impacted:

- **Families with low income:** Rising housing costs have forced many families into shared living situations despite being employed.
- **Individuals with chronic medical conditions:** Homeless individuals with conditions like diabetes, hypertension, and mobility issues face additional challenges, as they require specialized care.
- **Older Adults:** Older adults are simultaneously facing homelessness and increasing medical needs. They are significantly affected by the intersection of homelessness, inadequate housing, and chronic health conditions.
- **People needing assistance with daily living:** Individuals who cannot perform daily tasks, such as those with mobility or medical issues, face a lack of facilities and services capable of supporting them.
- **Alaska Natives:** Alaska Natives are disproportionately at risk of experiencing homelessness. Skill building programs inclusive of cultural practices and art can both help heal historical trauma and develop marketable skills, such as carving, fish processing, or performing arts, that can lead to future economic opportunities. By learning these skills, participants are better positioned to reintegrate into the workforce or start small businesses, which can help them transition out of homelessness.

Behavioral health challenges and access to care (mental health and substance use/misuse)

Key informants identified behavioral health as a major concern within the community. They discussed systemic gaps in services, cultural misalignments, and the need for more infrastructure, funding, and workforce support to effectively address the growing behavioral health needs. The demand for behavioral health services is expected to continue rising, particularly for young people and mothers with high-risk pregnancies. The lingering effects of the COVID-19 pandemic have significantly impacted behavioral health, with issues such as strained relationships, financial hardships, and workplace pressures increasing the demand for mental health services.

There is a call to integrate behavioral health into primary care to support whole-person health. Key informants emphasized that healing requires more than addressing physical needs; it involves treating "soul wounds"—deep traumas contributing to substance use, homelessness, and other challenges. Many health problems (e.g., substance use, domestic violence, and suicide) stem from historical trauma, displacement, and marginalization. These issues cannot be resolved by treating symptoms alone. Instead, a holistic approach is needed, addressing both physical and emotional traumas. Behavioral

health programs should focus on the holistic well-being of individuals, including their spiritual, emotional, and cultural health.

> *"We're treating the symptoms of the root cause without really looking at the root causes itself, whether it be historical trauma, access to resources, or really grounding our services in indigenous ways of knowing and being." – Key Informant*

Education and collaboration between nonprofits, healthcare providers, and social services are crucial for improving outcomes and navigating complex systems. Crisis stabilization centers are under development but not yet operational, leaving a significant gap in immediate care. Additionally, a lack of reliable transportation in Anchorage presents another barrier to accessing behavioral health services, particularly for those experiencing poverty.

Key informants shared that certain populations are disproportionately affected by gaps in services, access issues, and a lack of infrastructure to meet growing needs in behavioral health care:

- **Youth and Children:** Young children are often left out of behavioral health services. Children needing access to behavioral health care are at increased risk of being expelled from childcare, impacting their school readiness and development. Investment in early childhood mental health can have long-term benefits and prevent severe behavioral health issues later on.
  > *"Children are the infrastructure of our state, and if we want a thriving community, growing active workforce, that investment in their health is what we need to grow our future generation." -Key informant*
- **Older Adults:** Many older adults struggle to access behavioral health services due to high costs, especially those not yet eligible for Medicare or Medicaid.
- **Individuals with Low Income:** The high cost of behavioral health services, combined with transportation barriers, makes it difficult for those living in poverty to access care.
- **People with Substance Use Disorders:** This group faces limited resources, tools, and facilities to aid recovery. There is a lack of inpatient and outpatient treatment services connected to transitional housing, making it difficult for individuals completing treatment to maintain stable living conditions. This increases the risk of relapse, homelessness, or re-hospitalization.
- **BBIPOC (Black, Brown, Indigenous, and People of Color) and Immigrants:** Alaska Natives, immigrants, and people of color face disproportionate challenges in accessing behavioral health services. Leadership in many social service institutions is non-Native, despite serving predominantly Alaska Native populations. This lack of representation results in services that are culturally ineffective and do not address the holistic needs of the people.
- **People Who Have Experienced Trauma:** Trauma survivors are at increased risk of homelessness, mental health issues, and substance use disorders. Current services are insufficient to address the complex needs of this population. Historical trauma, particularly from boarding schools, is seen as a root cause of many of the social and health issues affecting the Alaska Native community. Education about intergenerational trauma is considered essential to providing compassionate and effective care.

Barriers to Accessing Behavioral Health Needs include:

- **Cost of Services:** High costs prevent many populations, including seniors and low-income individuals, from accessing behavioral health services, especially for those not yet eligible for Medicare or Medicaid.
- **Long Wait Times and Inadequate Capacity:** Behavioral health services are overwhelmed, leading to long wait times, which hinders the community's ability to address mental health crises in a timely manner.
- **Complex Service Navigation:** Many individuals, especially those with multiple needs, struggle to navigate between different services. Without adequate support, they cannot access the full range of behavioral health services available to them.
- **Geographical and Transportation Barriers:** Anchorage's spread-out geography, harsh winters, and unreliable public transportation make accessing care difficult for those without a vehicle, particularly low-income individuals and those with mobility issues.
- **Infrastructure Gaps:** Crisis stabilization centers and lower-barrier assisted living options are still being developed, leaving a gap in services for people with acute mental health needs, trauma, or homelessness. There is also a lack of inpatient and outpatient treatment services linked to transitional housing. Without stable housing options, individuals who complete treatment are at risk of relapse, homelessness, or re-hospitalization.

Access to Healthcare Services

Key informants discussed significant systemic and logistical barriers to healthcare access in the community, which disproportionately affect Alaska Natives, seniors, individuals experiencing poverty, and those with chronic conditions. Addressing these challenges will require additional resources, cultural competency, improved transportation, and a more inclusive, holistic approach to healthcare that considers the unique needs of the community's diverse populations.

Language and Cultural Barriers: Many in the community struggle with a lack of language support and culturally inclusive healthcare services. The absence of plain, understandable language in care, combined with culturally inappropriate service models, creates a disconnect between healthcare providers and the populations they serve.

Cultural Disconnect in Healthcare: Many healthcare programs serving Alaska Native populations are based on Western models that fail to incorporate the spiritual, emotional, and cultural aspects essential to holistic care. This disconnect between Western healthcare models and the cultural needs of Alaska Native people results in inadequate care. For example, cultural foods like salmon, which are integral to spiritual and cultural health, are often restricted by regulations that overlook Indigenous traditions. This mismatch between services and the community's needs negatively affects Indigenous populations.

Cultural Competency: Many healthcare providers, including doctors and nurses, lack knowledge about the historical traumas experienced by the communities they serve, such as Indian boarding schools and internment camps. There is a need for education to ensure providers understand the cultural and historical context of the populations they work with.

Cost Barriers: The high cost of healthcare is a significant obstacle, particularly for seniors not yet eligible for Medicare or Medicaid and for low-income individuals. Even when services are available, the inability

to afford them limits access, leaving many without essential care. Additionally, the growing number of providers no longer accepting Medicare or Medicaid patients exacerbates this issue.

Geographic and Transportation Challenges: Anchorage's sprawling geography and unreliable public transportation further hinder access to care, especially for low-income individuals without a vehicle. This lack of accessible transportation makes it difficult for people to reach healthcare services, worsening disparities in access.

Growing Chronic Health Needs: The demand for care related to chronic conditions like diabetes and hypertension is increasing. However, access to treatment is becoming more difficult as local pharmacies close or are acquired by national chains, further limiting access to medication and proper disease management, particularly in underserved areas.

Gaps in Services for Pediatric and Maternal Care: There are notable gaps in pediatric subspecialty services, making it difficult for children to receive the care they need within the state. Additionally, there is a growing need for maternal healthcare, particularly for mothers with high-risk pregnancies. These gaps in critical health areas highlight the need for expanded services.

Need for More Community Health Workers and Systemic Reform: There is a pressing need for more community health workers who can bridge the gap between healthcare services and the Anchorage community. Systemic reforms are also necessary to create more culturally relevant and accessible services and to ensure that service providers are educated about the historical and cultural traumas experienced by the populations they serve.

Certain populations are disproportionately impacted:

- **BBIPOC (Black, Brown, Indigenous, and People of Color) and Immigrants:** Alaska Natives, immigrants, and people of color face disproportionate challenges in accessing healthcare. Systemic inequities, cultural disconnects, and logistical challenges make it harder for these groups to navigate and benefit from the healthcare system. There is a need for healthcare services designed by and for Alaska Native people, rather than external programs that do not consider the community's cultural values and lived experiences.
- **People Experiencing Homelessness:** Individuals experiencing homelessness, especially those with chronic medical conditions, face substantial barriers to care. The limited complex care facilities available are overwhelmed, with long waitlists and insufficient capacity to meet the medical needs of this population. Additionally, many individuals fall through the cracks of the healthcare system because their needs do not align with the criteria for assisted living waivers.

Medium Priority Unmet Health-Related Needs

Two additional needs were often prioritized by key informants:

4. Economic Insecurity
5. Access to Childcare and Preschools

Economic Insecurity

Key informants identified economic insecurity as a pressing issue within the community. Economic security is tightly linked to health outcomes, with adverse childhood experiences (ACEs) such as domestic violence and child neglect often compounded by economic instability. These issues intersect with broader social determinants of health, such as housing, homelessness, and healthcare access. Long-term chronic economic instability is connected to difficulties in accessing essential health services. Key informants discussed a need to shift from a focus on problems or issues to a strength-based perspective, which highlights the opportunities for cultural healing, community engagement, and resilience. Focus should be on creating systems that allow people to thrive by building on cultural strengths and providing pathways for healing and economic security.

High Cost of Living: Wages in Alaska have not kept pace with the rising costs of living, making it harder for residents to afford basic needs like housing and food.

Childcare: Childcare is unaffordable for many families, while childcare workers remain underpaid despite the importance of their work. Events and activities for children, especially when parents are at work, are costly and difficult for families to afford.

Pathways to Employment: Economic insecurity contributes to difficulties in filling vacancies in essential services like nursing and police work. Rising living costs, stagnating wages, and a high demand for skilled professionals in these sectors create challenges for recruitment and retention. There is a need for clear employment pathways, but inadequate data makes it difficult to determine where efforts should be focused.

Economic Opportunities and Skill Development: Skill-building programs that incorporate cultural practices and art can help develop marketable skills, such as carving, fish processing, or performing arts, which can lead to future economic opportunities. These programs provide participants with the tools to reintegrate into the workforce or start small businesses, helping them transition out of homelessness.

Broken Systems: Organizations must recognize when their systems are failing and actively work to address these issues, particularly in addressing economic insecurity. Smaller organizations struggle to access equitable funding because large grant applications are often cumbersome and difficult to navigate, limiting their ability to serve the community.

Transportation Access: Significant barriers in transportation further limit residents' ability to access economic opportunities. Anchorage's limited public transportation system presents challenges for commuting, particularly during winter when snow clearance and access to bus stops are inadequate.

> *"If your bus stop isn't cleared out in the winter, how does someone with mobility issues access transportation?" – Key Informant*

Economic impact on well-being: Many people live below the poverty line, which deeply affects their overall well-being and health. Economic insecurity is a major contributor to health disparities in the community.

Access to Childcare and Preschools

The availability and cost of childcare are significant barriers for families. In Anchorage, childcare services are affected by low wages for providers, supply shortages, and high costs for families. High costs and a lack of available childcare force families to choose between working or staying home and receiving subsidies. Quality of care is also a concern, with insufficient funding to meet required standards. There is a mismatch between supply and demand for childcare, leaving many families unable to access age-appropriate care, which forces children into developmentally inappropriate environments.

Appendix 3: Community Resources Available to Address Significant Health Needs

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

Table_Apx 4. 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 CHNA Process Governance and Oversight

Table_Apx 5. Community Health Needs Assessment Committee Members

Organization	Name	Title	Sector
Alaska Literacy Program	Lori Pickett	Executive Director	Nonprofit Community Services
Alaska Native Heritage Center	Emily Edenshaw	President and CEO	Alaska Native Cultural Center
All Alaska Pediatric Partnership	Carmen Wenger	Director of Programs	Health Care
Anchorage Neighborhood Health Center	Lisa Aquino	CEO	Federally Qualified Health Center
Anchorage Health Department	Kimberly Rash	Acting Director	Local Public Health
Catholic Social Services	Robin Dempsey	CEO	Nonprofit Community Services
Providence Alaska Medical Center	Sarah Skeel	Chief Administrative Officer	Health Care
The Alaska Community Foundation	Alexandra Kim McKay	President and CEO	Philanthropy
United Way of Anchorage and Alaska 211	Sue A. Brogan	Chief Operating Officer	Nonprofit Community Services

Table_Apx 1. Providence Alaska Region Board Members

Name	Organization
Lisa Aquino	CEO, Anchorage Neighborhood Health Center
Sharolyn Baldwin, MD	Chief of Staff, Providence Hospital

Thomas Barrett	President, Alyeska Pipeline (retired)
Patricia Branson	Mayor, City of Kodiak
Carol Gore	Weidner Apartment Homes
Ella Goss	Region Chief Executive, Providence Alaska
Jyll Green	Nurse Practitioner
Stephanie Kesler	Community Member
Karen King	President & CEO, Spawn Idea
Donna Logan	Community Member
Sean Parnell	Chancellor, University Alaska Anchorage
Pamela Shirrell	Retired Public Health Nurse
Scott Wellmann, MD	Pediatric Cardiologist, Alaska Children's Heart Center & Providence Children's Hospital
Jeffrey Wolf	RN Case Manager, Chugachmiut Corporation
Greg Norkus, MD	Providence Kodiak Island Medical Center

Appendix 5: Health and Well-being Monitor™ Community Survey Report

Community Health & Well-being Monitor
2024 Results Report
Anchorage, Alaska

With Anchorage 2021 Benchmark Trend Results

August 2024

Prepared by:

Providence SWEDISH

Providence Institute for a Healthier Community

2024 Word Cloud

Table of Contents

Demographics*

Gender Identity	%
Male	51%
Female	49%
Self-describe	0%
Refused	0%

Age	%
NET: 18-34	***28%***
18-24	1%
25-34	27%
NET: 35-54	***30%***
35-44	10%
45-54	21%
NET: 55+	***29%***
55-64	11%
65-74	11%
75 or older	7%
Refused	12%

*Respondent data were weighted to reflect actual demographic distributions within the community. We did this to correct the total sample from under or over-representing specific groups that may have been less or more likely to take the survey. The tables on this page represent the weighted demographic proportions that were used for reporting.

Ethnicity	%
American Indian or Alaska Native	12%
Asian or Pacific Islander	8%
Black or African American	9%
White or Caucasian	71%
Hispanic or Latino	4%
Other	5%
Refused	5%

Household	%
Single, living alone or with other adults	30%
Couple with no children at home	30%
Single with children at home	4%
Couple with children at home	25%
Three generations in household	6%
Other	4%
Refused	1%

Employment	%
NET: Employed	***70%***
Employed full time	62%
Employed part time	8%
NET: Not employed	***28%***
Not currently employed	8%
Student	1%
Retired	19%
Refused	1%

Income	%
NET: Less than $50k	***21%***
Less than $25,000	8%
$25,000-$49,999	13%
NET: $50k-$99.9k	***24%***
$50,000-$74,999	13%
$75,000-$99,999	11%
NET: $100k+	***47%***
$100,000-$124,999	15%
$125,000-$149,999	12%
$150,000-$199,999	7%
$200,000 or more	14%
Refused	8%

Education	%
Did not finish high school	5%
High school diploma / GED	25%
Vocational / Technical school	9%
Some College	24%
NET: College Grad+	***37%***
Bachelor's Degree	23%
Graduate School	14%
Refused	0%

Sample Size	n=
2024	600

Defining the Measures: Glossary of Terms

1. **CORE4™ Measures**

   CORE4™ Well-being Index (grade average): 1 metric, linked to Core4™ satisfaction indicators

   CORE4™ Well-being Measure Scores (averages for each): 4 key satisfaction Indicators, that together inform the Index The four key satisfaction question are: satisfaction with life, overall-wellbeing, physical health and mental/emotional health.

   CORE4™ Well-being Segments: The distribution of our community's well-being, based on how each person answered each of the Core4

2. **CAN-DO™ Scores:** Capacity & Motivation to improve

3. **Six Dimensions of Health:** Indicators across six dimensions of health

4. **What It Takes for Communities to Flourish:** Indicators across the six dimension that most impact overall well-being (CORE4 Well-being Index)

5. **Topical Question(s):** Additional questions that that dive deeper into a current issue or need

6. **One Thing Make Your Life Better Word Cloud:** A visual compilation of text answers to 'one thing that would make your life better'.

Summary Six Dimension of Health

What Your Community is Telling You

Anchorage 2024

Relationships & Social Connections

- *Personal relationships* have improved since 2021, with fewer rating their relationships low this year (13% vs. 21% in 2021). As in 2021, nearly half (48%) continue to rate their relationships highly.
- Community connections have also shown some improvement. Fewer rate themselves low on *feeling like part of a community* (35%) than in 2021 (44%). *Community efficacy* remains a relative weakness, however, with more than half rating low (55% in 2024, vs. 53% in 2021).
- The proportion experiencing any *discrimination* trended up slightly to 22%, vs. 20% in 2021.

Mental & Emotional Health

- State of *emotional health* has improved, with movement away from low ratings to more moderate ones. Some 2 in 5 still rate highly.
- Importance of *religion and spirituality* was up significantly: 42% rate themselves highly, vs. 33% in 2021. Low ratings decreased significantly (41%, vs. 52% in 2021).
- *Purpose and meaning* also trended up, with movement from low ratings to moderate ones. Roughly half (49%) continue to rate highly.

Neighborhood and Environment

Neighborhood ratings all trended toward the middle this year:

- More now rate their *neighborhood quality* moderately (40%) than in 2021 (33%), with fewer rating both high and low.
- Moderate ratings *of community as a place to raise children* also gained (38%, vs. 33% in 2021), with fewer rating both high and low.
- Moderate ratings of *community as a place to grow old* were up 12% pts (38%, vs. 24% in 2021), again with fewer rating both high and low.

Physical Health

- *Physical health* trended up but continues to need improvement: One third rate their physical health highly (31%) up from 2021 (28%), but 31% also rate low.
- *Fruit and vegetable* consumption has improved, with 45% eating fresh food 5+ times per week, versus 40% in 2021. The number with zero fresh food days declined (13%, vs. 20% in 2021).
- *Exercise days* trended up, with 74% exercising at least 3 days per week, vs. 67% in 2021.

Work, Learning & Growth

- *Work satisfaction* has improved markedly from 2021. Nearly half (46%) rate highly on this measure this year, versus a 37% in 2021.
- Perceived *opportunities for learning and growth* are stable but remain a potential area of opportunity: Some 30% rate low on this measure While trending down, education remains among the top overall stated needs among Anchorage residents (16%, vs. 20% in 2021).
- *Job insecurity* dropped directionally to 13%, from 15% in 2021.

Security & Basic Needs

- *Financial security* moved towards moderate (37%, vs 28% in 2021), with fewer rating both high and low.
- In good news, however, the *ability to meet basic needs* improved, with far fewer low ratings (18%) than in 2021 (27%). *Access to medical care and health information* moved similarly, with 17% rating low this year, versus 27% in 2021.
- About half of Anchorage resident surveyed reported one specific basic need that they need help with, most commonly health care, power & water, and education. Needs are highest among those with the lowest incomes and single people.

Six Dimension of Health

*How Your Community Can Flourish**

Anchorage 2024

The good news: Your community is telling you that improvements in multiple Dimensions of Health can exert a powerful influence on your community's well-being.

Better news: These are inter-related. Improvement in any Dimension contributes to overall wellbeing *and* is likely to positively influence other areas as well.

Physical Health

1st most impactful indicator of overall well-being: current state of physical health

- Most influenced by state of mental/emotional health followed by sense of purpose and meaning.
- Also related to more exercise and ability to get medical care and information.
- Financial security and opportunities for learning and growth are also key to good physical health.
- Relationship satisfaction plays a role.

Mental & Emotional Health

2nd most impactful indicator of overall well-being: Current state of mental/emotional health (*each impacts the other*)

4th most impactful indicator: Sense of purpose and meaning (*each impacts the other*)

- Key to driving positive outcomes in both of these areas is physical health.
- Financial security and the ability to meet basic needs are also important.
- Feeling like a part of a community plays a strong role, too.
- Plus, relationships with others and opportunities play outsize roles in mental/emotional health.

Security & Basic Needs

3rd most impactful indicator of overall well-being: Financial security (*each impacts the other*)

7th most impactful indicator of overall well-being: Ability to get medical care and information (*each impacts the other*)

- The ability to meet basic needs (another security measure) is important in driving success in these two areas.
- One's mental/emotional state and physical health are also important.
- A sense of community belonging is important to both, and a sense of purpose and meaning plays an outsize role in driving feelings of financial security.
- Both areas are also impacted by opportunities for learning and growth.

Relationships & Social Connections

5th most impactful indicator of overall well-being: Relationships with other people

- Most influenced by one's mental/emotional state.
- Feeling like part of a community and neighborhood quality are also important.
- Additionally, access to medical care, physical health, and opportunities for learning and growth are key to driving positive relationships.

Work, Learning & Growth

6th most impactful indicator of overall well-being: Opportunities for learning & growth (*each impacts the other*)

8th most impactful indicator of overall well-being: Work or job satisfaction (*each impacts the other*)

- These work, learning, & growth measures are impacted by mental/emotional health.
- Additionally, financial security and ability to meet basic needs are important to driving success in these areas.
- Plus, relationships with others are important, and community as a good place to raise children and opportunities for learning play outsize roles in job satisfaction.

Neighborhood and Environment

- While neighborhood is less directly impactful on overall well-being than other measures, neighborhood quality is important in fostering relationships with others and the ability to get medical care and information.
- Community as a place to raise children also drives satisfaction with one's work or job.
- Promote neighborhood quality and community spaces where children and seniors alike feel welcome and safe.

*The impact of each indicator on overall well-being (and on other indicators) was measured using a relative regression technique. This model identifies the strength of each indicator in driving positive results.

Core4 Well-being Index Score

The Core4™ are measures of satisfaction across four well-being areas.

Scores are averaged across these four measures to create the composite score below.

Core4 Index Score: C

Key Influences

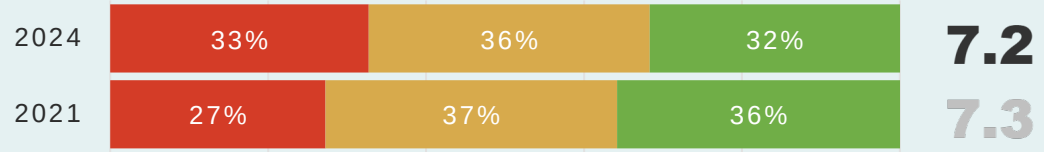
These measures are the most likely to impact your overall Core4 Index Score. They span across 5 of the 6 dimensions of health and well-being and are in rank order:

- Physical health (PH)
- Mental/emotional health (MES)
- Financial security (SBN)
- Sense of purpose and meaning (MES)
- Relationships with others (RSC)
- Opportunities for learning and growth (WLG)
- Ability to get medical care and information (SBN)
- Work or job (WLG)

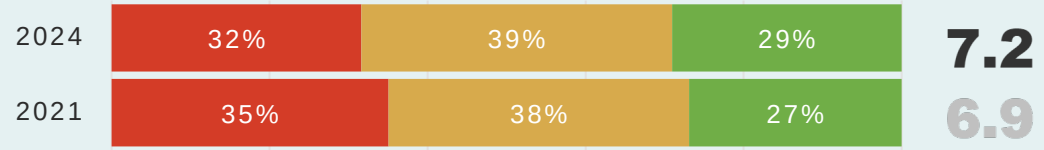
Core4 Well-being Score:

Averages on 0-10 scale, where 10=completely satisfied

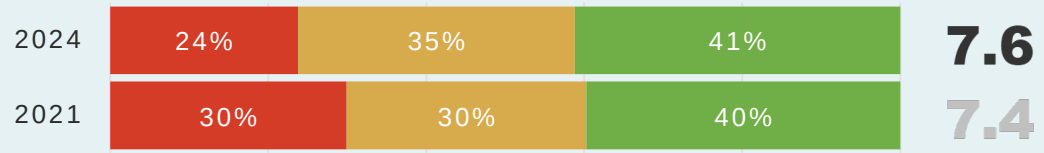
Overall Life Satisfaction



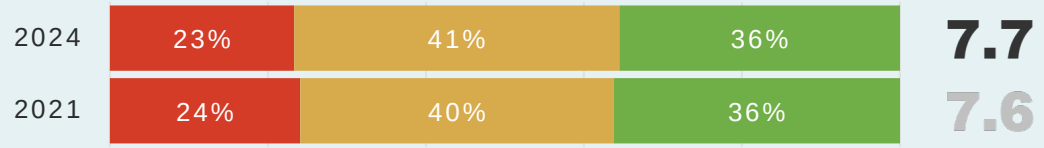
Satisfaction with Physical Health



Satisfaction with Mental or Emotional Well-Being



Satisfaction with Overall Well-Being



Low: 0-6 Medium: 7-8 High: 9-10

▼▲ arrows signify statistically significant difference from previous year

Well-being Segments

The HWBM Well-being segments give a picture of how each member of your community is doing across all four Core4 measures.

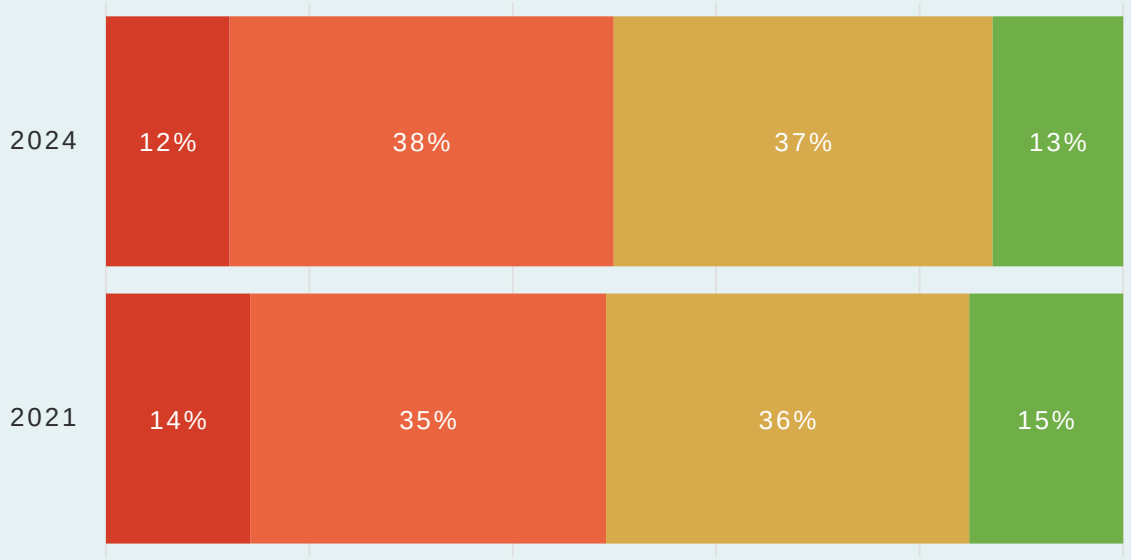
- People who score highest (9-10) on all four are FLOURISHING.
- Those whose scores are all positive (7-10) are DOING WELL.
- People with a mix of lower and higher scores (0-10) are MIXED.
- People whose scores are all low (0-6) are STRUGGLING.

Key Findings

- This year sees a small shift in well-being levels across Anchorage residents compared to 2021:
  - Slightly fewer are Flourishing and Struggling than in 2021, and slightly more are Mixed and Doing Well.
- With this shift toward the middle, the end result is similar to 2021: About half of residents Struggling/Mixed, and about half Doing Well/Flourishing.

Well-Being Segments Trends

Averages on 0-10 scale, where 10=completely satisfied



Struggling: All Low Scores	Mixed: Varied High & Low	Doing Well: All Positive	Flourishing: All Very High

▼▲ arrows signify statistically significant difference from previous year

Core4 Scores and Well-Being Segments

Core4 scores in your community are lowest among Native Alaskans, Hispanics, and those earning <$99.9k per year. Those ages 18-34, Native Alaskans, lower income earners (<$50k/year), and singles are the most likely to be Struggling.

Those ages 55+, Asian/Pacific Islanders, couples, and those earning $100k+/year have the highest Core4 scores, and are also the most likely to be Flourishing, along with those ages 35-54 and those with kids at home.

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Core4 Index Score	7.4	7.5	7.3	7.3	7.3	7.6	6.9	8.0	7.0	7.4	6.9	7.6	7.4	7.0	7.8	6.4	6.9	8.1

Average well-being score for each group

(darker = better)

	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Struggling	12%	10%	14%	18%	13%	9%	19%	10%	16%	13%	3%	6%	14%	20%	6%	34%	13%	3%
Mixed	38%	38%	38%	38%	35%	39%	35%	29%	38%	39%	80%	38%	39%	44%	35%	39%	54%	29%
Doing Well	37%	41%	33%	35%	38%	36%	41%	20%	43%	37%	10%	39%	34%	25%	43%	22%	25%	49%
Flourishing	13%	11%	15%	9%	14%	16%	5%	41%	3%	12%	8%	16%	13%	11%	16%	5%	7%	19%

% of each group falling into each well-being segment

(darker = higher)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Core4 Composite Measures

The groups most likely to score low across some or all of the Core4 measures include Hispanics, singles, and those earning less than $99.9k/year. In addition, those ages 18-34 are more likely than average to score low on overall life satisfaction, and Native Alaskans and Black residents on overall life and overall well-being.

Low Scores (0-6)		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Overall life	33%	35%	31%	47%	24%	29%	47%	18%	40%	32%	60%	22%	37%	48%	22%	65%	48%	12%
Physical health	32%	24%	39%	27%	39%	35%	30%	31%	28%	34%	23%	30%	32%	38%	26%	49%	35%	24%
Mental/emotional	24%	22%	26%	24%	25%	20%	25%	27%	21%	24%	64%	25%	21%	33%	16%	51%	30%	11%
Overall well-being	23%	24%	23%	29%	22%	20%	45%	16%	42%	23%	57%	19%	25%	35%	16%	45%	36%	10%

% of each group who scored low (0-6) on each measure

(darker = better)

The groups most likely to score high across all or most Core4 composite measures include those ages 55+, couples, Asian/Pacific Islanders, and those earning $100k+/year. In addition, women score higher on overall life and overall well-being, and those with no kids in the household on mental/emotional well-being.

High Scores (8-10)		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Overall life	32%	27%	37%	18%	32%	38%	8%	52%	46%	30%	26%	36%	29%	25%	35%	18%	19%	45%
Physical health	29%	28%	30%	41%	25%	27%	27%	46%	3%	27%	19%	35%	31%	27%	36%	20%	20%	35%
Mental/emotional	41%	40%	42%	48%	36%	49%	42%	56%	28%	41%	26%	37%	48%	43%	45%	27%	39%	48%
Overall well-being	36%	32%	40%	26%	37%	45%	18%	50%	12%	35%	32%	38%	39%	32%	42%	22%	21%	46%

% of each group who scored high (9-10) on each measure

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Well-being Segment Demographics

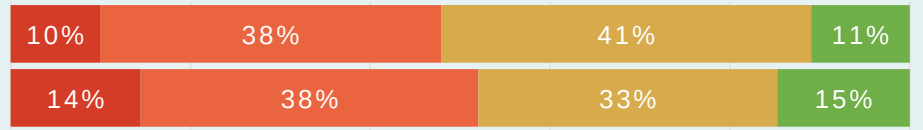
The HWBM Well-being segments differ across demographic characteristics in your community. Understanding these demographic characteristics can help you to better target groups most in need of additional help or resources.

While we can identify trends across demographics and well-being segments, it is important to note that some portion of each demographic falls into each segment. However, these profiles provide a good overview of who is most likely to be flourishing, struggling, etc.

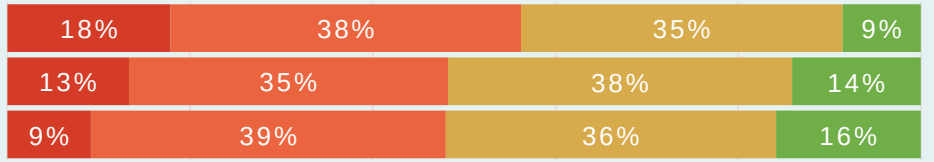
Key Findings

- FLOURISHING. Most likely flourishing in your community include those age 35+, couples, those with kids in the household, and $100k+ earners.
- DOING WELL. Those most likely doing well include couples, those with kids in the household, and $100k+ earners.
- MIXED. Singles and those earning a middle income ($50k-$99.9k per year) are most likely Mixed.
- STRUGGLING. Most likely to be struggling in your community are those age 18-34, single people, and individuals with incomes under $50k.

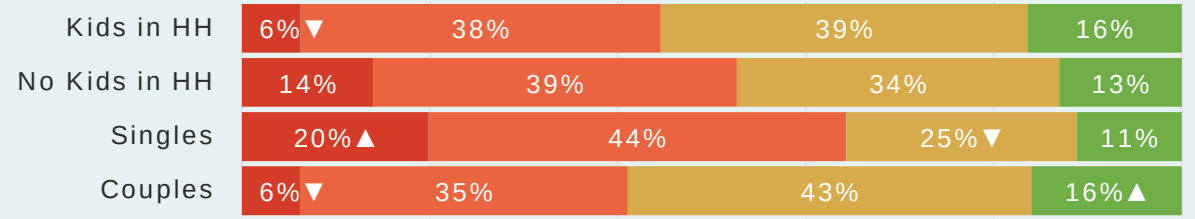
Gender



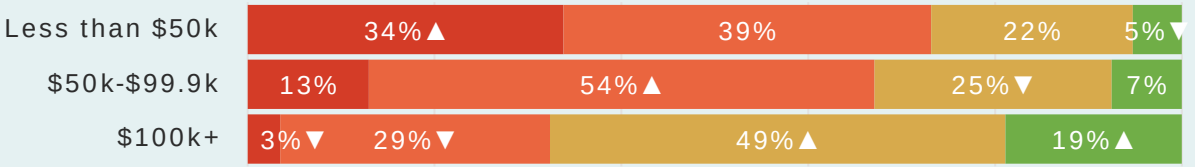
Age



Household*



Yearly Household Income



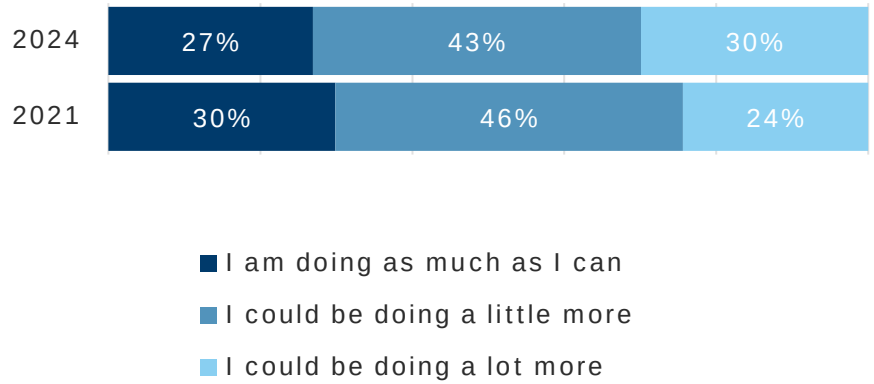
Struggling: All Low Scores (0-6)	Mixed: Varied High & Low (0-10)	Doing Well: All Positive (7-10)	Flourishing: All Very High (9-10)

▼▲ arrows signify statistically significant differences from others not in group

Individual Can-Do

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."

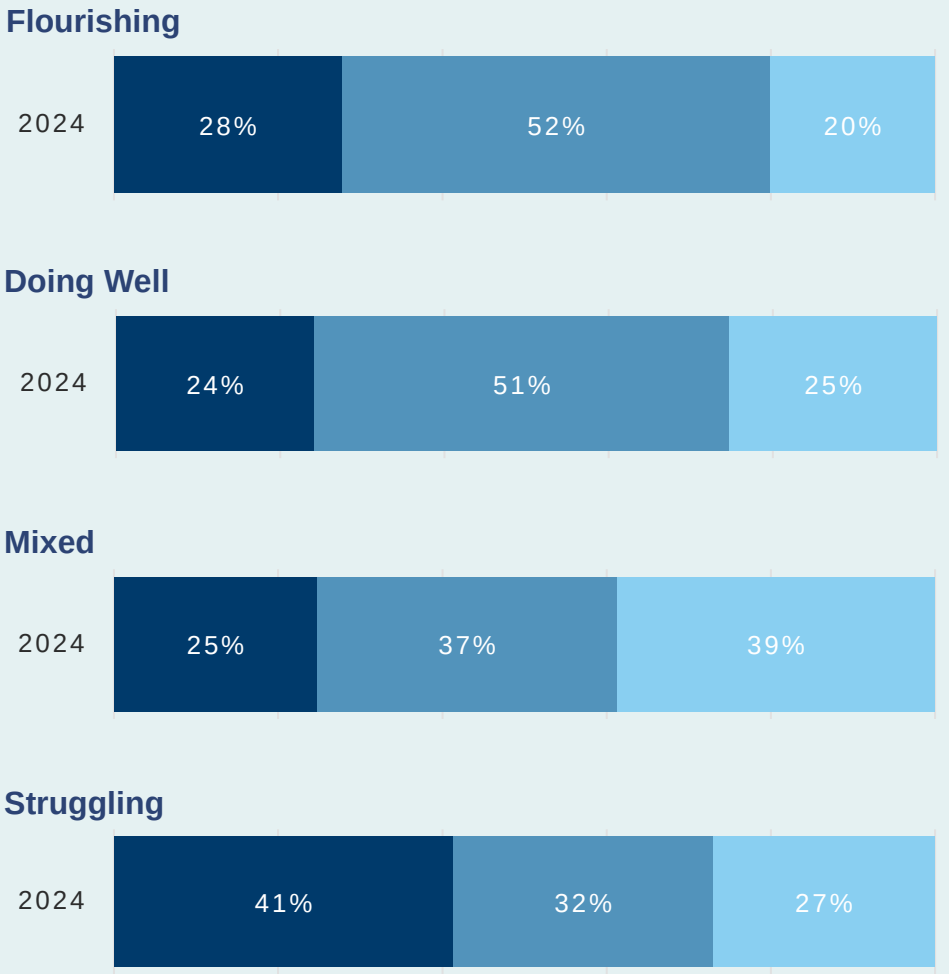
When it comes to maintaining or improving your health, which of these statements best describes you. (16)



Key Findings

- **Capacity** to change is higher than in 2021, with 73% able to do "a little" or "a lot" more, compared to 70% in 2021;
- **Motivation** to change is also up, with half (30%) indicating they could do "a lot" more, versus fewer in 2021 (24%);
- However, motivation is lowest among those Struggling, the segment most in need of health and well-being interventions.

Can-do by Well-being Level



arrows signify statistically significant difference from previous year

Individual Can-Do

The groups most likely to have capacity to change ("could be doing a lot /a little more") include women, Alaska Natives, Black/African American residents, couples, and those earning $100k+.

Those with the least capacity ("doing as much as I can") include men, Hispanics, singles, and those earning <$99.9k/year.

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
A lot	30%	31%	28%	32%	28%	25%	39%	47%	67%	29%	18%	34%	22%	30%	23%	21%	29%	35%
A little	43%	38%	48%	42%	43%	46%	39%	29%	19%	48%	16%	42%	49%	34%	54%	41%	38%	46%
As much as I can	27%	31%	23%	26%	29%	29%	21%	24%	14%	23%	66%	24%	30%	36%	23%	38%	33%	19%

% of each group choosing each response

(darker = higher)

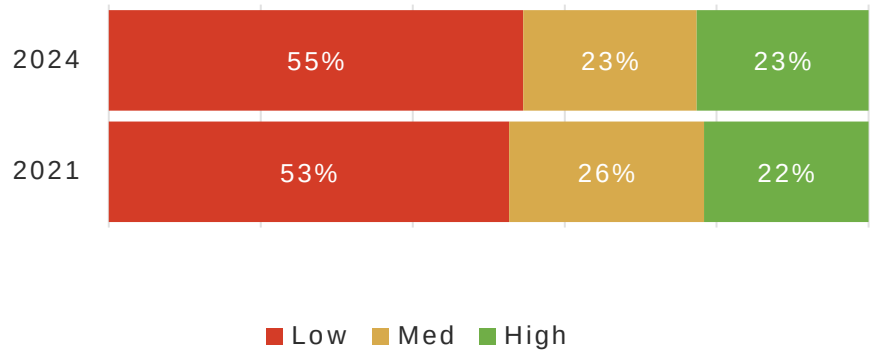
Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Community Efficacy

Community Efficacy is an individual's belief that they can influence well-being on a community-level.

While, Can-Do provides insights into respondents' capacities to improve their individual well-being.

Community Efficacy

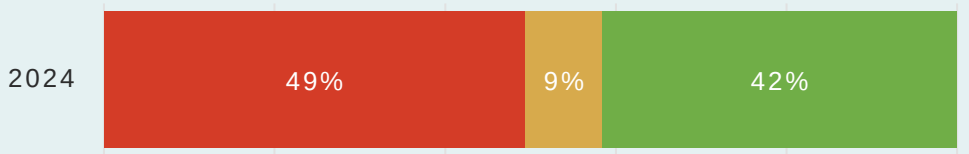


Key Findings

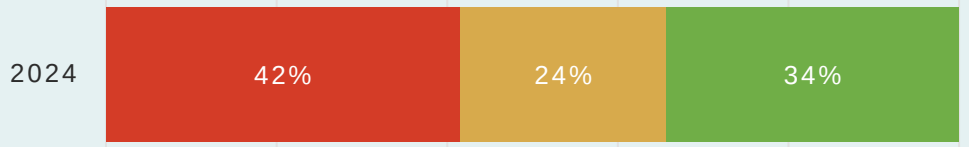
- Community efficacy is similar to 2021, with fewer than a quarter believing strongly that they can impact their communities.
- This year, community efficacy is particularly low among those in the Mixed well-being segment.

Community Efficacy by Well-being Level

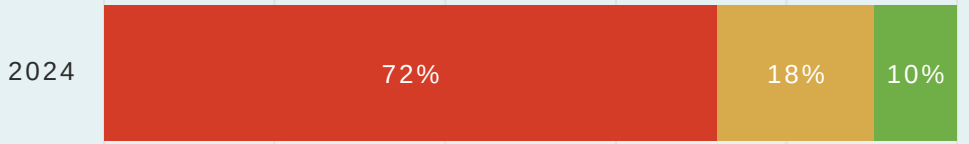
Flourishing



Doing Well



Mixed



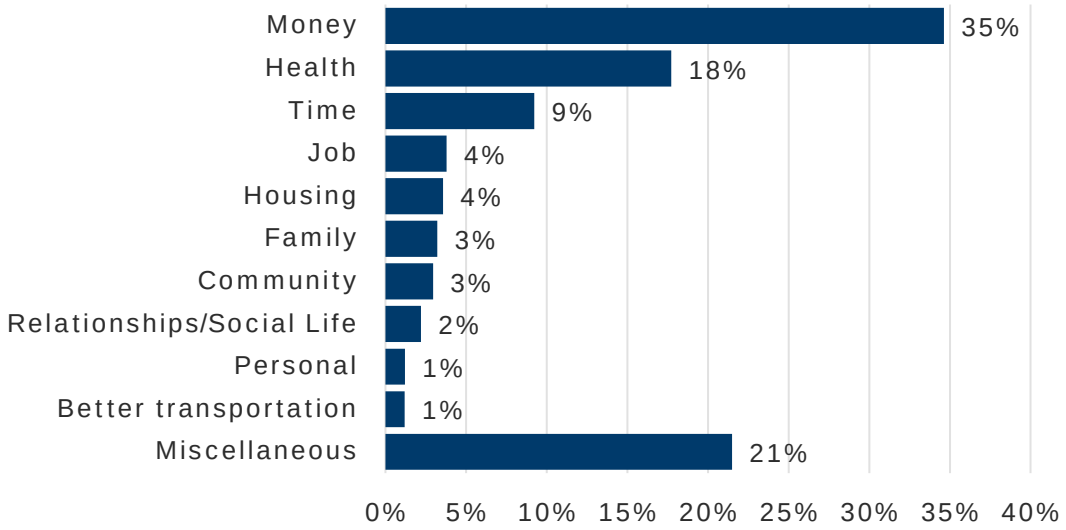
Struggling

▼▲ arrows signify statistically significant difference from previous year

"One Thing..."

Before asking specifics about respondent's health and well-being, we asked them to tell us, in their own words, the "one thing" that would make their lives better. We coded the individual responses (reflected in the chart to the right) into broad categories (reflected below):

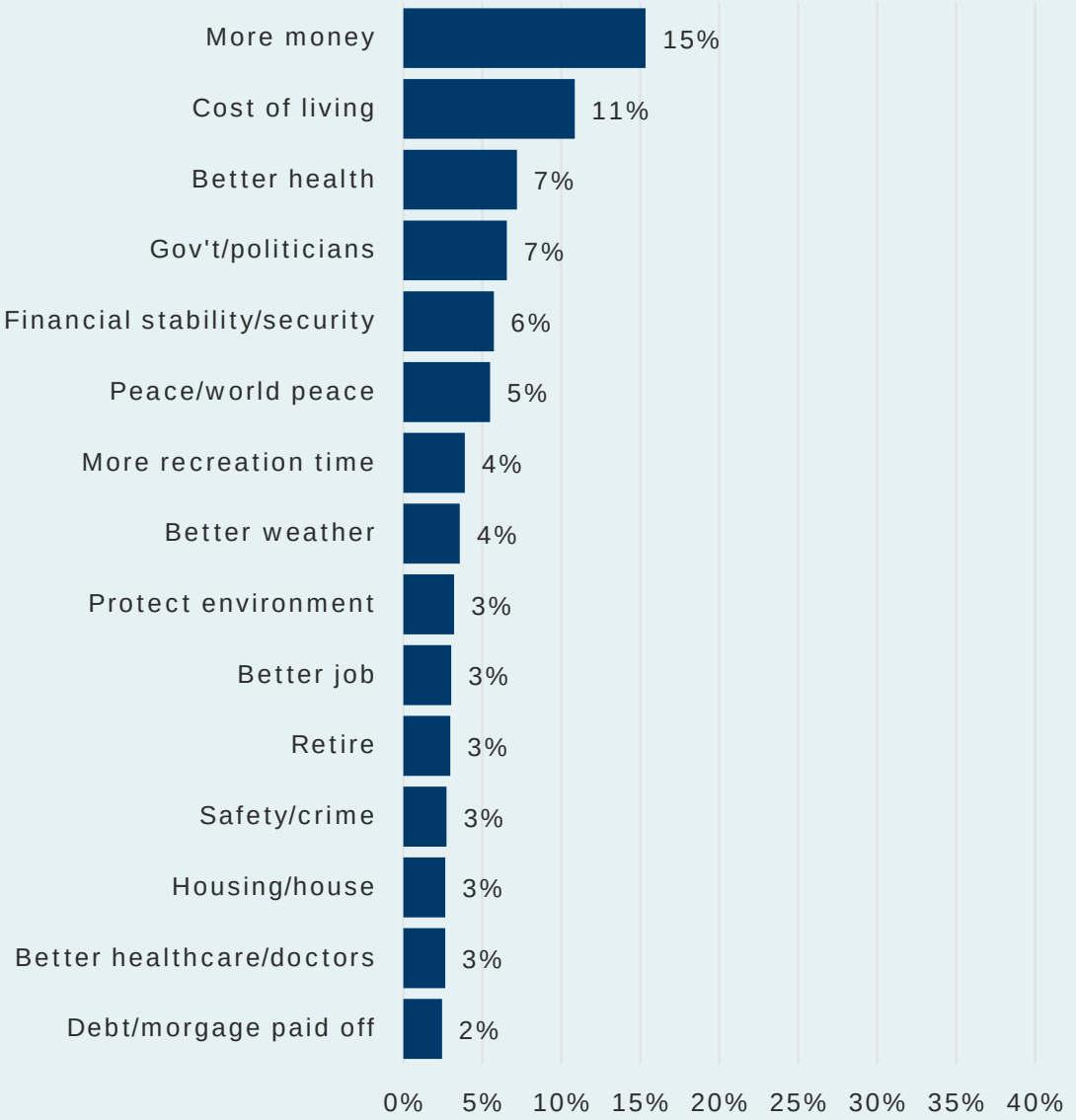
If you were to name one thing that would make your life better, what would that be?



Key Findings

- Money - specifically, *more money* & improvements in *cost of living* - are the top items respondents cite that would make their lives better.
- Health - or *better health* - ranks as the third most-cited area that would make the most positive impact on respondent's well-being.

"One Thing..." Individual Responses



- Relationship rating (q6g)
- Sense of community belonging (q7e)
- Community efficacy (q7c)

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.

How Your Community Can Flourish

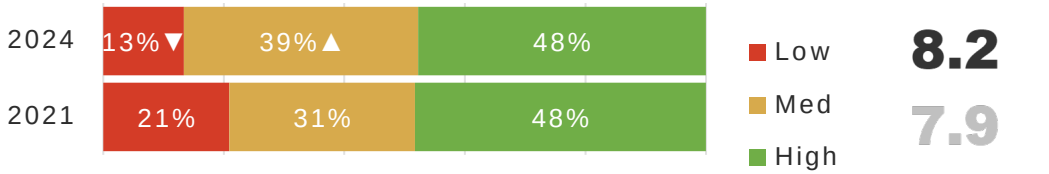
Relationships with other people have the **5th strongest impact on overall well-being** and are among the **most impactful indicators of mental and emotional health.**

Among the key indicators with the most impact on relationships: Mental/emotional state, feeling like part of a community, neighborhood quality, access to medial care, physical health, and opportunities.

Key Findings

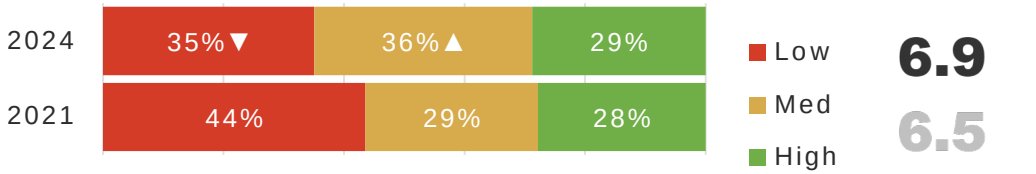
Personal relationships have improved since 2021

- Relationships with other people: Significantly fewer rate their relationships with others low in 2024 (13%) than did in 2021 (21%).

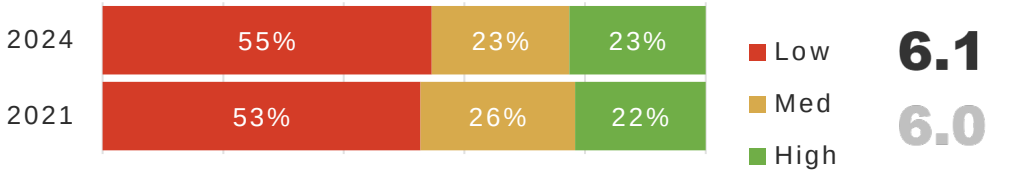


Community connections have shown some positive movement

- Part of a community/sense of belonging: Like personal relationships, this year, fewer rate themselves low on feeling like a part of their communities (35%) than did in 2021 (44%).



- Community efficacy: However, community efficacy is unchanged from 2021 and remains an area for improvement, with only a quarter rating themselves highly in this area (23%, vs. 22% in 2021).



▼▲ arrows signify statistically significant difference from previous year

Relationships & Social Connections

The lowest income earners (<$50k/year) are more likely than average to score low across all relationship measures. In addition:

- Alaska Natives and singles rate low on *personal relationships*. Women, those ages 55+, and Asian/Pacific Islanders rate low on *sense of belonging*. Those ages 55+ and singles rate low on having a *community efficacy*.

Low Scores (0-6)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Relationships	13%	13%	13%	11%	16%	16%	20%	4%	11%	15%	8%	10%	15%	24%	7%	28%	14%	7%
Belonging	35%	29%	42%	30%	37%	41%	30%	41%	25%	39%	17%	34%	32%	33%	32%	43%	31%	36%
Efficacy	55%	55%	54%	58%	54%	62%	52%	59%	36%	58%	24%	51%	58%	61%	52%	63%	54%	51%

% of each group who scored low (0-6) on each measure

(darker = better)

Black/African American residents and those earning $100k+/year more likely than average to score highly across all relationship measures. In addition:

- Hispanics, those with kids in the household, and couples score highly on *personal relationships*. Men and Hispanics rate highly on *sense of belonging*.

High Scores (8-10)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Relationships	48%	50%	46%	40%	42%	53%	48%	39%	71%	45%	85%	54%	45%	39%	53%	30%	49%	55%
Belonging	29%	35%	23%	15%	30%	31%	11%	23%	38%	26%	65%	30%	27%	26%	29%	20%	27%	34%
Efficacy	23%	25%	21%	16%	23%	20%	12%	26%	54%	20%	5%	20%	22%	15%	25%	6%	19%	31%

% of each group who scored high (9-10) on each measure

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

- Discrimination (10)
- Frequency of discrimination(10.1)

Discrimination

The impact of discrimination on well-being can be significant and detrimental on our health. Mental health, relationships, and physical health impacts include stress, anxiety, depression and chronic diseases. It can also erode confidence and a sense of belonging. Security and basic needs impacts include limiting opportunities to education, housing, employment and healthcare. It is crucial to address and combat discrimination in order to promote equality, inclusivity and overall well-being.

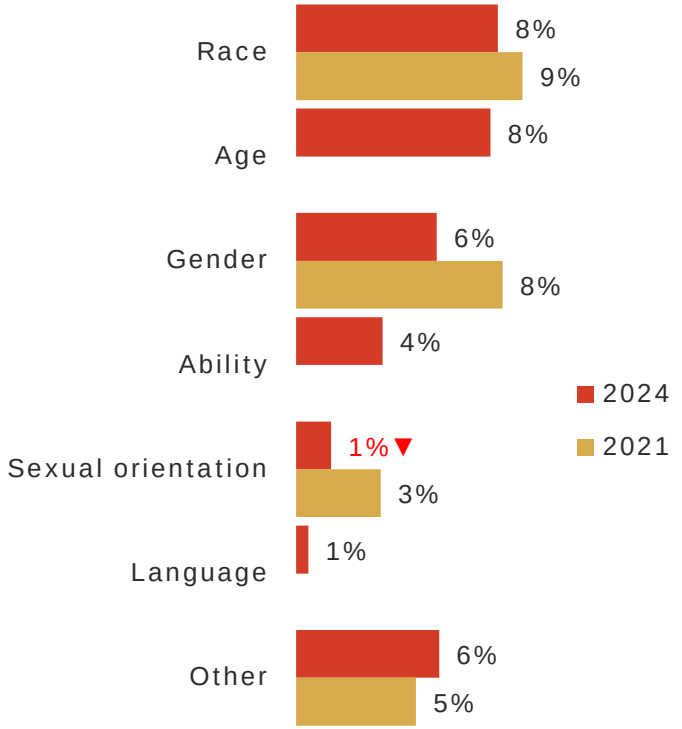
How Your Community Can Flourish

Promote a culture of belonging, help residents feel like they are a part of the community, ensure that resident's basic needs are met (a Security and Basic Needs measure).

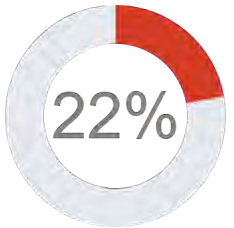
Key Findings

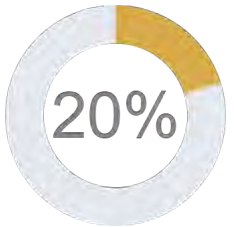
Reported discrimination slightly higher than in 2021

- Discrimination is slightly higher than in 2021, with 22% having experienced some form of discrimination in the past 12 months, vs. 20% in 2020.
- Top areas of discrimination this year include: Race (8%), age (8%), and gender (6%).



Experienced Any Discrimination





Other areas mentioned this year include:

- Disability
- Ideology
- Financial status (poor/welfare)

Discrimination

Groups most likely to experience any form of perceived discrimination include women (ability), those ages 55+ (age), Alaska Natives (race), Asian/Pacific Islanders (race), and those earning <$50k/year (ability).

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
% selecting each	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Any	22%	19%	26%	23%	22%	26%	24%	25%	17%	22%	12%	15%	23%	29%	15%	34%	16%	18%
Race	8%	10%	7%	7%	7%	11%	21%	15%	7%	6%	6%	6%	10%	9%	8%	8%	4%	9%
Age	8%	7%	9%	9%	5%	13%	6%	1%	2%	10%	0%	1%	9%	9%	5%	11%	5%	9%
Gender	6%	3%	8%	9%	6%	5%	1%	4%	4%	8%	0%	7%	4%	2%	6%	6%	2%	8%
Ability	4%	0%	7%	7%	2%	3%	3%	3%	0%	3%	0%	2%	3%	5%	1%	11%	2%	1%
Sexual orientation	1%	1%	2%	0%	3%	2%	0%	4%	2%	1%	6%	1%	1%	3%	1%	1%	2%	1%
Language	1%	1%	1%	0%	1%	1%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

% of each group choosing each response

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

- Emotional Well-being current state rating (q6h)
- Religion/Spirituality importance (q7a)
- Sense of Purpose & Meaning (q7b)

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.

How Your Community Can Flourish

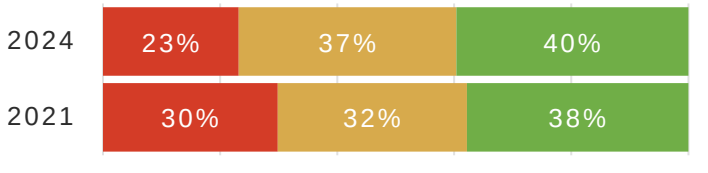
Emotional/mental well-being current state has the **2nd strongest impact on overall well-being.** Sense of purpose and meaning is **4th**.

Key indicators with most impact on driving positive outcomes in these areas are: Physical health, financial security, ability to meet basic needs, and feeling like part of a community. Additionally, relationships with others and opportunities are key to driving positive mental/emotional health.

Key Findings

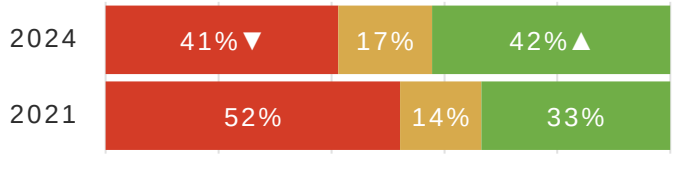
Mental/Emotional Health has improved since 2021

- Mental/Emotional Health: In a move away from low toward the middle, more rate moderate (37%) than in 2021 (32%), while fewer rate low (23%, vs. 30% in 2021).



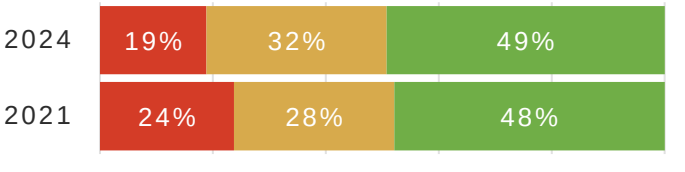
Religion and Spirituality is up significantly

- Religion and Spirituality: Some 42% report a high level of religion and spirituality in their lives this year, versus only 33% in 2021.



Purpose and Meaning has trended up

- Like many measures this year, fewer rate themselves low on purpose and meaning (19% vs. 24% in 2021) and more ratings land in the middle.



▼▲ arrows signify statistically significant difference from previous year

Mental, Emotional, & Spiritual Health

Singles and the lowest income earners (<$50k/year) are more likely than average to score low across all mental health measures. In addition:

- Those ages 18-34, Alaska Natives, Black/African American residents, and mid-income earners ($50-$99.9k/year) rate low on *emotional state*. Those ages 35-54 and Caucasians rate low on *religion & spirituality*. Alaska Natives, Black/African American residents, and mid-income earners rate low on *purpose*.

Low Scores (0-6)

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Emotional state	23%	21%	25%	31%	26%	18%	45%	31%	41%	26%	8%	22%	23%	38%	13%	50%	29%	10%
Religion & spirituality	41%	39%	44%	36%	49%	44%	46%	24%	36%	51%	12%	42%	41%	50%	36%	46%	35%	43%
Purpose & meaning	19%	16%	21%	23%	20%	18%	39%	15%	37%	21%	3%	9%	22%	29%	11%	34%	27%	9%

% of each group who scored low (0-6) on each measure

(darker = better)

No single group is more likely than average to rate highly across all mental health measures. However:

- Those ages 55+, Asian/Pacific Islanders, couples, and $100k+ earners rate highly on *emotional state*. Those agest 18-34, Asian/Pacific Islanders, Hispanics, and mid-income earners rate highly on *religion & spirituality*. Hispanics, couples, and $100k+ earners rate highly on *purpose & meaning*.

High Scores (8-10)

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Emotional state	40%	37%	42%	34%	41%	51%	18%	55%	12%	40%	29%	41%	44%	37%	46%	26%	32%	49%
Religion & spirituality	42%	41%	43%	47%	39%	41%	45%	61%	26%	34%	72%	45%	44%	41%	46%	43%	50%	36%
Purpose & meaning	49%	49%	49%	41%	49%	49%	42%	53%	46%	42%	84%	53%	47%	41%	55%	31%	37%	62%

% of each group who scored high (9-10) on each measure

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

- Neighborhood Quality Rating (6a)
- Cmty Good Place to Raise Kids (8a)
- Cmty Good Place to Grow Old (8b)

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.

How Your Community Can Flourish

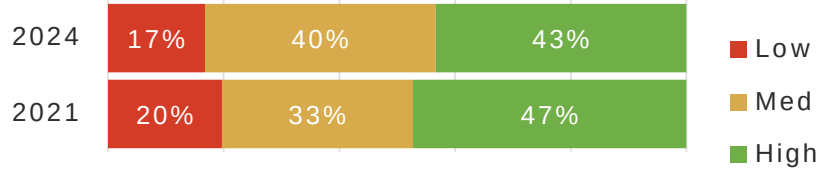
On its own, Neighborhood & Environment is less directly impactful than other dimensions on overall well-being.

However, there are key indicators here that greatly impact other measures: Neighborhood quality is highly impactful on relationships with other people and ability to get medical care and information. Community as a place to raise children is highly impactful on one's work or job satisfaction.

Key Findings

Satisfaction with neighborhoods holds relatively steady, with moderate ratings increasing slightly

- Neighborhood: High and low ratings trended down versus 2021, with more rating moderate this year (40%, vs. 33% in 2021).



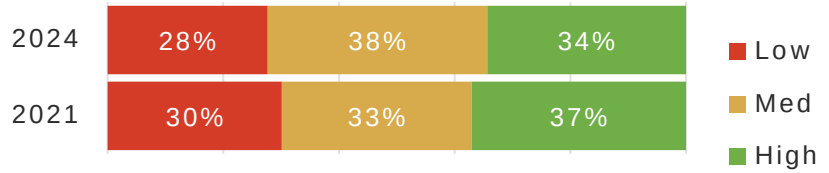
Average (0-10 scale)

8.0

8.0

Community as a good place to raise children more moderate

- Raise Children: Like neighborhood quality, fewer rate their community highly and low on being a good place to raise children than did in 2021, but more rate moderate.

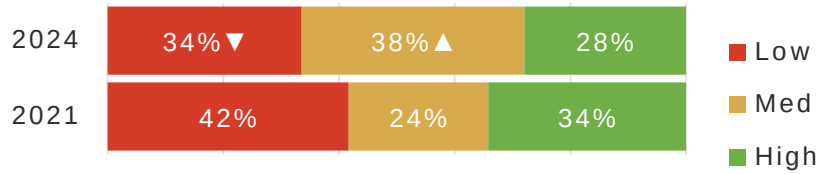


7.4

7.3

Community as a place to grow old also gains in the middle

- Grow Old: Fewer rate their communities both highly and low on this measure than did in 2021, but instead rate them as moderate (38%, vs. 24% in 2021).



7.0

6.7

▼▲ arrows signify statistically significant difference from previous year

Neighborhood & Environment

Singles and the lowest income earners (<$50k/year) are more likely than average to score low across all neighborhood measures. In addition:

- Alaska Natives rate low on *neighborhood quality*, and Alaska Natives and those ages 18-34 rate low on *community as a good place to raise children*. Those ages 18-34 rate low on *community as a good place to grow old*.

Low Scores (0-6)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Quality	17%	18%	16%	20%	12%	20%	30%	16%	3%	19%	4%	9%	21%	25%	12%	30%	13%	11%
Raise children	28%	27%	28%	36%	26%	27%	36%	16%	10%	29%	15%	16%	32%	45%	16%	54%	21%	17%
Grow old	34%	34%	33%	41%	31%	35%	34%	38%	15%	35%	17%	22%	38%	45%	25%	56%	25%	27%

% of each group who scored low (0-6) on each measure

(darker = better)

No single group rates above average across all neighborhood measures. However:

- Black/African American residents, Hispanics, and $100k+ earners rate highly on *neighborhood quality*. Those ages 35+, Caucasians, couples, and $100k+ earners rate highly on *good place to raise children*. Those ages 55+ and Alaska Natives rate highly on *good place to grow old*.

High Scores (8-10)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Quality	43%	48%	39%	31%	47%	47%	32%	32%	67%	42%	69%	45%	42%	41%	45%	26%	45%	52%
Raise children	34%	31%	38%	23%	41%	47%	36%	21%	28%	41%	21%	36%	37%	29%	41%	16%	33%	43%
Grow old	28%	25%	31%	24%	30%	37%	46%	23%	26%	30%	21%	26%	32%	25%	33%	13%	31%	32%

% of each group who scored high (9-10) on each measure

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

- Work or Job rating (q6d)
- Opportunities for Learning and Growth (q6g)
- Sense of Purpose and Meaning - *see Mental & Emotional Health* (q7b)
- Job Insecurity/unemployment (q9e)

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.

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 contributes greatly to all six dimensions of well-being.

How Your Community Can Flourish

Opportunities for learning and growth have the **6th highest impact on overall well-being**, with **work or job not far behind at 8th**.

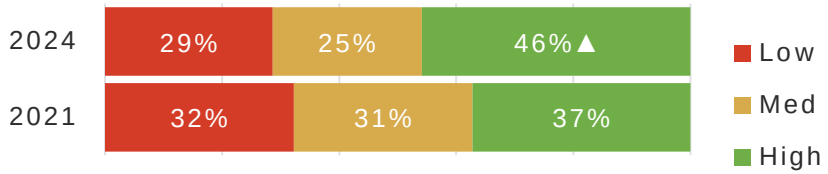
Key indicators with the most impact on these work, learning & growth areas include: Mental/emotional health, financial security, relationships with others, and ability to meet basic needs. Community as a good place to raise children and opportunities are also key to job satisfaction.

Key Findings

Work satisfaction is up versus 2021

- Work Satisfaction: Nearly half rate their work or job highly this year (46%), significantly more than did in 2021 (37%).

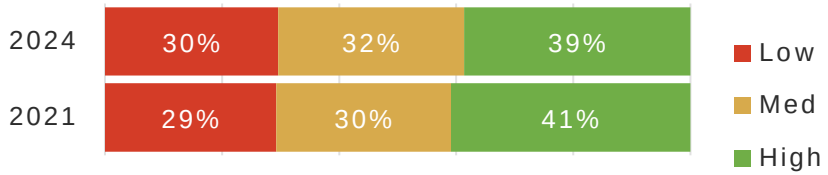
Average (0-10 scale)



7.5▲
7.0

Perceived opportunities for learning & growth similar to 2021

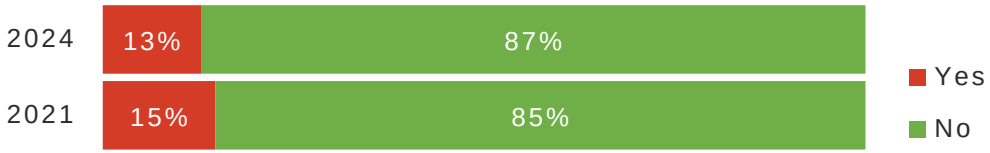
- Opportunities: While most rate moderately to highly on this measure, close to a third rate low (30%).
- Close to 1 in 5 report a need for education (*see TotalHealth 9*).



7.6
7.5

Job insecurity remains relatively low

- Job Insecurity: Only 13% report insecurity in their jobs, compared to 15% in 2021.



▼▲ arrows signify statistically significant difference from previous year

Work, Learning & Growth

Those ages 18-34, Alaska Natives, singles, and the lowest income earners (<$50k/year) are more likely than average to rate low across all work, learning & growth measures. In addition:

- Those with no kids at home rate low on *work or job*. Asian/Pacific Islanders, Hispanics, and mid-income earners rate low on *opportunities*.

Low Scores (0-6)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Work or job	29%	31%	26%	46%	21%	25%	34%	27%	9%	29%	4%	19%	34%	42%	21%	72%	22%	17%
Opportunities	30%	32%	27%	45%	19%	25%	36%	43%	14%	28%	61%	33%	29%	37%	25%	57%	35%	16%

% of each group who scored low (0-6) on each measure

(darker = better)

Those ages 55+, couples, and $100k+ earners are more likely than average to rate highly across all work, learning & growth measures. In addition:

- Black/African American residents and Hispanics rate highly on *work or job*. Those with no kids in the household rate highly on *opportunities*.

High Scores (8-10)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Work or job	46%	45%	47%	34%	41%	54%	27%	49%	57%	43%	88%	47%	44%	31%	53%	14%	41%	59%
Opportunities	39%	35%	42%	33%	41%	49%	30%	40%	6%	39%	28%	38%	44%	36%	46%	22%	26%	49%

% of each group who scored high (9-10) on each measure

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

- Future financial security (7d)
- Ability to Meet Basic Needs (6e)
- Access to Health Care and Information (6c)

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.

How Your Community Can Flourish

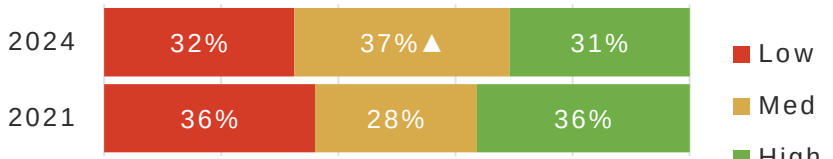
Financial security has the **3rd highest impact on overall well-being;** ability to get medical care and health information **the 7th highest.**

Key indicators with the most impact on these areas include: Ability to meet basic needs, mental/emotional state, community belonging, physical health, and opportunities for learning and growth. Additionally, sense of purpose and meaning has a strong impact on financial security.

Key Findings

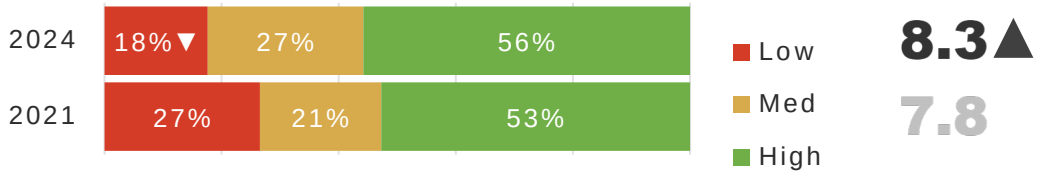
Financially security has trended toward moderate

- Financial Security: More rate moderately this year (37%) than did in 2021 (28%). Moderate ratings pull similarly from both high and low rating in 2021.



The ability to meet basic needs has improved significantly

- Meet Basic Needs: Far fewer rate themselves low on this measure this year (18%) than did in 2021 (27%). Both high and moderate ratings increased versus 2021 as a result.



▼▲ arrows signify statistically significant difference from previous year

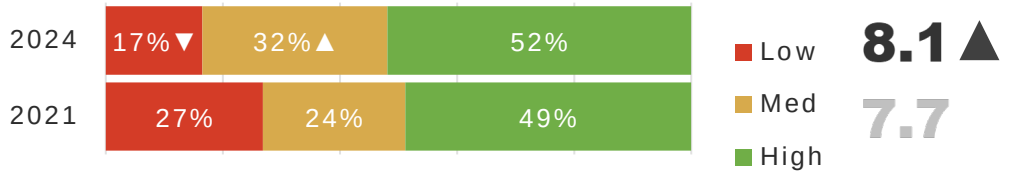
- Future financial security (7d)
- Ability to Meet Basic Needs (6e)
- Access to Health Care and Information (6c)

Security & Basic Needs

Key Findings (cont.)

Access to medical care and health information is also up

- Access to Medical Care/Information: As with basic needs, fewer report low ratings (17%) than did in 2021 (27%). The proportions rating themselves both moderate and highly on this measure increased (movement to moderate was significant).



▼▲ arrows signify statistically significant difference from previous year

Security & Basic Needs

The lowest income earners (<$50k/year) are more likely than average to score low across all security & basic needs measures. In addition:

- Those ages 18-34, Alaska Natives, Black/African American residents, singles, and mid-income earners rate low on *financial security*. Alaska Natives rate low on *ability to meet basic needs*. Women rate low on *ability to access medical care and information*.

Low Scores (0-6)		**Gender**		**Age**			**Race/Ethnicity**					**HH Composition**				**HH Income**		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Financial security	32%	31%	34%	43%	29%	28%	62%	14%	49%	35%	9%	24%	35%	41%	25%	61%	40%	17%
Basic needs	18%	15%	21%	21%	12%	16%	36%	12%	15%	16%	9%	11%	19%	21%	14%	39%	20%	5%
Medical care/info	17%	11%	22%	13%	16%	19%	16%	13%	16%	19%	3%	16%	14%	18%	13%	35%	13%	11%

% of each group who scored low (0-6) on each measure

(darker = better)

Those earning $100k+ per year rate above average across all security & basic needs measures. In addition:

- Those ages 55+ and Asian/Pacific Islanders rate highly on *financial security*. Those ages 35+, Hispanics, those with kids and home, and couples rate highly on *ability to meet basic needs*. Asian/Pacific Islanders, Black residents, Hispanics, those with kids at home, couples, and mid-income earners rate highly on *access to medical care*.

High Scores (8-10)		**Gender**		**Age**			**Race/Ethnicity**					**HH Composition**				**HH Income**		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Financial security	31%	32%	29%	22%	26%	42%	8%	44%	37%	28%	18%	25%	33%	25%	33%	19%	17%	44%
Basic needs	56%	53%	59%	41%	62%	63%	35%	59%	58%	54%	87%	67%	53%	39%	68%	23%	50%	75%
Medical care/info	52%	57%	47%	54%	44%	55%	57%	61%	73%	49%	87%	58%	51%	41%	61%	21%	59%	63%

% of each group who scored high (9-10) on each measure

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Total Health 9

The Community Health and Well-Being Monitor tracks nine specific critical basic needs in the community through the **Total Health 9 assessment**.

The question text for this assessment is on the right-hand side of this page, and this year's findings are on the following page.

Question Text

Below is a list of things that people sometimes worry about. Please tell us which of these, if any, you are worried about at the present time?

Select all that apply to you.

Abbreviation	Item Description
Food	Are you worried that you or others in your home won't have enough food to eat?
Transportation	Are you worried about getting to work, school, groceries or appointments because you don't have a way to get there?
Housing	Are you living without stable housing, currently homeless or worried about losing your housing?
Power & Water	Are you worried about paying your water and/or power bills?
Job	Are you without a stable job, or do you need help getting a better job?
Education	Do you need additional education or training to get the job and income you need?
Personal safety	Do you ever feel unsafe in your relationship or at home?
Child care	Are you living without stable child care, unable to find good child care, or worried about losing your child care?
Health care	Are you unable to get the medical or mental health care you need, or worried about losing your access to healthcare?

Below is a list of things that people sometimes worry about. Please tell us which of these, if any, you are worried about at the present time?

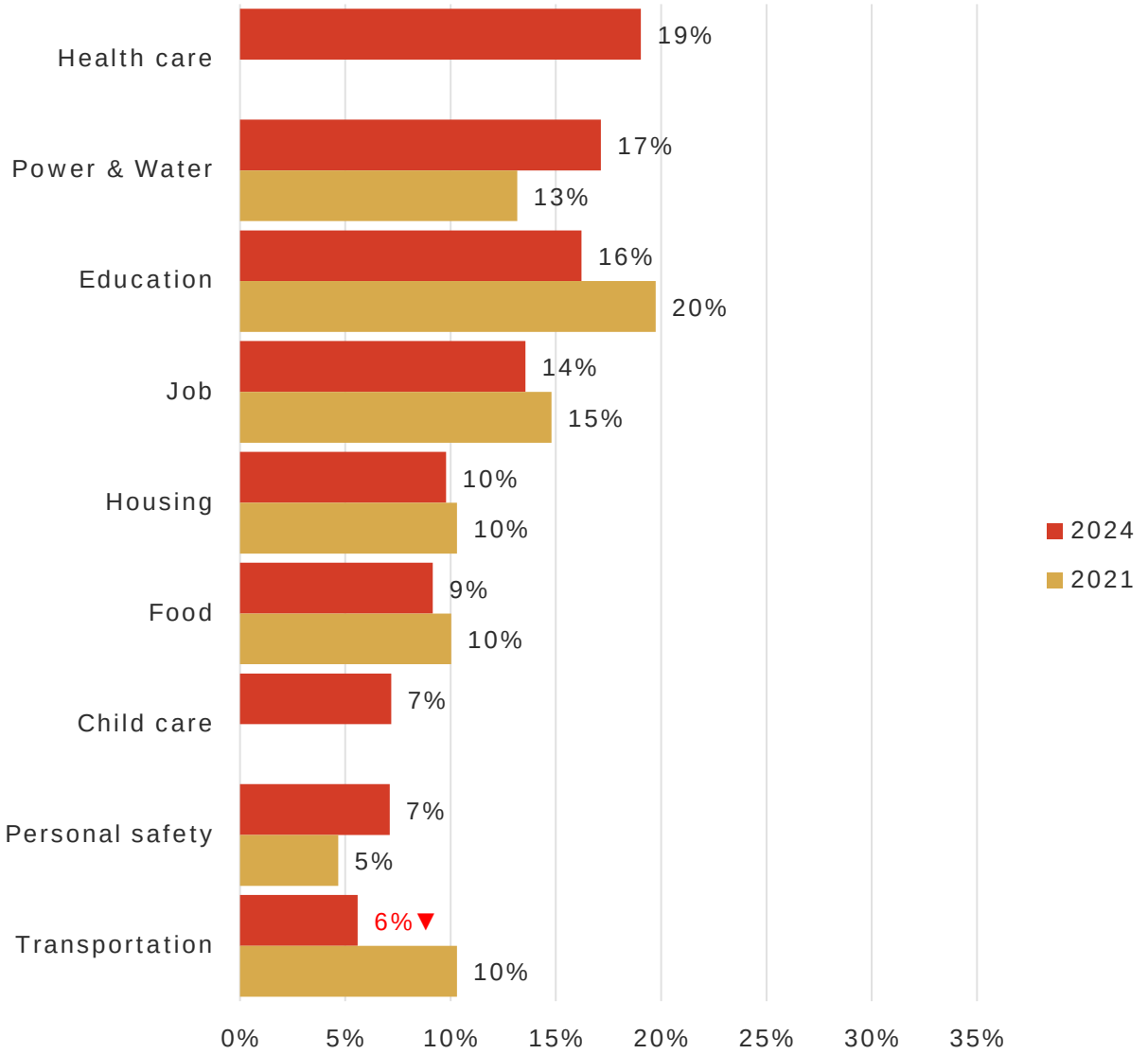
Total Health 9

Close to half this year (47%) reported having at least one of the specific needs measured through the Total Health 9. Across those needs also measured in 2021, the need for **transportation** was down significantly. The need for **education** also trended down**,** but **power & water** needs trended up**.**

Top Five Needs in 2024:

1. Health care: 19%
2. Power & Water: 17%
3. Education: 16%
4. Job: 14%
5. Housing: 10%

Key Findings



Total Health 9

Below is a list of things that people sometimes worry about. Please tell us which of these, if any, you are worried about at the present time?

Stated needs are highest among those earning <$50k/year. In fact, this group has above average needs across all categories. In addition:

- Singles have elevated needs across most categories, most notably power & water and personal safety.
- Alaska Natives also have higher than average needs for most areas, but the most needs in power & water, transportation, and education.
- Those ages 18-34 state higher than average needs for power & water, education, and job.
- Hispanics indicate a higher than average need for housing, Black/African Americans for food, and Asian/Pacific Islanders for education and child care.

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
% selecting each	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Any	45%	45%	44%	58%	43%	36%	54%	40%	34%	43%	63%	46%	45%	62%	36%	79%	45%	29%
Health care	19%	16%	22%	25%	18%	17%	20%	10%	19%	21%	1%	19%	17%	26%	14%	34%	15%	13%
Power & Water	17%	17%	17%	35%	11%	9%	31%	21%	20%	16%	1%	14%	18%	29%	9%	52%	14%	3%
Education	16%	14%	19%	28%	16%	8%	29%	18%	10%	13%	7%	17%	14%	19%	13%	29%	16%	8%
Job	14%	12%	15%	23%	12%	7%	19%	14%	16%	12%	5%	11%	14%	19%	10%	37%	10%	3%
Housing	10%	13%	6%	12%	5%	4%	13%	3%	16%	8%	52%	11%	10%	17%	6%	24%	16%	2%
Food	9%	4%	14%	8%	11%	7%	15%	4%	26%	9%	1%	6%	10%	17%	3%	23%	6%	4%
Child care	7%	4%	10%	9%	8%	4%	16%	15%	3%	8%	5%	13%	4%	11%	5%	13%	6%	4%
Personal safety	7%	9%	5%	12%	4%	5%	14%	6%	8%	8%	0%	5%	9%	18%	1%	21%	8%	1%
Transportation	6%	3%	8%	4%	7%	4%	22%	1%	7%	5%	1%	4%	6%	11%	2%	16%	7%	1%

% of each group choosing each response

(darker = better)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

- Physical Health Current State Rating(6b)
- Behavior: Days fruit & veggies (9a)
- Behavior: Days exercise > 30 minutes (9b)

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.

How Your Community Can Flourish

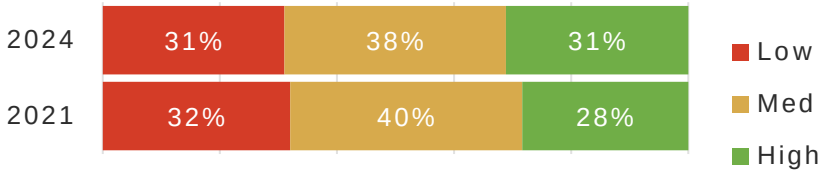
Physical health has the highest impact on overall well-being.

Key indicators with the most impact on physical health: Mental or emotional health, sense of purpose and meaning, relationships with others, financial security, opportunities for learning and growth, regular exercise, and ability to get medical care and information.

Key Findings

Physical health trends up but continues to need improvement

- State of Physical Health: Those rating their physical health highly trended up this year (31%, vs. 28% in 2021). However, similar to 2021, a third this year rates their physical health low.



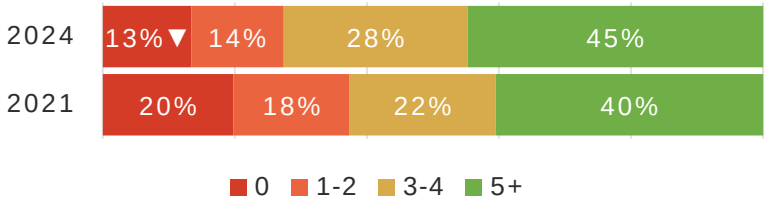
Average (0-10 scale)

7.2

7.0

This year sees improvement in consumption of fresh fruits and vegetables, and in regular exercise.

- Fruits & Vegetables: Some 45% report consuming fresh fruit and vegetables 5+ times per week, versus 40% in 2021. Additionally, the proportion reporting zero days with fresh food was down significantly.

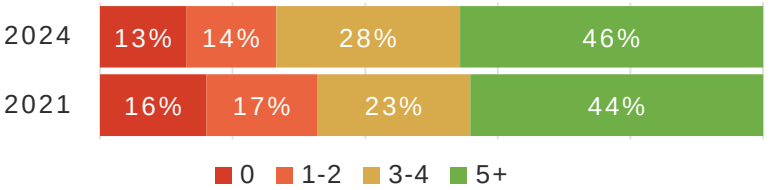


Average (0-7 scale)

3.9

3.6

- Exercise: Exercise days trended up, with 74% exercising at least 3 days per week, versus 67% in 2021.



3.9

3.8

▼▲ arrows signify statistically significant difference from previous year

Neighborhood & Environment

Black/African Americans and low-income earners (<$50k/year) are more likely than average to score low across all physical health measures. In addition:

- Alaska Natives and singles rate low on *physical health*. Those with no kids and singles rate low on *days with fresh fruit/vegetables*.

Low Scores (0-6)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Physical health	31%	28%	34%	31%	36%	33%	48%	34%	42%	35%	18%	28%	32%	44%	22%	46%	39%	22%
<3 days fruits/veg	27%	27%	28%	28%	28%	26%	30%	4%	36%	32%	9%	19%	33%	37%	23%	48%	30%	20%
<3 days exercise	27%	26%	27%	21%	22%	28%	11%	16%	62%	24%	16%	11%	31%	26%	23%	33%	23%	28%

% of each group who scored low (0-6) on each measure

(darker = better)

Asian/Pacific Islanders rate above average across all physical health measures. In addition:

- Those ages 18-34, couples, and higher income earners ($100k+/year) rate highly on *physical health*. Those ages 55+, Hispanics, and mid-income earners rate highly on *5+ days of fresh fruit and vegetables*. Those ages 18-34, Alaska Natives, and those with kids rate highly on *5+days exercise*.

High Scores (8-10)	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Physical health	31%	31%	31%	46%	27%	30%	34%	46%	2%	29%	17%	35%	34%	28%	39%	23%	22%	37%
5+ days fruit/veg	45%	49%	40%	42%	42%	55%	33%	68%	5%	44%	78%	48%	46%	46%	47%	23%	51%	49%
5+ days exercise	46%	47%	44%	60%	47%	41%	59%	60%	29%	49%	23%	59%	42%	49%	46%	49%	42%	44%

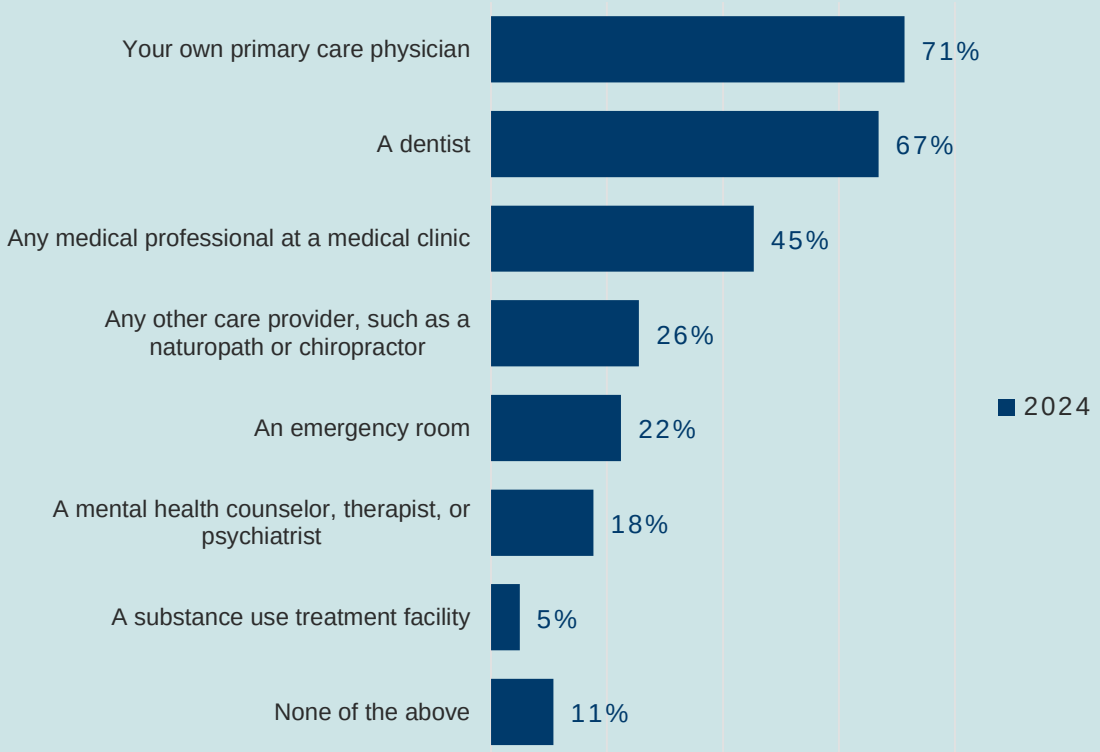
% of each group who scored high (9-10) on each measure

(darker = better)

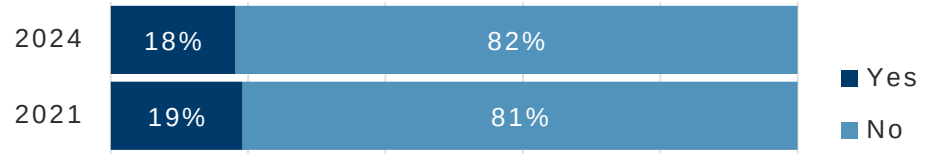
Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Tailored Questions

Q11. Have you visited any of the following at least once in the past year??

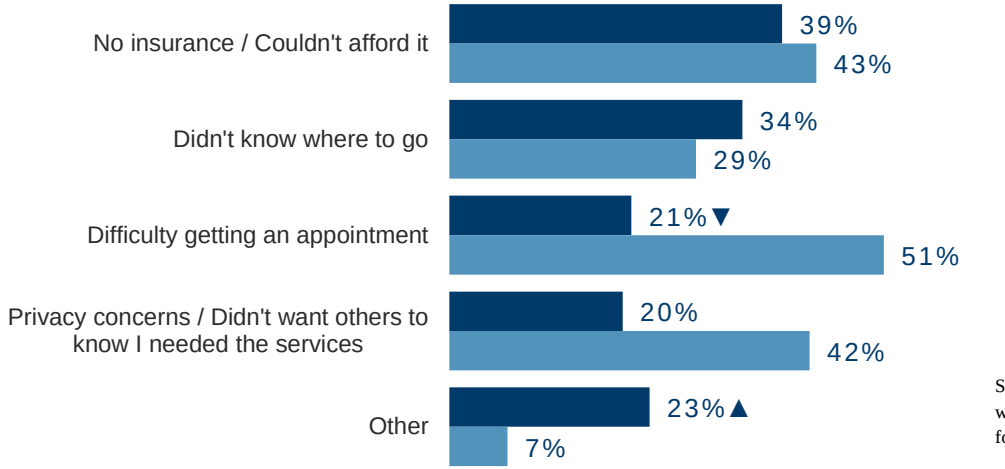


A2: In the last 12 months, have you or a family member needed mental health services (counseling or other help)?



A2a: Were you able to receive the needed mental health services?

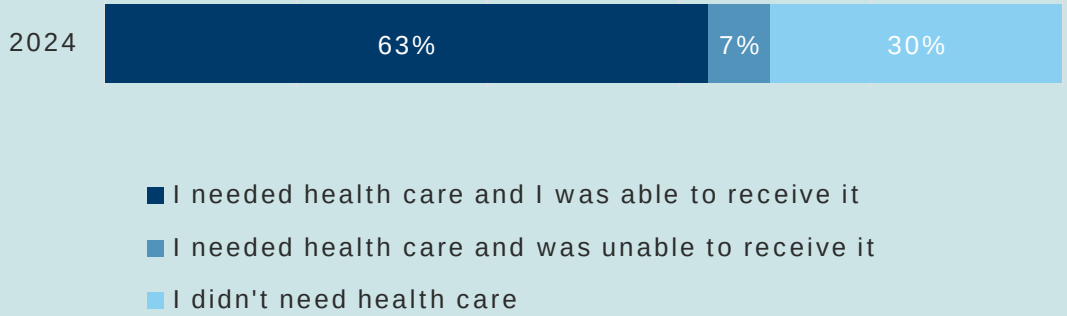
A2b: Why couldn't you receive needed mental health services?



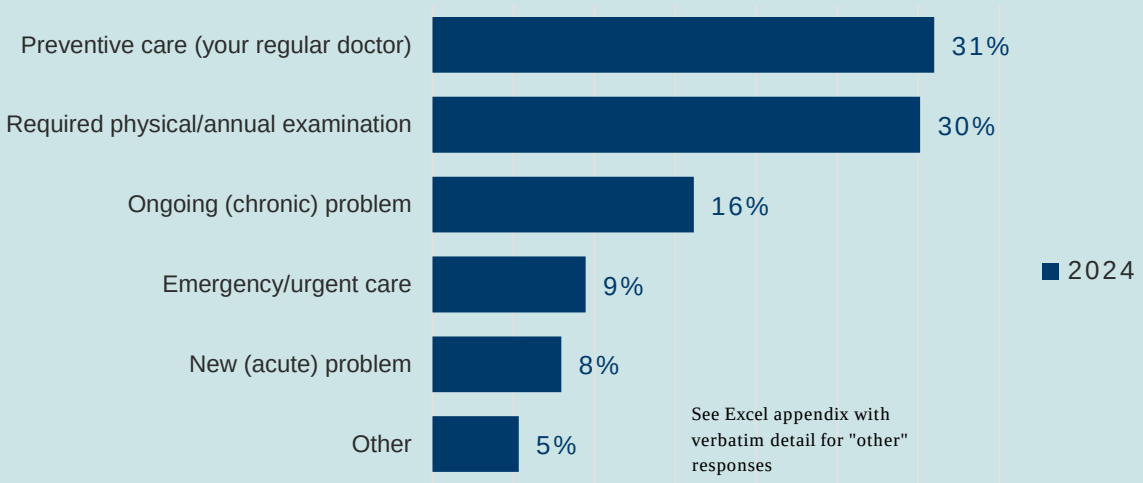
See Excel appendix with verbatim detail for "other" responses

▼▲ arrows signify statistically significant difference from previous year

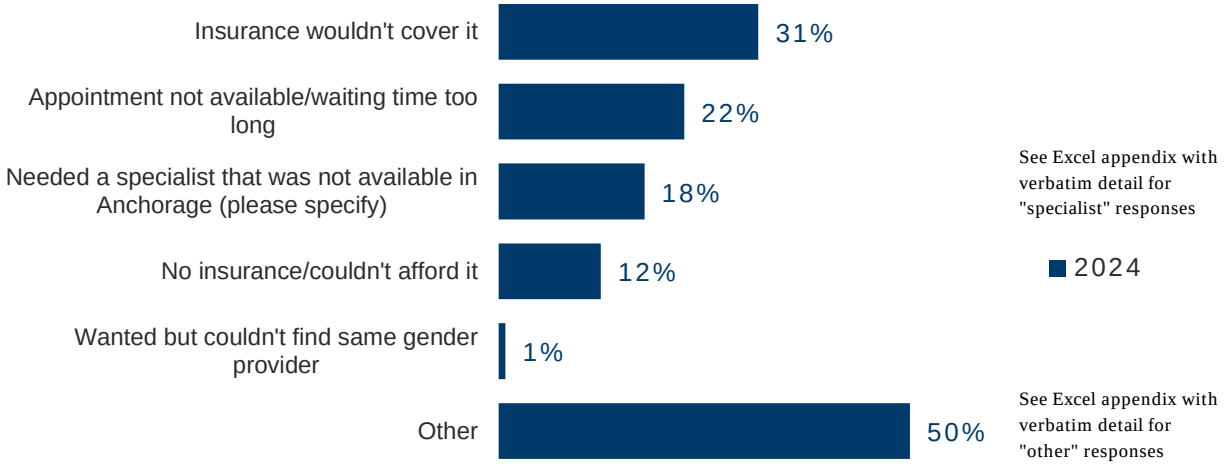
A3. Have you needed health care in the last 12 months and were you able to receive it?



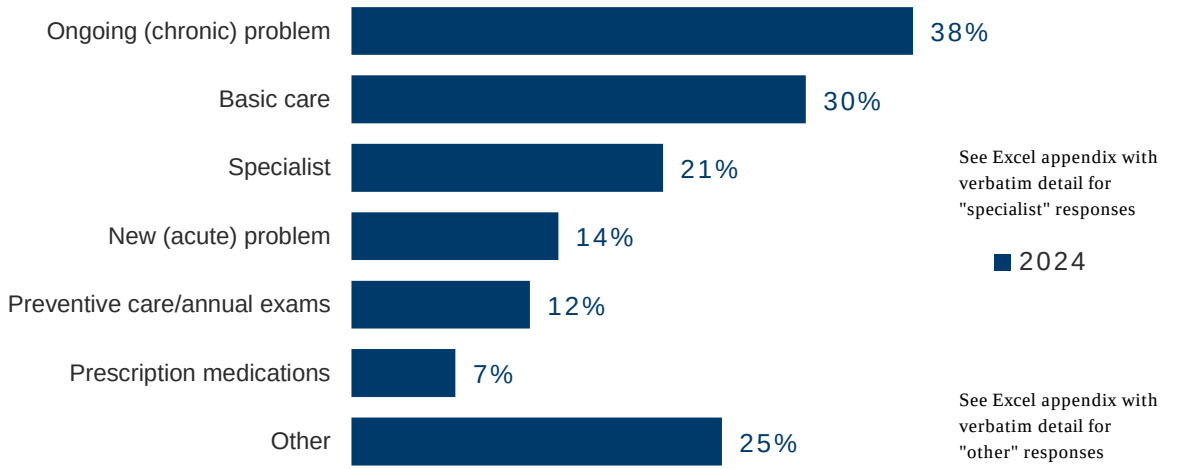
A3a: What was the primary reason for your most recent health care visit?



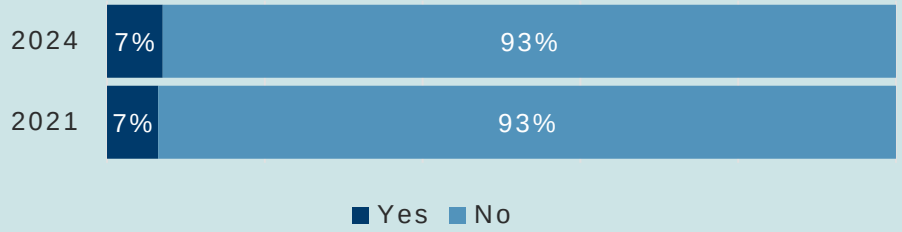
A3b. Why couldn't you receive health care?



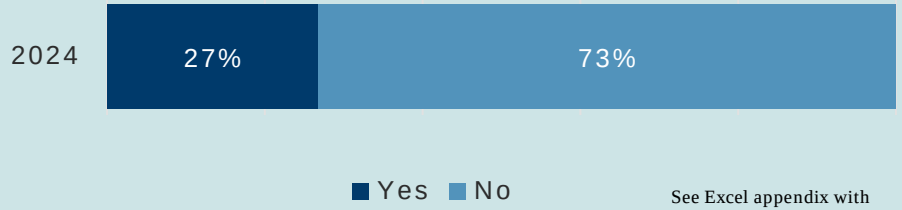
A3c. What type of health care did you go without?



A4. Have you had any thoughts of suicide at any time in the past 12 months?

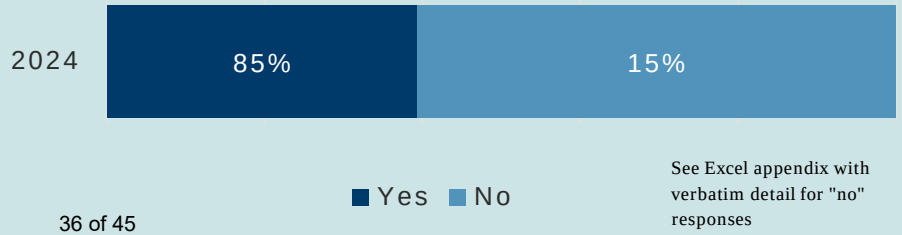


A5. Do you have any chronic diseases (e.g. congestive heart failure, diabetes, asthma, etc.)?



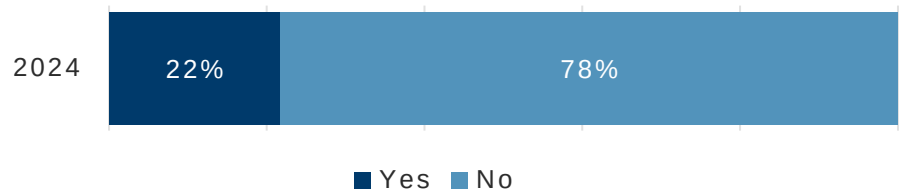
See Excel appendix with verbatim detail for "yes" responses

A5a. Do you have the resources needed to treat your chronic disease?

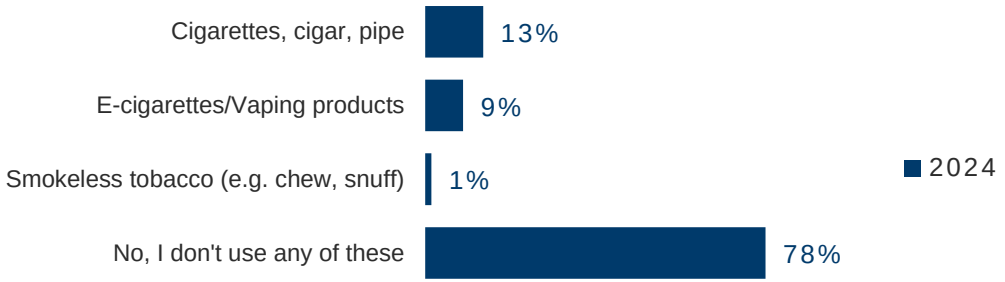


See Excel appendix with verbatim detail for "no" responses

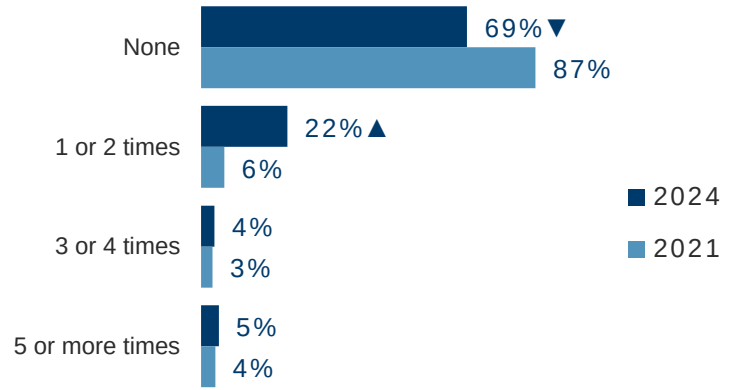
A6. Do you use any tobacco related products?



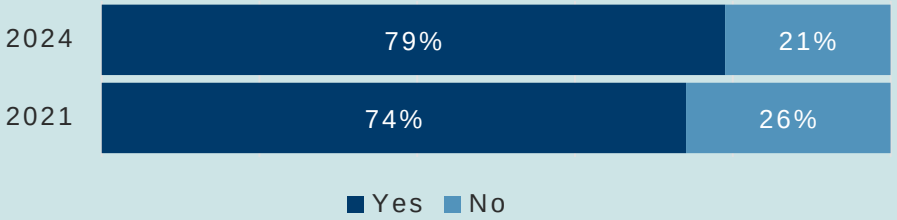
A6. Do you use any of the following tobacco related products?



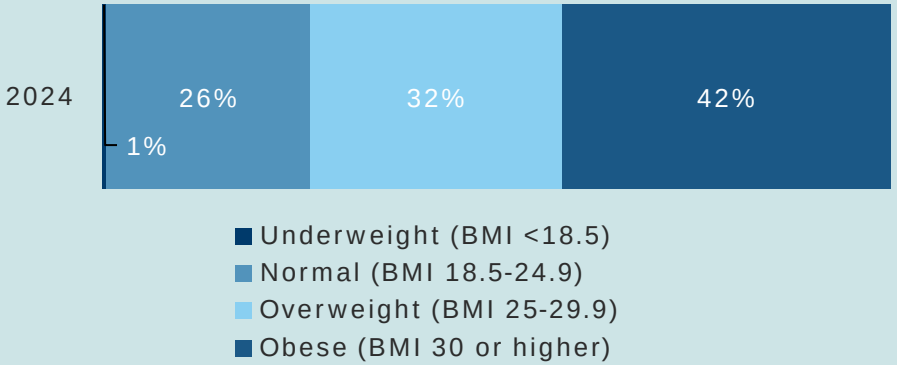
A7. During the past 30 days, about how often did you have 5 or more drinks containing any kind of alcohol within a two-hour period?



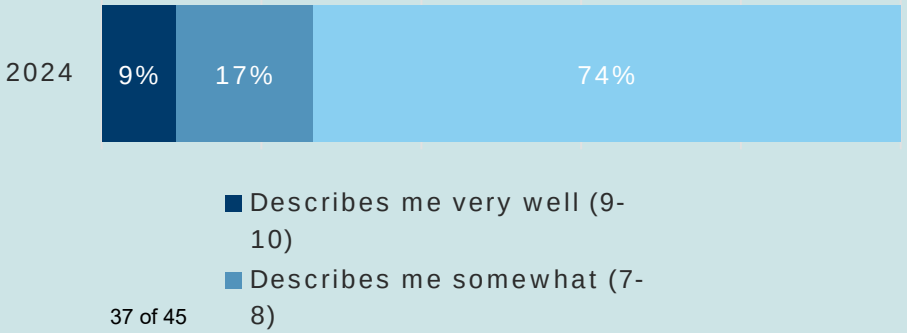
A12. If you were sick, could you easily find someone to help you with daily chores?



Body Mass Index (BMI)



Q6r6. I often feel isolated from others.



Tailored Questions

Q11. Have you visited any of the following at least once in the past year?

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Your PCP	71%	64%	79%	58%	69%	79%	58%	61%	69%	73%	98%	68%	71%	63%	75%	71%	69%	73%
Dentist	67%	66%	67%	65%	65%	63%	80%	48%	89%	69%	72%	65%	66%	64%	67%	60%	73%	67%
Any med. prof.	45%	38%	53%	23%	54%	55%	31%	27%	61%	49%	10%	45%	41%	42%	42%	45%	35%	51%
Other	26%	22%	29%	21%	31%	21%	6%	39%	47%	26%	22%	25%	21%	20%	23%	27%	19%	30%
An ER	22%	17%	28%	11%	22%	26%	14%	15%	56%	21%	17%	23%	16%	18%	18%	25%	19%	23%
Mental health	18%	15%	20%	12%	22%	9%	12%	15%	45%	18%	10%	19%	10%	10%	15%	16%	11%	23%
Substance abuse	5%	9%	1%	3%	1%	1%	8%	2%	34%	3%	0%	1%	2%	3%	1%	5%	2%	7%
None	11%	16%	5%	22%	7%	8%	6%	18%	2%	9%	2%	9%	13%	14%	10%	13%	9%	12%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Tailored Questions

A2: In the last 12 months, have you or a family member needed mental health services (counseling or other help)?

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Yes	18%	14%	23%	17%	26%	12%	12%	6%	13%	23%	3%	19%	16%	24%	13%	36%	15%	14%
No	82%	86%	77%	83%	74%	88%	88%	94%	87%	77%	97%	81%	84%	76%	87%	64%	85%	86%

% of each group choosing each response

(darker = higher)

A2a: Were you able to receive the needed mental health services? (If needed in the past 12 months)

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Yes	63%	67%	60%	90%	63%	44%	73%	69%	5%	66%	0%	63%	60%	52%	73%	63%	33%	81%
No	37%	33%	40%	10%	37%	56%	27%	31%	95%	34%	100%	37%	40%	48%	27%	37%	67%	19%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Data for "A2b: Why couldn't you receive needed mental health services?" excluded due to Low base size (n<25)s across subgroups.

Tailored Questions

A3. Have you needed health care in the last 12 months and were you able to receive it?

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Needed & recieved	63%	60%	66%	45%	61%	75%	39%	66%	56%	65%	87%	61%	62%	58%	64%	66%	55%	67%
Needed, didn't receive	7%	5%	8%	6%	10%	5%	8%	4%	6%	7%	0%	8%	5%	9%	5%	8%	5%	6%
Didn't need	30%	35%	26%	50%	29%	20%	53%	30%	38%	28%	13%	31%	33%	33%	31%	26%	40%	27%

% of each group choosing each response

(darker = higher)

A3a. What was the primary reason for your most recent visit (among those who needed HC and received it)?

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Preventive care	31%	32%	30%	26%	33%	32%	26%	36%	7%	30%	65%	40%	31%	23%	40%	14%	34%	34%
Physical exam	30%	39%	22%	51%	19%	18%	17%	51%	83%	25%	14%	21%	31%	37%	23%	47%	25%	28%
Chronic problem	16%	11%	21%	5%	20%	24%	19%	6%	4%	19%	9%	15%	18%	18%	16%	9%	21%	18%
ER/Urgent	9%	7%	12%	0%	17%	11%	10%	3%	0%	10%	5%	13%	8%	7%	11%	6%	10%	10%
Acute problem	8%	9%	7%	8%	8%	11%	22%	5%	6%	10%	6%	8%	10%	12%	7%	9%	9%	8%
Other	5%	3%	8%	10%	2%	4%	6%	0%	0%	6%	0%	4%	2%	2%	3%	14%	2%	3%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for QA3: Black/African American and Hispanic; data are directional

Note: Low base size (n<25) for QA3a: Ages 18-34, Asian/Pacific Islander, Black/African American, Hispanic; data are directional

Data for "A3b: Why couldn't you receive health care?" and "A3c: What type of health care did you go without?" excluded due to Low base size (n<25)s across subgroups.

Tailored Questions

A4. Have you had any thoughts of suicide at any time in the past 12 months?

		Gender		Age			Race/Ethnicity					HH Composition				HH Income		
	Total	Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Yes	7%	5%	9%	6%	12%	5%	13%	10%	14%	8%	8%	9%	6%	11%	5%	10%	8%	5%
No	93%	95%	91%	94%	88%	95%	87%	90%	86%	92%	92%	91%	94%	89%	95%	90%	92%	95%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Tailored Questions

A5: Do you have any chronic diseases (e.g. congestive heart failure, diabetes, asthma, etc.)?

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Yes	27%	21%	33%	21%	26%	33%	14%	9%	21%	28%	64%	23%	28%	28%	25%	38%	30%	20%
No	73%	79%	67%	79%	74%	67%	86%	91%	79%	72%	36%	77%	72%	72%	75%	62%	70%	80%

% of each group choosing each response

(darker = higher)

A5a: Do you have the resources needed to treat your chronic disease? (Among those with a chronic disease)

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Yes	85%	95%	78%	79%	79%	88%	94%	100%	62%	83%	100%	90%	90%	83%	95%	72%	86%	95%
No	15%	5%	22%	21%	21%	12%	6%	0%	38%	17%	0%	10%	10%	17%	5%	28%	14%	5%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for Q5: Black/African American and Hispanic; data are directional
Note: Low base size (n<25) for QA5a: Ages 18-34, Alaska Native, Asian/Pacific Islander, Black/African American, Hispanic; data are directional

Tailored Questions

A6: Do you use any of the following tobacco related products?

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Cigarettes, cigar, pipe	13%	15%	11%	21%	13%	11%	11%	26%	10%	11%	4%	12%	16%	18%	12%	20%	12%	12%
E-cigarettes/Vaping	9%	8%	10%	15%	8%	3%	29%	2%	3%	8%	4%	8%	7%	8%	7%	10%	6%	11%
Smokeless tobacco	1%	3%	0%	0%	5%	0%	3%	0%	0%	1%	6%	3%	1%	1%	2%	0%	2%	2%
None of these	78%	76%	80%	67%	77%	86%	65%	72%	89%	81%	86%	79%	78%	76%	79%	74%	81%	76%

% of each group choosing each response

(darker = higher)

A7: 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?

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
None	69%	65%	74%	70%	74%	76%	45%	76%	34%	75%	41%	65%	72%	70%	70%	88%	59%	64%
1 or 2 times	22%	28%	17%	30%	10%	14%	45%	24%	61%	16%	59%	24%	21%	23%	21%	9%	35%	23%
3 or 4 times	4%	4%	3%	0%	7%	4%	8%	0%	0%	3%	0%	5%	4%	3%	5%	0%	3%	6%
5+ times	5%	3%	6%	0%	9%	5%	3%	0%	5%	5%	0%	7%	3%	4%	5%	3%	3%	7%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Tailored Questions

Body Mass Index (BMI)

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
BMI	29.8	29.8	29.8	28.6	31.8	28.9	27.3	27.2	31.4	30.1	27.0	29.4	29.3	30.3	28.7	32.3	29.5	29.2

Average for each group

(darker = higher)

A12: If you were sick, could you easily find someone to help you with daily chores?

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Yes	79%	87%	72%	84%	79%	77%	69%	81%	74%	80%	89%	84%	76%	69%	84%	60%	73%	89%
No	21%	13%	28%	16%	21%	23%	31%	19%	26%	20%	11%	16%	24%	31%	16%	40%	27%	11%

% of each group choosing each response

(darker = higher)

Note: Low base size (n<25) for Black/African American and Hispanic; data are directional

Tailored Questions

Q6r6. I often feel isolated from others.

	Total	Gender		Age			Race/Ethnicity					HH Composition				HH Income		
		Male	Female	18-34	35-54	55+	Native AK	Asian/ PI	Black/ AA	White	Hispanic	Kids in HH	No kids in HH	Singles	Couples	<$50k	$50k - $99.9k	$100k+
Describes me well (9-10)	9%	6%	12%	11%	9%	7%	1%	18%	16%	9%	3%	6%	10%	8%	9%	13%	13%	6%
Somewhat (7-8)	17%	15%	19%	24%	18%	14%	15%	29%	3%	18%	5%	20%	17%	24%	15%	22%	16%	16%
Doesn't describe (0-6)	74%	79%	68%	65%	73%	79%	84%	53%	81%	74%	92%	74%	73%	68%	76%	64%	71%	78%

% of each group choosing each response

(darker = better)

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Note: Low base size (n<25) for Black/African American and Hispanic; data are directional