

# COMMUNITY HEALTH NEEDS ASSESSMENT 2020

## Providence Valdez Medical Center



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



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# EXECUTIVE SUMMARY

## Understanding and Responding to Community Needs, Together

Improving the health of our communities is foundational to our Mission and a commitment deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2020 CHNA was approved by the Providence Alaska Region Board on November 17, 2020 and made publicly available by December 28, 2020.

## Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across the Valdez community, information collected includes local community health survey responses, state and national public health data, qualitative data from stakeholder interviews, and hospital utilization data. Stakeholder interviews were conducted with representatives from organizations that serve people who have chronic conditions, are from diverse communities, have low incomes, and/or are medically underserved.

## Identifying Top Health Priorities, Together

The Valdez CHNA Advisory Committee guided the CHNA process from inception to completion. The committee was comprised of local community leaders and health-related experts that represent the broad interests and demographics of the community.

The Valdez CHNA Advisory Committee supported the Regional Director of Community Health Investment in establishing questions for a community-wide health survey, identifying relevant state and federal data, and selecting key community stakeholders to participate in interviews regarding community needs and strengths. The committee was also tasked with reviewing and analyzing the resulting information to identify and prioritize the top health-related needs in the community. After reviewing the quantitative and qualitative data, the Valdez CHNA Advisory Committee established the top needs for Valdez using a criteria-based prioritization process. The top three rank-ordered health-related needs identified through the process were the following:

## PRIORITY 1: MENTAL HEALTH/ SUBSTANCE MISUSE

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

## PRIORITY 2: HEALTHY LIFESTYLE (E.G. CHRONIC DISEASE, OVERWEIGHT/OBESITY, PHYSICAL ACTIVITY, ETC.)

Roughly thirty percent of the determinants of an individual's health are due to their behaviors and lifestyle choices, with socioeconomic, environmental, and health care related factors combined making up the remaining seventy percent. Creating an environment that favors the adoption of healthy behaviors related to 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.

## PRIORITY 3: BARRIERS TO APPROPRIATE HEALTHCARE ACCESS (RIGHT CARE, RIGHT TIME, RIGHT PLACE)

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 care and specialty care services, lack of means to pay or being uninsured, and can include cultural, language and even transportation challenges.

## PRIORITY 4: SOCIAL DETERMINANTS OF HEALTH

There is substantial and increasing evidence that social factors, also known as the "social determinants of health," are just as important to an individual's health as genetics or certain health behaviors. Social determinants of health include topics such as education, discrimination, housing, social and community environment, and economic stability.

Providence Valdez Medical Center will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners in early 2021 considering resources, community capacity, and core competencies. The 2021-2023 CHIP will be approved and made publicly available no later than May 15, 2021.

## RESPONDING TO THE COVID-19 PANDEMIC

The 2020 Community Health Needs Assessment process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted survey fielding and community listening sessions. Additionally, the impacts of COVID-19 are likely to effect community health and well-being beyond what is currently captured in secondary and publicly available data. We will seek to engage the community as directly as possible in prioritizing needs and through the community health improvement process.

We recognize that in these unprecedented times, COVID-19 is likely to exacerbate existing community needs and may bring others to the forefront. Our commitment first and foremost is to respond to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. While this is a dynamic situation, we recognize the greatest needs of our communities will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our communities in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

# INTRODUCTION

## Mission, Vision, and Values

*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

## Who We Are

Providence continues its Mission of service in Valdez through Providence Valdez Medical Center (PVMC) and the Providence Valdez Counseling Center (PVCC). PVMC is a critical access hospital that features 11 acute care beds and 10 long-term care beds, located in Valdez, Alaska. Major programs and services offered to the community include the following:

- 24-hour emergency services
- Obstetrical services, anesthesia, labor and delivery, postpartum care
- Laboratory – CLIA-certified
- Imaging services to include ultrasound, CAT scan, and bone densitometry
- Physical, occupational, and speech therapy
- Stress testing
- General medical care
- Endoscopy and minor surgical services
- Sleep disorder studies
- Specialty physician clinics

## Our Commitment to Community

PVMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, Providence Health and Service Alaska provided \$65 million in community benefit<sup>1</sup> in response to unmet needs to improve the health and well-being of those we serve in Alaska. Our region, Providence St. Joseph Health—Alaska (PSJH—Alaska), includes 16 ministries. The majority of facilities are located in the Anchorage area, but there are also services in four other Alaska communities. Additionally, services are expanded to other communities in Alaska via connecting technologies (e.g. telestroke and eICU services). Providence Alaska Medical Center (PAMC), a 401-bed acute care facility, is 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 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.

PHSA has a family practice residency program, a continuum of senior and community services, and a developing medical committee. PSJH—Alaska manages three critical access hospitals located in the remote communities of Kodiak, Seward and Valdez, all co-located with skilled nursing facilities. PSJH—Alaska operates community mental health centers in Kodiak and Valdez. It also partners to provide additional services through five joint ventures including Providence Imaging Center, St. Elias Long Term Acute Care Hospital, Imaging Associates, LifeMed Alaska (a medical transport/air ambulance service), and Creekside Surgery Center.

PVMC further demonstrates organizational commitment to the community health needs assessment (CHNA) through the allocation of staff time, financial resources, participation and collaboration to address community identified needs. The Regional Director of Community Health Investment is responsible for ensuring the compliance Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

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<sup>1</sup> A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

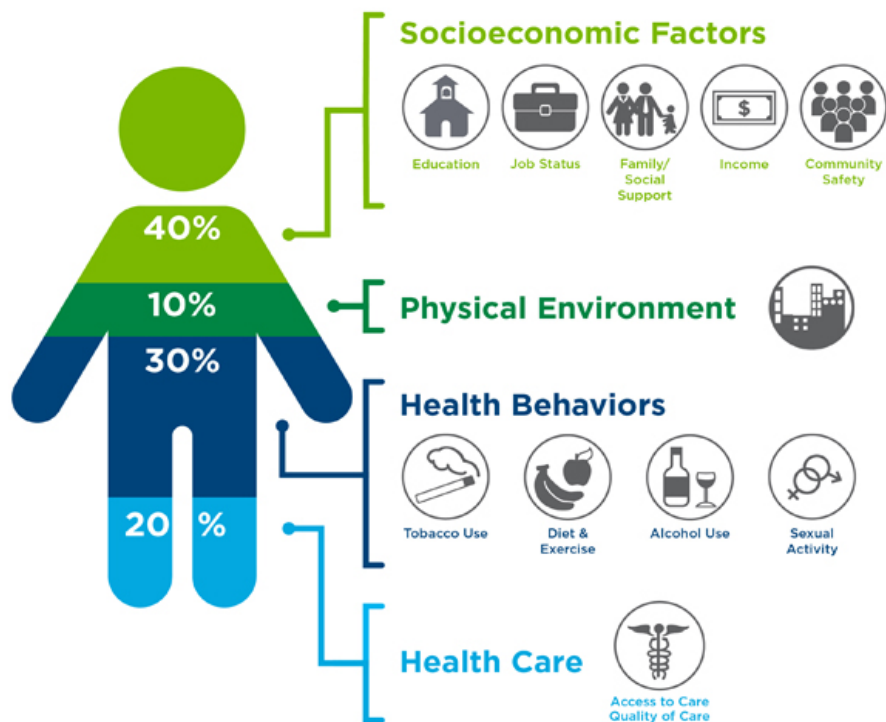


## Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1<sup>2</sup>).

**Figure 1. Factors Contributing to Overall Health and Well-being**

## What Goes Into Your Health?

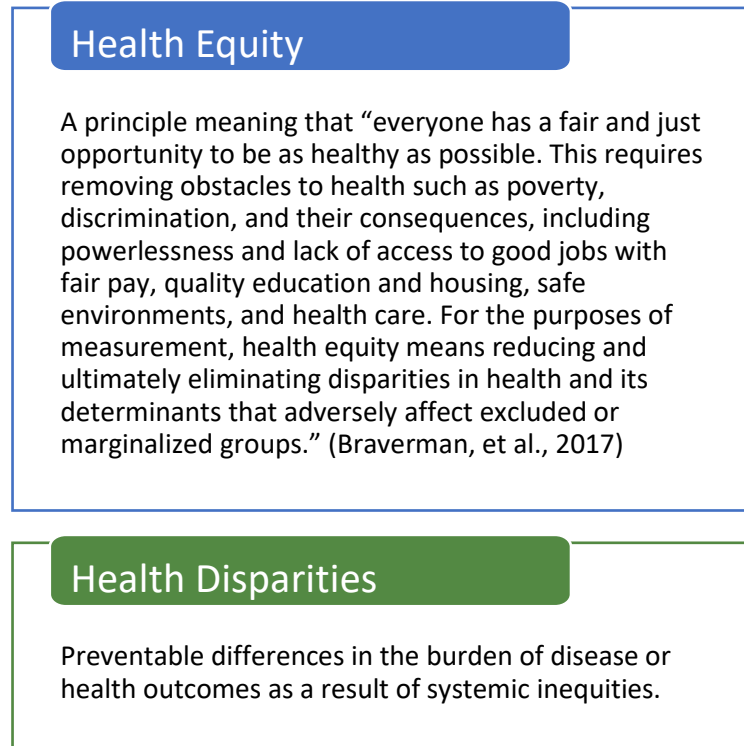


Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The Bridgespan Group

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

**Figure 2. Definitions of Key Terms**



The Community Health Needs Assessment (CHNA) is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms<sup>3</sup>). 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.

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

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



### **Approach**

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language



### **Community Engagement**

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities



### **Quantitative Data**

Report data at the block group level to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

# OUR COMMUNITY

## Description of Community Served

The service area of Providence Valdez Medical Center is defined as the city of Valdez. Valdez is located on Prince William Sound and surrounded by the Chugach Mountains. The city is connected to the interior of Alaska by the Richardson Highway and is roughly 300 miles by road from Anchorage. The area sees significant annual precipitation with an average snowfall of nearly 300 inches per year. Valdez is a fishing port for both commercial and sport fishing. It is also the terminus of the Trans-Alaska Pipeline System where Alaska North Slope oil is loaded onto ships for transport to external markets.

Valdez includes a population of approximately 3,870 people, a decrease of 109 people from the prior assessment.

## Hospital Total Service Area

Being the only acute care hospital in Valdez, the community served by the hospital is defined as the entirety of the city of Valdez.

**Figure 3. Providence Valdez Medical Center Service Area**



## Community Demographics

### POPULATION AND AGE DEMOGRAPHICS

The city of Valdez has approximately 3,870 people, with a slightly higher percentage of males (54%) than females (46%). Almost 64% of the population is between the ages of 18 and 64 years.

**Table 1. Population and Age Demographics in Valdez**

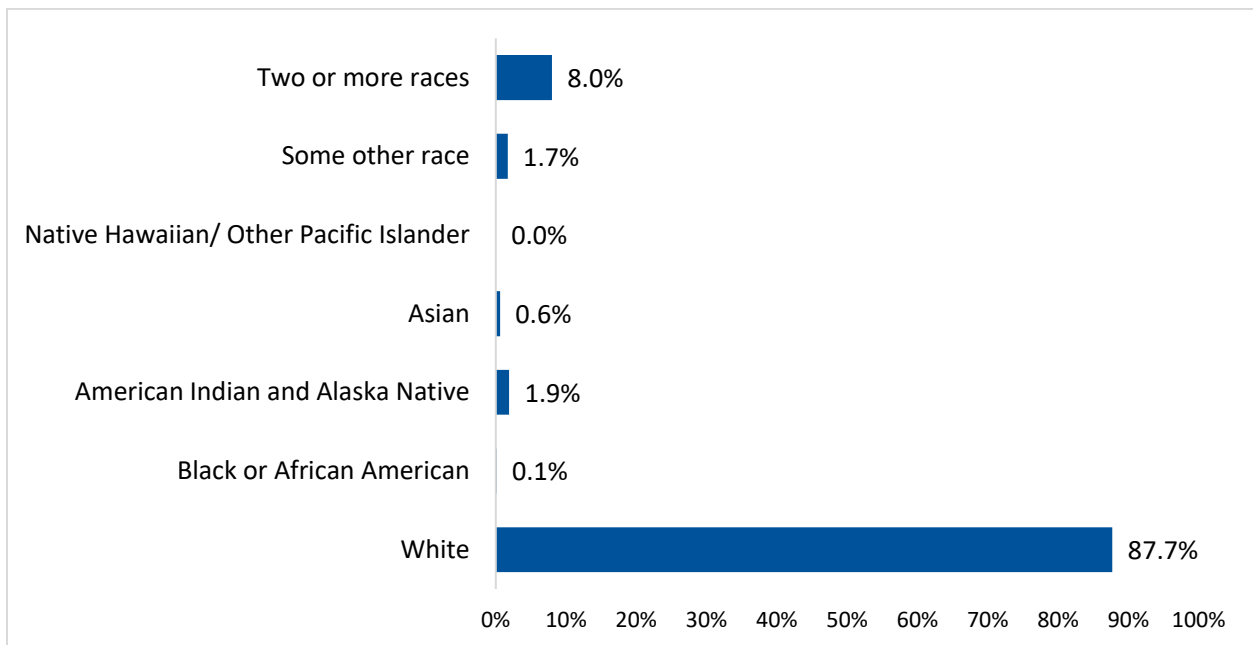
Indicator	Valdez
Total population	3,870
<b>Population by Sex</b>	
Male	53.7%
Female	46.3%
<b>Population by Age Group</b>	
Youth (Under 18 years)	25.2%
Adults (18-64 years)	63.9%
Older Adults (65 years and older)	10.9%

Source: 2018: ACS 5-Year Estimates

### POPULATION BY RACE AND ETHNICITY

The population in Valdez is primarily white (88%), although 8% of the population identify as two or more races. Almost 5% of the population identify as Hispanic or Latino.

**Figure 4. Population by Race in Valdez**



**Table 2. Hispanic Population in Valdez**

Indicator	Valdez
Hispanic or Latino (of any race)	4.7%
Not Hispanic or Latino	95.3%

Source: 2018: ACS 5-Year Estimates

### INCOME AND HOUSING INDICATORS

In comparison to the state of Alaska, Valdez has a higher median household income and per capita income, as well as lower levels of poverty. The median household income in Valdez is \$95,847 and the average household size is 2.83 persons. The median gross rent in Valdez, \$1,125, is roughly equivalent to that of Alaska. Based on the 2020 Valdez Community Health Survey, 2% of residents in Valdez are experiencing homelessness.

**Table 3. Income and Housing Indicators in Valdez**

Indicator	Valdez	Alaska
<b>Income</b>		
Median household income	\$95,847	\$75,463
Per capita income in the past 12 months (in 2018 inflation-adjusted dollars)	\$47,054	\$35,874
% children under age 18 living in poverty	12.6%	15.2%
% of residents of all ages living in poverty	9.0%	10.8%
<b>Housing</b>		
Average household size	2.83	2.81
Median gross rent	\$1,125	\$1,231
% of owner-occupied homes	79.3%	64.0%
Individuals experiencing homelessness (living unsheltered or in a temporary situation)	2%	Comparable statewide data not available

Source: 2020 Valdez Community Health Survey

Source: 2018: ACS 5-Year Estimates

### HEALTH PROFESSIONAL SHORTAGE AREA

All of Valdez is designated a mental health HPSA. There are no dental health HPSAs in the Valdez-Cordova County, although north of the city of Valdez there is a primary care HPSA.

# OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data is reported at the ZIP code or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. A glossary of terms from the CHNA can be found in [Appendix 1](#).

## 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. The most recent available data from state and federal secondary sources are more than two years old.

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

Written comments were solicited on the 2017 CHNA and 2018-2020 CHIP reports, which were made widely available to the public via posting on the internet in December 2017 (CHNA) and May 2018 (CHIP), as well as through various channels with our community-based organization partners.

To date, no public comments have been received.

# HEALTH INDICATORS

## Hospital Utilization Data

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

The Prevention Quality Indicators (PQIs) are similar, although they are based on inpatient admissions. Both PQIs and AED serve as proxies for inadequate access to, or engagement in, primary care. As possible, we look at the data for total utilization, frequency of diagnoses, demographics, and payor to identify disparities.

**Table 4. Avoidable Emergency Department Visits for PSJH Alaska Hospitals**

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Providence Seward Medical Center	1,116	496	1,612	30.8%
Providence Valdez Medical Center	708	317	1,042	30.4%
Providence Kodiak Island Medical Center	1,954	755	2,713	27.8%
Providence Alaska Medical Center	31,329	15,965	47,294	33.8%
Providence Alaska Region	35,107	17,533	52,661	33.3%

Across PSJH's Alaska service area, Providence Valdez Medical Center had a below average percentage of potentially avoidable ED utilization in 2019.

Providence Valdez Medical Center had the second highest average rate of PQIs, after Providence Seward Medical Center, compared to other PSJH hospitals in Alaska (95.89 per 1,000 compared to an average of 65.32). Each of the PQI composite scores (90, 91, and 92) for Providence Valdez Medical Center were above average.

The most common PQIs for Providence Valdez Medical Center are the following:

1. COPD or asthma in older adults: 47.06 per 1,000 visits
2. Urinary Tract Infection: 27.40 per 1,000 visits
3. Diabetes short-term complications: 20.55 per 1,000 visits



**Table 5. Prevention Quality Composite Rates for Providence Valdez Medical Center**

Indicator	Label	Numerator	Denominator	Observed Rate Per 1,000 Visits
PQI 90	<b>Prevention Quality Overall Composite, per 1,000 visits</b>			
	Providence Valdez Medical Center	14	146	95.89
PQI 91	<b>Prevention Quality Acute Composite, per 1,000 visits</b>			
	Providence Valdez Medical Center	6	146	41.10
PQI 92	<b>Prevention Quality Chronic Composite, per 1,000 visits</b>			
	Providence Valdez Medical Center	9	146	61.64

See [Appendix 2: Quantitative Data](#) for more information on AED and PQI data.

# COMMUNITY INPUT

## Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence Valdez Medical Center conducted stakeholder interviews with 14 representatives from 11 community-based organizations in July and August 2020. During these interviews, nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in Appendix 3.

The following findings summarize the significant community needs, based on feedback from stakeholders:

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### **Access to health care (primary care and specialty care)**

Valdez boasts a robust family medicine workforce allowing community access for most acute care needs, illnesses, and chronic care management. However, stakeholders were concerned about access to health care for those who do not qualify for Medicaid and are not affiliated with employer-based plans.

Stakeholders noted the most significant gap is specialty care, which necessitates traveling outside of the community for hundreds of miles. Specialty care is further complicated by limited transportation options, and due to distance, patients traveling for care must pay for food and lodging, in addition to transportation costs and health care bills.

Medical stakeholders noted inclement weather necessitates more robust services than emergency care, including stabilization and transfer of patients. Valdez has a local medical culture dedicated to readiness and skills training. These essential services take continuous effort to balance and maintain. Stakeholders exalted the city council's medical debt program but stressed the Valdez model can be tenuous without continuous effort and dedication.

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### **Housing**

Affordable housing was consistently prioritized as a top issue in the community. Current housing stock often consists of older, low-quality mobile homes. Housing may be more affordable outside of town, but distance necessitates reliable transportation. Stakeholders also noted that housing poses a challenge for seniors wanting to age in place. Without assisted living facilities, many seniors must leave the community due to a lack of appropriate living situations.

Current conversations around land-use and rezoning are promising long-term solutions. Stakeholders emphasize there is an immediate need for innovative, outside-of-the-box solutions for lower-cost, quality housing alternatives. Stakeholders shared the lack of quality housing has thwarted recruitment of professionals to the area and often necessitates creative workarounds until appropriate housing becomes available. Stakeholders stressed more affordable housing options will also provide an opportunity to encourage the 20-30-year-old population to stay in the area.

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**Economic insecurity**

Stakeholders shared that many community members are not paid sufficient income to meet their basic needs and there are significant income disparities. Stakeholders noted that Valdez residents pay 25%-30% higher prices for food and utilities due to shipping and air service costs. Economic insecurity is further compounded by the lack of affordable housing, with the average home renting for \$1,300 to \$1,800 per month.

Stakeholders described a large community of seasonal workers, who are often low-income, vulnerable, have low educational attainment and participate in high-risk vocations. There is a division in the community, where stakeholders noted people are either resource rich and well-integrated into the community or people have few resources, little education and limited means to change their stature.

Stakeholders noted the community is in need of economic diversification and more robust, reliable transportation options for long-term viability. Oil, fishing, and tourism drive the economic stability of Valdez, and all have been impacted by COVID-19.

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**Transportation**

Stakeholders unilaterally described transportation as unpredictable, limited and expensive. Inclement weather complicates transportation and residents who do not have vehicles, licenses to drive, or a support network may experience additional barriers.

Numerous stakeholders noted the strength of community, where fellow neighbors and volunteers endeavor to help. Yet, essential trips to the grocery store, food bank, post office and pharmacy can be cumbersome, particularly for low-income residents and seniors.

COVID-19 led to the elimination of the only regional airlines. Presently, the road system is the only transportation available to residents.

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**Childcare/ daycare/ preschool**

Childcare services were consistently prioritized by a majority of stakeholders as a top issue in the community. Valdez has a well-funded K-12 school district and a small college, but the local childcare center has struggled to stay economically viable. Stakeholders described Valdez as a community where both parents need to work; affording childcare on a minimum wage job as a single parent isn't sustainable.

Economically feasible solutions to childcare have proven elusive, as families cannot afford to pay enough to enable childcare professionals a sustainable living. A lack of childcare has become an impediment to recruiting and maintaining professionals in the community.

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**Behavioral health (mental health and substance use)**

Stakeholders stressed the unique geography and extreme winters in Valdez cause isolation and residents may feel alone and disconnected. Residents without a support system struggle in Valdez and stakeholders shared it is difficult to engage people who are disconnected.

As a small town, there is a perception that nothing is confidential. This poses a barrier to seeking out mental health care services. Stakeholders are concerned about the lack of substance use inpatient treatment services in the community. Recovery patients, who often rely on a support culture, are struggling with isolation, which may cause relapses.

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Stakeholders discussed the **effects of the COVID-19 pandemic** on the communities they serve:

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<b>Effects of COVID-19</b>	Stakeholders noted people are delaying care due to COVID-19 and not everyone is able to engage successfully using telehealth. Stakeholders worry COVID-19 has made people less socially connected and there is more divisiveness within the community. Stakeholders noted exacerbated unhealthy behaviors and mental health challenges, with increased anxiety.
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See [Appendix 3: Stakeholder Interviews](#)

## COMMUNITY SURVEY

Due to the limited data available for Valdez through state and federal sources, Providence fielded an online survey from July 17 through August 23, 2020. A total of 541 responses were received, including 5 hand-administered surveys. Providence placed door hangers at all reasonably accessible households (about 1,550) in Valdez and the survey was well promoted through community, local government, and business channels. Every effort was made to ensure the survey responses represented the diversity of the community and captured input from those with low incomes and otherwise underserved in the community.

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

See [Appendix 6: CHNA Community Health Survey for full methodology and findings from the survey](#)

## Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented Providence Valdez Medical Center from completing any in-person conversations. In prior Community Health Needs Assessment years, the hospital conducted public in-person community forums in accessible public spaces. Our initial planning for this assessment included the intent for a public forum but given the need to avoid in-person interaction due to COVID-19, we shifted our community input strategy to focus on online stakeholder interviews and anonymous online surveys. In previous years we have fielded paper surveys in community settings, which was not possible this year. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews.

# SIGNIFICANT HEALTH NEEDS

## Prioritization Process and Criteria

The Valdez CHNA Advisory Committee reviewed and analyzed the resulting information from the CHNA to identify and prioritize the top health-related needs in their community based on the criteria of size/scope, severity, and ability to impact. The committee also considered the extent to which the need has been exacerbated by the COVID-19 pandemic. After reviewing and analyzing the CHNA quantitative and qualitative data, the Valdez CHNA Advisory Committee established the top needs for Valdez using the following criteria-based prioritization process.

**The CHNA Advisory committee reviews the data**—The Valdez CHNA Advisory Committee reviews and analyzes the aggregated quantitative and qualitative data. They then complete an online prioritization survey. The prioritization survey tool has two elements:

- **Criteria-based ranking** – The CHNA Advisory Committee members are asked to complete a survey to rank each issue (area of need) based on the following criteria prior to the in-person health needs prioritization meeting:
  - **SIZE/SCOPE:** How significant is the scope of the health issue - number of people affected?
  - **SERIOUSNESS:** How severe 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? Respondents consider assets such as community resources, whether there are known interventions, and community commitment or readiness.
  - **COVID-19:** What is the extent to which the need has been exacerbated by the COVID-19 pandemic?
- **Qualitative input: Advisory Committee Member Perspective** – As a check step, the CHNA Advisory Committee members are each asked what they personally view as the top health needs for their community.

**The CHNA Advisory Committee identifies top health needs** –The results of the online criteria-based ranking and the qualitative community experience ranking are presented to the CHNA Advisory Committee during an in-person meeting as a starting point for identifying the CHNA priorities.

- The top three to four health needs identified in the CHNA Advisory Committee survey are reviewed, confirmed and/or modified based on the discussion and local knowledge of the Advisory Committee members.
- Members are then asked to give specific reasons why they selected each of the top three to four needs. This step helps fully capture the unique aspects of the “high-level” issues (areas of need) for their community.

- The top three or four needs and detailed input of the CHNA Advisory Committee members are then documented and summarized to drive subsequent community health improvement planning

## 2020 Priority Needs

The list below summarizes the rank ordered significant health needs identified through the 2020 Community Health Needs Assessment process:

### PRIORITY 1: MENTAL HEALTH/ SUBSTANCE MISUSE

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

### PRIORITY 2: HEALTHY LIFESTYLE (E.G. CHRONIC DISEASE, OVERWEIGHT/OBESITY, PHYSICAL ACTIVITY, ETC.)

Roughly thirty percent of the determinants of an individual's health are due to their behaviors and lifestyle choices, with socioeconomic, environmental, and health care related factors combined making up the remaining seventy percent. Creating an environment that favors the adoption of healthy behaviors related to 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.

### PRIORITY 3: BARRIERS TO APPROPRIATE HEALTHCARE ACCESS (RIGHT CARE, RIGHT TIME, RIGHT PLACE)

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 care and specialty care services, lack of means to pay or being uninsured, and can include cultural, language and even transportation challenges.

### PRIORITY 4: SOCIAL DETERMINANTS OF HEALTH

There is substantial and increasing evidence that social factors, also known as the "social determinants of health," are just as important to an individual's health as genetics or certain health behaviors. Social determinants of health include topics such as education, discrimination, housing, social and community environment, and economic stability.

## 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 health care delivery systems include the Department of Public Health and two primary care practices. 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 4.

**See [Appendix 4](#): Resources potentially available to address the significant health needs identified through the CHNA**

# EVALUATION OF 2018-2020 CHIP IMPACT

This report evaluates the impact of the 2018-2020 Community Health Improvement Plan (CHIP). PVMC 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.

## LOCAL HEALTHCARE PROVIDER WORKFORCE

**Table 6. Outcomes from 2018-2020 CHIP: Local Healthcare Provider Workforce**

Focus Area	Program or Service Name	Results / Outcomes
Sufficient provider capacity to ensure access to needed care	PVMC will engage the community through its Health Advisory Council to <b>explore existing facility space constraints</b> as it relates to primary care and other outpatient services	Beginning in the first quarter of 2019, PVMC facilitated and supported the creation of the “Healthcare Campus Expansion Task Force.” The Task Force recommended several expansion foci that included expanding existing primary care and outpatient service space. The City of Valdez is currently finalizing a Request for Proposal (RFP) for the planning and designing of the Task Force’s recommendations. It is anticipated that the RFP will go before the City of Valdez City Counsel in early 2021, and planning & design work will follow shortly thereafter.
Sufficient provider capacity to ensure access to needed care	Providence will <b>implement a “well-being” plan</b> to address the mental health needs of mental health providers to reduce burnout and turnover	Providence Valdez continues to work on a well-being plan that has become increasingly more important considering pandemic response related burnout. To date, the organization has invested in creating wellness spaces that previously did not exist for caregivers to decompress while at work.
Sufficient provider capacity to ensure access to needed care	PVMC will partner with the Valdez Medical Clinic (VMC) to <b>establish sufficient health care provider staffing levels</b> to serve the needs of the community – <i>currently understood to be approximately five (5) full time equivalents.</i>	With residents included, Valdez was able to maintain +5 FTEs of provider coverage from December 2018 to August 2020.



Focus Area	Program or Service Name	Results / Outcomes
Sufficient provider capacity to ensure access to needed care	<b>Medical Provider Loan Repayment</b> (Sharp III)- PVMC will join with other similarly impacted rural health care facilities and practices that struggle to attract and retain necessary healthcare workforce to lobby the State of Alaska for relief around the high cost of entry into medical and other healthcare professions. Providence will seek community partners (including from the city and state) to develop a community-based loan repayment program that makes Valdez more competitive and attractive when recruiting medical providers, especially primary care physicians.	Despite the hurdles of needing to pass new legislation, PVMC and the Providence Valdez Health Advisory Council were instrumental in their support of the state of Alaska’s SHARP III program. SHARP III passed with bipartisan support and was signed into law on August 1, 2019. After the necessary public comment and rule making process SHARP III is on track to begin soliciting applications in January of 2021. The Providence Valdez Health Advisory Council dedicated a gift of \$50,000 to seed the new program for when it became operational.

**MENTAL HEALTH AND SUBSTANCE MISUSE**

**Table 7. Outcomes from 2018-2020 CHIP: Mental Health and Substance Use**

Focus Area	Program or Service Name	Results / Outcomes
Access to needed mental health and substance use disorder services	<b>Telehealth</b> – Providence intends to increase remote and out-of-clinic access to care through piloting two telehealth initiatives. One of these pilots – remote delivery of substance abuse and behavioral health counseling – is occurring in Valdez. The second - remote delivery of emergency de-escalation psychiatric consults – could be offered in Valdez if it is successful in the primary pilot location.	Telehealth was explored incrementally and added to the service line at Providence. The first conception was providing access to clinical services (SUD and MH) from Anchorage to clients presenting at PVCC. Psychiatric consults were expanded to the Emergency Department. Telehealth expansion was increased to encompass all clinical services delivered by the counseling center due to the COVID-19 pandemic.
Access to needed mental health and	PVMC will engage the community through its Health	Offices were de-identified as counselor workspace and designated as client-care

Focus Area	Program or Service Name	Results / Outcomes
substance use disorder services	Advisory Council to explore existing real estate <b>space constraints</b> as it relates to <b>Counseling Center services</b> and determine the way forward for identified upgrade and expansion needs.	space. This allowed for more utilization of limited space for client care. Under-utilized workspace was redesigned to provide additional workspace for counselors when not providing client care.
Access to needed mental health and substance use disorder services	Providence will continue to collaborate with <b>Valdez School Counseling Program</b> to better address <b>mental health needs of children</b> in the Valdez community.	Providence Valdez Counseling Center, the Valdez School Counseling staff, and the Special Education Program developed a Memorandum of Agreement. This partnership outlined a mental health crisis response and the provision of mental health counseling to students in need.
Community mental health and substance use disorder awareness, education and collaboration	PVCC will Partner with Copper River Basin Child Advocacy Center, Valdez City Schools, Prince William Sound College and Advocates for Victims of Violence to <b>reduce domestic violence and abuse</b> among <b>adults and children</b> through community education and outreach.	The partnership between the organizations includes participation on the Prevention Coalition, the CBRCAC multidisciplinary team, and the Disability Abuse Response Team. These partnerships have supported prevention activities and initiatives in the community, including free parenting courses and wellness book clubs at the high school.
Community mental health and substance use disorder awareness, education and collaboration	PVCC will partner with local agencies and state officials to <b>reduce substance use disorders</b> (especially opioid use disorder) among all community members through health professional training, community education and outreach.	PVCC provided education to medical professionals about evidence-based treatment for opioid use disorder and partnered with Public Health to provide substance use disorder education to the community. PVCC applied for and received a grant to make biofeedback more available, a treatment modality that may be used to help address opioid use disorder.

**ACCESS TO SPECIALTY CARE**

**Table 8. Outcomes from 2018-2020 CHIP: Access to Specialty Care**

Focus Area	Program or Service Name	Results / Outcomes
Access to specialty care services	PVMC will <b>leverage nurse specialties</b> and <b>expand scope of practice</b> when possible (i.e.	Beginning in 2018 PVMC made concerted efforts to obtain local expertise in RN led wound care. By sponsoring training, PVMC

Focus Area	Program or Service Name	Results / Outcomes
	wound care, lactation, chemotherapy, etc.) to help address the need for specialty care in the Valdez community.	has managed to increase access to this increasingly needed service. At this time in 2020 PVMC now has four (4) certified wound care nurse specialists on staff. Delayed by COVID-19, but finally coming to fruition in late 2020/early 2021 is PVMC's prenatal and lactation counseling resources.
Access to specialty care services	PVMC will continue to seek out, solidify and maintain enduring <b>relationships with specialty providers</b> who are willing to provide care on-site in Valdez.	Prior to COVID-19, PVMC was making great strides in expanding the number of specialists coming to Valdez, including the first outpatient surgical procedure by a visiting specialist. This work will continue once travel restrictions are lifted.
Access to specialty care services	Providence will continue to explore emerging <b>telemedicine</b> technologies as a means to further expand access to specialty services in Valdez.	PVMC has transformed the ED experience with the addition of tele-psychiatry. New also has been the development of telemedicine resources for mother and baby. The on-set of the COVID-19 pandemic brought advancement in primary care telemedicine availability at the local level.

HEALTHY LIFESTYLE/CHRONIC DISEASE

Table 9. Outcomes from 2018-2020 CHIP: Healthy Lifestyle/ Chronic Disease

Focus Area	Program or Service Name	Results / Outcomes
Healthy lifestyle opportunities; chronic disease prevention, treatment, and management; social connections/ supportive social networks	Direct local and Providence Alaska region efforts in relation to the <b>HRSA Population Care Coordination pilot project</b> . The Population Care Coordination Process provides a framework for provider collaboration and <b>more effective multilevel care</b> based on population- and patient-centered principles.	Beginning in 2017 PVMC focused a multi-agency effort on reducing ER admissions of fish processing workers. This work has culminated in tremendous advancements of not only improving ED utilization, but other public health, employee safety, education, and mental well-being for this population. Beginning in 2019 and stemming from a critical shortage of day care access in the community of Valdez, the population health group began to turn its attention to early childhood development and family support.
Healthy lifestyle opportunities; chronic disease	Expand and improve <b>PVMC caregiver wellness culture and practices</b> through wellness	PVMC continued to support and resource the efforts of its internal Wellness Committee. Focused on diet, activity, substance use,

Focus Area	Program or Service Name	Results / Outcomes
prevention, treatment, and management; social connections/ supportive social networks	committee sponsored activities that extend to outside organizations and exemplify transformative employee wellness models.	stress, and sleep hygiene this group succeeded in rolling out facility-wide programs to promote overall wellness at work. In 2020, PVMC developed nearly two dozen programs focused on addressing provider burnout at PVMC.
Healthy lifestyle opportunities; chronic disease prevention, treatment, and management; social connections/ supportive social networks	Providence will <b>partner with Prince William Sound College</b> to enhance the “ <b>Healthier Valdez</b> ” initiative that supports education and programming centered on nutrition, health, and wellness.	Although PWSC did manage the “Healthier Valdez” program with the support of PVMC, beginning in 2020 and largely due to the pandemic, a community-wide reboot of this event occurred and was managed by the Sound Wellness Alliance Network. PVMC continues to partner with both SWAN and PWSC on community wide wellness initiatives made ever more important in the current pandemic period.
Healthy lifestyle opportunities; chronic disease prevention, treatment, and management; social connections/ supportive social networks	Providence will <b>partner with Sound Wellness Alliance Network (SWAN)</b> to assist in its population health approach to <b>community wellness</b> .	SWAN will continue to partner with community sectors including the Providence Valdez Medical Center to create and promote programing and wellness opportunities in hopes of strengthening our community’s overall well-being and lessening the burden of the pandemic.  In 2019 SWAN sponsored several wellness activities, including Healthier Valdez, Ski for Free, and a virtual Week of Wellness (230+ attendees).

### Addressing Identified Needs

The Community Health Improvement Plan developed for the Valdez 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 PVMC 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 PVMC 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 PVMC and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2021.

## 2020 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted on November 17, 2020 by the Providence Alaska Region Board<sup>4</sup> of the hospital. The final report was made widely available<sup>5</sup> by December 28, 2020.



12/3/2020

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

Date

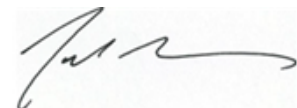


12-1-20

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Pam Shirrell, RN  
Chair, Providence Alaska Region Board  
Providence Health and Services Alaska

Date



12/16/2020

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Joel Gilbertson  
Executive Vice President, Community Partnerships  
Providence St. Joseph Health

Date

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

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<sup>4</sup> See [Appendix 5: Process Governance and Oversight](#)

Sector: Hospital, Community-based Organization, Education, Affordable Housing

<sup>5</sup> Per § 1.501(r)-3 IRS Requirements, posted on hospital website

# APPENDICES

## Appendix 1: Definition of Terms

**Access to health care services:** The timely use of personal health services to achieve the best health outcomes (excluding oral health and behavioral health care services, which are included in other categories). Health care services include primary care providers, pediatricians, OB/GYN, and specialists. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

**Access to oral health care services:** The timely use of oral health care services to achieve the best health outcomes related to dental care, tooth loss, oral cancer, and gum disease. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system. Access to safe, nearby transportation

**Accessibility for people with disabilities:** The ease with which a person with a disability can utilize or navigate a product, device, service, or environment.

**Affordable daycare and preschools:** All families, regardless of income, can find high-quality, reasonably priced, convenient childcare options for their children birth to five. This includes free or reduced cost daycare and preschools for families that meet certain income requirements.

**Aging problems:** The challenges faced by adults as they age, specifically those over the age of 65, who may experience memory, hearing, vision, and mobility challenges. Adults over the age of 65 make up a larger percentage of the U.S. population than ever before and require specific supportive services related to health care, housing, mobility, etc.

**Air quality:** The degree to which the air is pollution and smoke-free.

**Avoidable Emergency Department Utilization (AED):** Based on algorithms by Medi-Cal and NYU, PSJH Healthcare Intelligence developed an “AED” flag. This is a list of conditions by diagnostic code that should not require Emergency Department care and are better treated at a more appropriate level of care. Reported at the hospital level and by payor group.

**Behavioral health challenges and access to care:** Includes challenges related to both mental health and substance use disorders, as well as difficulties getting the support services and care to address related challenges. Covers all areas of emotional and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

**Bullying and verbal abuse:** Put downs and personal attacks that cause a person emotional harm. Examples include name calling, shaming, jokes at the expense of someone else, excessive criticism,

yelling and swearing, and threats. Specifically referring to instances taking place outside of the home, in places in the community such as school and the workplace.

**Child abuse and neglect:** “Injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child by any person under circumstances which indicate that the child’s health, welfare, and safety is harmed.”<sup>6</sup>

**Discrimination:** Treating a person unfairly because of who they are or because they possess certain characteristics or identities. Examples of characteristics or identities that are discriminated against include the following: age, gender, race, sexual orientation, disability, religion, pregnancy and maternity, gender reassignment, and marriage and civil partnership.<sup>7</sup>

**Domestic violence:** Also called intimate partner violence, “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain control over another intimate partner.”<sup>8</sup>

**Economic Insecurity:** Lacking stable income or other resources to support a standard of living now and in the foreseeable future.

**Few arts and cultural events:** A lack of representation of different cultures and groups in the community demonstrated through music, dance, painting, crafts, etc.

**Firearm-related injuries:** Gun-related deaths and injuries.

**Food insecurity:** A lack of consistent access to enough good-quality, healthy food for an active, healthy life.

**Gang activity/ violence:** Encompasses the incidence of crime and violence in the community as well as the fear of it, which prevents people from using open space or enjoying their community.

**Health Equity:** A principle meaning that “everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.”<sup>9</sup>

**HIV/AIDS:** Acquired immunodeficiency syndrome (AIDS), a chronic potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Refers to challenges addressing the spread of HIV in the community and challenges providing treatment, support, and health education related to HIV and AIDS.

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<sup>6</sup> <https://www.dcyf.wa.gov/safety/what-is-abuse>

<sup>7</sup> <https://www.eoc.org.uk/what-is-discrimination/>

<sup>8</sup> <https://www.thehotline.org/is-this-abuse/abuse-defined/>

<sup>9</sup> Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

**Homelessness/ lack of safe, affordable housing:** Affordability, availability, overcrowding, and quality of housing available in the community. Includes the state of having no shelter or inadequate shelter.

**Job skills training:** Occupational training with an emphasis on developing the necessary skills to support and guide individuals in finding jobs that meet their interests and pay a livable wage.

**Lack of community involvement:** Individuals in a defined geographic area do not actively engage in the identification of their needs, nor do they participate in addressing those needs.

**Obesity:** Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

**Poor quality of schools:** Schools that do not provide a quality education to all students regardless of race, ethnicity, gender, socioeconomic status, or geographic location. A quality education is defined as one that “provides the outcomes needed for individuals, communities, and societies to prosper. It allows schools to align and integrate fully with their communities and access a range of services across sectors designed to support the educational development of their students.”<sup>10</sup>

**Racism:** “Prejudice against someone based on race, when those prejudices are reinforced by systems of power.”<sup>11</sup>

**Safe and accessible parks/recreation:** Issues around a shortage of parks or green spaces, or existing parks/green spaces being poorly maintained, inaccessible, or unsafe.

**Safe streets for all users:** People walking, biking, driving, and using public transportation can generally trust that they are safe on the road. Includes safety features such as crosswalks, bike lanes, lighting, and speed limits.

**Social Determinants of Health:** Conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Unemployment/ lack of living wage jobs:** Not having employment or lacking a job that pays the minimum income necessary for a worker to meet their basic needs.

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<sup>10</sup> <http://www.ascd.org/ASCD/pdf/siteASCD/policy/ASCD-EI-Quality-Education-Statement.pdf>

<sup>11</sup> Oluo, Ijeoma. *So You Want to Talk About Race*.



## Appendix 2: Quantitative Data

### HOSPITAL LEVEL DATA

#### *Avoidable Emergency Department (AED) Visits*

Emergency Department discharges for the year 2019 were coded as “avoidable” per the Providence St. Joseph Health definition for Providence Valdez Medical Center and nearby PSJH hospitals. Avoidable Emergency Department (AED) visits are based on the primary diagnosis for a discharge and include diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

***Apx 2\_ Table 1. Top 20 ICD Diagnosis Categories for Avoidable Emergency Department Visits at Providence Valdez Medical Center***

<b>Top 20 Principal ICD Diagnosis Sub Categorization for AED Visits</b>	<b>Avoidable Visits</b>	<b>Percent of Total Avoidable Visits</b>
Providence Valdez Medical Center	317	
Acute upper respiratory infections	38	12.0%
Chronic lower respiratory diseases	32	10.1%
Other joint disorders	31	9.8%
Other dorsopathies	23	7.3%
Mental and behavioral disorders due to psychoactive substance use	17	5.4%
Other diseases of the urinary system	15	4.7%
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	14	4.4%
General symptoms and signs	14	4.4%
Infections of the skin and subcutaneous tissue	13	4.1%
Diseases of middle ear and mastoid	12	3.8%
Influenza and pneumonia	9	2.8%
Renal tubulo-interstitial diseases	8	2.5%
Other diseases of intestines	7	2.2%
Diabetes mellitus	6	1.9%
Diseases of oral cavity and salivary glands	6	1.9%
Diseases of esophagus, stomach and duodenum	5	1.6%
Diseases of male genital organs	5	2.0%
Hypertensive diseases	5	2.0%
Symptoms and signs involving cognition, perception, emotional state and behavior	5	2.0%
Disorders of conjunctiva	4	1.3%
Mycoses	4	1.0%

### Prevention Quality Indicators

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

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

[https://www.qualityindicators.ahrq.gov/modules/pqi\\_overview.aspx](https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx)

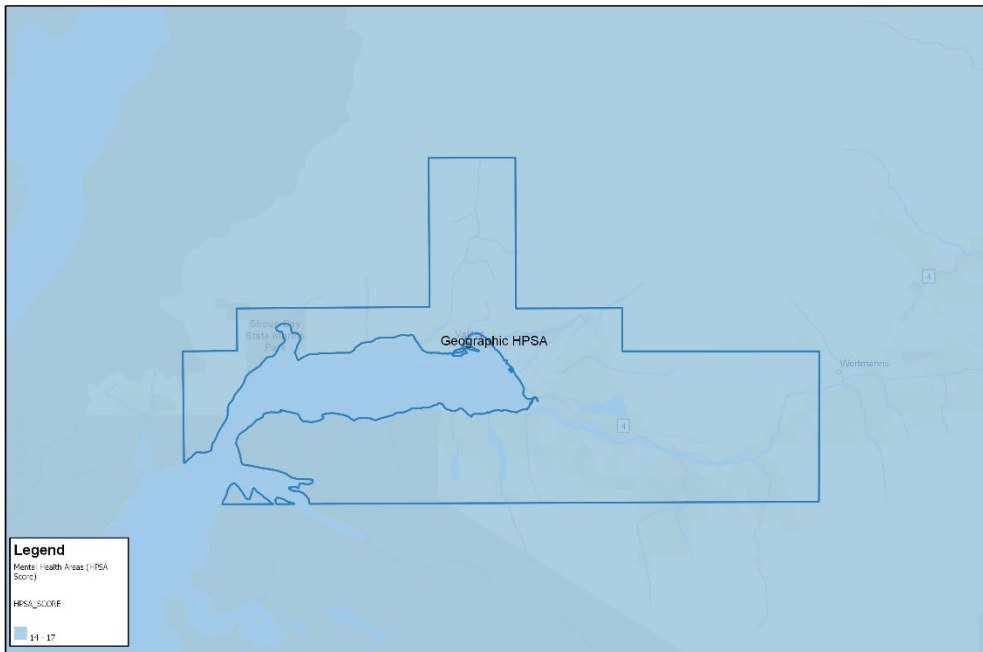
[https://www.qualityindicators.ahrq.gov/modules/pqi\\_resources.aspx](https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx)

PQIs were calculated using inpatient admission data for the year 2019.

### 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). All of Valdez is designated a mental health HPSA. There are no dental health HPSAs in the Valdez-Cordova County, although north of the city of Valdez there is a primary care HPSA.

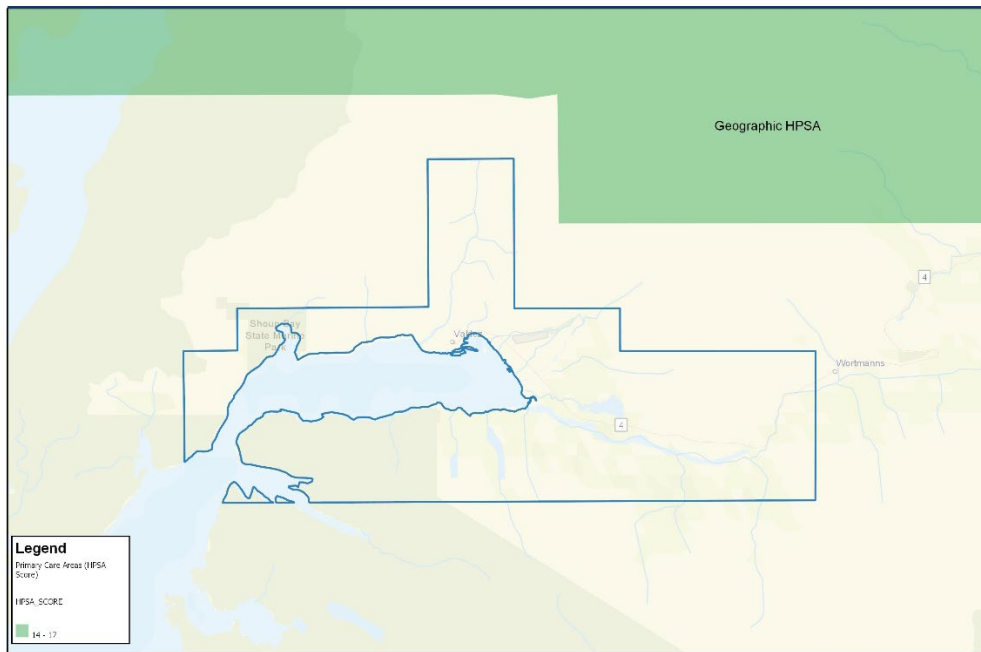
**Apx 2\_Figure 1. Mental Health HPSA in Valdez**



data.HRSA.gov

Prepared by:  
Division of Data and Information Services  
Office of Information Technology  
Health Resources and Services Administration  
Created on: 1/21/2020

**Apx 2\_Figure 2. Primary Care HPSA in Valdez**



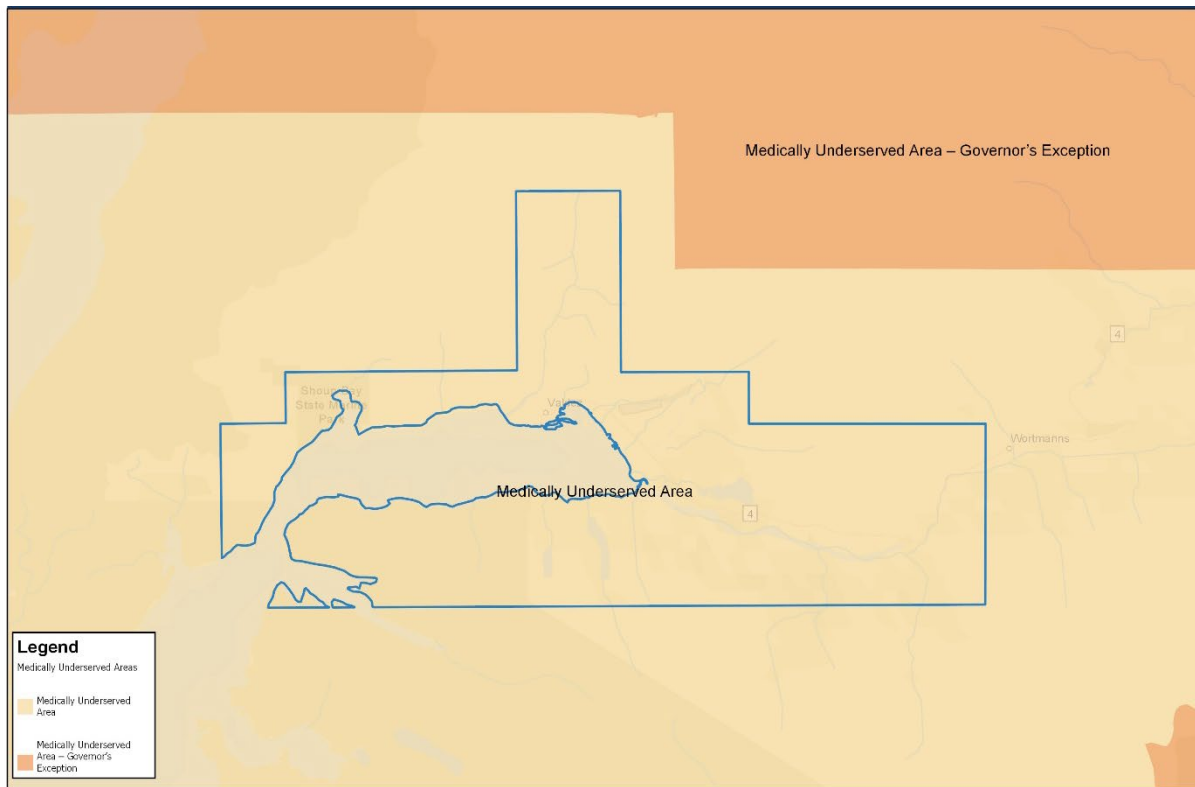
data.HRSA.gov

Prepared by:  
Division of Data and Information Services  
Office of Information Technology  
Health Resources and Services Administration  
Created on: 12/1/2020

## 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. Valdez is designated an MUA, but not an MUP.

**Apx 2\_Figure 3. Medically Underserved Area in Valdez**



[data.HRSA.gov](http://data.HRSA.gov)

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Division of Data and Information Services  
Office of Information Technology  
Health Resources and Services Administration  
Created on: 12/1/2020

## Appendix 3: Stakeholder Interviews

### INTRODUCTION

Providence Valdez Medical Center conducted stakeholder interviews, recognizing the importance of including the voices of community leaders who help make Valdez healthier. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder interviews are particularly important this CHNA cycle as the COVID-19 pandemic has prevented us from facilitating community forums. We relied on community stakeholders to represent the broad needs of the communities they serve.

Providence Valdez Medical Center included the insight of 14 stakeholders, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. The goal of the interviews was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

### METHODOLOGY

#### *Selection*

The community stakeholders were identified by Providence Valdez Medical Center. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Interviewees included local health or other departments or agencies that have current data or other information relevant to the health needs of the community. Input was obtained from the Alaska Department of Health and Social Services Division of Public Health.

***Apx 3\_ Table 1. Community Stakeholder Interview Participants***

<b>Name</b>	<b>Title</b>	<b>Organization</b>	<b>Sector</b>
Angela Alfaro	Physician, Family Medicine	<b>Valdez Medical Clinic</b>	Health care
Anna Bateman	Tribal Administrator	<b>Valdez Native Tribe</b>	Tribal services
Dan O'Connor	Director	<b>Prince William Sound College</b>	Education
Debbie Plant	Executive Director	<b>Valdez Senior Center</b>	Aging services
Jeremy O'Neil	Administrator	<b>Providence Valdez Medical Center</b>	Health care
John Cullen	Physician, Family Medicine	<b>Valdez Medical Clinic</b>	Health care
Kaitlin Pabo-Eulberg	Mission Integration Manager/Chaplain	<b>Providence Valdez Medical Center</b>	Health care, spiritual services

Kathleen Todd	Physician, Family Medicine	<b>Valdez Medical Clinic</b>	Health care
Mark Detter	City Manager	<b>City of Valdez</b>	Government
Matthew Wadsworth	Director	<b>Providence Valdez Counseling Center</b>	Mental health and substance use
Rhonda Wegner Taylor	Executive Director	<b>Sound Wellness Alliance Network</b>	Public health, mental health
Rowena Palomar	Executive Director	<b>Advocates for Victims of Violence</b>	Domestic violence
Shawn Arnold	Superintendent	<b>Valdez City Schools</b>	Education
Terri Lynch	Valdez Public Health Nurse	<b>Alaska Department of Health and Social Services Division of Public Health</b>	Public health

*Facilitation Guide*

Providence St. Joseph Health developed a facilitation guide that was used across all hospitals completing their 2020 CHNAs:

- The role of the stakeholder’s organization and community served
- Prioritization of unmet health related needs in the community, including social determinants of health
- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

*Training*

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

*Data Collection*

The identified stakeholders were invited by email to participate in a phone interview. Appointments for the interviews were made on dates and times convenient to the stakeholders. At the beginning of each interview, the purpose of the interview in the context of the needs assessment was explained. The stakeholders were asked if the session could be recorded. They were assured their responses would be aggregated and not associated with their names, and consent to proceed was given. In conjunction with the interviews, the community stakeholders were asked to prioritize a list of community needs according to the level of importance in the community. The prioritization process occurred through an electronic SurveyMonkey® survey. The link to the survey and the interview questions were

sent to the community stakeholders when the interview appointments were confirmed. Attachment 2 presents the list of prioritized community needs.

## FINDINGS FROM STAKEHOLDER INTERVIEWS

The following information represents summaries of participants' responses and should not be considered transcripts of the interviews, nor are they direct quotes. Each bullet point under a question represents the response from a different stakeholder.

### *How would you describe the community your organization serves?*

- Our town is a small, isolated, rural town, of approximately 3,000 people, at the end of the road system. You can drive here, we had fleets coming in and out, but that has stopped service and transportation is an issue. We have a mixture of highly educated people with secure jobs and income and a lower income population with seasonal workers who come for construction and the fisheries. And we also have tourists who are from all over the world and they are part of our population at certain times of the year.
- This is a small, rural, isolated community. We have 63 full time and part time employees. Our student population is not your typical community college. You have a small residential population, most residential students come from out of state, and we get a few local students. 30% of our students are online and a large part of what we do is fishing vessel training for oil training, about 1,800 students. They are students but they are really fisherman that work on vessels for incident response and are not traditional students, to say the least. Fishing vessel people are 30 and older.
- I work with senior citizens and disabled individuals and the vulnerable population. Our mission is to meet the needs of people so they can remain independent in their homes. That depends on people's health and how connected they are to the community and what family support they have. I have an individual who lived here 30-40 years, and they had to relocate for appropriate health care and living arrangements. The majority of seniors attempt to stay here as long as they can. Many of the older population are people who have been here for quite some time or fell in love with it on vacation years ago. The senior population is growing because not as many people are leaving, as younger people are finding other opportunities and relocating away from here. There can be good jobs that come up in the community, but housing availability is an issue. Our intent is to assist with essential needs, like food security or transportation assistance and running errands and getting prescriptions and groceries and mail, we step in to make it easier so people can stay in their homes and if they are eligible through the state for Medicaid, for personal care services, there is another agency that can provide personal care services. Someone may be in a home that suits their needs and we supplement it for them to make it easier for them to stay in their homes. If you are on Medicare, hopefully you have supplemental insurance for personal care services. We have a few clients we bill their insurance companies, because Medicare does not provide that. We offer private pay for services like dressing, grooming, light housekeeping and cooking. If you do not have family or friends, we can step in, and there is another nonprofit called Connections. There is a misconception that it is for hospice, but it is not. They help anyone with need for assistance due to illness or injury.

We have a very small population that does private pay, it is 0.001% of our clients that do private pay. We charge \$24 an hour, which is far below the state rate, for staff and supervisor of our PCA.

- I'm a city manager, I've been here less than a year, so I have a fresh perspective or a less than experienced perspective. It is a safe, friendly and overall pretty prosperous community. COVID dealt us certain setbacks like everyone else. But we've dealt with that pretty well. One thing I'll say, the last six months colors how you see everything. I feel almost like the entire community acted very responsibly during this and were concerned about other people's health. That tells you a lot about a community when the local residents consider the safety and health of everyone when making a decision. Over 90% are staying safe and healthy, it is a top priority and why we have less than 10 cases of COVID with our residents so far.
- We are a community of seasonal and ship workers. People struggle with feeling connected to each other, except during times of crisis. If someone passes away in a tragic accident people come together like no other community. But every other day, it feels alone and disconnected. With the pandemic, some people are introverted, this is their wheelhouse, and they are doing quite well, and others are struggling and having a hard time managing, but they are not coming to counseling. There is a lot of anger and hate we are seeing in this community, not something I've seen in the five years I've been here. Now, I see quite a bit of hate. I'm sure that it is not just COVID, it is just the target of displaced conflicts. Our community has a lot of gaps in socioeconomic status. Some folks own land and property and they do well and persons in the oil industry, they do well and there are a handful of professionals and then everyone else who is needed to maintain a community. They get paid enough to live, but that is about it. We have a lot of people on Medicaid. It is the largest payor in our community, with a budget of \$121 million. Many people leave the community for health care. It is a small community and people don't want everyone to know their personal information. There is a perception that nothing is confidential. If you go to the hospital or the counseling center, if someone knows, everyone knows about it. Some people come for ship work, but they have ties and live in other communities. With the food bank, half the people have been or are clients of the counseling center. That population is pretty vulnerable, and they can't take a day off of work without financial difficulties.
- I work for SWAN, Sound Wellness Alliance Network, a nonprofit that serves all demographics, all ages, we reach out to everyone we can possibly reach and to those who are harder to include and less likely to participate in events. We realize those people are the ones with usually more severe health needs and that demographic is always hard to include, but it is one of our goals to include services to them.
- We are a domestic violence shelter. We provide services to an area almost as big as the state of Ohio. Advocates for Victims of Violence provides services to women, children, men and LGBTQ and seniors and the underserved population. These are immigrant women, people with disabilities, we serve everyone, we don't choose who we serve, whomever walks in door we provide services. Anyone who calls our crisis line we provide services.
- My personal organization serves the local community, our town demographics, we are middle class, the school district serves 720 students with 130 employees. We are primarily middle class, not low



income in how we identify the schools, we do not have a large free or reduced lunch program, about 85% of students are white. We have a robust special needs program, disabilities, not sure if you are familiar with the vernacular and lexicon in education, we serve high incidence and low incidence students with disability. Low incident is more severe, needing life skills as well, more severe, they will never be living independently upon graduation to high incidence of disability, like ADHD. About 15% of the school population falls in that disability range. English is the primary language.

- Public Health is the safety net for people in Alaska, so we serve people who are uninsured or don't have a medical provider and have nowhere else to go. We don't have a FQHC here, we are the only place that provides services on a sliding scale and we don't turn anyone away due to inability to pay. That is missing in this community. The native corporation, before COVID started, were thinking of building their own, they were having some issues with the clinics here. Cordova has one – it belongs to the hospital and they have the Alaska clinic and a native clinic. We are larger, about a 1,000 more people live here. We have two medical practices here, but they do not have sliding scale service. It is very expensive to live here and to find affordable housing. I don't know how those making minimum wage make it here actually, I've never seen a place rent for less than \$1,300-\$1,600 dollars month. And that is not counting utilities, so I don't know how they make it. We have a voucher program but there is a waiting list from the state and the city is trying to address it, but it is a big issue. We do family planning, immunizations, STI, TB, and we get everyone in, we have scattered times now with COVID, but we've not turned anyone away.
- We are a frontier community of 4,000 people. We are approximately 300 miles away from the nearest tertiary hospital. Our service area is extensive and we are very isolated. We are limited by geography and weather and we have a well-educated population that has high employment. From a demographic perspective, as a rural community, we are a young community. We have a lot of people who have lots of children, which is unusual for a rural area. We do not have as many elders for a rural community, that may be due to the weather. The pipeline is a large employer, and the refinery, and in addition, we have fishing and a fishing industry. It is seasonal, but it is a large one. There is government employment through the schools and government programs, and we have the hospital and clinics, they are a significant population. And the Coast Guard and restaurants.
- We are a small, rural, remote native and nonnative population and we are pretty spread out on the ages. And we have transients. We have more people coming and going than other Alaskan communities, or other communities in general. We have people who don't have a lot of money and people who have plenty.
- We serve all the community, it is our mission to be focused on the poor and vulnerable and in so doing, are able to provide a unique compassionate level of service to anyone, anyone who walks through our doors that needs care qualifies under our poor and vulnerable program. Health care can be very scary and daunting, and an unfamiliar place and we seek to ease peoples' way. In the summertime, we have an influx of people coming to participate in the seasonal workforce, fishing, construction, tourism industry or as tourists themselves. We absolutely serve these folks. A number of years back, in being able to address fish processing issues with the overutilization of the ED, and reoccurring health conditions, we focused our energy through our population health brand to

improve the health of our seasonal fish processing workforce and we did a remarkable job. And it was very prophetic in understanding and preparing for COVID because of all these relationships and all this work we'd done previously to address known infectious diseases. We are trying to address typical communicable diseases in very concentrated living conditions like they have. We were early on in meeting with industry folks and state and local partners to help the workforce be safe from infection from themselves and from the community to them because they live in very congested dormitory style setting and work in that setting too. They did have one mild outbreak, and they have all since recovered, a positive sign we did what we could to keep people safe and there were measures to contain and provide the best chance of limited spread after that.

- The majority are Alaska Natives and we also have Native Americans from the lower 48 tribes that are beneficiaries for this service area, where they get Indian health coverage and Bureau of Indian Affairs (BIA) education and vocational assistance and opportunities. We average consistently 750 individuals and there are 100 elders and 100 children, ages 0-18. We have 10-12 who are going to become an elder within a couple of years and we consider elders ages 55 and older. We have special programs for elders. Another thing for demographics, we have contracts with the Bureau of Indian Affairs (BIA) and Indian Health Services (IHS) and Chugachmiut, the consortium for Alaska Natives in this region. They are 7 tribes, 2 of them are not federally recognized, Valdez being one of those.
- I have dual roles, as pastor of a church and the spiritual care manager at Providence; both have different stakeholders. Income disparities happen a lot here. People either have a lot of resources and are connected or have very little and little education and have few resources to get out of that. As to race, 6% are Alaska indigenous, 56% live under the poverty line, so they need resources like the food bank. Income and education disparity are major issues. We are isolated and childcare is as issue as well. We have great opportunities for ages 4 and 5, but before then, there is not a lot of prenatal or post-natal care or education resources. We have a counseling center that has some classes, but it is not well utilized by people. We have some childcare, but not a lot, and it may be one reason why people who are educated and have jobs are leaving town. There are a lot of people who could use mental health resources but there is that stigma that I don't want anyone to know I use that because everyone will know, they will see me in the office and judge me. One of the things that happens here is people don't like to sign up for things, especially if it is free, so they just sign up and do not go or if it is a nice day, they go fishing instead and there is not a lot of accountability. I want to enjoy the nice day, that is a factor as well. And there is not a newspaper or places to learn what is going on, so it is Facebook, which is not the healthiest way to spend your time. People may not know how to read, so they do not hear about a parenting class unless people reach out to them. To get information out, we have a radio station and you pay to advertise, and they will put things out. Facebook is our major source of venting and for information, we have many Facebook group pages. The faith community, if you are already connected, it is a good resource, but there is not a lot of communication between faith communities, and there is not a lot about engaging needs to resources. The food bank is a better place to say I need health care, classes, or rent assistance. We have a college that has evening classes for adults and ESL, GED courses, and that is another place to

go. The faith community is good at taking care of themselves, within that group. If they hear about something, they will help, but there is not a lot of outreach.

*Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.*

- Local health care is family medicine-based, which is great for a rural population. We can meet a lot of their needs for acute care and illness and chronic management. For some specialties, there is a sporadic need, and it doesn't make sense to have a specialty here, because a practice needs many patients to feed into a specialty group. Family medicine and physician extenders in our community do a good job. I think that access is a problem. I opened about a year ago because I felt there was a need. I was focusing on chronic disease management, it is a big need that is missed, it is not taken care of here. It is through a lot of episodic care, high blood pressure, diabetes, etc., leading up to disastrous vascular issues that were not being addressed. We have pretty good prenatal care and OB care here in town. We have a big need for improved nutrition education and an ability to get healthy food. It is a huge concern if people don't know how to cook or get access to good food, that creates health problems. Transportation is also an issue. Airplanes are not flying so if you need care in another location, you have to figure out how to get a person there. A population that doesn't have ways to drive, etc. makes it extremely difficult. We had someone with an eye injury who needed follow-up with an ophthalmologist. Trying to get to that specialty care, it can be extremely challenging and dangerous for people. A lot of first management steps can be performed in our ED with providers and staff for advanced life support, we have medication that can be given, however, if, depending on the condition and what is needed, a majority of patients are transferred to Anchorage. We stabilize them and consult via telephone and arrange for transport. Stroke is a similar scenario. We have access to some telemedicine and tele-stroke. They help us to make decisions. Initial role out very helpful and the folks we utilize are very knowledgeable about the area we live in. We do a lot of phone consultations with other ED physicians and specialists, we have them look at x-rays or film, or for questioning about how to cast, or what type of management is recommended for an injury, They are directing us through them but it is not the same as having a specialist there. It makes it interesting, you get to do all these things, but it can be hard for a patient, especially if they come from a big city or little bit bigger of a city and are used to that type of care. People ask, why can't we have all these specialists in this town? But it is not reasonable. It is not feasible. For the most part, we cover the ED work and we cover calls. We have a contracted price to manage patients who come through ED and our time to talk to specialists, that is considered ER time and for the specialists on the other end, they are not compensated. Everyone is very generous with their time and the tele-stroke program may have a separate compensation with the hospital. The ICU helps monitor care and tele-psych as well. The majority of biopsies of lungs, kidneys they have to be referred out. Chemotherapy and infusion start out of town, but we are in a position to continue to manage the patient here, depending on the nursing comfort level to administer chemo.

- Because we are small and have a relatively small hospital, some services are not available, but we are fortunate to have a hospital, period. Many communities don't have anything, maybe a clinic, but to have a hospital that does what we do is pretty fortunate.
- Seniors comment that there is a need for a podiatrist, someone who treats for diabetes, doctors who can treat cardiac conditions, instead of having to go to Anchorage for specialist care. Food-wise, I think the agencies that provide food security, that isn't really an issue for the seniors unless they aren't aware and know it is out there. We do regular postings and advertising and at the senior center and through Meals on Wheels and the food bank. I'm not sure it is as important as our housing needs. We have seniors who are on wait list for the 15 apartments for seniors. We keep a waitlist of about 24-25 people at a time, there doesn't seem to be enough affordable housing for seniors who can no longer live in their current homes. We are the lead agency for community transportation, but we serve primarily seniors and disabled individuals. We have a cab system, but we are down to one person and I don't see it very often. We do not have any real public transportation, buses, etc. People ride bikes and walk; it is a small area. If you are in the center of town, you can walk around and get anything they need. But a lot of people live down the highway, at 6 mile through 10 mile, without transportation to the post office, the bank, the store, so we pick them up and take them around on errands. We serve lot of people at 10 mile outside of town for Meals on Wheels.
- We could use some more expanded alcohol and drug dependency programs. We have our fair share of struggles like any community. Our counseling center deals with some of it, but there are not many treatment options. We could use more ramping up of dependency programs, it is a major area that there needs to be more concentration. Childcare is definitely a particular need in this community, we have a good school system, but we have a childcare center that has struggled to be economically viable and they have had a hard time finding housing based on various circumstances. We could see a better facility which would mean more utilization of preschool services. The facility itself, they need better space than they have now.
- Housing, food and transportation are issues. Housing is an issue because it is so expensive to live here, and we don't have a homeless shelter here. There is a lot of couch surfing, that is homelessness, but they have an address. So, they are not technically homeless. And living in tight quarters, you get blurred boundaries and there can be sexual abuse and other issues. We are a population of 3,000 to 4,000 so the prevalence isn't as high as other places, but it does happen, and I'm worried that more happens than we hear about. Living situations are difficult to maintain. People have a hard time living here. If you live in town, you are fine, but that isn't where most poor people live – most live in trailer parks out of town. For those with substance use and misuse, people will say they couldn't get to group, because there is no transportation, other than the taxicab which can run, but sometimes it doesn't. And they can't afford to pay for that to come into town. Internet – some don't have it in their home, but almost everyone has a cell phone and they have internet that way, most of them. With COVID, the school helped them get internet to finish out the year. We are very fortunate our school is well funded. The haves don't like that money is going to the have nots. There is conflict, some say that is entitlement, that they are taking my tax money, but that is

something only the haves say. There are some coffee shops open, gas stations are still running, restaurants are trying to get by with deliveries and some social distancing, there is quite a bit of business function, but tourism is missing. I see more people coming to the food bank, and we are seeing people who we don't normally see, people who have jobs at agencies, and it's hard to come get help. The counseling center has seen a decline in client volume that has to do with switching to telehealth. There is some dissatisfaction, many are not excited about it, so as soon as they can come back to the office, they will start in-person counseling again. It is really hard on recovery folks. They rely heavily on that support culture, so we are still struggling how to do that. They need more daily contact, so it is difficult, and some have turned back to drinking. Drinking is the biggest substance of choice, but there is also meth and cannabis use. There is a long history of drinking in this town.

- We are a small community, so a small community cannot provide everything, that is realistic, but for our size, we are sufficient with health care. We have dental, and eye care is coming every other week. We don't have specialists, so for example, if you are type 1 diabetic, you might seek a doctor in Anchorage or Fairbanks. For SDOH, transportation is a big one, especially since we lost our regional airlines. And the state ferry system has also been hit or miss and they are not around this summer, or last winter. So, the only transportation is to drive, and the weather plays a big factor. It is 300 miles to a major city. Affordable housing is another issue. We lack housing overall, but certainly affordable housing. Daycare is a big issue and especially affordable daycare. I don't think income is all that bad in the community, but the fact is, we just don't have services like housing and daycare, so it is difficult for young people moving to Valdez. We have a really good school district and we have a couple of different home school programs as well.
- There are so many limited programs that we have here in Valdez. For those we serve, they are advised to get into a Batterers Intervention Program, so they have to go online or take it from Anchorage or Fairbanks. The enrollment for the program is so limited and if they miss one class, they have to wait for the next session, to complete their program. For our population, there is a lack of medical care. People have to travel to Anchorage to meet with specialists. That brings up transportation issues. This is a small town of Alaska, we have a road system, and there is only one airline carrier that commutes between Anchorage and Valdez, called Raven. After Covid hit, they filed for bankruptcy so now we have no aircraft that flies to Valdez and transports passengers. On top of that, there is this one transportation company that is based in Kona, which is 2 hours from Valdez. In the summertime, they come to Valdez to pick up passengers and bring them to Anchorage, but because of COVID, they stopped transportation too and the only car rental company in Valdez had to close business as well. Technically, there is no public transportation to and from Anchorage. That is where we have most of our medical care. Everyone has to go to Anchorage. That is one of biggest problems here, transportation. With COVID, there are people that avail telehealth. Telehealth is an option, but for most people, they would still like to see a physician in person. For cases that cannot have telehealth, like bloodwork, they still need to travel, and that is where we have a barrier. At the start of COVID, as a domestic violence shelter that knows the trends, we know people are going to become even more anxious because the kids are at home and the parents are at home. We opened two additional crisis lines for people to call and that has been utilized very well

because we only had one line before. A lot of people are calling our center because they do not know how to deal with everyone at home, no money, no jobs, even with unemployment assistance, it took a long time to get through the system because it is not just Alaska, but the whole country that is impacted by COVID. For most of the high-risk individuals for domestic abuse, they couldn't call us on a regular basis because their perpetrators are at home with them. We have to wait for them until they call us. If we initiate the call, they might get into deeper problems. We partnered with the radio station and we have ads on the radio to call us, we added additional crisis lines, virtually assistance on Facebook.

- There is not affordable health care and housing. The hospital has an indigent program, which is wonderful, but it is very expensive if you get sick. Not everyone is on Medicaid or can get help, and a lot of people fall through the cracks. It is expensive to have a car, and there is only one cab service in town, with only one cab. People who live in town can walk everywhere, but that is dangerous in the winter with the snow and ice. We need more affordable housing. A lot of people will have roommates or live in a trailer park, but that is not always an ideal housing situation.
- We are one of the shining stars on how to do frontier medicine. We have more capacity than larger rural communities throughout the country, so much so that there is talk of the Valdez model. It is really about how do we maintain what we have? Specifically, we have a robust physician workforce and our hospital is full spectrum. We deliver babies and do surgeries as well as have a level 4 trauma center. Despite being a community of 4,000, in the middle of nowhere, we have extremely high-quality care. Our infant mortality rate is much less than the national average. In many respects, we are the exception that proves the rule with health care. I have a hard time thinking what else we need to do versus continue to do what we are doing. This is an effort it is not something that exists without substantial work on everyone's part. One of the things we do here that is unique, is we have the same nurse who follows the patient, regardless of where they are in the hospital. The ER, obstetrics, inpatient, the nurse does all of it. That is a project, to get rural nursing to become a specialty because it is and it should be paid more too. A lot of hospitals, they drop obstetrics because they can't afford labor and delivery only nurses. Our hospital hasn't fallen prey to following what makes money. It doesn't really work in our town. we need the capacity to handle emergencies and that includes things that don't necessarily make money. It is building capacity versus fee for service. We are lucky, we have an enlightened administration and support from our city. It is hard in a small town for people to not value what they have and wish they had something better. But we have one of the best systems in the country.
- We have, especially now, without airplanes, a problem with specialist consultations and various things that need to be done elsewhere and are only available if you have access to transportation. There are always people in the gaps, small business owners, people who work at small businesses with no insurance. Medicaid is good. When we hear someone has Medicaid, we are glad because we can get them transportation. Medicare people have the same problem. Those are people who don't really get what they need. We take all insurance and Natives and people who are uninsured. Sometimes we don't have enough doctors or front office staff or building people, it fluctuates wildly when you are a small community.

- Early childhood development is a big need. There is a licensed day care provider in town, and we endeavor to support them. They have done a great job, but we could do a lot better for the 0-5 year old population, especially now with more understanding about early childhood brain development and how it contributes to less interventions and health conditions later in life. The population health force that worked on the fishing project has picked up early childhood as its next project for the community population. When we talk about SDOH here, it is housing. We have a lack of options that might follow a young adult through their lifespan. Our housing is very limited and costly.
- A big issue right now is mental health. In Valdez, mental health wasn't covered for the Valdez native tribe. Due to a recent supreme court case, we recently got a doctor contracted for the tribe, she started her own practice. She sees more than tribal, but because she is contracted with the tribe, she was able to establish her office on her own. Physicians and medical care across the board were overcharging tribes for health care. So, the federal government established Medicare like rates. Because of COVID, we went to telehealth right away, we were the first in Valdez to do it and pay for it. We added mental health about a year ago, and we established a good arrangement with Providence and their mental health providers. Unfortunately, they just lost one of them, she was the main mental health provider for our tribal beneficiaries. We have a large veteran population too. Most Native American families have someone who is or was in the military, so veteran representation is key for getting health care.
- A major issue that keeps coming up is childcare. People will say that you should have someone stay home. That is the narrative, but that may not be possible, especially for minimum wage workers. It is not possible and there are not a lot of resources. Another issue is mental health and how to engage people who are not connected. There is a huge need for substance use and misuse and depression. It would be helpful to have mental health telehealth in the community, but I don't see low income folks who are struggling mentally using telehealth. Do they have equipment and a camera? They can do it on their smart phone, but do they have a smart phone?

*Can you prioritize these issues? What are your top concerns?*

**A summary of the stakeholder interviews identified these significant community needs (listed in alphabetical order):**

- Access to health care (primary care and specialty care)
- Childcare/day care/preschool
- Economic instability
- Housing
- Mental health
- Substance use
- Transportation

A discussion of these and other community needs follows.

- Affordable housing, I think that is always a concern for people in town. Some of the living conditions, there are some people who live in squalor. It is expensive and it is hard to get housing, there are not a lot of options for people.
- Health education, in general. There is so much access right now to anything you want to learn, so it is surprising that folks may not know what is best for their health. Is that due to health literacy and not understanding what is being provided out there?
- Access to healthy food and education are top concerns. It is very expensive here, you can do it, if you can afford it. There are delivery options in the summertime, but it really comes down to a couple of grocery stores in town.
- From a health standpoint, what we've learned is the importance of dealing with that population and their long-term potential health care risks. It is a real opportunity to come together as a community to resolve that issue and Providence needs to be at the center of that discussion. In a small community like ours, no one entity can take on those challenge. The college can't do anything without the Coast Guard, the school district, the hospital, the city. We are way too small to deal with issues that come up like this: infrastructure, recreation, economic growth. We do pretty well because up until this point, the city has basically funded a lot of those entities, because of the price of oil. Now, that has drastically changed. Providence has been an excellent partner, but they can't be asked to solve all local needs. We do not have a comprehensive task force addressing these issues. There is a health advisory committee at Providence, a school board, city council, the economic diversity commission but they are separate entities. A comprehensive community plan is being put together by an outside entity that is gathering information about some of these issues, but they are not focusing on health issues. They are focusing on housing, economic diversification, outdoor recreation, community enhancement projects, and harbor development. They are operating totally as a separate entity with no cohesive unit looking at these issues. There is no communication between these entities, not at the level that we need for decisions to be made.
- One issue is receiving health care without the difficulty and expense of getting to Anchorage. How do we get people the care they need without such expense and such stressful circumstances? Two, housing and aging in place. We have long term care through Providence, but it limited, maybe 9-12 beds. Often, there is a waiting list. We also have 15 independent living units, but there is nothing in-between. Assisted living comes up over and over again. Three, there is a need for specialists.
- Housing is number one. Most of our economic and demographic data show we have older mobile homes that are not always high-quality housing. If we could convert to multifamily housing and other lower cost housing alternatives of quality, that would be the first thing. And build more single-family residential homes. The biggest challenge is trying to replace what is not quality housing with mobile and manufactured housing in the community. Two, we need economic diversification and a long-term plan for the transatlantic pipeline. It is now 40 years old and it has another 20-30 years lifespan. When that is no longer a viable option, that only leaves Valdez with tourism. The development of ports and a harbor and a transportation system would be a big help in diversifying our options. Our pipeline is aged out. Three, transportation enhancement. The road system is fine, we have a two-lane roadway most of the way between Anchorage and here. But we need



enhancement in the future for air service. Right now, we don't have any air service with the pandemic. It stopped working temporarily and we need something more reliable. Even before COVID, it was not very reliable. Anecdotally, 1 in 5 flights were canceled. The ferry service was cut back by the state, and that has an impact on transportation and the community. Another thing we've talked about is enhancement for rail service. We are having another discussion about that now, as another form of transportation beyond road and air service. For shipping in general. It would cut costs for our community to ship by rail. If we developed it over the long term, it would be another type of replacement of economic value. With shipping and over-road shipping and air service, it makes the cost of our goods very expensive. It is another way to bring in goods while decreasing the cost of living. We have to pay 25% to 30% higher prices because of shipping and air service costs. We do not have any cheap alternatives.

- One, access to the fitness center. It is such a small center. For Providence employees, the hospital helps pay for the membership, but if you are in a vulnerable group, in Valdez, you do not have access. If there is no gym, you have to go outside. A lot of men work here for oil. There is no housing for the vulnerable, it is more for transient oil workers. There are some rentals in the community, but they rent from \$1,300-\$1,600 a month. And you have to pay first and last and a deposit. That is small fortune for a family. If you work at a gas station, that is not going to work. People need housing assistance. The food bank and churches help with rental deposits, but it is a struggle. Many people here work two weeks on, two weeks off, then they are gone. Some don't even live in Alaska, they live in Montana, Anchorage, Southern California and they fly home. Our workforce, many do not live here, they just work here, and that impacts the connectedness of the community. People who work like that, when they are off, they are not terribly involved with the day to day community, they are not really very present. They are not vested in the community.
- Transportation, housing and day care.
- Alaska is a 3-legged stool economy that is oil, fishing and tourism and all three have been impacted this year and all have impacted our community which will ripple out to other areas.
- People feel childcare is the most important thing versus primary care. We are down a physician right now and that is a problem. We need another one, and it is scary because do we have enough money right now to hire another physician when people aren't coming in? To have a new physician come in, they have to be able to cover the ED and do emergency surgery. That is not something they learn in residency now. We have to train them. If they are not trained in residency, but they can be trained here, that is ok, but it is only ok if they are going to stay here for enough years to teach the next person down the line. If you are only coming for 3-5 years and then you move, to be closer to family, to tour the world, that is a problem. At some point, we will want to retire. People believe midlevel practitioners will take the place of physicians and we will lose all c-sections and ultrasounds, all the things Valdez does for the community. This will disappear if we go to a model of 2 physicians to cover midlevel practitioners. It will not work. That is my main concern over the next few years. It is the same with nurses. Finding nurses that feel comfortable doing as much as they do here. There is no training track in nursing anymore to be a generalist. How can they be trained to do things they only do once in a while, and how do they keep up that ability? Nurse training and

continual education is just as important as it is for physicians. Surge capacity, that is tricky. We only have one MRI tech. If they are on vacation, we can't do an MRI. Tech and lab people who can do everything, that is not how it works anymore. Everything is a sub specialist. Items that got added to last CHNA, such as childcare, it is still important. The medical system, is a part of community wellbeing, however, we are not in charge of it all. We should concentrate on what we are best at and advocate for all the other things.

- The early childhood piece is important, and assisted living and long-term care. Long term care is addressed in part because we have it, but for the person without Medicaid coverage, it is not affordable. There is bridge system where you can become Medicaid covered, but often times a family is unprepared and unwilling to undertake that preparation. Having affordable options for those that are not covered, that is generally not managed by anyone, it is very much a mom and pop service. We do not have assisted living. Assisted living is not reimbursed well, so not many people get into the business. I'd put kids as our first priority because so much happens downstream when we get it wrong and they do not get opportunities to fully develop.
- The cost of living is high in Valdez. So, when we have seniors on fixed incomes, they have to decide between keeping the lights on or getting their prescriptions. There are safety nets in place, like energy assistance.
- Childcare, income and poverty disparities, and mental health and substance use and misuse.

*Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?*

- For vulnerable populations, we have those folks who have poor social networks and levels of education. It is difficult to get them follow-up care and get their needs met. Those groups have a little more of a hurdle. Then there is health inequity going on because of other things that get in the way like housing, access to food, reliable jobs. Not having daycare, poor social support and coping skills, that impacts their health. Maybe it is not their access to health care, but it is their perceived access to health care. It is hard to deal with your health when you are dealing with all those other barriers.
- I don't think there are any. If you go to Providence, even if you have no money, they still take care of you. If you need mental health services, they take care of you. If you have to get to Anchorage, then you are on your own, but that is everyone in town, it does not discriminate.
- Those living in poverty or who have serious health issues, those who cannot afford health care for whatever reason and they cannot qualify for Medicaid. Some people fall through the cracks. They may not be eligible for Medicaid, but they can't afford private care for what they need.
- My perception is senior citizens are underserved in a variety of ways because we do not have specialized procedures. We also don't have long term care or assisted living for older adults. There are a couple of things available, but we need more of it for people who have retired and want to stay in the community a bit longer and can't stay in their home any longer. Most people who have to consider a smaller home have to leave Valdez to find options. We have 12 apartments and 12 long-term units at the hospital ambulatory units. Demographically, we have grown from when that was

established. Everyone in communities across the states are seeing the graying of communities. Post 65, people are staying here more than they did previously, but it is still an ongoing challenge.

- I think it would be younger families with younger children and both parents trying to work and finding a place to live and daycare for the kids. Those with older kids in school, or teens that can fend for themselves after school, it is not as much of an issue. For transportation, that impacts everyone. The nature of our weather, with the darkness in winter and a lot of rain and snow, it makes it difficult for people to get around, so transportation as well.
- Single parents, low income, some seniors, some people with disabilities.
- We have a community of haves and have nots. We have a lot of haves in our community and we are a well-funded school district with the oil industry and people with jobs tied to the oil industry. But those who struggle in entry level work, there is an impact. Our cost of living is higher than many places. We have a population that sometimes do not receive representation on boards and the community because they are not in high-powered jobs. So, a ski trail not being groomed might get more attention than a road not being paved, or around not having affordable adequate housing.
- Single parents, those with lower paying jobs, it is tough. Childcare is very limited here. The day care center was closed for a while. It was a very expensive childcare. I have no idea how people here can afford day care and a place to live. We have a task force on age 0-3 to try to get affordable day care here, but then COVID came. That age before getting into school is a very underserved population. There is not much money going into that and it is our future. We need to get them a safe, affordable place to live, learn and thrive. It's not happening here. We see that need.
- That middle group whose company does not buy health insurance for them and they are not poor enough to get Medicaid. People who fall in the cracks who are paying for their own insurance. Assistance for that group probably takes something beyond Valdez, it takes a more universal, countrywide solution. There are some transportation barriers to care. People who can't get to their medical appointments or who have a hard time picking up their medications from the pharmacy, those on some kind of disability and the state has cut everyone's hours so they do not have a helper to take them to a medical appointment. Some people have family, some people have friends and the church, but some don't and they tend to not be able to show up.
- We've done a great job, the state and nation, with the ACA. We've seen a noticeable increase in access to services and unmet needs. The middle of the road, the people who don't have or qualify for Medicaid and are not affiliated with employer-based plans fall into that expensive middle ground. That is underserved, that small businessperson who is making too much for the marketplace and Medicaid and they have to pay the entire cost of their health care. That is enough to make folks opt for noncoverage.
- Our elders. Because of shortages and recommendations to not buy things in bulk, we partnered with the senior center who had partners already established and they work with the food bank and churches to make sure that food bags and care packages are distributed to our elders. A lot of them live alone, they don't have transportation. Valdez is an interesting community because when the census was done 10 years ago, people had jobs and incomes were up, so we are classified as not

meeting low income standards. But today, people are retired. They still have an income, but it is a fixed income. We also have transportation and weather issues.

- We are 87% white in this town and the other racial make-up, the second largest is 6% Alaskan or indigenous. We have many people in the lower 48 other tribes. 56% of those people are low income. Race and education and poverty intersect. We have community seasonal workers who do a lot of fishing, and the lower 48 come, and people at the poverty level, they come from the Philippines and Mexico and eastern Europe and work 14-hour days. We have discrimination with those people and the pandemic. People think they will bring us COVID. We have a lot of attention on fish processors, so we have processes in place. We have 300 Ukrainian documented workers and they cannot open a bank account at a bank in town to wire money to their families and that is why they are here. They don't need the money here. They are housed and provided food, and they work too much to use any of their money. The reason they are here is to send the money back to their families. Our bank can't help them because they can't come into town.

*Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?*

- It has changed it a lot. We see folks not reaching out early on in illnesses, because of a fear of the hospital and being exposed and it has changed access to care. They have improved tele-health, it is more available and utilized and reimbursed better and it's encouraged. That is better, which it should have been all along, but it has changed how people get care. And COVID has changed the mental health aspect and created huge anxiety and it's definitely exacerbated unhealthy behaviors. People are less socially connected and probably isolated in their homes more and eating unhealthy food and not getting exercise. You can still go outside and get fresh air, but the anxiety issue itself, COVID exacerbates anxiety and impacts their health.
- There were multiple events we couldn't do. Some were significant as far as generating revenue, we had to cancel multiple things, we had to send students home early and pay to transfer them out of Valdez and refund their housing costs. It hit us pretty hard. We had to cancel all our fishing vessel training, that was a huge financial hit for us. Right now, if people can work from home, a lot of positions we will get lost. We will consolidate, someone will work from home in another area and take over multiple functions. If people aren't on campus, they will consolidate activities and make it one job. Our enrollments across the Alaska University system in last 5 years has been declining anyway, so now we really got hit because people do not want to send their kids out of state or to a place where they do not have access to adequate health care. It will hurt enrollments across the entire system. The University of Alaska system has been declining over the last 5 years. With the cost of oil, the state is in trouble financially. Fewer kids are graduating from Alaskan high schools and those that do, they don't stay in Alaska to complete higher education. Instead, they are going to Montana, Oregon, Idaho and Washington, remote little places and they run \$60,000 into debt in their first year and they could have gotten an Alaska performance scholarship and been debt free.
- For seniors, sometimes we are their only contact. We have very loyal seniors who come here every day for lunch. We had to close our facility so now there are no congregate meals. There is no

nonessential transportation, no events, fundraising, bingo, activities. All the things that were important for our seniors to avoid being disconnected and to see their friends. Many seniors don't feel comfortable going around now, so we call for informal wellness checks and do quick visits over the phone. That is helping with isolation and depression. Many people are self-isolating because they are nervous going around town, even with masks. And until recently, very few people were wearing masks, so people stayed home. We stepped in and delivered meals and we pick up prescriptions, go to the post office for them, etc.

- One of the pillars we focus on is social connecting and getting people out of the house. It is very important for strong mental health and the pandemic has put a strain on meeting that need. We are trying to do it virtually, but that is not the same as talking and sitting with each other. I'd also note it has taken a toll on mental health, we are having more issues with people suffering with depression and there is an increase in substance use. The counseling center and Advocates for Victims of Violence and AA are all resources for substance use. The school district has counselors as well for teens. There has been a virtual running group so you can run, walk, and log in your miles for the day and someone manages the Facebook page to track the miles, to encourage people to get outside and exercise. We contracted with a virtual conferencing company and have a calendar of events with virtual presentations and activities like cooking demonstrations and a book club and we will have our presentations recorded, so people can watch them for 30 days. We contracted with Holly Brooks in Anchorage for mental health. She will address mental health in 5 sessions and keynote speakers will talk about how COVID has impacted wellness and workarounds for that. It is free. You get a care package sent to you, with a hand sanitizer, energy drink, eye mask and a nutrition bar, a little something to hook them in.
- In March, 65% of family physicians started doing telemedicine for the first time. Here, the vast majority of visits were tele-med through May. Now we are about 50% in person and we screen people prior to their coming to the clinic with tele-med, and if they need to be seen in person, we do that as well. We have tele-ICU and tele-neurology. We can get an immediate consult with stroke. The tele-ICU is to manage patients in the night with an intensivist in Anchorage. It would be nice if they had a system in the daytime as well. The tendency with policy makers is to think that telemedicine is a rural solution, not that it is a tool. We still need physicians in these communities for things like surgery and babies, and intubate, etc. Telemedicine is a pretty good tool. Having a longitudinal relationship is important with telemedicine, you get a lot more information that way versus telemedicine where the doctor doesn't know the person and you see someone different every time.
- Housing inspections for affordable housing, is delayed now because there are restrictions. After reopening, people are having a difficult time finding jobs. At the shelter itself, we have to limit the number of people staying at the shelter. I have to use hotels. Most of our rooms have 2 beds, but because of COVID I can only accommodate one person in each room. So, with 7 beds, I can only have 3 people unless it is a family. That adds expenses on our end. Due to Covid, the court system, has postponed many cases and family law visitations. They are only looking at domestic violence cases, sexual assault cases. So, for those people who want a divorce, it has been postponed.

- It is a little more difficult to get health care outside the community and that is a barrier. Folks are less likely to seek out medical services out of fear they might get sick.
- It changed everything. How do we do business? Go to the grocery store? The way people get educated, the socialization. We have an issue with 20 to 40-year-olds still going to bars, but on the whole, people are doing the right thing. Jobs have been impacted, but I think we've done a really good job to save jobs and keep people working in most places. We have a lot of tourism, and that has been influenced as well. We've seen a huge difference this year with salmon fishers. But the campgrounds are  $\frac{3}{4}$  full. Fishermen are trying to stay home. Across the bay, we have a road that leads to the pipeline, it is usually lined with campers and trucks with people fishing. I've not noticed it this year, so maybe people are staying home. We are doing contact tracing. We've had some close calls, people can't remember who they were with, what day they were there. We just got through a big outbreak. I'm a one nurse station, the only public health nurse in Valdez, handling all the cases here. There was an outbreak with the fish processing plant. It is just getting the education out there; we are very proactive here. We got a Public Information Officer (PIO), a whole team monitors Facebook, corrects misinformation, it's a place where people can ask questions, and we try to make sure the information out there is correct. It is about correcting misinformation, we are working really hard but now with summer, people say, "I'm done" and we are having these outbreaks.
- We have embraced telemedicine in a huge way. From the fishery point of view, we are worried about having coronavirus spread rapidly because they are in a dormitory setting, with 5 people to a room, 140 to a floor, and one bathroom per floor. So, we've spent a lot of time to develop cohorts, where they eat with the same people, sleep with the same people, etc. We had one cohort that got it, and it spread within that cohort, but there was no one else that got it. Most canneries, they had 50% of their workforce who got it, we had 27 people. We really quarantined people. It was really hard on them, and the canneries brought in a physician assistant so they did not have people going back and forth between the cannery and town. Usually, there is an enormous amount of work in the ED. They show up all hours of the night with workers compensation cases and it is a major stressor on the system and they do not have insurance. It's worked out pretty well with the PA, it didn't stress system nearly as much. With the pandemic, we didn't have the tourism that we normally have. And mental health, there is a lot of anxiety. And anxiety manifests in either extreme denial and anger to just not leaving the house. It is frustrating to get everyone to wear a mask. We expected a lot more cases and we changed the workflow in the hospital and created negative pressure wings in the hospital and acquired PPE. But we really did not have a major surge. Maybe we've had 7 people in town and 27 in the cannery. With the schools opening, our numbers might increase. For the cannery population, they come from all over the world, but our governor shut things down early and mandated quarantine to visit the state and all of the have helped. We still need to try to figure out why it transfers sometimes and not others. There is a lot we have to learn about how it works.
- People are staying away in droves and putting off things they shouldn't, like checking their hemoglobin or blood pressure. Some are asking for refills over the phone, some are not doing it at all because they are scared to leave the house. It impacts the medical system because those bread

and better appointments impact bottom lines. We do a lot more telehealth, that works out except for blood pressure, labs, etc. We can get away with that for a while, but not forever. In-person appointments are good for somethings. It is interesting to see how this pans out in the long run. In general, the whole feel of things, everyone wearing a mask and being asked questions – it feels like, are you welcome here? People who do not like doctor offices in first place or feel marginalized, now when they go to the doctor's office, they have to call the doctor from the parking lot and be approved to be admitted. It feels even less comfortable.

- There are some long-standing needs, mainly home health and getting telemedicine more broadly incorporated into the menu of services. The pandemic has accelerated the acceptance and availability of telemedicine. Before we had zero telehealth and now, we have 100% telehealth offerings in primary care. Home health things like wound care, physical therapy, that has historically been forbidden because of regulatory hurdles, those were relaxed and we can now do nursing care in homes from hospital-based RNs and that has and will continue to be a gap in the community. For the first time, in my tenure, that has been achieved. I believe it is a reimbursable charge that allows the hospital to get paid for it. My sense is it is a temporary measure, and it will not be available after the pandemic. But I'm interested in seeing it explored as far as efficacy and appropriateness to be based out of the hospital and reimbursed in a sustainable way.
- We already had an emergency preparedness committee group. We knew there were things we needed, but now we know better, like food storage, communication systems etc. An issue we have is avalanches here and they close the road, so our only method getting in or out is gone. In 2016, we had a ferry come bring supplies and now we don't have a ferry, so there is a potential here for catastrophic emergency. On a positive note, it has made us all aware of agencies and departments, who they are and what they do. Outreach is great and the connections are awesome.
- It continues to isolate people more. I've seen more people reach out for mental health issues than before which is great, they are too low to care about stigma. They say, I just need to deal with my PTSD, because with isolation, it is too much. We are a very resources rich town. The city also provided \$1,700, anyone who applied got it, no income questions, if you applied, you got it. So that has been a good resource for folks. There has been a lot of divisiveness in town, people do not want to wear masks. People feel it is an infringement on their rights. Right now, teachers and bus drivers, resource officers and nurses and parents and students all are struggling. We will be in person with school starting this fall. A continual issue that pops up around COVID is to cycle through trauma, fear, uncertainty, and depression. And with BLM and not having large conversations in town about this, someone said to me, as person of color, I'm emotionally exhausted by people asking me what I think. The city of Valdez did a COVID Conscious program, it is a \$500 grant to offset things you've had to purchase as a business. It is an incentive for the community and stores to be safer. It's been a great idea, anyone who is COVID conscious, they call your name out on the radio and you get free advertising as well. The city is doing a really good job, thinking of any way to incentivize people.

*Please identify and discuss barriers to and gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.*

- Home care is a big gap. Leave vulnerable folks at home and have a visiting nurse and do medication management, that would be great. It is being done right now, but figuring out reimbursement will be difficult, it is a big gap in our community. Like many communities that are small and don't have the need for a home health business, we have to fight hospital regulations that would make it an ok thing to do. During this time, the hospital figured it out and now they have nurses going to homes for wound care, they are thinking outside the box. We get a lot of people who bring their parents here and many people come to retire here and if you do not ski, hike, or fish... but there are a lot of people who work here and bring their parents, so geriatric population care is needed here. COVID is really impacting the senior center, it is limiting folks getting social connection. Another gap is we have a really robust prenatal and post-natal after birth, but to do a home nurse to check on things, making sure children are cared for and getting what they need. We are working on 0-3 task force to improve vaccination rates, ACES, healthy food. We are trying to look at ACEs and the important years 0-3, it is in the works, but having more resources for that in the community is a big one and that leads to affordable daycare. Trying to afford daycare on a minimum wage job is not sustainable and there are grants and programs to help for low income. But bump up to middle class workers who have ok jobs, care is still very expensive. Not everyone can have one parent stay at home to care for their child, and that impacts everything else. We encourage breast feeding at delivery but some people go home in a day, so how do you foster that? We have had lactation consultants; we are working on getting that again. Home visits a week or two after birth, asking how can I help? how are things going? We are looking at that now. That is a big gap. We had a WIC office, but we don't have that anymore, so who is out there making sure kids are getting what they need? That trickles down to the future, so it is our job to let people know how important that is. But for people who are taking care of their parents and then they have their own issues, to tell people to focus on babies, it isn't always seen as a priority. But it impacts society. In a community like this where there are a lot of gaps, it is hard to focus on who gets attention right now. How do we serve everyone? We are working on 0-3 and also continuity to care and geriatrics. Usually, the same folks work on the same issues and determine how to prioritize issues and use funds, and that can be challenging.
- It is a small community, so there is not enough of any one thing. We don't have the resources that a larger metropolitan community has. We have one grocery store, we have no mail delivery, you have to go to the post office. It is the nature of living in this community and the cost of living here.
- Affordable housing, assisted living, and health care. It is expensive to go elsewhere for health care. You need to cover food and lodging, in addition to your health care bills to get a battery replacement in your pacemaker.
- More utilization of daycare and childcare services. There is an opportunity to market to post college graduates, that 20-30 age group, but because we don't have enough entry level housing, post college individuals can't afford to put a down payment on a \$300,000 home. Which is typical around here for quality housing with a couple of bedrooms. If we had more affordable or entry level housing, duplexes, etc., we would have an opportunity to grow our 20-30 population which we've



seen decrease. And that has to do with affordability of living. They just don't have that kind of wherewithal to buy something and if the quality of housing is too low, people will only sacrifice so much to live where they want to live.

- Availability of resources like housing and daycare. It's not affordable even if they are available. Valdez is not remote, but it can feel that way with all the snow and you can feel literally snowed in. The idea is to keep people strong mentally and reduce substance use and misuse in the winter months. In our community, there is a lot going on and lot of organizations are doing good things, but communication, funny enough, in a small community, is the biggest barrier. Everyone has lot going on, but they are not always communicating that. SWAN tries to be a backbone institution and connect with all the entities in the community and share the information it gathers in a one-stop shop: art and culture, outdoor activities, gardening, cooking, all those things.
- Transportation, housing and a delay in services because of COVID. Everything has been either closed or delayed, even the DMV. Also, we have limited foster families in town. And very limited 3<sup>rd</sup> parties that can supervise the visitations. We used to have a lot of prevention events in town that normally we would partner with and collaborate but because of COVID, none of those events have happened.
- Daycare, jobs, creating an FQHC, and making all those things affordable. If you work with the oil company or are in the medical field or work with the city, you are good. They pay well. But if you work at the grocery store or the hardware store or are a waitress, those are tough jobs and I don't see how people make it and pay for daycare. It's so expensive to live here, we lose people here and with the daycare issue, people don't want to come here. We have the national guard here and they don't want to come here because there isn't a decent daycare. Our daycare closed because there was a fire and water damage and mold, and it's re-opened since then, but it is a big issue, all these kids. Before, we had day care for 125 kids, and when it moved, it was less than half of that.
- Assisted living and robust home health.
- Childcare is a major need in the community, and an early childhood center and if we were able to employ early childhood educators. We need jobs for educated folks, and that is a great job for people and it provides child care. Something I'm very much interested in is a city-wide conversation around race in Alaska. There is not a lot of narrative of people who inhabited this community before we were a town. There were a lot of indigenous natives. It was a gold rush town and now it is an oil town, so reclaiming and listening to the perspective of indigenous people is important. There is an indigenous community center and another out on the water, we could strengthen our relationship and provide needs for and with them. The narrative here is let's not talk about racism, but I think we need to talk about it as a community. There is a group of folks who are interested in bringing the topic to city council and paying for anti-racism training, open for the public, and let them know this is an issue we need to address. People are very interested in talking about it. This is on people's minds and people want to talk about it themselves. Income and racial disparities in health care. There is need for more training and understanding implicit bias and having polices in place to care for people. There is not a lot of clash because we are not talking about it – the biggest intersection – it's people who want to wear a mask and those who don't want to mask. That is a major topic here,

when we could also be talking about racism and dismantling that. You can live in a bubble, even in tiniest of towns, and most people would rather be status quo.

*What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health-related needs you identified earlier?*

- The population health group with the hospital, they've looked at different populations over the years, most recently the people who come from all over the world to work in our community, that has been more challenging where they are coming from this year, with COVID, and how to accept them into our community, because they are isolated, especially now, to protect everyone and COVID. They are also looking at 0-3 with families. SWAN has been helpful in trying to get initiatives, like the health fair and wellness symposium, to encourage healthy behaviors and social connections, their pillars of healthy eating, wellness, and moving more and social connections and being mentally strong, it is a holistic approach to wellness. At the community garden, people are encouraged to grow their own food.
- We have several volunteer groups who help with errands and helping people in their homes with snow removal and light housekeeping. There is a neighborhood volunteer group and a Connections to Care, a volunteer group, the food bank. Valdez is an incredible community. We have an online bulletin board, if we have a worry or need to ask for help, people step right up and will give their shirt off their backs. There is a feeling in this community where people come together to help others. And the counseling center, they are quite busy right now. When someone has a relative that needs help, it is like a Go Fund Me, and people will say, so and so's father passed away. We are donating for a memorial service, and you'll get comments, what do you need, how can I help, immediately. It is amazing to see. We have a vent cycle, if someone is not happy with something, it goes to city council where people express a concern. It is so different here.
- The Providence Health Advisory Board identifies issues and discusses it and makes recommendations to the city council and the community in general. I know the Valdez Native Tribe has done some work on getting housing. The hospital and the Valdez Native Tribe tries to work together with certain things. The domestic violence group, their main concentration is as a safe haven, but at a certain level when you deal with someone in that situation, you have to help in all regards, so they may have to take on substance use and misuse issues as well. I think you have to go out of the community to get detox services, maybe the hospital can handle a case or two, but most have to go outside of the community. With mental health, we need an expansion on counseling and more inpatient treatment, it would be nice to keep it more inside the community and have more immediate assistance for that type of thing. We had a situation recently, a woman had mental health issues and she was processed through our jail on some kind of drug. The legal parameters to deal with a person with addiction issues and commit them is not as simple as it should be. And it's arranging for care outside of town. That is what happened with her. She was clearly in an altered state and there was not much to do but find her a hotel room and see what the next day brings. If

you have drug dependence or mental health issues, without a support system around you, it gets really difficult to survive here. It is hard to come here without a support system.

- SWAN is a powerhouse in the community. Parks and recreation, I don't know if they realize the value of activities to mental health, but they are really helpful in maintaining the community's mental health. And AVV, the work they do is fantastic for nonviolence with kids and women. Men are absent in a lot of that work, but they do engage with women and children. The college has a snowshoes program. People who would never have access otherwise can use them, because many people cannot buy cross country skis. We have a swimming pool and a rock wall. We have a good interfaith community, probably the greatest strength in Valdez. If you are involved, that is where people are really close and bonded. If you are not involved, there are not a lot of ways to get connected with people other than work.
- The city has great facilities like parks and recreation with ski trails all winter, they try to offer the school gym for activities if there is not sport practice going on. They have pickle ball, volleyball, a rock wall, and the college has a wellness center and they do a good job reaching out to the community to provide that facility. We have a community garden and people can lease out plots every season, that has been a success. We have a senior center, they provide activities for seniors in the community, they have Meals on Wheels and activities like movie night and bingo and they partner with the high school to do a program for high school kids to chit-chat with seniors and do activities like a big brother big sister program, but reversed. There is a need there, and with COVID, we can't do it in person yet. We have cooking and nutrition classes in partnership with the college. We did soup classes and everyone who came got an Instant Pot and it was a free class. It promoted better eating and utilizing food from the food bank because sometimes people don't know what to do with food they receive there.
- The city right now they are providing incentives to organizations they call it COVID Consciousness. Every business and agency, the city provides some guidelines, and if they meet them, they are awarded with a COVID Consciousness award and then those agencies are eligible for \$500 reimbursement or funding they can use to buy more supplies. Valdez is very resourceful area, and everyone is willing to help.
- Outside of the hospital services, we have mental and physical health. There is SWAN wellness group here in town, they promote healthy living, eating and physical activity and lifestyles, they help organize a health fair in the community every year, with weight check, cholesterol checks, all free. The churches are involved in the food pantry and ensure folks have meals. We also have a local food bank and AVV, Advocates for Victims of Violence, a domestic women's shelter and they do outreach and provide support for families. The local Valdez Native Tribe Association – they do a lot of work with their members so their people are supported. So, there is a lot of support for our community, you have to avoid it or try to not get support and help in this community. There is a lot of support for domestic violence, there isn't a greater need in our community, but there is a need. They are also regional, so the outlying communities here, the native villages further out, they do support those local families as well. It is very confidential and anonymous. And we do have tough stuff that goes on in our community, we are not immune to it.

- There is population health at the hospital, I work with Olivia Foster, she is an infection preventionist and public health person. We go to the fish processors every year to do orientation about how to stay healthy while they are here and doing STI screenings. This year, we made a video of our presentation. We advocate for them. We have a good senior center; they help with groceries and care. We have a seasonal population with the fisheries, they are about 800 of them, from May to September, they are a very high risk group, they come from all over the world and have to work really hard in harsh conditions and they are coming to the ED a lot. The counseling center is there, and they go there and talk about stress and anxiety and mental health. And last year they were talking about ACES and they did a talk about nutrition, handwashing, and alcohol safety and STI and TB and how to stay healthy. The program has now expanded to college ESL classes and GED and citizenship preparation classes and the pharmacy did a multilingual chart of symptoms and over the counter products you can get for each thing. We are very proud of that. There is a lot of stigma with that population, so we try to advocate for them. They are very high risk. One year the patients I saw in here, there were probably 8 or 9 out of 50 with a history of sexual child abuse. And smoking, not going to the doctor, or they have no history of medical care in the past. We see a lot of high-risk things going on there. Some people come from other countries to work here; they work 16-hour days with no days off. We had 100 ED visits in a month, and the hospital said, what can we do about this? So, we created this program. We don't have a lot of Natives; I didn't even know they were here my first year. There is a new director, she is fabulous for that population. Last time I checked, I think there were over 800 people in the tribe, it is a mixture of other tribes. She is a dynamic director, she has brought in a lot of good things, and she has thought of building a clinic.
- The counseling center does a good job. We have a drive-through for COVID. We have our additional payment system for physicians from the city council. That is really important. Health care is an economic multiplier. With the loss of health care services, city revenues decline.
- There was a task force on childcare. They worked hard to find a place and they are trying to keep childcare as a private enterprise, on general principle, and not get the city involved in running it. That whole system is hard to fix because people can't afford to pay for childcare as much as the workers need to earn to sustain a living. I know the senior center is trying harder to have vans that are available to people to go to their medical appointments, and to go to the store. Meals on Wheels is functioning very successfully. SWAN hasn't been as active recently in terms of figuring out how to get the community moving. Some people get a lot of exercise, and others can't figure out anything to do in the winter. It is easier to motivate the people who are already motivated versus people who don't get out, but SWAN, they are thinking about that and working on it, like senior exercises with a chair, other things to motivate people to be more active physically. We have WIC, but in recent years, you have to sign up through a phone number to get coupons, but there is not a person there who encourages them. We are a small town, we do not get a fulltime WIC, infant learning office. We have a telephone number and we have coupons, but no support.
- A few years ago, it was pointed out that just because people think we need a neurosurgeon doesn't mean we need to get one versus creating an education plan to share with the community as to why

certain specialists can be here and others can't. Maybe we need education about what things will work and what won't. And we need to know societal expectations to educate to those things.

- The work is a bit embryonic on 0-3. Providence Valdez's population health unit picked it up in the last 12-18 months. Interest is high. You have to take care of basic needs first and that was when the daycare was closed because of fire damage in an adjacent unit. Today, it is in better shape than before but there are tons of opportunities to strengthen child development. Right now, private industry is doing their part in constructing new homes, and there is discussion about a government supported project. With COVID, it's overwhelmed capacity, so assisted living has not had much momentum. And we could use some innovative type, outside the box problem solving.
- We have an opportunity to create an isolation house through a COVID-related fund. And the isolation facility can double as something else after the pandemic is over. So, we will submit that grant this month and ask for an isolation house that can be used as a medical shelter once the pandemic is over. 32% of our population is on long-term opioid prescriptions. Why aren't the doctors taking them off this? We were about to address this when COVID hit.
- In the counseling center there are handouts, "What are the signs of mental distress for adults and children?" That is good. We have SWAN events and they promote mental health and physical activity and a variety of ways to understand wellness. And we have stakeholders who come to talk about improving Valdez continuously. There is a lot of funding, a lot of events in town to promote wellness and community. It is a hard thing, usually you see the same people, some people who might need help are not seeking it out. Transportation can be a major issue, if you live 10 miles out of town, it can be difficult to get to events. Even 2 miles out of town, it can be difficult to get there. Many neighbors don't have cars or licenses. Even if it is only a 30-minute walk, that can be inhibitive if there is rain or snow. And people aren't aware of some events that happen. Those who are educated and connected in the community, they are the ones that hear about those things. Something the school did last year was a community potluck that was free and everyone brought food and there were hundreds of people there and Indigenous people in town spoke and danced and there was a speaker, a pretty well-known Alaska Native and they talked about mental health issues. There was a cross section of people who attended that, it was very successful. How can we incorporate Indigenous narratives into our town?

*What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?*

- We definitely need to cooperate, and organizations have come together in this time when no one is excited to do in-person meetings, it is so easy to do Zoom meetings. I hope we continue that after COVID, not only in our community but other communities as well. Alaska is so big, but so small, so reaching out to other areas to see what other communities are going through and their challenges and how we can help, it has been pretty humbling. No one knows the right answer and we have to take a step back. We should always think we don't know everything and reach out to others and see their challenges and successes. This is so unknown that it allows vulnerability; when you are not vulnerable, you are not as open and able to have cooperation.

- There needs to be more cohesive, comprehensive planning that results in the action of things getting done. In a small town, one person can drive the agenda for the 3 years they are on city council, and that is what has happened. There is resistance to change. There is communication and planning and consultants and more consultants, and a 5, 10, 15-year plan and an incredible amount of money spent on planning. But no action.
- I sit on four boards, besides being the director here. That is how we partner and have closer connections; we partner quite a bit.
- Looking at it from a business standpoint, we don't have a chamber of commerce. We have a convention and visitor bureau, but it would be nice to have people engaged in all types of commerce to get together to talk about workforce development, city services, and capacity related to health care and mental health. When I envision a chamber of commerce, it is not just restaurants and the pipeline, but everyone in the community – college, schools, all levels of business that impact the economy and our community. It is a weak point. If we can identify a need, we can get more momentum. We have splintering of groups that deal with one sector. We don't have one group where people come together to discuss a variety of issues. It would be nice to have a centralized group, otherwise it falls to the city and the government driving these things, and that isn't the greatest option either.
- I would like to see silos break down and see more involvement with each other. More integration of mental health. There is some hesitation, some do not want to be involved with mental health because of the stigmas around it, but we are making some inroads and breaking some of that down. No one wants to pay for prevention. Much of mental health is designed to be putting out fires. We don't prevent fires, we try, but if you do not come in with disorder, it isn't billable, it is out of pocket, Medicaid won't cover it, no one will. People come in, in distress but not at that level yet, we are getting there though, and in another 3 months they will be in distress, so give them some books and good luck and when they become dysfunctional in 2 areas in their life, we can treat them. I can see them smoldering, but there needs to be a fire before we can help them. We need to break down silos and help people. It's bureaucracy and the system in place. The hate and vitriol you see in social media, the politicizing of things, it muddies water, and hate. Pain demands to be felt, it is to be shared, and you can share in good ways, to talk, or you make people feel your pain – it stirs the pot, and you can't un-stir that. You can't do that in mass messaging, we will feel acts of violence and shootings, and expressions of "feel my pain." I don't like the way things are playing. It is very concerning. There is so much hate. It is ok to disagree. It's gotten much more extreme and I don't understand, where is moderation?
- So many people are doing good things in our community, but they just don't get the word out. People say, I wish I knew that was happening, I hear that a lot, so we are trying to fix that issue.
- First and foremost, we have to take a deep breath and keep calm and then adapt to the changes. We are not going back to the old normal, we all need to be patient and understanding. We need to identify problems and have conversations about alternative solutions to solve these problems. We cannot go back to the old normal, this is a different world we are moving in right now.

- One, we have a few overlapping communities that are local, so continued collaboration or enhanced collaboration on what services can be provided to different groups. Another one is connecting ties and helping with disabled adults. So, for example if a student with a disability has some employability, but they need a work coach, having someone to help. As far as communities, we are not perfect, but we are robust. We offer quite a bit and we have a lot funded or coordinated through the city of Valdez. We have a higher quality of life. Having lived in many communities in Alaska, I know we have many things offered that aren't usually offered, so quality of life is typically better here, but a barrier that comes up is the nature of our geography. We have some extreme winters that cause isolation. That can impact physical and mental health.
- This has improved, so there is not as much duplication of services or competition of services. That is always good, and everyone has the same message and agenda. It has improved the overall health of the community. We don't want 2-3 organizations competing for the same funding, for the same things, when can work together and accomplish more.
- If we could distribute the survey the right way, it might be interesting to do a survey that ask the poor about was it hard to get to your medical appointments? Or, is that something they are even concerned about? We need to talk to those people because I don't know what I don't know.
- We have a pretty integrated system already. We aspire to have 5 doctors, we had one leave, but we will recruit a 5<sup>th</sup> again. All providers take calls in the ED and all providers work for one of 2 clinics. The disconnect occurs outside of primary care. Physicians cover the whole town, and in terms of hand off, they are all very loosely aligned for the best chance of handoff to occur. And if that were to improve in any way, I don't think it would be structure. It would only be to add more people to carry the load. During the last CHNA, the larger conversation was around stabilizing certain things and achieving a level of care. Valdez's desire for five physicians, we could never get there, and it became clear that recruitment and sustainment was not easy. The city council debt program has done miracles and will continue to do miracles. The nursing program is a lifesaver, it is essential, the ability to grow our own, and have that connection to the community, where they've grown up here, have roots here. Without that program, which is received by satellite through a college, we would be in a different situation. We have a lot of their grads and they are some of our best prepared, most capable RNs. And add to that, the CNA program. These are lifesaver programs that the local college is able to provide. Once upon a time, we had to fight to preserve it because it looked like it was on the chopping block, that was in 2013. Since then, it has never had an interruption and it keeps producing RNs every two years and we take everyone we can get. The instructor is employed by the college and has responsibilities here at the hospital and they do clinical rotations locally and in Anchorage, depending on the subject matter. Some CNA grads, when they graduate, they come work for us and we encourage them to become a nurse and continue their education.
- Teamwork has been awesome. We couldn't have done it without it. We have been so successful, even the grocery store stepped up. For the workers that tested positive at the fisheries, because they were quarantined, the local grocery store brought them groceries and set up a general store for them, to protect everyone in the community.

- I'm not sure, we have a lot of great organizations doing great work, often they do not have resources to do it well, but everyone is going in their own direction and are not well-connected and they are off doing their own project and there is not a lot of collaboration or energy for collaboration. Everyone is just off doing their own thing. There is a lot of space for people to do a lot of great collaboration, compassionate people who want to make a difference. How do we best do that and make the best use of their time and energy?

#### *Additional Questions and Comments*

- I appreciate the survey and the CHNA. We've been really using that information to create programs and support nonprofits in the community, so it will be interesting to see since it is so different this time, how that impacts things. It will be difficult, but it seems touchy feely versus objective information and that makes it difficult because people want to fix tangible things: for these dollars we can impact this and make a change. This will give us a goal. It is not telling us how to fix it, rather it is finger on the pulse, and now you go out and figure it out, because only we can figure that out. There was more ability for write-ins last time, and more questions about smoking and drinking and health concerns, you get a different feel for it this time than last time, but you probably won't know the difference until you compare them side by side.
- Housing can't come fast enough for us. Valdez needs more affordable housing if we do not want to see older citizens leave. Our college has to put new employees in student dorms for 2-3 months while they try to find housing. And the rent is like a mortgage.
- Right now, we are working on our 10-year comprehensive plan with the city. It is a 10-year vision for the community that should include the health of the community and future land use and reimagining where to put housing. We haven't had good guiding documents coming out of the city. The master plan should be like a blueprint to help the group to develop future plans. With housing, we zone a lot of areas for industrial use but there is more market for residential use. Previously, there was a broader vision of recruiting and retaining industry in town. But, in the course of time, lifestyles change, and people can work remotely if they have a transportation system that is reliable. We need to revisit land use planning to identify more residential housing areas and look for multiple housing options. In the last 40 years, we have not re-envisioned land use. It was initially sent up with the 1964 earthquake and then the pipeline came in with a need for housing and development then. But since those times, we've not really looked at or re-envisioned those ideas. Once we identify areas, then we can make an infrastructure plan and create appropriate land use regulations to attract high density housing, single housing, etc.
- Valdez is so fortunate, and we are so thankful the hospital staff are really doing their best. Administrators to staff and physicians, and I do not want to forget to give credit to the local stores that we have here, like Safeway, they have everyone doing their job at this difficult time. We are so thankful that we have Providence here. We would not have this kind of service if we were in a big community. Our partnership, even in COVID times, with the hospital and counseling center, our



referrals back and forth, it did not change. Same with the police department. This is a really big effort that we are all doing to keep our people safe in Valdez.

- In the grand scheme of things, we are very fortunate for the level of professionals, medical providers, doctors and nurses, for the size of the community we have. And support staff. Everyone cares about the community and its betterment and the safety of our community. People always try to advocate for the voices that are often unheard.
- It is really hard to exercise in winter unless you ski and not everyone is an avid winter sports person here. We are the 10<sup>th</sup> snowiest place in the world. As the northern most rainforest, in the winter it turns to snow and we have a lot here. And we get ice, so it is dangerous to walk outside. We had one place to work out, but at \$600 a year, the average person can't swing that. If you are not a skier or snowboarder, it is hard to exercise in the wintertime.
- The role of telemedicine in the future is important. We still have to figure it out. We are building a plane while flying it. My hope is that we can deliver the same level of care with telemedicine, where we can bring any specialist into the office. In the worst case, tele-medicine makes it hard to maintain a physician workforce in town. As long as we can maintain those levels of service and emergency capacity, that is really the key. We cannot have only emergency and stabilize and transfer because the weather is so terrible here so often. Our health care has to be more robust than that.
- There are unique features to Valdez, there is a lot of shift work, a lot of dark nights, a lot of isolated days, and a lot of that is weather. Shift workers work long days, many in a row, and that takes a toll. Isolation, whether it is light or weather, it takes a toll, these are all things we are acutely aware of and it impacts individuals and their family and children. We aspire that we understand that and see what we can do to offset the imbalances and what we can do from a wellness standpoint. Mental health and social connections, eating right and physical activity and living your best Valdezian life. It takes energy to do all that, as it does anywhere. Unlike Blue Zones, where due to the nature of where you are living together, you are predisposed to better health outcomes, all of our food, with the exception with seafood and berries and small gardens, it is all one grocery store and it can be very expensive. Where we could do better from a Blue Zone standpoint, is we could take all the things that cause us to be isolated and then hardwire community-based offsets.
- Sharing some responses to BLM: one person shared that they live here on purpose because there is more safety in being known. There are plenty of Indigenous people who are exhausted by ACES. We had a couple of ACES videos and there is a doctor in town who does ACES screenings every time a patient comes in. There are people who ignore trauma and they keep the cycle going and there are others who get liberated talking about it and others who do not want to talk about it anymore, they want to heal. Everyone needs different care.

### *Prioritization of Community Needs*

The stakeholders were asked to rank order (possible score of 4) selected community needs according to highest level of importance in the community. The total score for each significant need was divided by the total number of responses for which data were provided, resulting in an overall average for each need.

Behavioral health (mental health and substance use), affordable day care and preschools, and access to health care, were prioritized as the top three needs in the service area. Calculations from community stakeholders resulted in the following prioritization of the significant community needs.

***Apx 3\_ Table 2. Rank Order Scores of Significant Needs by Stakeholders***

Significant Needs	Rank Order Scores (Total Possible Score of 4)
Behavioral health (mental health and substance use)	4.00
Affordable day care and preschools	4.00
Access to health care	3.64
Bullying/verbal abuse	3.58
Accessibility for people with disabilities	3.57
Domestic violence/child abuse/neglect	3.57
Housing/homelessness	3.57
Access to safe nearby transportation	3.46
Food insecurity	3.46
Access to oral health care	3.43
Aging problems	3.29
Job skills training	3.29
Obesity (healthy eating and physical activity)	3.29
Racism/discrimination	3.08
Safe and accessible parks and recreation	3.00
Lack of community involvement	2.93
Safe streets	2.93
Unemployment	2.93
Air quality	2.86
Firearm-related injuries	2.85
Lack of arts/cultural events	2.64
Poor quality of schools	2.31
Gang activity/violence	2.29
HIV/AIDS	2.29

## Appendix 4: Community Resources Available to Address Significant Health Needs

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

### PROVIDENCE VALDEZ MEDICAL CENTER

Phone: (907) 835-2249

Business Fax: (907) 834-1890

Confidential Fax: (907) 834-1885

Physical Address: 911 Meals Avenue, Valdez

Mailing Address: P.O. Box 550, Valdez, AK 99686

Website: [www.providence.org/alaska/valdez](http://www.providence.org/alaska/valdez)

- 24-hour Emergency Services
- 11 acute care and 10 long-term care beds
- Obstetrical services, anesthesia, labor & delivery, post-partum care
- Laboratory - CLIA-certified
- Imaging services to include MRI, ultrasound, CAT scan, and bone densitometry
- Physical, Occupational and Speech Therapy
- Stress testing
- General medical care
- Endoscopy and minor surgical services
- Specialty Physician Clinics

### PROVIDENCE VALDEZ COUNSELING CENTER

Evening Group Sessions, and Local Emergency On-Call Staff

Phone: (907) 835-2838

Fax: (907) 835-5927

Physical Address: 911 Meals Avenue, Valdez

Mailing Address: P.O. Box 1050, Valdez, AK 99686

Website: <http://www.providence.org/alaska/valdez>

- Individual and Group Therapy
- Psychiatric Services & Medication Management
- Substance Abuse Prevention and Treatment
- Outpatient Counseling
- Domestic Violence Intervention & Treatment
- Anger Management
- Case Assessments and Referrals
- Case Management Services
- Prime for Life Youth Group
- Alcohol Drug Information School (ADIS) 79
- Supervised Visitation

- Parenting Classes
- Couples & Family Counseling
- 24 hour Emergency Services
- Crisis Intervention
- Behavioral Health Disaster Response
- Community Education and Outreach

### VALDEZ MEDICAL CLINIC

Phone: (907) 835-4811

Fax: (907) 835-5162

Physical Address: 1001 Meals Avenue, Valdez (Adjacent to the hospital)

Mailing Address: P.O. Box 1829, Valdez, AK 99686

- Family practice clinic
- Medical treatment by appointment (preferred) or on walk-in basis during business hours
- Physicians provide emergency on-call service at the hospital
- Patient Referrals as appropriate

### THE ALFA DOC, LLC

Phone: (907) 835-2532

Physical Address: 154 Fairbanks Drive, Valdez, AK 99686

Mailing Address: P.O. Box 2507, Valdez, AK 99686

Email: livingwell@thealfadoc.com

The Alfa Doc, LLC aims to guide the way through personalized education, supporting individual accountability and interpreting complex health information for everyone to be their healthiest self.

### VALDEZ PUBLIC HEALTH CENTER

Phone: (907) 835-4612

Fax: (907) 835-2419

Physical Address: 1001 Meals Avenue, Valdez

Mailing Address: P.O. Box 950, Valdez, AK 99686

- Newborn baby visits and health checks
- Weight and height checks
- Infant and child nutritional information
- Nutritional screening and education, obesity and healthy lifestyle
- Breastfeeding information
- Well-child checks and developmental screenings
- Parenting concerns and information
- Childhood immunizations for children from birth to 18 years
- Infectious disease and tuberculosis screening and service
- Domestic violence and interpersonal violence screening and referral
- Vision screening for all ages

- Emergency Planning
- Family Planning Services or Women and Men:
- Pap Smears, breast screening and birth control
- Reproductive services
- STD Screening
- Services to children and adults sliding scale based on ability to pay
- No one will be refused services due to inability to pay
- All services available through in-community and office visits
- Referral services as needed

### CONNECTING TIES, INC.

Phone: (907) 835-3274

Fax: (907) 835-3512

Toll free: 866-835-3275

Physical Address: 128 Chenega Street, Ste A, Valdez

Mailing Address: P.O. Box 2017, Valdez, AK 99686

Website: <http://www.connectingties.org/>

Provides community support and opportunities to individuals who experience a disability. Home and community-based waiver services for: children with complex conditions, Alaskans living independently and persons with developmental disabilities. Medicaid Consumer directed personal care services. Fee agent for Medicaid. Low-cost voucher for local transportation needs. We are here to help or assist you in any way we can, to make your life more enjoyable and enable you to attain the necessary services to live in the community of your choice in a safe and healthy environment.

### VALDEZ FOOD BANK

Phone: (907) 835-3663

Physical Address: 278 Rich Hwy., Valdez

Mailing Address: P.O. Box 848, Valdez, AK 99686

Website: <http://www.foodbankofalaska.org>

Valdez Food Bank's mission is to assist people in need and lacking sufficient nutrition through regularly scheduled distribution of basic food items. Our clients are underemployed, on disability, unemployed, or experiencing circumstances beyond control. The Valdez Food Bank also provides other types of emergency assistance such as heating, electricity, dental services, medical prescriptions and treatment. Such assistance is awarded on a case by case basis by the board and requires evidence of actual dire need. This assistance is given in the absence of other available sources.

### VALDEZ SENIOR CITIZENS CENTER

Phone: (907) 835-5032

Fax: (907) 835-2518

Physical Address: 1300 E. Hanagita Place, Valdez

Mailing Address: P.O. Box 1635, Valdez, AK 99686

Website: <http://www.valdezeniorcenter.org>

- Home delivered and congregate meals to seniors & adults with disabilities 7 days
- per week Noon to 1:00 PM
- Personal care Attendants & Medicaid Choice Waiver services to eligible adults
- Exercise programs, swim programs, activities, crafts, and transportation for individuals unable to drive

### SOUND WELLNESS ALLIANCE NETWORK (SWAN)

Phone: (907) 834-1807

Fax: (907) 834-1890

Physical Address: 911 Meals Avenue, Valdez

Mailing Address: P.O. Box 550, Valdez, AK 99686

Website: [www.swanalaska.org](http://www.swanalaska.org)

SWAN's mission is to promote health and wellness for all. In partnership with other Local organizations our programming includes:

- Ski for Free – Free Nordic ski checkout
- Healthier You – A three month event engaging the community to make healthy Positive change.
- Valdez Run Series – a series of 5K's and half-marathons throughout the summer months

### FRONTIER COMMUNITY SERVICES

Phone: (907) 835-4504

Fax: (907) 835-4527

Mailing Address: P.O. Box 1310, Valdez, AK 99686

Website: [www.fcsonline.org](http://www.fcsonline.org)

Frontier Community Services, nationally accredited through the Council on Accreditation (COA), provides independent living support to Adults with Physical and Developmental Disabilities (APDD), Children with Complex Medical Conditions (CCMC), Intellectual and Developmental Disabilities (IDD) and Alaskans Living Independently (ALI). The Home and Community Based waiver services we provide in Valdez are assisted living, respite care, nursing oversight, chore services, supported employment, day habilitation, supported living, and care coordination. We are committed to providing the highest level of care for our consumers and will continue to expand our services to meet the needs of all the people living in this special community. Our aim is to provide choices to local residents in need of services to ensure their health, safety, and quality of life.

### VALDEZ HOSPITAL AUXILIARY

Physical Address: 911 Meals Ave, Valdez

Mailing Address: P.O. Box 94, Valdez, AK 99686

The Valdez Community Hospital Auxiliary also provides support to hospital and community services through the purchase of equipment, and by volunteer efforts.

Membership is open to all interested individuals willing to support the Auxiliary's activities through personal volunteering.

- Hospital gift shop
- Health education
- Safe Sitter program
- Education brochures
- Newborn gift bags
- Healthcare scholarship

### LOCAL EMERGENCY PLANNING COMMITTEE (LEPC)

Phone: (907) 835-4560 or 1-907-255-6056

Mailing Address: P.O. Box 601, Valdez, AK 99686

Website: <http://www.valdezlepc.org>

- Provides community right-to-know reporting on hazardous and toxic chemicals
- Provides emergency planning services for the community of Valdez

### ARCTIC CHIROPRACTIC

Phone: (907) 835-8777

Fax: (907) 835-8702

Physical Address: 501 E. Bremner

Mailing Address: P. O. Box 1706, Valdez, AK 99686

- Primary focus of neck pain, back pain, headaches, and migraines
- Chiropractic adjustments
- Massage therapy
- Vibration therapy
- EMS therapy
- DOT and Sports Physicals

\* Now accepting Medicaid for patients under 21

### VALDEZ NATIVE TRIBE

Phone: (907) 835-4951

Fax: (907) 835-5589

Physical Address: 1750 Zurich Loop Road, Valdez

Mailing Address: P.O. Box 1108, Valdez, AK 99686

### SAFEWAY PHARMACY

Phone: (907) 835-1226

Physical Address: 1313 Meals St., Valdez, AK 99686

- Prescription pharmacy
- Health – related products
- Physician’s Formula Cosmetics (hypo-allergenic)

#### PWSCC HEALTH & FITNESS CENTER

Phone: (907) 834-1684

Fax: (907) 834-1691

Physical Address: 303 Lowe Street, Valdez, AK 99686

Mailing Address: P.O. Box 397, Valdez, AK 99686

Website: <http://pwsc.alaska.edu/health-fitness-center>

Full gym, including weight room, cardio floor, exercise classes, showers, and towel service. Home of the Ski for Free program: Free access to Nordic ski equipment (skis, boots, poles), snowshoes, GPS units, headlamps, gaiters- membership not required for this access



## Appendix 5: Process Governance and Oversight

### PROVIDENCE ALASKA REGION BOARD

The Providence Alaska Region Board serves as the CHNA approving body. The members are as follows:

- Doug Capra
- Estrada Bernard, Jr., MD, FACS
- Joe N. Faulhaber
- Kathy Hurlburt, MD
- Lindsay B. Cobb, MD
- Lisa D.H. Aquino, MHS
- Noah Laufer, MD
- Pamela Shirrell, RD, Chair
- Pat Branson
- Preston Simmons, DSc – Ex Officio Member
- Sarah Barton
- Scott T. Habberstad
- Stephanie Kesler, Secretary
- Steve Smith, MD
- Tim Bateman, MD

### CHNA ADVISORY COMMITTEE MEMBERS

The Valdez CHNA Advisory Committee was formed to guide the CHNA process. The committee was composed of Valdez community experts and representatives. These partners were invited to ensure the assessment process was guided by community stakeholders that represent the broad interests of the community. Together, the partners brought in the public health perspective and the interests of members of medically underserved, low-income, and minority populations. These members were key to ensuring the assessment reached out to the entire Valdez community.

**Dan O'Connor** – Prince William Sound College Campus Director, PVMC Health Advisory Council, Secretary he was appointed by the University of Alaska Board of Regents as President of Prince William Sound College in April of 2014. When PWSC became a college within the University of Alaska Anchorage, he was named CEO and College Director. Dan has 44 years of experience in education with assignments in colleges and universities in Pennsylvania, Ohio, California, and now in Alaska

**Pam Shirrell**, Registered Nurse (RN), Licensed Nursing Home Administrator, 25 year resident of Valdez. 12 years acute care experience as an RN prior to moving to Valdez, 6 years as Health Services Director, Harborview Developmental Center, and 17 years as the Valdez Public Health Nurse retiring in 2013. Currently: Chair, Providence Valdez Health Advisory Board; Member, Providence Regional Ministry Board; Chair, Prince William Sound Community College; Member, Valdez Local Emergency Planning Committee; Co-Chair, Prince William Sound Traveling Health & Safety Fair.

**Jon Berkeley** - PVMC Health Advisory Council Member and Valdez City Schools High School Principal. Mr. Berkeley came from Nome, AK for the 2019-2020 school year with two decades of experience in the field of Education. Valdez City Schools is a rural, public school district with only one high school.

**Ruth E. Knight**, - Head of the Valdez Homeschool Program. Unlike many homeschool programs that are “provided” from a distance, Valdez Schools provides personal time, planning efforts, and a commitment to assist at any level. Ruth has actively served on the PVMC Health Advisory Council for many years.

**Anna Bateman**, - PVMC Health Advisory Council Member and Tribal Administrator for the local Valdez Native Tribe which was formed as a 501c3 non-profit for the local Native community in 1974 that provides culturally relevant, health, social, and educational services to their members.

**Patrick Drayer** - Pat Drayer is originally from Gahanna, Ohio. He has served in the US Coast Guard since 1993, with Valdez being his third Alaska assignment. With two teenage sons that will be graduating high school in Valdez, the community ties to Valdez will be lifelong.

**Angela Alfaro MD, MSHS, FAAFP** - Board Certified Family Medicine physician with special interest in community health and integrative approaches to wellness. She currently works with the Valdez Medical Clinic to provide emergency room coverage for Providence Valdez Medical Center. She opened her own integrative medical practice in September 2019 called The Alfa Doc, LLC ([www.thealfadoc.com](http://www.thealfadoc.com)) where she is the sole member and works with a wonderful staff to provide comprehensive and personalized family medicine. Current Board Chair of Sound Wellness Alliance Network (SWAN)- a community based organization that works collectively to affect real and sustainable change in the health and wellness of the residents of Valdez, Alaska. SWAN partners with the community to raise awareness, educate and deliver programming that is centered around individual and community well-being and is based on the pillars of eating well, moving more, living socially connected and standing mentally strong. Among many other duties Dr. Alfaro provides medical consultations for Valdez City Schools and The City of Valdez.

**Shawn Arnold**, Shawn Arnold has served as superintendent of Valdez City Schools since 2018. Mr. Arnold spent his adult life in Alaska, first arriving for military service after college in 1994. After 10-years of active duty, he worked as a teacher across the state before moving into educational administration and retiring from the United States Air Force Reserve in 2017.

**Jeremy O’Neil**, Chief Administrative Officer, Providence Valdez Medical Center. PVMC provides comprehensive health care to residents and visitors of Valdez; Prince William Sound and Richardson Highway communities. As a critical access hospital (CAH), PVMC features 11 acute care and swing beds. PVMC delivers about 45 babies annually and provides general acute care services, including emergency care; diagnostic lab; an imaging center; and rehabilitation therapy (PT, OT & Speech) services. In addition PVMC provides 10 extended care beds and a counseling center.

**Pauline Doucet**, Assistant Administrator-Director of Clinical Services, PVMC. Her responsibilities include community outreach, physician engagement and day-to-day management of clinical operations (Acute Care departments and Long Term Care- as LTC Administrator and Manager). She brings 30 years of clinical nursing experience to her role at PVMC.

**Kaitlin Pabo-Eulberg** - Mission Integration and Spiritual Care leader, PVMC; and pastor of the Epiphany Lutheran-Episcopal Church in town. Her responsibilities including providing mission and core values education, encouraging the animation of the mission and values in all the “people of Providence” – caregivers and health advisory council.

**Samuel Shirk, MD**, Chief of Staff, PVMC and member of the PVMC Health Advisory Board. The Valdez Medical Clinic is a full service family practice clinic, consisting of four physicians, which also includes coverage of the hospital’s emergency room. It is the only primary care clinic located in Valdez.

**Mark Detter** - City of Valdez representative, PVMC Health Advisory Council Member. The City of Valdez is responsible for a variety of public services, including emergency services and public safety, community planning, public facilities and city lands, hazard mitigation and flood zone management, harbor management, snow and garbage removal, water and wastewater provision, parks and recreation, annual budgeting, Valdez permanent fund management, and governance. Healthcare Continuum of Care has been a long-standing priority for the community of Valdez, as it strives promote a superior healthcare system for its residents.

# Appendix 6: CHNA Community Health Survey



# Welcome.

Congratulations on taking this next step on the journey to assess and enhance the health and well-being of the Valdez community! As you progress with your 2020 Community Health Needs Assessment, your PIHC Community Health and Well-being Monitor™ data provides a snapshot of your community's health and well-being – perceptions, satisfaction, and behaviors, related to Six Dimensions of Health™ that resonate with your community because they were affirmed by your community.

Having this survey data reveals health and well-being strengths in Valdez, along with opportunities for improvement. While comparing different communities has its limits, accompanying 2020 benchmarks throughout your report add context to your HWBM results (for an independent comparison of Valdez and the Benchmark 2020 Community, see Appendix).

Finally, the Providence Institute for a Healthier Community is honored to join you on your journey to better community health. Through your commitment to collect data over time through the CHNA process, the Valdez community builds on years of past Community Health Needs Assessments. It is our greatest hope that this report supports your efforts to set community health improvement priorities that better reflect the overall health and well-being of Valdez, Alaska.

## At A Glance

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

- ✔ **A snapshot** of your community's overall health and well-being
- ✔ **A benchmark** to compare to the county or similar communities
- ✔ **Insights** into focus areas for improvement
- ✔ **A way to monitor progress** over time, with subsequent Health & Well-being Monitors.

## About the Health & Well-being Monitor

This report, along with all the work of PIHC, is organized into Six Dimensions of Health™ and well-being, based on foundational work of the institute in community-based participatory research in 2015, listening to and learning how communities define health and well-being.

The original qualitative research drew on insights from 130 community members from organizations as diverse as Familias Unidas, The Tulalip Tribes, the NAACP, Minority Achievers Program alums, low-income housing residents, university students, YMCA members, faith community leaders; street interviews; and a series of conventional market-research focus groups gathering people of different ages, income levels and geography.

The question was simple: how do you define health and well-being? Through this qualitative work, combined with literature review, 24 common attributes emerged. PIHC tested the model in a January 2016 quantitative survey fielded by Elway Research. The survey was augmented with a broad range of validated health behavior, social-determinant and demographic questions – many based on the Behavioral Risk Factor Surveillance Study of the Centers for Disease Control and Prevention and Healthy People2020; HealthLEADS™, PRAPARE. Factor analysis of the 24 attributes revealed natural groupings, faithful to the voice of the community, into Six Dimensions of Health™. PIHC has organized all of its work around these dimensions ever since.

Since 2016, about 9,000 people have taken PIHC's countywide and Community Health & Well-being Monitor studies, yielding a growing body of research data including low-income and vulnerable populations who are unlikely to be included in conventional research, along with innovations in community-based fielding techniques.

# How Your Results are Organized

Your results for Valdez 2020 are organized into three parts:

- ✓ Part I: Summary Results & Six Dimensions Roadmap
- ✓ Part II: Key Findings
  - › Your Core4™ Well-being Index Score
  - › Your HWBM Composite Measure™ (the “Speedo”)
  - › “One More Thing”: Your Respondents’ Wishes for Health
  - › Community Health Needs Assessment Insight: A Profile of “STRUGGLING”
  - › Your Cantril’s Ladder well-being score
- ✓ Part III: Detailed Results
  - › Charts, graphs and highlights for each indicator, organized into Six Dimensions of Health
  - › Index to Results of your Tailored Questions (reported in the relevant Six Dimensions section.)

**Appendices:** Here you will find a summary of the Survey Methodology, Response Profile, Demographic Profile of “Struggling & Mixed” Valdez Residents, and a 2020 Benchmark Community Comparison Chart. Verbatims of open-ended questions available upon request.

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# Things to Keep in Mind

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

---

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

---

## » The Six Dimensions of Well-Being

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



Connections and Relationships



Physical Health



Mental/Emotional and Spiritual Health



Security and Basic Needs



Neighborhood and Environment



Work, Learning and Growth



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



# **Summary Results & Six Dimensions of Health Roadmap**





# Valdez 2020 Dashboard

### Key

- ↑ Above benchmark
- At benchmark
- ↓ Below benchmark

### Your Engagement Results

**19%** 19% of ~2,896 Valdez Adults 18+  
 35% of Valdez Households  
 14% of 3,800 Valdez Population

### Core4 Well Being Index

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

**7.20**  
 Valdez 2020  
 C-

**6.99**  
 Benchmark 2020  
 D+

### CORE4™ Well-being Scores

Satisfaction Indicators  
 A catalyst for change  
 See page 11

#### Life Satisfaction

**7.5**

Benchmark 2020: 6.7

#### Physical Health Satisfaction

**6.5**

Benchmark 2020: 6.69

#### Mental/Emotional Satisfaction

**7.2**

Benchmark 2020: 7.09

#### Overall Well-being Satisfaction

**7.7**

Benchmark 2020: 7.34

### HWBM Composite™

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

#### Struggling

**13%**

Benchmark 2020: 14%

#### Mixed

**45%**

Benchmark 2020: 45%

#### Positive

**32%**

Benchmark 2020: 33%

#### Flourishing

**10%**

Benchmark 2020: 8%

### Your CAN-DO™ Scores

Capacity & Motivation to improve:  
 Individual and your community  
 See page 15

#### Individual Capacity

**86%**

Benchmark 2020: 73%

#### Individual Motivation

**48%**

Benchmark 2020: 47%

#### Individual High Motivation

**39%**

Benchmark 2020: 25%

#### Community Efficacy: Belief in ability to effect change

**25%**

Benchmark 2020: 19%

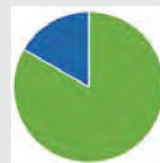
### Six Dimensions Of Health™

comprehensive view of health & well-being, defined by community, with 42 trusted, actionable indicators  
 See next page for detail  
 Beginning on page 21

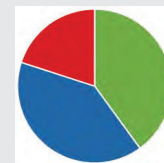
#### Relationships & Social Connections



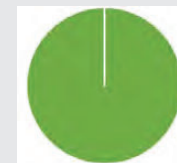
#### Mental Emotional Spiritual



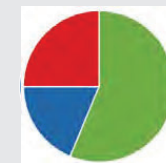
#### Neighborhood & Environment



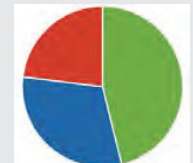
#### Work Life, Learning & Growth



#### Security & Basic Needs



#### Your Physical Health



# The Six Dimensions Roadmap



## Work, Learning and Growth

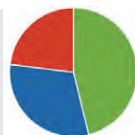


- ↑ Your work/job rating (6D)
- ↑ Opps for learning / growth rating (6H)
- ↑ Sense of purpose and meaning (7B)
- ↑ Education/training gap - living wage (9)
- ↑ Job insecurity/unemployed (9)

Detailed Results **Pg. 32**



## Physical Health



- ↓ Physical health satisfaction (4)
- ↓ Physical health current state (6B)
- ↑ Medical / health condition (18)
- Poor physical health days/mo (11)
- ↑ Debilitating health days/mo (13)
- ↓ Behavior: days fruit & veggies (14A)
- ↑ Behavior: days exercise 30 min (14C)
- Behavior: days sleep 7+ hours (14D)
- ↑ Are you living with a chronic illness (such as diabetes, heart disease or cancer)? (v5)
- ⓘ Behavior: Do you smoke tobacco products, e-cigarettes or use smokeless tobacco? (v6)
- ⓘ Behavior: 5+ alcoholic drinks in 2 hours (v12)
- ⓘ Body Mass Index (v13-14)
- ⓘ Coronavirus effects (v7)

Detailed Results **Pg. 44**



## Mental, Spiritual and Emotional Health



- ↑ Mental/emotional wellbeing satisfaction (5)
- ↑ Emotional well-being rating (6E)
- Religion / spirituality importance rating (7A)
- ↑ Sense of purpose and meaning (7B)
- ↑ Poor mental health days/month (12)
- ↑ Debilitating mental health days/mo (13)
- ⓘ During the past 12 months, did you ever seriously consider attempting suicide? (v1)

Detailed Results **Pg. 25**



## Relationships & Social Connections



- ↑ Rate Relationships with others (6G)
- ↑ Rate Sense of belonging / part of a community (7E)
- ↑ Rate community efficacy (7C)
- ↑ Behavior: gather with friends/ family (14F)
- ↑ Past week, days talking with your neighbors (14B)
- ↑ Discrimination, Past 12 months (8)
- ↑ Frequency of discrimination (8.1)
- ↑ Trend in frequency of discrimination? (8.2)

Detailed Results **Pg. 21**



## Security and BN

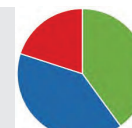


- ↑ Ability to meet basic needs rating (6F)
  - ↑ Future financial security rating (7D)
  - ↑ Behaviors: Frequency go without a meal due to lack of money (14E)
  - Access to health care insurance (17)
  - ↓ Ability to get medical care & health info (6C)
  - Behavior: # healthcare visits past 12 months (15)
  - ⓘ Access to nearby help with chores if ill (v11)
  - ⓘ Access: ER as main source of health care (v15)
- Social Determinants of Health (TotalHEALTH™7)
- ↑ Education/training gap - living wage (9)
  - ↑ Job insecurity/unemployed (9)
  - ↓ Trouble paying utility bills (9)
  - ↑ Food insecurity (9)
  - ↑ No transportation/ transpo worries (9)
  - ↑ Homeless/unstable housing (9)
  - ↑ Intimate violence/unsafe at home (9)

Detailed Results **Pg. 36**



## Neighborhood/Env.



- ↑ Neighborhood rating (6A)
- ↑ Behavior: days exercise >30 mins (14C)
- ↓ Behavior: days fruit & veggies (14A)
- ⓘ HH type: presence of non-partner adults (v16)
- ⓘ HH type: Living situation past 12 mo (v18)

Detailed Results **Pg. 29**

# Key Findings:

Core4™ Well-Being Index

HWBM Composite Measure™

‘One More Thing’: Respondents’ Wish for Health

CHNA Insight: A Profile of “STRUGGLING”

Individual and Community Level Can-Do™

Cantril’s Ladder Score

# KEY FINDINGS:

- Core4™ Well-Being Index
- Composite Measure
- ‘One More Thing’: Respondents' Wish for Health
- CHNA Insight: A Profile of “STRUGGLING”
- Cantril’s Ladder Score

## The Core4™ Index: A Powerful Link to Many Aspects Of Well-being

The Core4™ Index is linked to:

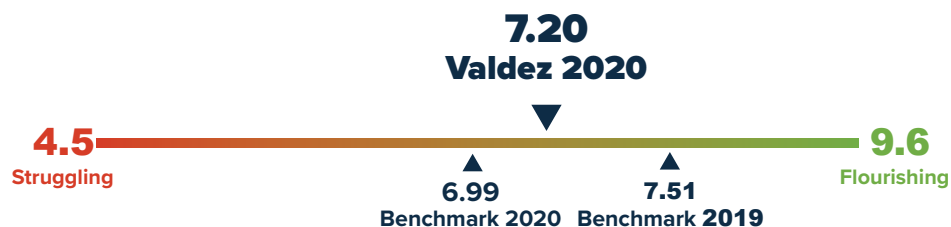
- ✓ Poor health days
- ✓ Eating fruits and vegetables
- ✓ Talking more with neighbors
- ✓ Exercising more regularly
- ✓ Getting a good night’s sleep
- ✓ Getting together with family & friends
- ✓ Neighborhood health
- ✓ Physical health
- ✓ Access to medical care and health information
- ✓ Work or job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

## Key Findings

- ✓ Valdez2020 Core4 Well-being Index Score 7.20 or C, 3% above the HWBM 2020 Benchmark.
  - › The Core4 Index is a composite satisfaction score combining four attributes: overall life, physical health, mental / emotional health, and overall wellbeing.
- ✓ The Core4 Index score is very strongly correlated (.82-.89) with Life Satisfaction, Mental/emotional health, Overall Well-being satisfaction. This is consistent with other use of the Monitor.
  - › Physical health, while still very strong, is less strongly correlated (.77).
- ✓ Poor Health Days: The Core4 Index score and every Core4 measure was strongly inversely associated with rates of poor physical, mental and debilitating health days.
- ✓ Cantril’s Ladder Scores:
  - › We included the Cantril’s Ladder well-being score for Valdez.
  - › Cantril’s Ladder wellbeing score was strongly correlated (.54-.70) with the overall Core4™ Index score and Core4 Indicators.
  - › Again this year, the Core4 Index Score is further validated by our inclusion of the Cantril’s Ladder score.
  - › Cantril’s Ladder/present-day was more weakly associated with Poor Health Days, and Cantril’s Future and Financial were weakly associated.

# CORE4™ WELL-BEING INDEX SCORE

## AVERAGES



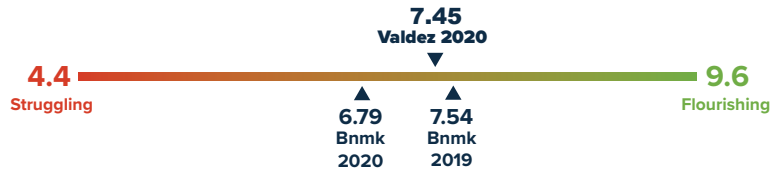
### Key Findings

- ✓ Valdez Core4 Well-being Index Score of 7.20 (a 'C') was 3% above the 2020 benchmark mean score (Snohomish County, WA – see Appendix for similarities/comparison)
- ✓ Strongest correlations with
  - › emotional wellbeing (.75)
  - › relationships with other people (.6)
  - › Number of poor mental health days / month (.6)
  - › Debilitating health days/month (.5)
  - › opportunities for learning and growth (.5)
  - › work or job rating (.5)
  - › Sense of purpose and meaning (.5)
- › Security about financial future (.5)
- › Sense of belonging and community connection (.5)
- › Access to medical care and health information (.45)
- › Ability to pay electric and water bills (.3)
- › Sleep hours (.3)
- › Regular walking/exercise (.3)
- ✓ Overall, differences in Core4 Index score were not highly associated with demographic characteristics; strongest was education (.2)
- ✓ Moderate to weak correlation with most Valdez Tailored questions (smoking, coronavirus concerns, alcohol, etc.)

# CORE4™ WELL-BEING SCORES

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

## AVERAGES

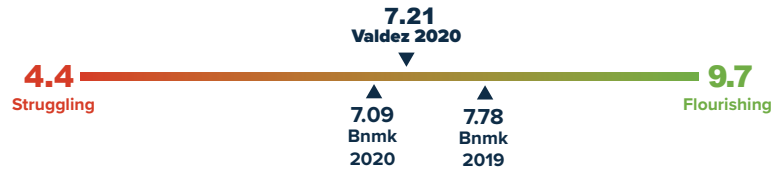


## DISTRIBUTION



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

## AVERAGES

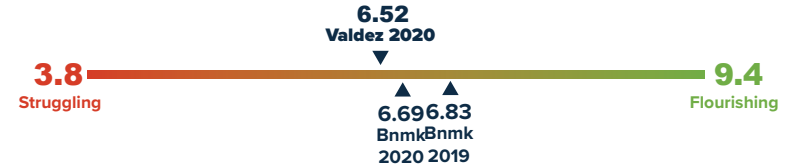


## DISTRIBUTION

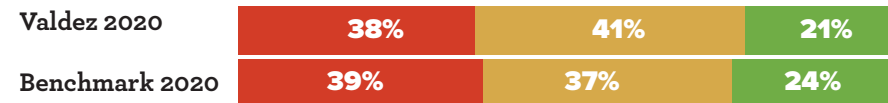


Thinking about your physical health, are you satisfied or dissatisfied with the current state of your physical health? (4)

## AVERAGES

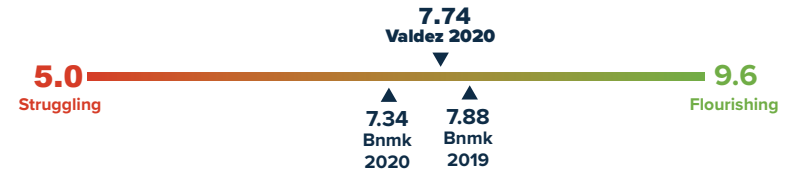


## DISTRIBUTION



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

## AVERAGES



## DISTRIBUTION



# HWBM COMPOSITE MEASURE™

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

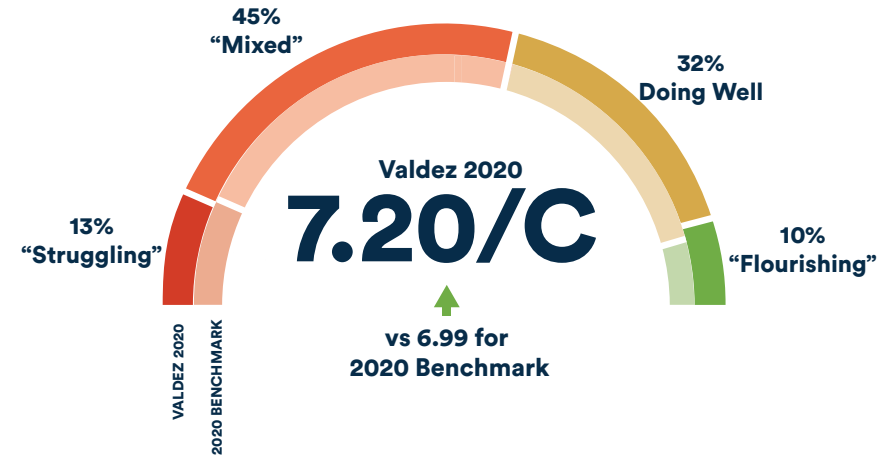
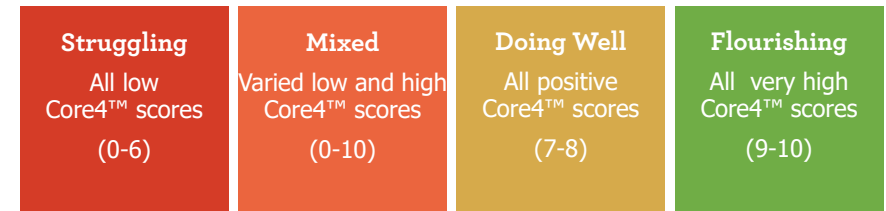
However, a calculated average does not tell the whole story. Five years of research with over 9,000 respondents has shown that many things must go well for well-being to flourish.

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

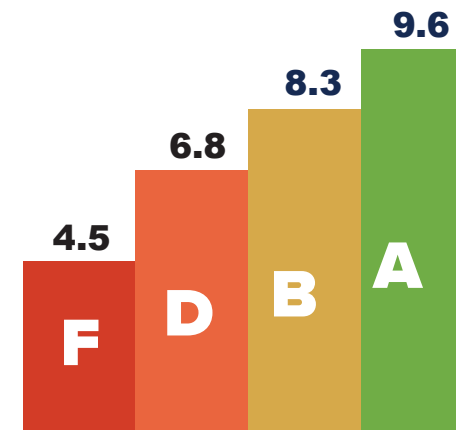
- ✔ People who are scoring highest (9-10) on all four are Flourishing
- ✔ Those whose scores are all positive (7-10) are Doing Well.
- ✔ People with a mix of lower and higher scores (0-10) are Mixed.
- ✔ People whose scores are all low (0-6) are Struggling.

Your community's Composite Measure is displayed on an arc (we call The Speedo), compared to a broader community benchmark – in this case, all of Snohomish County, Washington, in 2020.

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



## CORE4™ by HWBM Index Category Valdez 2020







# CHNA Insight: A Profile of “Struggling”

The HWBM generally relies on a strength-based framework. However, to support the 2020 Valdez Community Health Needs Assessment, we include here a profile/persona of the 13% of your community categorized as “STRUGGLING” based on individual HWBM Composite Measure results. (This profile is organized by the Six Dimensions of Health & Well-being developed by community-based participatory research in 2015 and used by more than 9,000 people in the past 5 years.) While this directly defines 13% of the population, the benefits of improving in these areas will be valuable across the community.

## Neighborhood & Environment

- ✓ 4% in subsidized/temporary/unsheltered (2x average)
- ✓ 34% not satisfied with their neighborhood (2.7x average)
- ✓ 34% report walking 0 times/week (3x average)

## Work, Learning and Growth

- ✓ 70% dissatisfied with work/job (3x average)
- ✓ 65% dissatisfied with learning & growth opportunities (3x average)
- ✓ 71% have a low sense of purpose & meaning in life (3x average)
- ✓ 19% lack education needed for financial security (1.4x average)
- ✓ 14% jobless or at risk (1.4x average)

## Mental, Spiritual & Emotional

- ✓ 100% are not satisfied with mental/emotional health (3x average)
- ✓ 66% do not find religion/spirituality important (1.4x avg)
- ✓ 71% do not have a strong sense of purpose and meaning (3x average)
- ✓ 79% report more than 1 week/month of poor mental health days (3x avg)
- ✓ 56% report more than 1 week/month of debilitating health days (2.6x avg, 19x more than flourishing)
- ✓ 12% reported suicidal ideation in past year (3.4x average)
- Another 8% said they did not know

## Relationships & Social Connections

- ✓ 58% dissatisfied in Relationships (3x average)
- ✓ 69% lack sense of community belonging (2.1x average)
- ✓ 72% don't believe they can have a positive impact on their community (2x average)
- ✓ 53% gather with family/friends <2x/week (1.25 avg)
- ✓ 67% talk with neighbors <2x per week (1.25x avg)
- ✓ 28% experience discrimination (1.8x average)

## Physical Health

- ✓ 100% are dissatisfied with their physical health (2x avg)
- ✓ 95% rate their physical health as low (2.6x avg)
- ✓ 49% have a medical condition requiring ongoing treatment or special care (1.5x avg)
- ✓ 42% report a chronic illness such as diabetes, heart disease or cancer (2x average)

## Security and Basic Needs

- ✓ 34% dissatisfied in ability to meet basic needs (3.7x average)
- ✓ 65% not secure about their financial future (2x average)
- ✓ 8% have missed meals in past week due to lack of money (2x average)
- ✓ 56% dissatisfied with access to medical care and health information (2.3x avg)
- ✓ TotalHEALTH7™ Social Needs Panel:
  - 12% food insecure (2.2x average)
  - 17% lack transportation (2.6x average)
  - 18% unsheltered or unstable housing (3x average)
  - 38% worry about paying for water and electricity (2.3x average)
  - 14% jobless or worried about losing job (1.4x average)
  - 19% lack education for living wage (1.4x average)
  - 5% are in unsafe personal relationships (2x average)
- ✓ 7% lack health coverage (average)
- ✓ Higher rates of NO MD visits or 3+ visits/year than community average
- ✓ 30% say they could not find someone to help them with chores if ill (1.5x average)
- ✓ 16% report using ER as main source of healthcare (1.25x average)
- NOTE: 84% of respondents did not answer this question

NOTE: A demographic profile of the 53% of Valdez residents who are ‘STRUGGLING’ and ‘MIXED’ is found in Appendix B.

# INDIVIDUAL & COMMUNITY LEVEL CAN-DO™

## »» Why it Matters

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

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

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

## »» What this Community Can Do

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

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

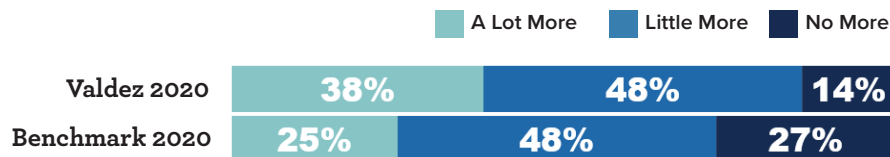
**Create nurturing environments**—emotions influence self-efficacy. Stress, anxiety, and depression have a 'negative' interpretation from society. Recognize emotions as normal and okay, while also working to address anxiety, depression and negative perceptions.

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

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

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

### DISTRIBUTION



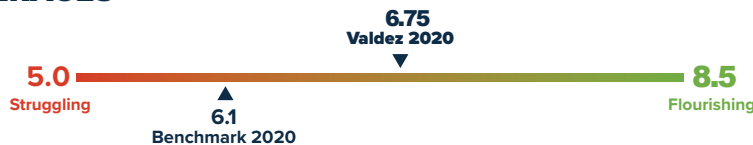
#### Key Findings

- ✓ High capacity to improve health:
  - › 18% greater capacity than 2020 benchmark community
- ✓ High Motivation to improve health
  - › All of Valdez' differences are explained by higher rates of HIGHLY MOTIVATED respondents
- ✓ Demographics
  - › Motivation increases with education
  - › Overweight/obese are 53-89% more likely to report there is more they can do

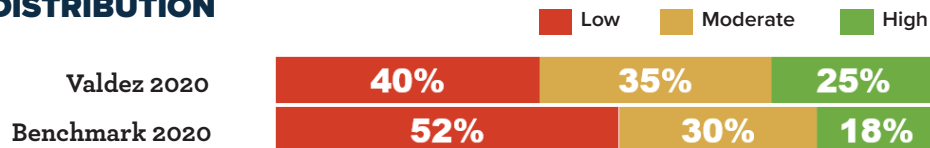
- ✓ Capacity:
  - › Relatively lower capacity to improve among with lower income, females, couples with children, singles living with other adults
- ✓ Lack of capacity to improve is revealed in Valdez Tailored questions. Among those who say they can do no more:
  - › 22% experiencing discrimination can "do no more" vs. 12% not reporting discrimination)
  - › 27% reporting suicidal ideation can "do no more" vs. 13% not reporting suicidal thoughts
- › 21% with Chronic illness can "do no more" vs 11% not ill
- › Opposite is true of smokers: 7% can "do no more" vs. 15% of non-smokers
- › "Can do no more" is twice as high among those reporting impact of Coronavirus
- › 20% who Lack of someone to turn to for help if ill can "do no more" vs. 12% of those who can find help

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

### AVERAGES



### DISTRIBUTION



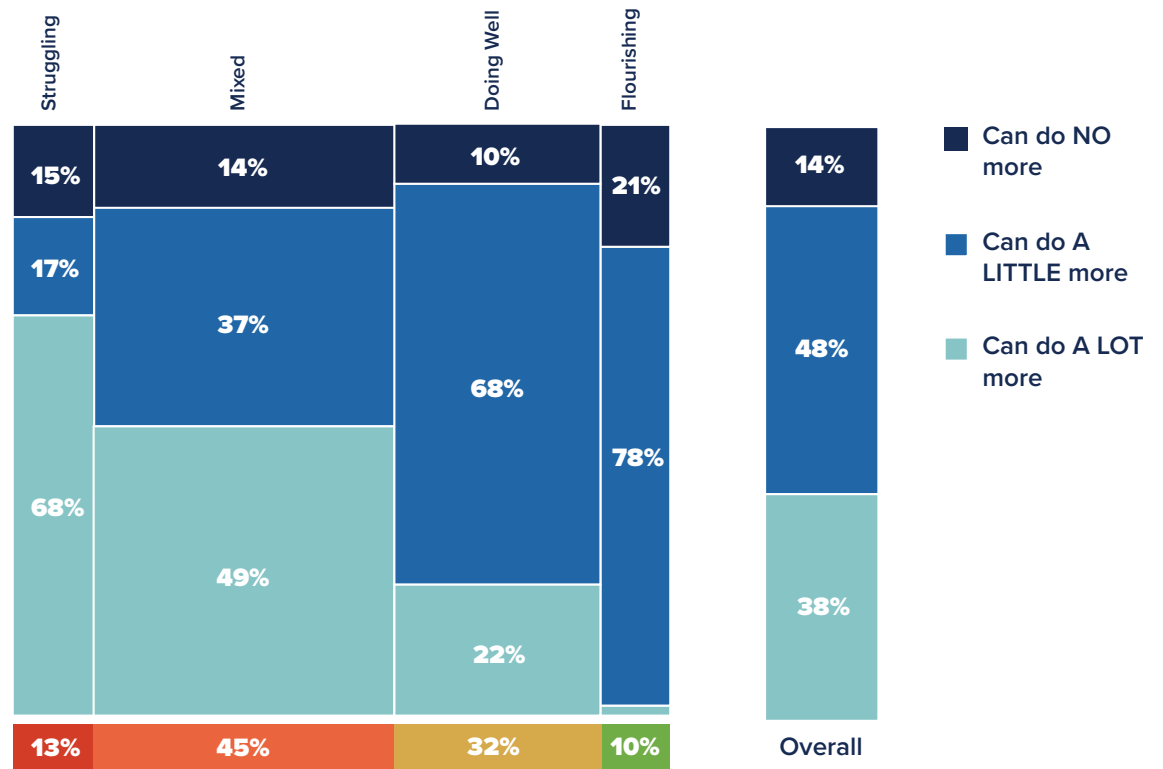
#### Key Findings

- ✓ 10% above 2020 benchmark
- ✓ Over half of community is optimistic
- ✓ Potential improvement (upper boundary as defined by your FLOURISHING segment) is 25% above the 2020 benchmark
- ✓ Based on changes in benchmark scores, your 2020 rating may reflect a significant recent decline

# CAN-DO BY WELL-BEING LEVEL

» This grid presents a remarkable picture relative to other communities we have studied. Valdez residents report:

- ✓ Unusually high capacity to improve – 86% of residents say they can do more
- ✓ Unusually high motivation to improve – 48% are motivated to do a little more, and 38%, a LOT more
- ✓ Capacity to do a LOT more is distributed where it can make the greatest difference: among those classified as “STRUGGLING” and “MIXED”
- ✓ Especially given the outsized focus on health in a Coronavirus era (39% of respondents listed “Covid-19” or “health” as the ‘one thing that could make life better’), this is a community at an inflection point.



Percent of Valdez Adults Over Age 18

# CANTRIL'S LADDER

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

- ✓ **The “Cantril’s Ladder” questions correlate with multiple indicators of well-being on this survey.**
- ✓ **Compared to the HWBM Core4™ Index, Cantril’s Ladder scores generally are not as strongly correlated with a range of health and wellbeing indicators.**
- ✓ **Inclusion of the Cantril’s results adds a comparative, independent measure to the Valdez 2020 CHNA, and serves to further validate the strength of the Health & Well-being Monitor Core4™ Well-being Index and survey.**
- ✓ **Based on Gallup groupings, Valdez residents in general fall at the low margin of the “THRIVING” category.**

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

Analyses of data from different regions of the world make it clear that the general tendency is for respondents to provide more optimistic views of the next five years than the present. This is the case for respondents in most countries, with a few exceptions. Based on statistical studies of the ladder-present and ladder future scale and how each relates to other

items and dimensions as outlined above, Gallup formed three distinct (and independent) groups, for summary purposes:

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

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

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

Imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you. (V2)

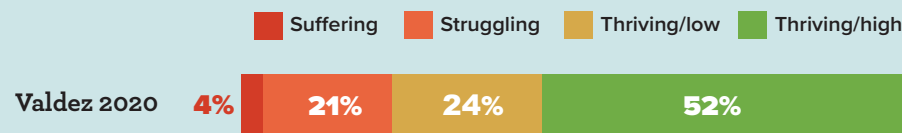
### DISTRIBUTION



- Cantril's Ladder Score (Present) of 7.2 is considered low-end of 'thriving' on the Cantril's Thriving/Struggling/Suffering scale.
- 71% Thriving; 51% low and 20% high.
- Ladder score correlates with Core4™ Wellbeing Index, with similar but consistently weaker correlations to a range of other health indicators.

On which step of the ladder do you think you will stand in about five years from now? (V3)

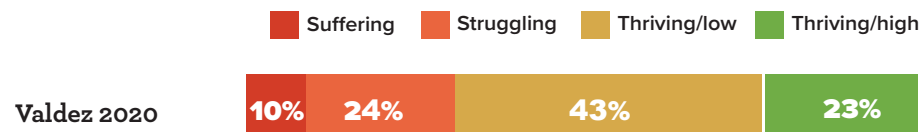
### DISTRIBUTION



- Cantril's Ladder Score (Future) of 8.2 is mid- 'thriving' on the Cantril's (8+) Future Thriving/Struggling/Suffering scale.
- While included, this indicator is significantly less correlated with other health and wellbeing indicators in this report.

Now imagine the top of the ladder represents the best possible financial situation for you, and the bottom of the ladder represents the worst possible financial situation for you. Please indicate where on the ladder you stand right now. (V4)

### DISTRIBUTION



- Cantril's Ladder Score (Financial) of 7.0 is marginally 'thriving' on the Cantril's (7+) Financial Future Thriving/Struggling/Suffering scale.
- This indicator correlates highest with moderately correlated with the TotalHEALTH7™ panel Utility Bill Pay Concern indicator (.46) and Housing worries (0.33), and weak correlations on other basic needs indicators.
- Moderately associated with household income (0.3) and weakly associated with rising age (.23).

# **Six Dimensions of Health**

## **Detailed Results**







## Dimension 1

# Relationships & Social Connections

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

## Overall Scores



**100% above benchmark**  
**0% at benchmark**  
**0% below benchmark**

## »» What This Community Can Do

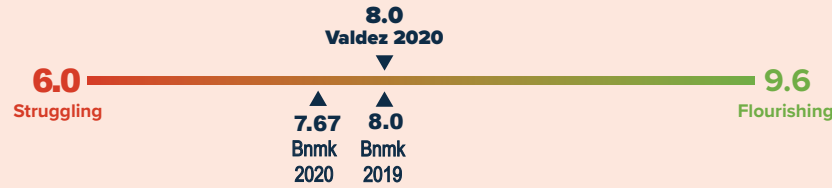
**Advocate** for the time and energy needed to build relationships, foster trust, civic engagement and support equality/ and fairness where people can share their interests, connect and empathize with one another.

## Key Findings

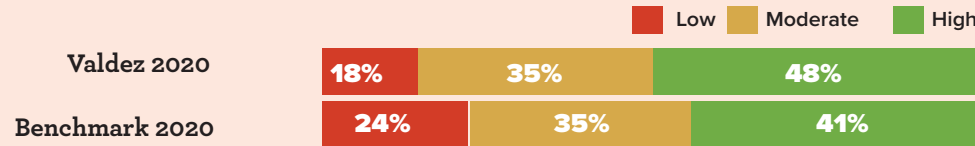
- ✓ Among 8 key indicators, Valdez was above benchmark on 8 (100%).
- ✓ HWBM Composite Indicators are strong guides for action:
  - › 49% to 66% with high ratings are DOING WELL/FLOURISHING
  - › 45% to 83% with low ratings are classified as STRUGGLING
- ✓ Indicators in this dimension are moderate-to-strongly correlated with higher overall life satisfaction, mental/emotional health ratings, satisfaction with overall wellbeing, purpose and meaning, financial security, and community belonging.
- ✓ Respondents with lower ratings share these attributes in higher proportions:
  - › Couples, with and without children
  - › Adults living alone
  - › Younger (age 18-34)
  - › At times, Black Indigenous people of color (BIPOC)
  - › Underemployed or unemployed
  - › Lower education levels
  - › Household incomes under \$49,000 per year
  - › Lower self-ratings on spiritual importance
- ✓ Key Driver Analysis of your data suggests relevant changes with most potential to improve Valdez well-being might include:
  - › Strategies that enhance feelings of individual and community purpose and meaning
  - › Enhancing opportunities to deepen feelings of community belonging
  - › Cultivating frequent connections with neighbors
  - › Gathering with family and friends
  - › Cultivating a more vibrant spiritual life

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

**AVERAGES**



**DISTRIBUTION**

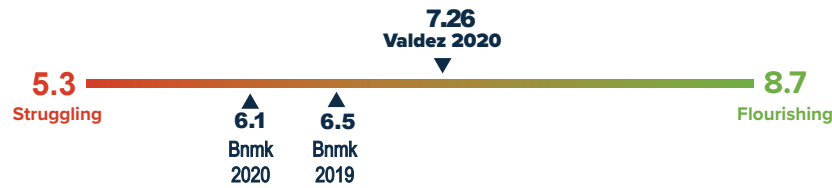


**Key Findings**

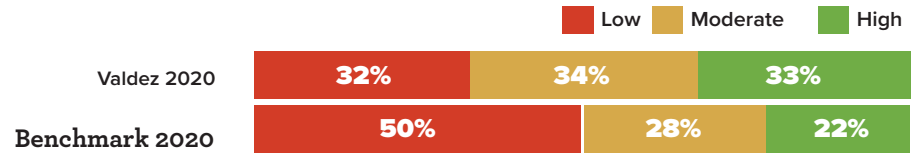
- > 62% with high ratings are DOING WELL/FLOURISHING; 45% with low ratings are STRUGGLING
- > Strong correlation (.55-.59) to life satisfaction, mental/emotional health, overall wellbeing
- > Moderate correlation with access to basic needs (.45)
- > Lower scores linked to higher rates of low spiritual importance, couples w/o kids, age 18-34, unemployed

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

**AVERAGES**



**DISTRIBUTION**

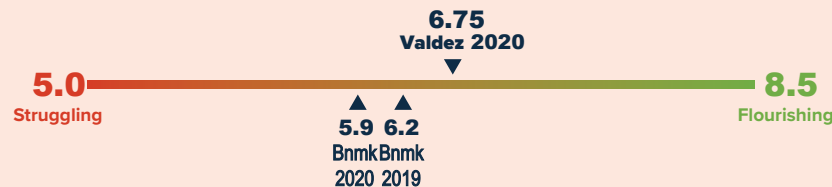


**Key Findings**

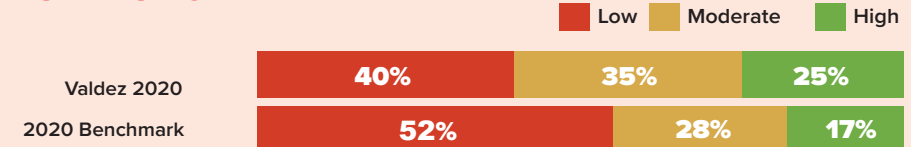
- > High community belonging: 19% > 2020 benchmark
- > 66% with high ratings are DOING WELL/FLOURISHING; 83% with low ratings are STRUGGLING
- >> Moderate/Strong correlation (.38-.52) to mental/emotional health, life satisfaction, overall wellbeing, purpose and meaning, financial security
- > Lower scores linked to higher rates of couples with children, BIPOC, age 18-34, unemployed, low spiritual importance

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

**AVERAGES**



**DISTRIBUTION**

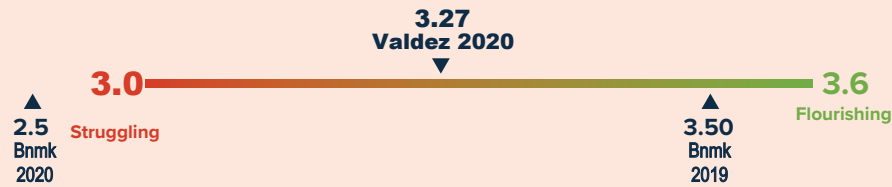


**Key Findings**

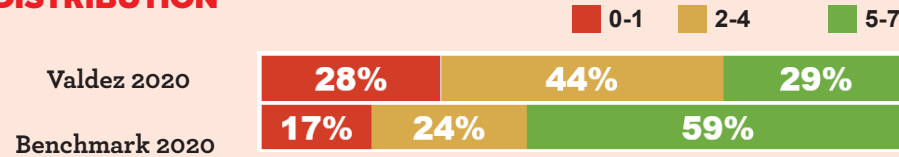
- > High community belonging: 14% > 2020 benchmark
- > 63% with high ratings are DOING WELL/FLOURISHING; 73% with low ratings are STRUGGLING/MIXED
- > Moderate/Strong correlation (.43-.46) to purpose and meaning, community belonging
- > Lower scores linked to higher rates of HS or less education, income <\$49K, low spiritual importance

In the last week, how many days did you: Get together with friends/family. (14F)

### AVERAGES



### DISTRIBUTION

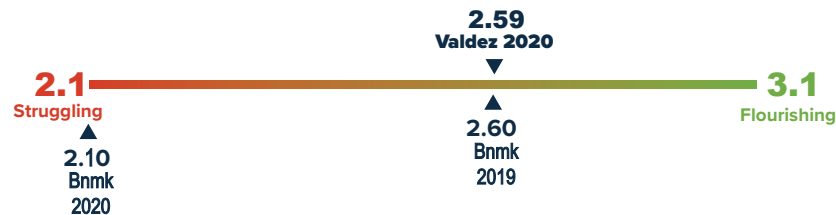


### Key Findings

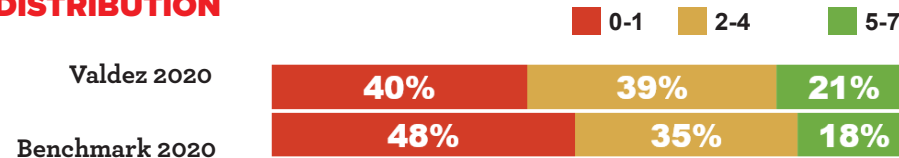
- > High community belonging: 30% > 2020 benchmark
- > 49% of 3+ days/week are DOING WELL/FLOURISHING; 68% of <3/wk are STRUGGLING/MIXED
- > Lower scores linked to higher rates of HS or less education, income <\$49K, low spiritual importance

In the last week, how many days did you: Talk with your neighbors? (14B)

### AVERAGES



### DISTRIBUTION

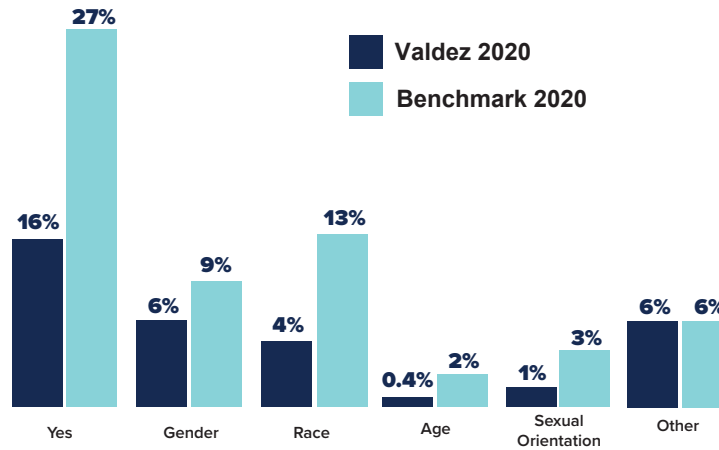


### Key Findings

- > 12% >2020 benchmark
- > 51% of 3+ days/week are DOING WELL/FLOURISHING; 63% of <3/wk are STRUGGLING/MIXED
- > Lower scores linked to higher rates of singles living with other adults; HS or less education

During the past 12 months, have you personally experienced discrimination or been treated unfairly because of your race, ethnic background, gender, or sexual orientation? (8)

**DISTRIBUTION**

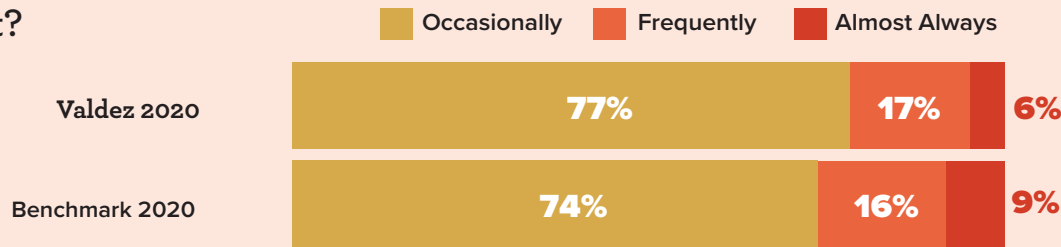


**Key Findings**

- > Low overall rate of reported discrimination (41% below) relative to 2020 benchmark
- > 73% of those reporting discrimination are STRUGGLING/MIXED
- > Where reported, primarily related to:
  - >> Race (40% Black, 31% Asian/PacIslander; 18% Latino; 8% Alaska Native, 2% white)
  - >> Gender (25% Black; 16% Latino; 8% Alaska Native; 7% white)
- > Primarily BIPOC and singles living with other adults (2x average)

How often do you feel like you are discriminated against? (8.1)

**DISTRIBUTION**

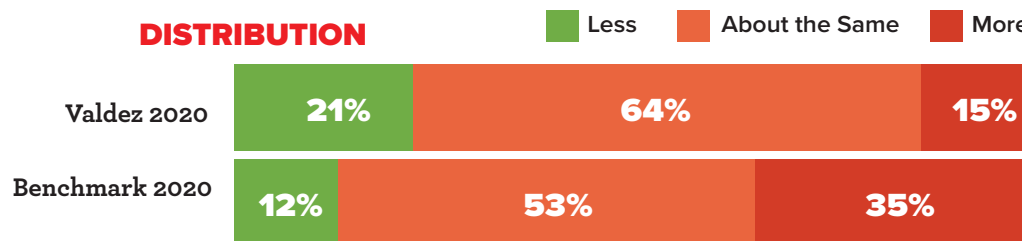


**Key Findings**

- > Similar to 2020 benchmark
  - >> Frequent/continual discrimination reported by:
    - >> 95% of Asian/PacIslanders; 62% of Blacks; and 31% of Alaska Natives

Compared to the year before, did you experience more or less discrimination this year? (8.2)

**DISTRIBUTION**



**Key Findings**

- > Among the 16% reporting discrimination, 8 in 10 experienced the same or more this year.
- > Those reporting LESS were DOING WELL/FLOURISHING at 3.5 times the rate of those reporting SAME/MORE.



## Dimension 2

# Mental, Emotional & Spiritual Health

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

### Overall Scores



**83% above benchmark**  
**17% at benchmark**  
**0% below benchmark**

## »» What This Community Can Do

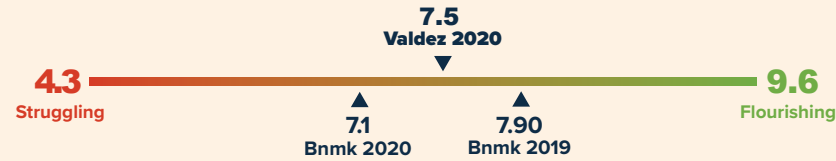
Facilitate warm connections with others and encourage opportunities to express gratitude, self-compassion, mindfulness. Offer resources to support healthy coping skills, recovery and resiliency.

### Key Findings

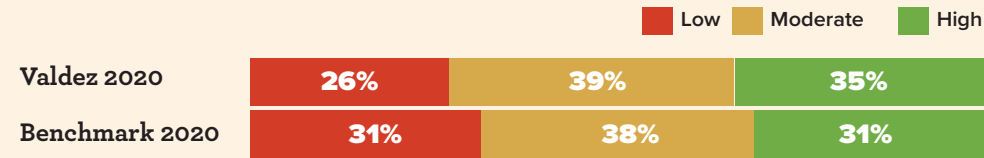
- ✓ On 6 key indicators, Valdez was above benchmark on 5 (83%).
- ✓ **HWBM Composite Indicators are strong guides for action:**
  - › 55% to 78% with high ratings are DOING WELL/FLOURISHING
  - › 69% to 98% with low ratings are classified as STRUGGLING
- ✓ **Indicators in this dimension have the strongest correlations with the Core4™ Well-being Index scores.**
  - › Indicators are also moderately to very strongly correlated with quality of relationships, work/job ratings, opportunities for learning and growth, sense of purpose and meaning, sense of community belonging, and fewer poor mental health days and debilitating health days.
- ✓ **Respondents with low ratings tend to share these attributes in higher proportions:**
  - › Single with children at home
  - › Singles living with other adults
  - › Household incomes under \$49,000 per year
  - › Low spiritual importance
  - › Younger (age 18-34)
  - › Under-employed or unemployed
- ✓ **Key Driver Analysis of your data suggests relevant changes with most potential to improve Valdez well-being might include:**
  - › Efforts to enhance high-quality work environments
  - › Pursuing initiatives to understand and address local causes of poor and debilitating mental health days
  - › Programming to address depression
  - › Improving sleep and exercise
  - › Cultivating a rich inner and spiritual life
  - › Deepening sense of belonging with community
  - › Engaging in efforts that build a sense of meaning and individual/common purpose

## Rate your emotional well-being. (6E)

### AVERAGES



### DISTRIBUTION

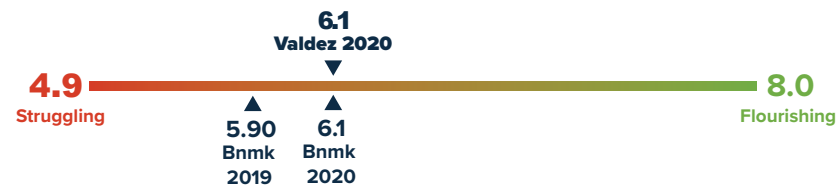


#### Key Findings

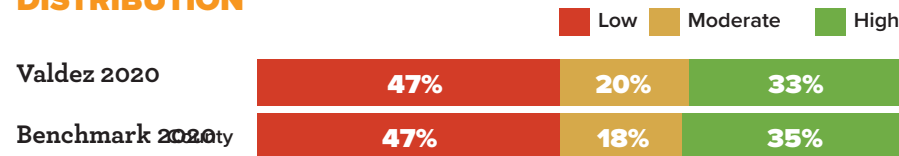
- > 6% above 2020 benchmark
- > 78% with high ratings are DOING WELL/FLOURISHING; 98% with low ratings are STRUGGLING/MIXED
- >> Very strongly correlated with Core4 Wellbeing Index (.75)
- >> Strong correlation (.5-.6) with quality of relationships; work/job; opportunities for learning & growth
- > Lower scores linked to higher rates of singles with children at home; HH income <\$25K, low spiritual importance

## Religion or spirituality is important to me. (7A)

### AVERAGES



### DISTRIBUTION

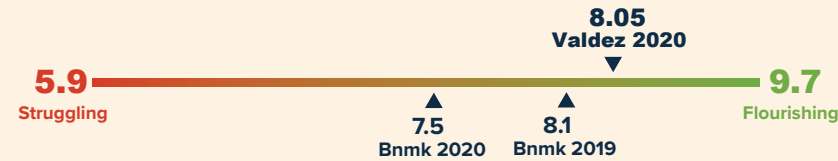


#### Key Findings

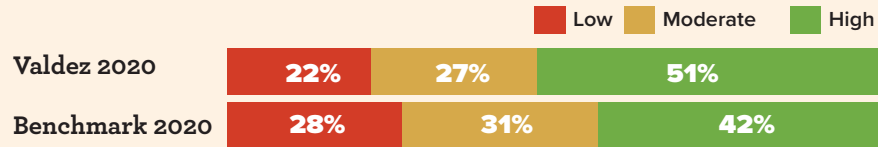
- > At 2020 benchmark
- > 68% with high ratings are DOING WELL/FLOURISHING; 69% with low ratings are STRUGGLING/MIXED
- >> Correlated with sense of purpose and meaning (.44)
- > Lower scores associated with age 18-34 (1.3x avg); HH income <\$49K (1.5x avg), low spiritual importance (2.1x)

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

### AVERAGES



### DISTRIBUTION

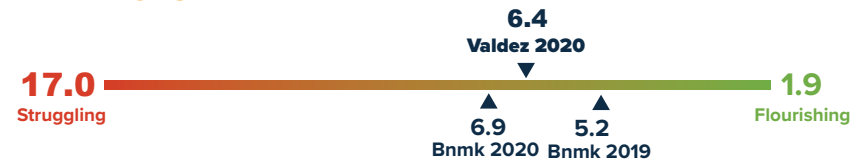


#### Key Findings

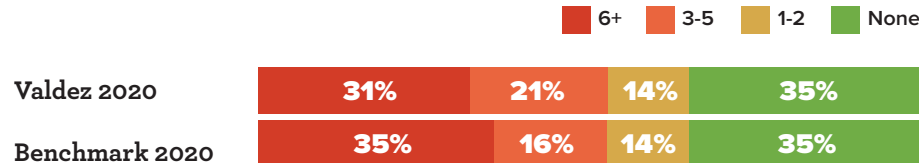
- > 7% above 2020 benchmark
- > 55% with high ratings are DOING WELL/FLOURISHING; 83% with low ratings are STRUGGLING/MIXED
- >> Strongly correlated with Core4 Wellbeing Index (.50), overall wellbeing satisfaction (.51), community belonging (.49)
- >> Moderate correlation with spiritual importance, mental-emotional health, community efficacy, financial security (.43-.49)
- > Lower scores linked to higher rates of singles with children at home; HH income <\$25K, low spiritual importance

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

### AVERAGES



### DISTRIBUTION

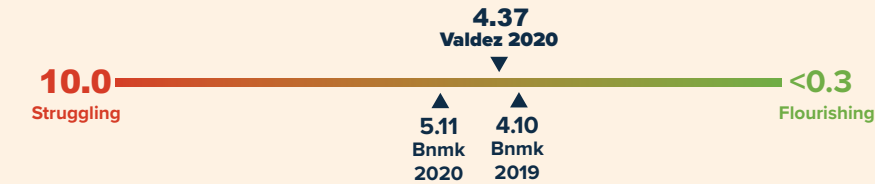


#### Key Findings

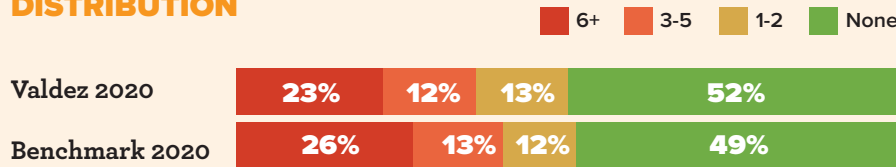
- > 7% lower than (favorable to) 2020 benchmark; mainly due to lower average in 6+days/month range
- > 61% of 0-1 day/month are DOING WELL/FLOURISHING; 91% of 7+ / month are STRUGGLING/MIXED
- >> 50 % of 2-6 days/month are STRUGGLING/MIXED
- > Strong correlation with Core4 Well-being Index (-.56); satisfaction with mental-emotional health (-.63); overall well-being satisfaction (-.52) debilitating health days (.5);
- > Moderate correlation with overall life satisfaction (-.42)
- > "7+ days/mo " tend to be singles with children at home (1.9x), 18-24 (1.4x), HH income <\$49K (1.7x, unemployed (1.8x)

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

### AVERAGES



### DISTRIBUTION



### Key Findings

- > 14% lower than (favorable to) 2020 benchmark; mainly due to lower average in 6+ day range
- > 57% of 0-1 day/mo are DOING WELL/FLOURISHING; 88% of 7+ days/month are STRUGGLING/MIXED
- >> 68% of 2-6 days/month are STRUGGLING/MIXED
- > Strong correlation with Core4 Well-being Index (-.56); satisfaction with mental-emotional health (-.63); overall well-being satisfaction (-.52) debilitating health days (.5);
- > Moderate correlation with overall life satisfaction (-.42)
- > "7+ days/mo" tend to be HH income <\$49K (1.9x), unemployed (2.0x)

During the past 12 months, did you ever seriously consider attempting suicide? (V1)

### DISTRIBUTION



### Key Findings

- > Unchanged from 2017 CHNA survey result
- > 3% YES; 2% Don't Know (but analytics suggest DK=YES)
- > 90% (46% of YES and 44% of DON'T KNOW) are STRUGGLING/MIXED
- >> Moderately correlated with use of ER as main healthcare source (0.36)
- > "YES/DK" tend to be singles living alone/with other adults (2.7x), BIPOC (2x); HH income <\$25K (5.3x), employed part-time (2.9x) or unemployed (4x)





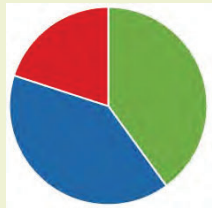
### Dimension 3

# Neighborhood & Environment

In important ways, your location defines your health. Safe, connected, walkable neighborhoods with access to nutritional food, good education for children, and human services make it easier to enjoy well-being.

Being in nature not only makes you feel better emotionally, it contributes to your physical well-being. It soothes, restores and connects. People who live near parks and natural areas are more physically active, live longer, and these open spaces draw people together, enhancing social connections.

### Overall Scores



**40% above benchmark**  
**40% at benchmark**  
**20% below benchmark**

## »» What This Community Can Do

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

### Key Findings

- ✔ Valdez was above or at benchmark on 4 out of 5 indicators (80%).
- ✔ HWBM Composite Indicators are strong guides for action:
  - › 42% to 59% with high ratings on these indicators are classified as DOING WELL/FLOURISHING
  - › 77% to 96% with low ratings are classified as STRUGGLING
- ✔ Indicators in this dimension are slightly to moderately correlated with the Core4™ Well-being Index scores.
  - › Indicators are also moderately correlated with mental-emotional health, physical health satisfaction, access to healthcare and basic needs, relationships, opportunities for learning and growth.
- ✔ Respondents with low ratings tend to share these attributes in higher proportions:
  - › Younger (age 18-34)
  - › Household incomes under \$49,000 per year
  - › Single with children at home
  - › Male
  - › Lower education levels
  - › Unstably housed or unsheltered
- ✔ Key Driver Analysis of your data suggests relevant changes with most potential to improve Valdez well-being might include:
  - › Encouraging neighborhood and community connections especially around healthy food and exercise
  - › Cultivating financial security
  - › Pursuing & supporting community and formal education
  - › Engaging in efforts that build a sense of meaning and individual/common purpose
  - › Building visibility and active efforts to improve housing stability
  - › Lower education levels
  - › Unstably housed or unsheltered

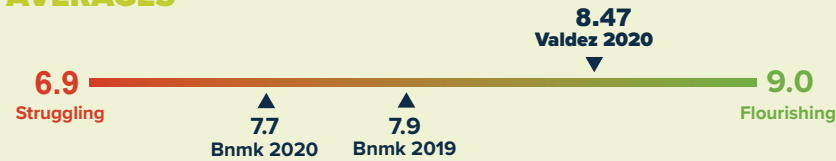


**ENVIRONMENT & WELL-BEING.** A healthy physical environment – with access to clean water and air - is crucial to good health & well-being.

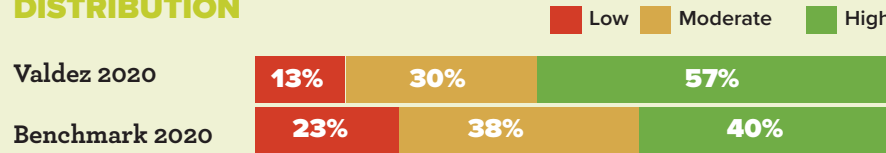
Increasingly, the threat of global climate change may dwarf all other dimensions of health in the future – threatening our social and political stability, economies, food supply, the viability of life and civilization on earth as we know it.

## Rate the neighborhood you live in. (6A)

### AVERAGES



### DISTRIBUTION

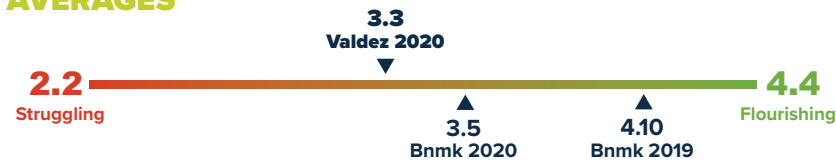


### Key Findings

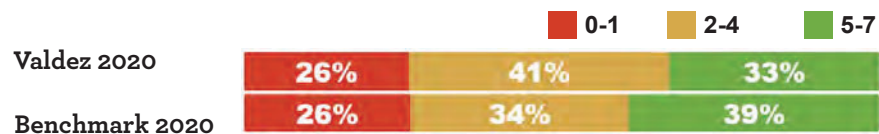
- > 10% > 2020 benchmark; high rating is 43% above benchmark
- > 49% with high ratings are DOING WELL/FLOURISHING; 81% with low ratings are STRUGGLING/MIXED
- > Strong correlations with Core4 Wellbeing Index, the HWBM Composite Category, mental/emotional health rating (.49), Cantril's Ladder/current, opportunities for learning and growth, and relationship rating
- > Lower scores associated with age 18-34 (1.6x); HH income <\$49K (2.3x)

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

### AVERAGES



### DISTRIBUTION

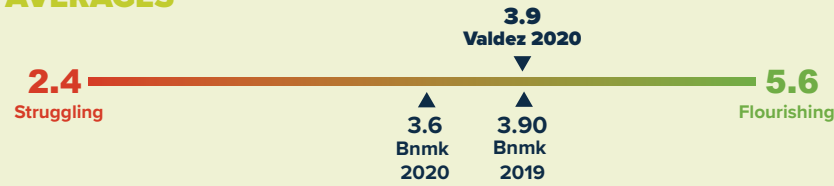


### Key Findings

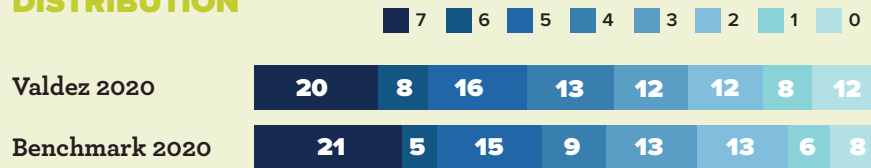
- > 6% below 2020 benchmark
- > 59% of 5+ days/wk are DOING WELL/FLOURISHING; 78% of < 3 days/wk are STRUGGLING/MIXED
- > Weak correlation (.2-.3) with most indicators
- > <3 days/wk tend to be singles with children (1.9x), males (1.2x), <HS education (1.2x)

How many days did you walk or exercise 30 minutes or more, past week? (14C)

**AVERAGES**



**DISTRIBUTION**

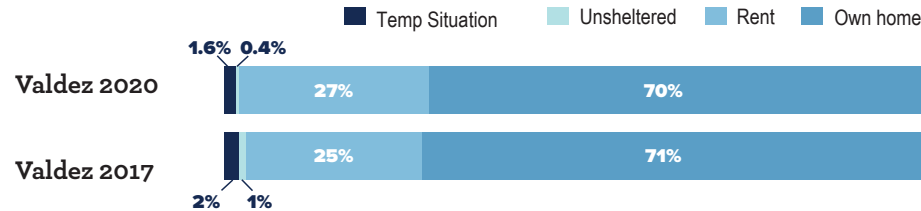


**Key Findings**

- > 8% > 2020 benchmark
- > 55% of 5+days/wk are DOING WELL/FLOURISHING; 77% of <3 days/wk are STRUGGLING/MIXED
- > Moderately correlated with physical health satisfaction (.37), BMI (-.35); weak correlation with poor physical health days (-.18)
- > <3 days/wk is distributed very evenly across the community

Which answer best describes your housing situation for the majority of the past 12 months? (Tailored v18)

**DISTRIBUTION**



**Key Findings**

- > Similar to 2017 CHNA survey results
- > 42% of Own/Rent are DOING WELL/FLOURISHING, VS. 7% OF Temp/Unsheltered
- > Of 2% who are Temp/Unsheltered:
  - >> 96% are Struggling/MIXED
  - >> 85% are single, 71% live with other adults; 70% 18-34; 71% <=HS education
- > No correlations with any key indicators

Are you living with other adults besides yourself or a partner? (Tailored v16)





#### Dimension 4

# Work, Learning & Growth

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

Using available resources to develop and create opportunities that resonate with your unique gifts, skills, and talents contributes to meaning and purpose, and helps you remain active and involved throughout life. Education is deeply connected with well-being. Opportunities for ongoing growth brings a sense of purpose and meaning. A work life or career consistent with your personal values, interests, beliefs and balances both work and can contribute greatly to all six dimensions of well-being.

#### Overall Scores



**100% above benchmark**  
**0% at benchmark**  
**0% below benchmark**

## »» What This Community Can Do

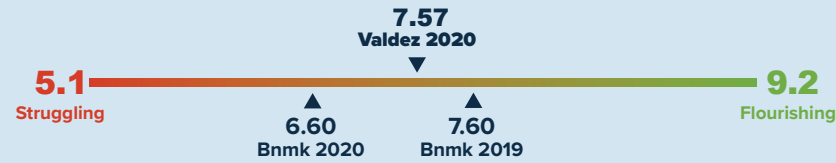
**Facilitate equitable access** to life-long learning at home, in schools, at work and community/society. Seek and offer education and growth opportunities in work and life. Boost confidence, purpose, skills and connect with others.

#### Key Findings

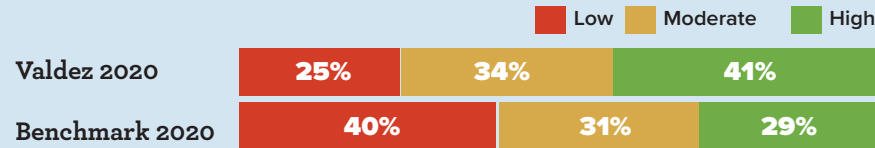
- ✓ On 6 key indicators, Valdez was above benchmark on 6 (100%).
- ✓ HWBM Composite Indicators are strong guides for action:
  - › 55% to 78% with high ratings are DOING WELL/FLOURISHING
  - › 69% to 98% with low ratings are classified as STRUGGLING
- ✓ Indicators in this dimension have the strongest correlations with the Core4™ Well-being Index scores.
  - › Indicators are also moderately to very strongly correlated with quality of relationships, work/job ratings, opportunities for learning and growth, sense of purpose and meaning, sense of community belonging and fewer poor mental health days and debilitating health days.
- ✓ Respondents with low ratings tend to share these attributes in higher proportions:
  - › Single with children at home,
  - › Singles living with other adults
  - › Household incomes under \$49,000 per year
  - › Low spiritual importance
  - › Younger (age 18-34)
  - › Under-employed or unemployed
- ✓ Key Driver Analysis of your data suggests relevant changes with most potential to improve Valdez well-being might include:
  - › Enhancing access to education and training to improve financial security
  - › Community/employer partnerships to improve employment opportunities
  - › Deepening sense of belonging with community
  - › Efforts that improve access to basic needs, enabling residents to invest in futures
  - › Engaging in efforts that build a sense of purpose and individual/community meaning
  - › Pursuing initiatives aimed at reducing or avoiding poor and debilitating mental health days
  - › Providing resources and options for residents in unsafe relationships

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

### AVERAGES



### DISTRIBUTION

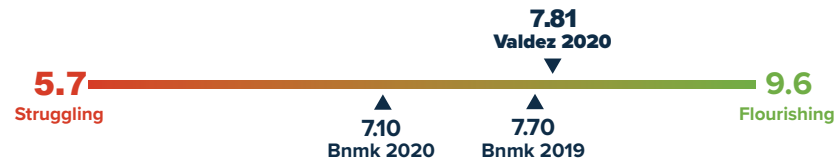


### Key Findings

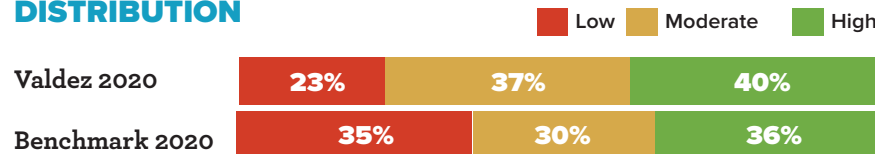
- > 15% > 2020 benchmark
- > 59% with high ratings are DOING WELL/FLOURISHING; 84% with low ratings are STRUGGLING/MIXED
- > Strongly correlated with the Core4 Wellbeing Index (.54), overall well-being satisfaction (.53); emotional health rating (.49), mental/emotional wellbeing satisfaction (.48), opps for learning & growth (.47), life satisfaction (.46); relationship ratings (.45);
- > Lower scores linked to higher rates of singles with children at home (1.7x); ages 18-44 (1.4x); HH income <\$25K (1.7x); unemployed (1.5x), students (1.8x).

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

### AVERAGES



### DISTRIBUTION

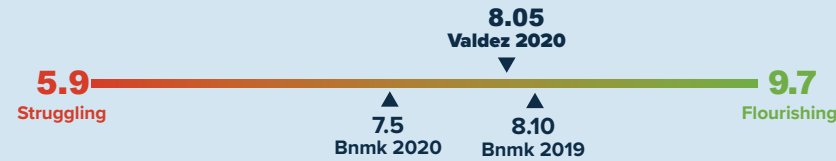


### Key Findings

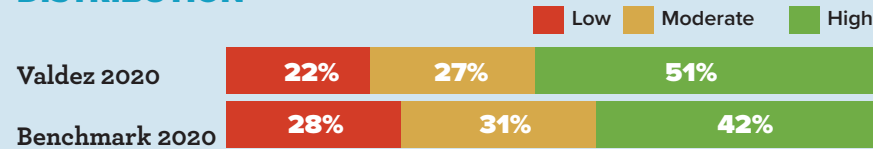
- > 10% > 2020 benchmark
- > 57% with high ratings are DOING WELL/FLOURISHING; 88% with low ratings are STRUGGLING/MIXED
- > Strongly correlated with relationships (.58); cmtly belonging (.53); overall well-being (.52); purpose & meaning (.50); Core4 Well-being Index (.49); mental/emotional health (.48)
- > Lower scores linked to higher rates of singles with children at home (2.1x); ages 18-44 (1.4x); HH income <\$25K (1.6x); uncultivated spiritual life (1.5x)

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

### AVERAGES



### DISTRIBUTION



### Key Findings

- > 7% above 2020 benchmark; more than half rate this high
- > 55% with high ratings are DOING WELL/FLOURISHING; 83% with low ratings are STRUGGLING/MIXED
- >> Strongly correlated with Core4 Wellbeing Index (.50), overall wellbeing satisfaction (.51), community belonging (.49)
- >> Moderate correlation with spirituality, mental-emotional health, community efficacy, financial security (.43-.49)
- > Lower scores linked to higher rates of single with children at home; HH income <\$25K, uncultivated spiritual life

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

### DISTRIBUTION



### Key Findings

- > 32% < 2020 benchmark (favorable)
- > 87% "yes" are STRUGGLING/MIXED
- > Strongly correlated with relationships (.58); cmtly belonging (.53); overall well-being (.52); purpose & meaning (.50); Core4 Well-being Index (.49); mental/emotional health (.48)
- > Lower scores linked to higher rates of singles living with other adults (2.1x); 18-34 (1.8x); some college (1.6x); with children at home (2.1x); ages 18-44 (1.4x); HH income <\$25K (1.6x); uncultivated spiritual life (1.5x); HH Income <\$25K; student or unemployed (3.7x)

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

### DISTRIBUTION



### ✓ Key Findings

- 47% < 2020 benchmark (very favorable)
- 79% with this need are STRUGGLING/MIXED
- Strongly correlated with relationships (.58); cmtly belonging (.53); overall well-being (.52); purpose & meaning (.50); Core4 Well-being Index (.49); mental/emotional health (.48)
- Lower scores linked to higher rates of couples with children at home (1.6x); BIPOC (2.1x); age 18-34 (1.8x); HH income <\$25K (2.7x); P-T job (2.4x); unemployed (3.7x); and students (3.7x)



## Dimension 5

# Security & Basic Needs

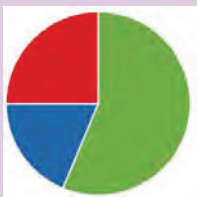
Having enough, and freedom from worry. We need enough money for food, rent or mortgage, health care, medical bills and basic expenses of daily living.

Lack of access to basic needs and personal safety are linked at all stages of life to physical and mental illness, post-traumatic stress, shorter lifespans and poorer quality of life.

The experience of others affects you. 2019 Monitor™ research found that overall community well-being was measurably lower for ALL where rates of homelessness are higher.

Research shows that 'extras' don't really contribute to our well-being- unless it is for fun activities and friends, or expenses that match our values.

### Overall Scores



**56% above benchmark**  
**19% at benchmark**  
**25% above benchmark**

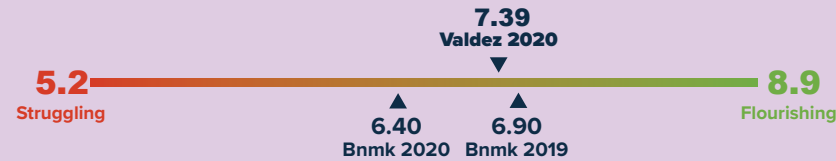
### Key Findings

- ✔ On 16 key indicators, Valdez was above benchmark on 9 (56%).
- ✔ HWBM Composite Indicators are strong guides for action:
  - › 48% to 61% with high ratings are DOING WELL/FLOURISHING
  - › 68% to 90% with low ratings are classified as STRUGGLING
- ✔ Indicators in this dimension are
  - › strongly correlated with the Core4 Wellbeing Index score, overall wellbeing satisfaction, security about financial future, job ratings
  - › moderately correlated with sense of community belonging, sense of purpose and meaning, mental-emotional health rating, use of ER as main source of healthcare
- ✔ Respondents with low ratings tend to share these attributes in higher proportions:
  - › Single with children at home
  - › Single living with other adults
  - › Living alone
  - › HH income under \$49,000 per year
  - › Education high school or less
  - › Sometimes Black Indigenous people of color (BIPOC)
  - › Low spiritual importance
- ✔ Key Driver Analysis of your data suggests relevant changes with most potential to improve Valdez well-being might include:
  - › Programs that improve stable housing
  - › Efforts that improve equity and reduce discrimination
  - › Efforts that improve job access and job satisfaction
  - › Facilitating access to higher education

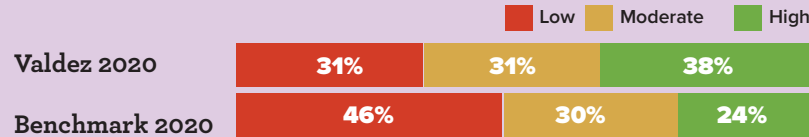


I feel secure about my financial future. (7D)

### AVERAGES



### DISTRIBUTION

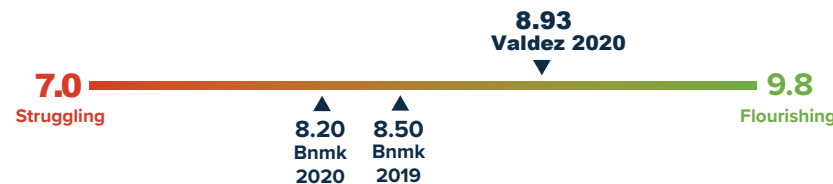


#### Key Findings

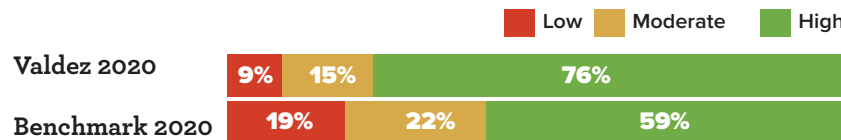
- > 15% above 2020 benchmark
- > 61% with high ratings are DOING WELL/FLOURISHING; 84% with low ratings are STRUGGLING/MIXED
- >> Strongly correlated with overall wellbeing satisfaction (.51), Core4 Wellbeing Index (.47); moderately correlated with community belonging (.46); purpose & meaning (.44); mental-emotional health satisfaction (.39)
- > Lower scores linked to higher rates of single with children at home (1.9x) or living alone (1.6x); 18-34 (1.4x); HH income <\$75k (1.7x); uncultivated spiritual life (1.3x)

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

### AVERAGES



### DISTRIBUTION

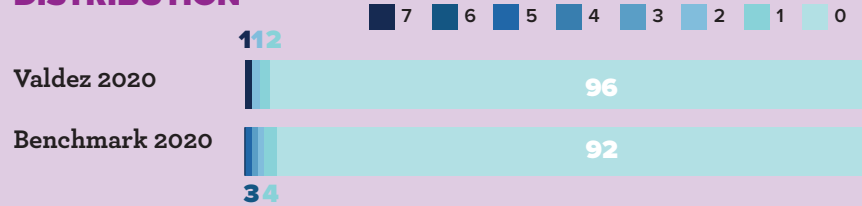


#### Key Findings

- > 11% above 2020 benchmark
- > 48% with high ratings are DOING WELL/FLOURISHING; 86% with low ratings are STRUGGLING/MIXED
- >> Strongly correlated with security about financial future (.47); overall wellbeing satisfaction (.45), relationships (.45); moderately correlated with Core4 Wellbeing Index (.47); job rating (.45) and other factors.
- > Lower scores linked to higher rates of singles living with other adults (3x); some college (1.6x); HH income <\$25k (3.5x)

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

### DISTRIBUTION

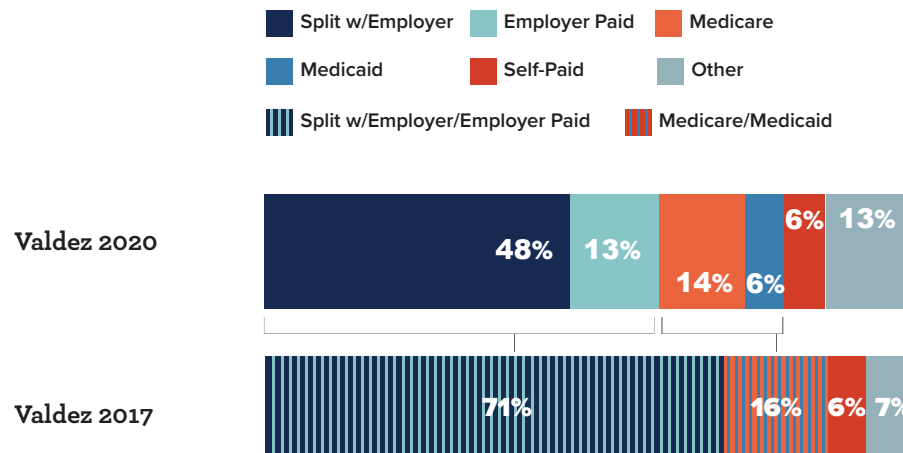


### Key Findings

- > 4% of respondents reported 1+ days/wk
- > 80% with 1+ /week are STRUGGLING/MIXED
- >> Strongly correlated with security about financial future (.47); overall wellbeing satisfaction (.45), relationships (.45); moderately correlated with Core4 Wellbeing Index (.47); job rating (.45) and other factors
- > Lower scores linked to higher rates of BIPOC (2.4x); 18-34 (2.4x); <=HS Education (1.7x); <\$25K (7.8x); and actively cultivating spiritual lives (2.6x)

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

### DISTRIBUTION



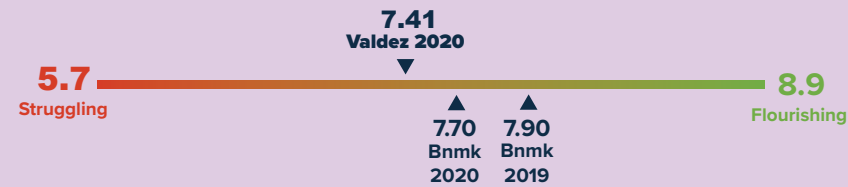
### Key Findings

- > 7% of respondents were uninsured in 2020, unchanged from 2017.
- > Among the 93% with health coverage, this shows sources in 2017 and 2020 as reported by respondents.

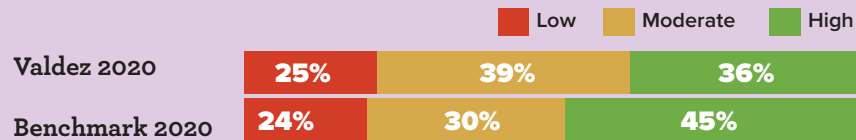
Note that this question was worded differently in 2017 and 2020, resulting in additional detail available this year.

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

### AVERAGES



### DISTRIBUTION

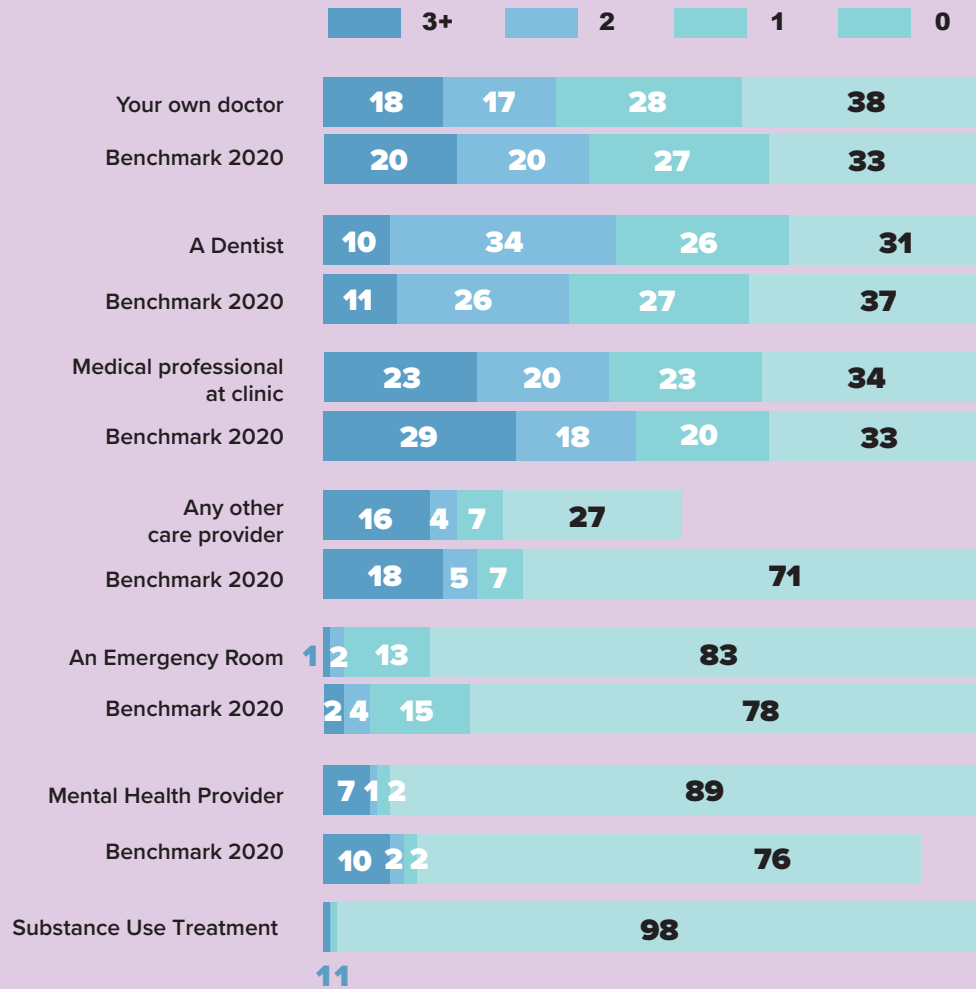


### Key Findings

- 4% below 2020 benchmark
- 50% with high ratings are DOING WELL/FLOURISHING; 90% with low ratings are STRUGGLING/MIXED
- Moderate/strongly correlated (.32-.46) with all Well-being Indicators
- Lower scores linked to higher rates of age 18-34 (2.4x); HS education or less (1.4x); HH income <\$49K (1.6x)

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

### DISTRIBUTION



# Valdez 2020 And The TotalHealth7™ Basic Needs Panel

» TotalHEALTH 7 – Active Worries about Basic Needs (Social Determinants of Health Panel) (9)

TOTAL HEALTH QUESTION	Valdez	Benchmark 2020
FOOD: Are you worried that you or others in your home won't have enough food to eat?	5%	9%
TRANSPORTATION: Are you worried about getting to work, school, groceries, or appointments because you don't have a way to get there?	6%	9%
HOUSING: Are you living without stable housing, currently homeless or worried about losing your housing?	7%	10%
POWER & WATER: Are you worried about paying your water and/or power bills?	17%	11%
JOB: Are you without a stable job, or do you need help getting a better job?	10%	19%
EDUCATION: Do you need additional education or training to get the job and income you need?	13%	19%
INTIMATE ABUSE/VIOLENCE: Do you ever feel unsafe in your relationship or at home?	3%	6%

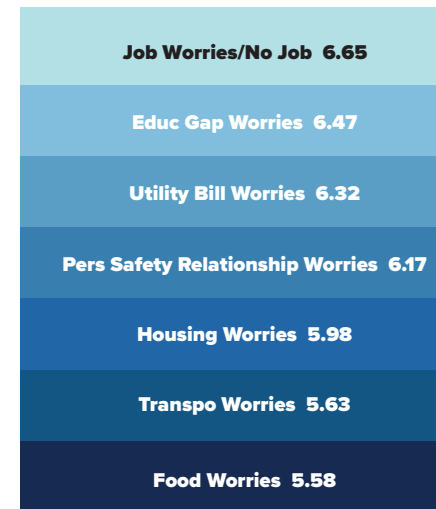
# of Worries	0	1	2+
Valdez	69%	31%	14%
Benchmark	61%	40%	20%

## TOTALHEALTH7™ BASIC NEEDS PANEL

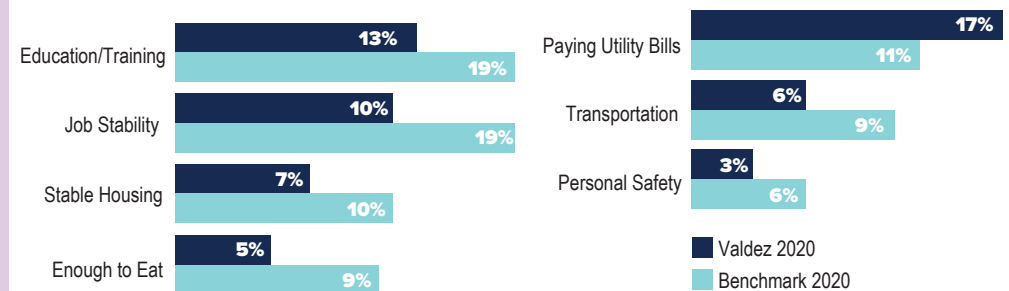
- » TotalHEALTH7™ is a panel of questions tied to key security and basic needs issues.
- » While Valdez residents generally fare better than the 2020 benchmark community, nearly 1 in 3 Valdez residents (31%) report they are currently experiencing or worried about one or more of these basic needs.
- » Core4 Well-being Index scores are 8% to 23% lower than average among residents reporting gaps in basic needs -- see table.



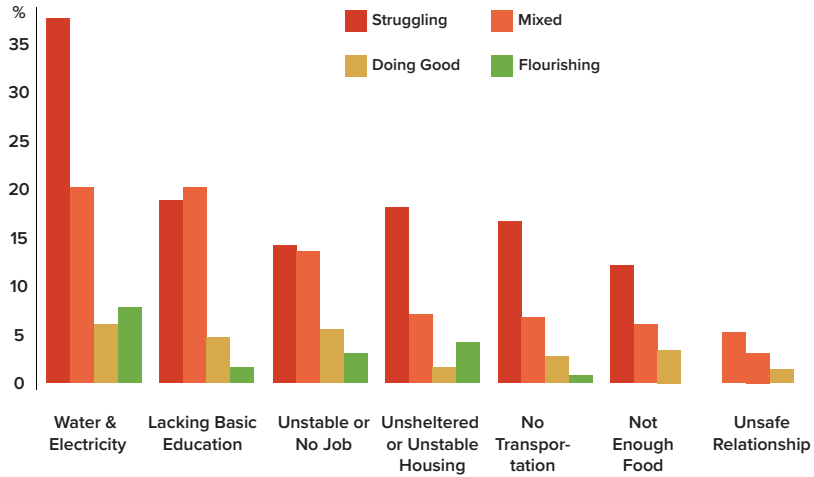
Core4 Index Mean:



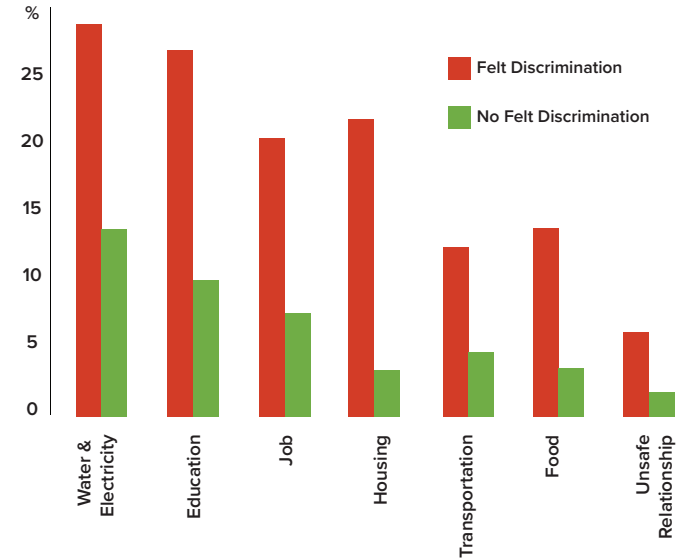
Percentage of Valdez 2020 who reported significant need in each of seven key social needs follows:



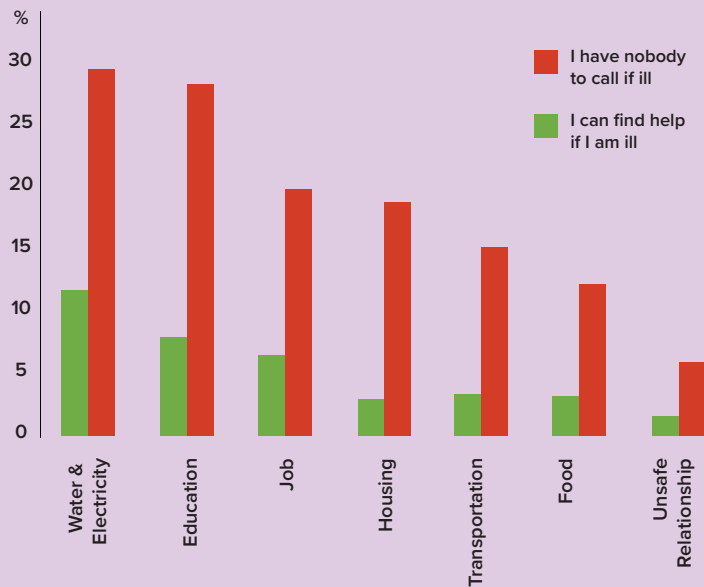
## TotalHealth7™ Worries dramatically higher among Struggling and Mixed HWBM Composite Categories



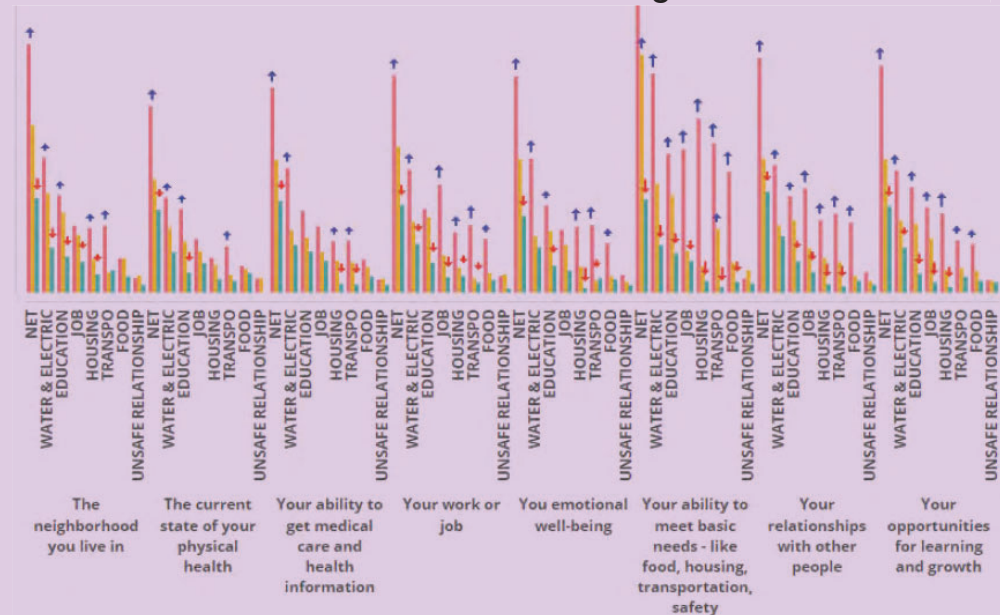
## TotalHealth7™ Worries are 2 to 10 times higher among people reporting discrimination



## TotalHealth7™ Worries are 2.5 to 7 times greater among those with nobody to turn to for chore help if they are ill.

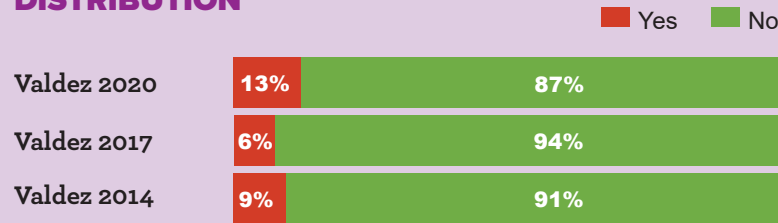


## TotalHealth7™ Worries are affected by dissatisfaction with a broad range of life conditions



Do you use the emergency room as your main source of health care? (v15)

### DISTRIBUTION

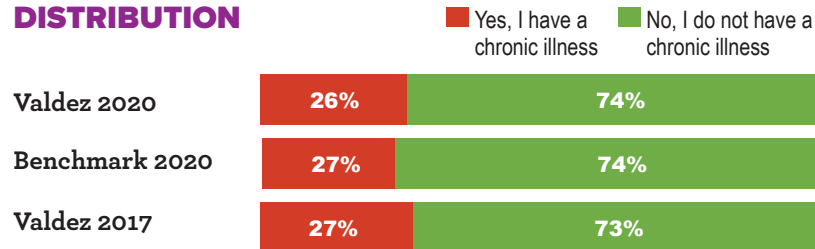


### Key Findings

- > Rate doubled from 2017.
- > 84% (452 out of 541) did not provide a response to this question alone, making more detailed results unreliable.
- >> The reason that so few answered this question is in itself of interest.

Are you living with a chronic illness (such as diabetes, heart disease or cancer)? (V5)

### DISTRIBUTION

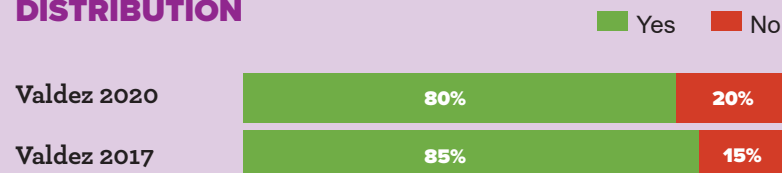


### Key Findings

- > Unchanged from 2017
- > 68% of YES are STRUGGLING/ MIXED
- >> Moderate correlation with use of ER as main source of healthcare (.27)
- > "YES" tend to be couples without children (1.4x); age 45+ (1.5x); retired (1.7x)

If you were sick, could you easily find someone to help you with daily chores? (V11)

### DISTRIBUTION



### Key Findings

- > 20% of respondents reported NO, up 33% from 2017
- > 73% of NO's are STRUGGLING/ MIXED
- >> Inversely correlated with overall satisfaction with Wellbeing Index (-.26);
- > "NO" tend to be single living alone (2.2x); (2.4x); 18-34 (2.4x); <=HS Education (1.7x); <\$25K (7.8x); and actively cultivating spiritual lives (2.6x)



## Dimension 6

# Physical Health

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

## Overall Scores



**46% above benchmark**  
**31% at benchmark**  
**23% below benchmark**

## »» What This Community Can Do

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

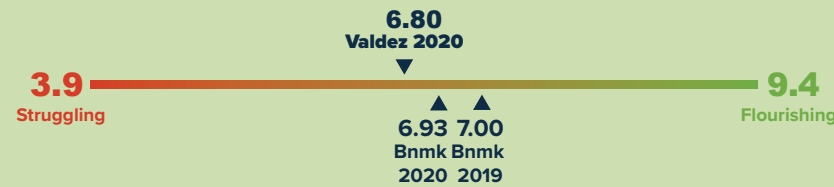
## Key Findings

- ✔ On 13 key indicators, Valdez was above benchmark on 6 (46%).
- ✔ HWBM Composite Indicators are strong guides for action:
  - 48% to 61% with high ratings are DOING WELL/FLOURISHING
  - 68% to 90% with low ratings are classified as STRUGGLING
- ✔ Indicators in this dimension are
  - strongly correlated with the Core4 Wellbeing Index score, overall wellbeing satisfaction, security about financial future, job ratings
  - moderately correlated with sense of community belonging, sense of purpose and meaning, mental-emotional health rating, use of ER as main source of healthcare,
- ✔ Respondents with low ratings tend to share these attributes in higher proportions:
  - Single with children at home
  - Single living with other adults
  - Living alone
  - HH income under \$49,000 per year
  - Education high school or less
  - Sometimes Black Indigenous people of color (BIPOC)
  - Low spiritual importance
- ✔ Key Driver Analysis of your data suggests relevant changes with most potential to improve Valdez well-being might include:
  - Community and employer-based initiatives to improve exercise and nutrition
  - Efforts that instill/enhance a sense of purpose and meaning
  - Efforts that improve job access and job satisfaction
  - Strategies focused on understanding and eliminating causes of more than 2 poor physical health days per month
  - Strategies to understand and eliminate causes of more than 7 debilitating health days per month

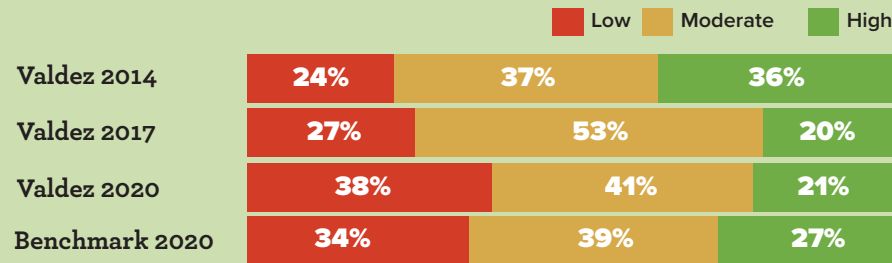


## Rate the current state of your physical health. (6B)

### AVERAGES



### DISTRIBUTION

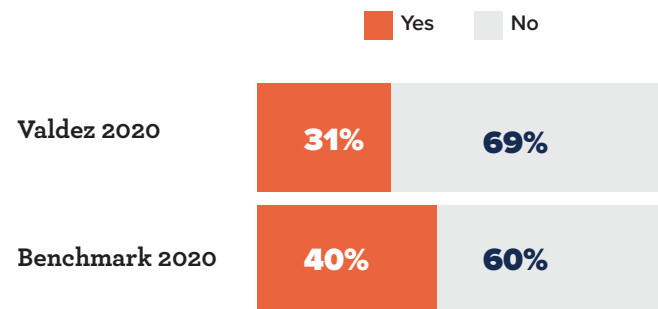


### Key Findings

- > Slightly below 2020 benchmark; declining since 2014 with **low ratings up 58%**
- > 80% Very Satisfied are DOING WELL/FLOURISHING; 98% with low ratings are STRUGGLING/MIXED
- >> Strong/very strong correlation with physical health satisfaction (.80); Core4 Wellbeing Index (.66); overall well-being satisfaction (.58), emotional wellbeing (47); moderate correlations to most other factors.
- > "Not Satisfied" tend to be singles with children at home (1.8x); <=HS Education (1.3x)

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

### DISTRIBUTION

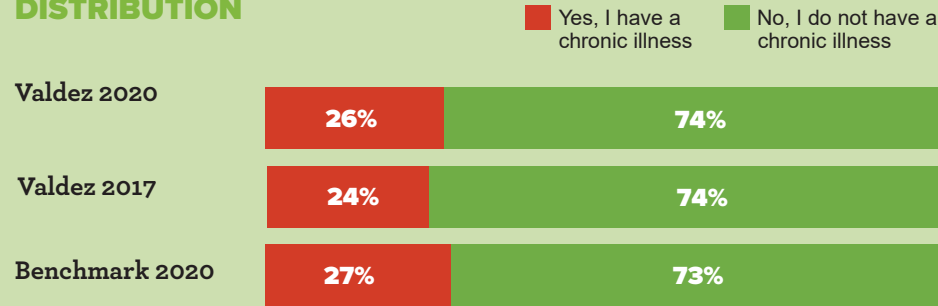


### Key Findings

- > 37% below 2020 benchmark (favorable)
- > 44% of NO are DOING WELL/FLOURISHING; 44% of YES are STRUGGLING/MIXED
- > "YES" tend to be couples with no children at home (1.3x); age 65+ (1.8x); retired (1.9x)

Are you living with a chronic illness (such as diabetes, heart disease or cancer)? (V5)

**DISTRIBUTION**

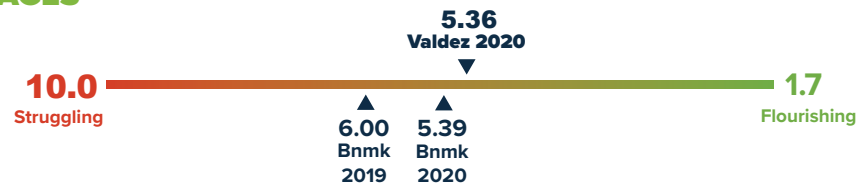


✓ **Key Findings**

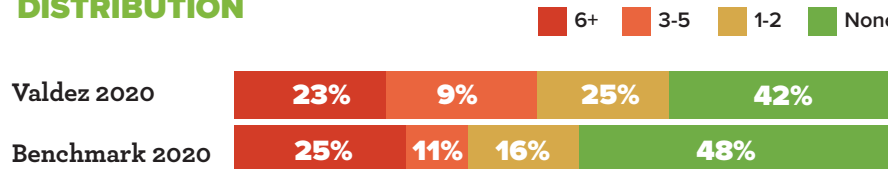
- > 8% increase since 2017; similar to 2020 Benchmark
- > 68% of YES are STRUGGLING/MIXED
- >> Moderate correlation with use of ER as main source of healthcare (.27)
- > "YES" tend to be couples without children (1.4x); age 45+ (1.5x); retired (1.7x)

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

**AVERAGES**



**DISTRIBUTION**

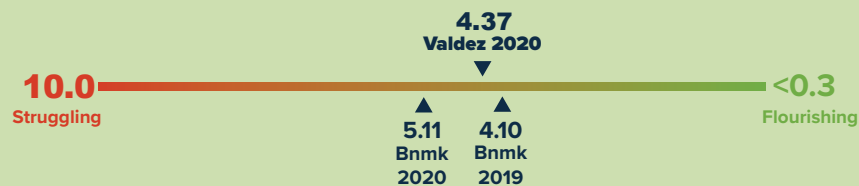


✓ **Key Findings**

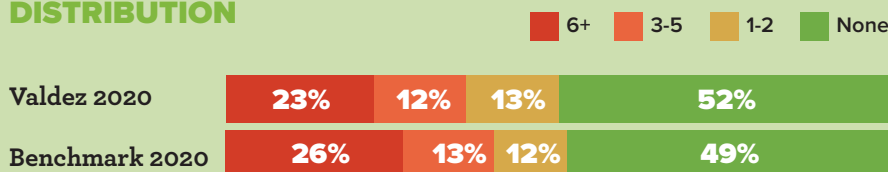
- > Similar to 2020 benchmark
- > 58% of 0-1 day/mo are DOING WELL/FLOURISHING; 85% of 7+/month are STRUGGLING/MIXED
- >> 68% of 2-6/month are STRUGGLING/MIXED
- > Moderate-strong correlation with Core4 Well-being Index; debilitating health days (.5)
- > "7+ days/mo" associated with HH income <\$25K (1.7x), retired (1.6x)

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

### AVERAGES



### DISTRIBUTION

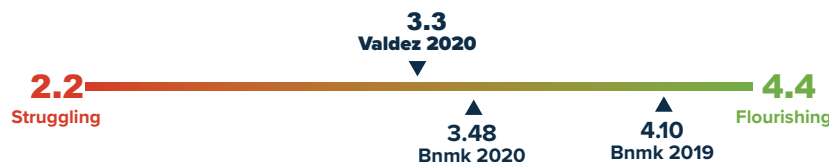


### Key Findings

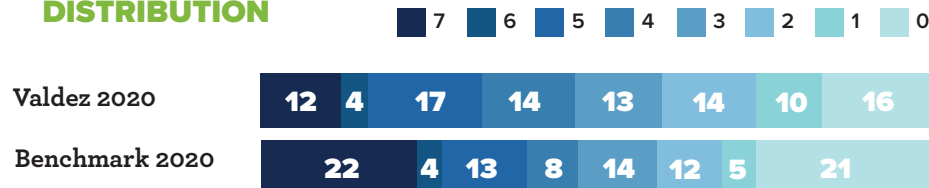
- > 14% lower than (favorable to) 2020 benchmark; mainly due to fewer people with 6+ days/month
- > 57% of 0-1 day/mo are DOING WELL/FLOURISHING; 88% of 7+/month are STRUGGLING/MIXED
- >> 68% of 2-6/month are STRUGGLING/MIXED
- > Strong correlation (.5-.6) with Core4 Well-being Index (-.56); satisfaction with mental-emotional health (-.63); overall well-being satisfaction (-.52) debilitating health days (.5)
- > Moderate correlation with overall life satisfaction (-.42)
- > "7+ days/mo " tend to be HH income <\$49K (1.9x), unemployed (2.0x)

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

### AVERAGES



### DISTRIBUTION



### CDC RECOMMENDATIONS

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

### Key Findings

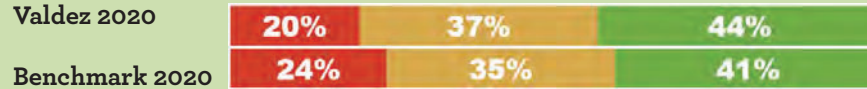
- > 5% < 2020 benchmark;
- > 59% of 5+ days/wk are DOING WELL/FLOURISHING; 78% of < 3days/wk are STRUGGLING/MIXED
- > Weak correlation (.2-.3) with most indicators
- > <3 days/wk tend to be singles with children (1.9x), males (1.2x), <HS education (1.2x)

How many days did you walk or exercise 30 minutes or more, past week? (14C)

### AVERAGES



### DISTRIBUTION

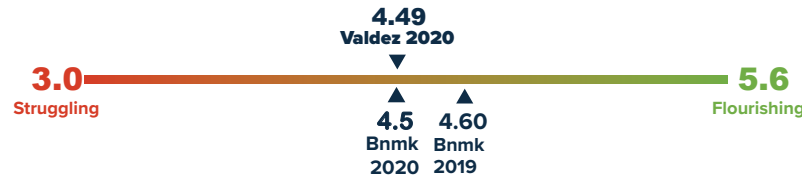


#### Key Findings

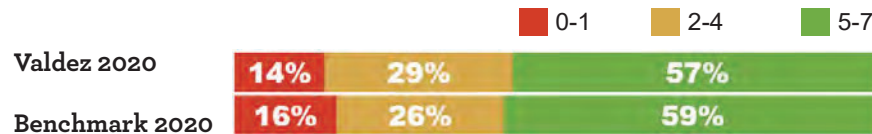
- > 8% > 2020 benchmark
- > 55% of 5+days/wk are DOING WELL/FLOURISHING; 77% of <3 days/wk are STRUGGLING/MIXED
- > Moderately correlated with physical health satisfaction (.37), and BMI (-.35); weak correlation with poor physical health days (-.18)
- > <3 days/wk is distributed very evenly across the community

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

### AVERAGES



### DISTRIBUTION



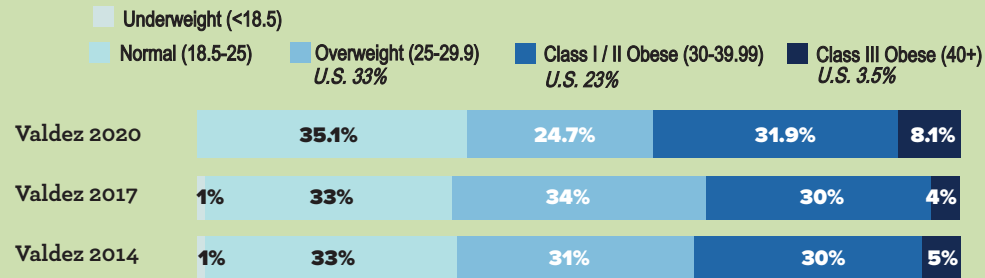
#### Key Findings

- > Same as 2020 benchmark;
- > 55% of 3+ days/wk are DOING WELL/FLOURISHING; 79% of < 3days/wk are STRUGGLING/MIXED
- > Moderately correlated with Life Satisfaction, physical health satisfaction, Core4 Wellbeing Index, Fruits and veggies, and inversely correlated with poor mental health days, debilitating health days
- > <3 days/wk tend to be BIPOC (1.5x), males (1.2x), <HS education (1.5x); HH income <\$25K (2.3x)

## Body Mass Index Rates

From:  
Height (V13)  
Weight (V14)

### DISTRIBUTION



### 2020 COMPARATIVE RATES OBESITY RATES (>30 BMI)

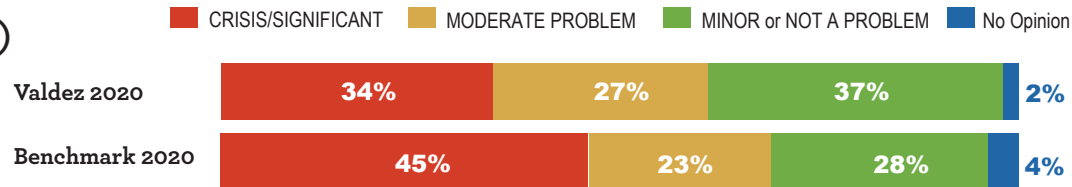
Alaska: 34.2% Obese  
Valdez: 40.0% Obese  
USA: 29.4% Obese

#### Key Findings

- > Obesity rates above Valdez 2017 and nationwide levels
- > Core4™ Index correlations:
  - >> Physical health
  - >> Mental/emotional health
  - >> Overall well-being

In our community, would you say that Coronavirus is... (V7)

### DISTRIBUTION



#### Key Findings

- > 78% viewing it as "minor/not a problem" are DOING WELL/ FLOURISHING; 58% viewing as "crisis/significant problem" are STRUGGLING/MIXED
- > Moderate correlation among chronically ill (.2) and using ER as main source of healthcare (.37); weak correlation with worries about finding help if they become ill
- > Ages 18-34 tend to have no opinion (2.5x); 35-44 lean toward not a problem (1.3x). College educated respondents more likely to view as a moderate problem (1.5x avg)

Which of the following have you personally experienced since the beginning of the Covid-19 outbreak in the U.S.? Have you: (V8)

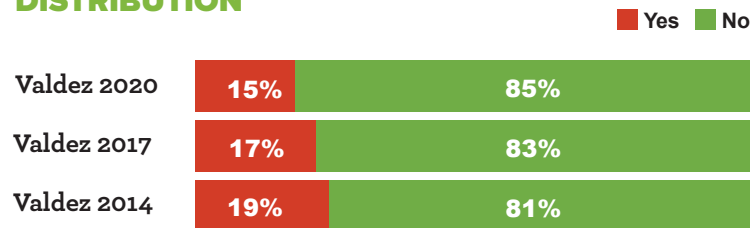
**DISTRIBUTION**

	Frequency	Impact on Core4 Well-being Score
1.	Children home from school 26%	Lost a family member to Covid-19 7.3
2.	Instructed to work from home 25%	Lost your job 7.3
3.	Had your work hours reduced 12%	Instructed to work from home 7.3
4.	Suspect/Confirm you have Covid 7%	Family member infected 7.2
5.	Family member infected 7%	Had your work hours reduced 7.1
6.	Furloughed from your job 6%	Children home from school 6.9
7.	Lost your job 6%	Lost a friend/coworker to Covid 6.8
8.	Lost a friend/coworker to Covid 6%	Furloughed from your job 6.7
9.	Missed mortgage /rent payment 2%	Missed mortgage /rent payment 6.7
10.	Lost a family member to Covid-19 2%	Suspect/Confirm you have Covid 6.5

> Note: small sample sizes for items 6 through 10 make impact on resulting wellbeing score unreliable.

Do you smoke tobacco products, e-cigarettes or use smokeless tobacco? (V6)

**DISTRIBUTION**

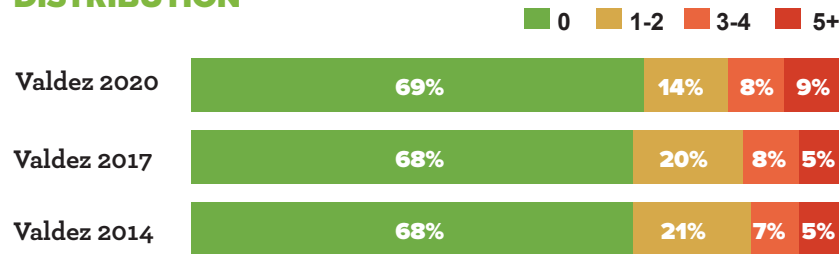


✓ **Key Findings**

- > 46% of non-smokers are DOING WELL/FLOURISHING; 81% of smokers are STRUGGLING/MIXED
- > Moderate correlation on Core4 Wellbeing Index (-.24), Life satisfaction (-.24), physical health satisfaction (-.2) and excess alcohol consumption (.2)
- > Smokers tend to be single with children at home (2.6x); BIPOC (1.7x); HH income <\$50K (1.9x)

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? (V12)

### DISTRIBUTION



### Key Findings

- > Average of 1.6 times / month
- > High frequency of heavy drinking (3+ / month) is up 31% from 2017
- > 44% reporting "None" are DOING WELL/FLOURISHING; 68% of 5+/mo are STRUGGLING/MIXED
  - >> 62% of 3+ / mo are STRUGGLING/MIXED
- > Slight/moderate correlation with tobacco use and BMI (.2), and weak correlation with use of ER as main source of healthcare (.14)
- > Respondents tend to be single with children at home (3.7x); male (1.4x); 18-34 (1.4x); <=HS Education (1.9x); BIPOC (1.7x); HH income <\$50K (1.9x); jobless (1.8x)

# 2020 Valdez CHNA Tailored Questions

**17** tailored questions were added by Valdez CHNA team to the Core Survey. Many of them were incorporated into their relevant Dimension of Health. Those were:

- **v1: Suicide ideation: p.28**
- **v2: Cantril's Ladder today: p.19**
- **v3: Cantril's Ladder 5 years hence: p.19**
- **v4: Cantril's Ladder / financial: p.19**
- **v5: Chronic illness rates: p. 46**
- **v6: Tobacco use: p. 50**
- **v7: Coronavirus perceived severity: p. 49**
- **v8: Effects of Coronavirus: p. 50**
- **v11: Ability to find help with chores if ill: p. 43**
- **v12: Alcohol consumption: p. 51**
- **v13/14: BMI Rates (height and weight): p. 49**
- **v15: Use of Emergency room for healthcare: p. 43**
- **v16: Presence of other Adults in Household: p. 31**
- **v17: Raffle entries**
- **v18: Housing Situation, past 12 months: p. 31**
- **v19: Confirm Valdez resident**



# Appendices





## APPENDIX A: Valdez 2020 Health & Wellbeing Monitor™ survey methods and data

The primary purpose of this study was to provide insights for the Valdez Health Advisory Council overseeing the work of the Providence Valdez Medical Center 2020 Community Health Needs Assessment. The results of this and other research will be used to set priorities for a three-year Community Health Improvement Plan.

The survey of Valdez residents began in July 2020. The Monitor™ was conducted online from July 17 through August 23, 2020.

**DATA COLLECTION.** We used community-based participatory research to promote and field the study. Technically this is a convenience sample; however, efforts were made to reach every resident in Valdez via invitations placed on door hangers at every household (about 1,550) in Valdez and the survey was well promoted through community, local government and business channels.

**SURVEY RESPONSES.** A total of 541 responses were received including 5 hand-administered surveys.

**BENCHMARK RESULTS.** To date, more than 9,000 people have taken the PIHC Health & Wellbeing Monitor. A hallmark of the HWBM™ is providing our clients with the most recent available community-wide benchmarks for comparison. Results of the 2019 and 2020 annual Snohomish County Health & Well-being Monitor are included here for comparison. An independent comparison of key health indicators for Valdez vs. Snohomish County, WA, is included in Appendix D.

**DATASET USED TO DEVELOP THIS REPORT.** In this report, the full data set is being used. As a result, the data were weighted based on age, gender and education as per the 2018 U.S. Census Bureau American Communities Survey to bring the data closer to known demographic parameters. The dataset and topline results were reviewed along with survey results from 2017 and 2014, and the data profile was found to be consistent with past surveys. A response profile is included in Appendix B to this report.



# APPENDIX B: RESPONSE PROFILE

		%	Count	Weighted Count	
q21: Demo - Age	18-24	6%	27	33	AGE* 6%
	25-34	21%	110	113	21%
	35-44	20%	120	109	20%
	45-54	16%	103	84	16%
	55-64	22%	110	120	22%
	65-74	13%	57	71	13%
	75+	1%	9	7	1%*
q28: Demo - Gender	Male	54%	157	287	GENDER* 54%
	Female	46%	376	244	46%
q25: Demo - Race (FILTER)	WHITE	88%	471	471	RACE* 88%
	AK Native/ Native Am	7%	30	37	8%
	Asian /Pac Islander	4%	22	24	- 2.4%
	Black or African Am	2%	8	8	.1%
	Hispanic or Latino	2%	19	12	-
	Other	3%	14	14	-
					2%
q27: HH Income Yr	Missing data	4%	23	23	
	\$25K or less	9%	42	49	INCOME* 16%
	\$25-\$49K	11%	56	58	16%
	\$50-\$74K	16%	79	83	6%
	\$75-\$99K	16%	87	84	21%
	\$100,000 to \$124,000	17%	89	94	17%/2
	\$125,000 to \$149,000	10%	58	55	- 17%/2
	\$150,000 to \$199,000	11%	60	59	- 7%
	\$200,000 or more	6%	42	31	- 16%

## Response Profile & Topline Results: Adjusted % adults 18+

		%	Count	Weighted Count	
q22: Demo - Education	HS or less	36%	79	195	EDUCATION 34%
	Voc / Some College	33%	216	177	36%
	BA / BS	15%	135	82	- 15%
	Grad Sch	15%	106	82	17%
q26: Is there a language other than English spoken in your home?	Spanish	4%	21	20	
	Chinese	1%	3	4	
	Korean	1%	3	5	
	Other	2%	13	13	
q24: Demo - Employment (FILTER)	NO. English Only	93%	499	498	
	Employed FT/PT	74%	398	399	
	Not Currently Employed	8%	51	45	
	Student	2%	13	12	
q17: Health Insurance?	Retired	15%	72	78	
	Missing data	0%	1	0	
	Yes	93%	499	499	
q23a: Demo - #Children in HH	No	7%	36	36	
	Missing data	59%	307	315	
	0	2%	16	13	
	1 + 2	27%	156	144	
	3 + 4	10%	48	54	
	5 +	2%	9	9	
	Self-paid	7%	35	33	

\* from ACS 2018. All adjusted to 18+ except Race (all pop). Income is HH income.  
[valdez.acs: https://data.census.gov/cedsci/table?q=valdez,%20Alaska&tid=ACSDP5Y2018.DP05&hidePreview=false](https://data.census.gov/cedsci/table?q=valdez,%20Alaska&tid=ACSDP5Y2018.DP05&hidePreview=false)



# APPENDIX C: DEMOGRAPHIC AND HEALTH PROFILE OF VALDEZ RESIDENTS WHO ARE “STRUGGLING” OR “MIXED”

OVERALL, 13% OF ALL ADULT VALDEZ RESIDENTS ARE “STRUGGLING.”

## ✓ RACE:

- › 13% of all whites, 15% of BIPOC are STRUGGLING (distributed proportionately in the population)

## ✓ GENDER:

- › 9% of all males (underrepresented), and 17% of females (1.3x avg) are STRUGGLING

## ✓ AGE:

- › STRUGGLING is distributed proportionately by age groups in Valdez

## ✓ INCOME:

- › 38% of STRUGGLING have HH incomes under \$49K/yr (1.9x avg);
  - ›› 73% of all households with incomes under \$49K/year are STRUGGLING or MIXED.

## ✓ EMPLOYMENT:

- › 29% of STRUGGLING are unemployed (2.3x avg);
  - ›› 66% of all unemployed residents are STRUGGLING or MIXED

## ✓ HH MAKEUP:

- › 23% of STRUGGLING are single with children at home (3.3x);

- › 80% of all singles with children at home are STRUGGLING or MIXED.

- › 18% of STRUGGLING are single and living alone (1.8x);
  - ›› 62% of all singles living alone are STRUGGLING or MIXED

## ✓ PRESENCE OF CHILDREN:

- › 55-58% of all STRUGGLING have children in the home (1.4x avg);
  - ›› 57%-59% of all households with children are STRUGGLING or MIXED.
- › 23% of STRUGGLING have 3+ children in the home (2.1x);
  - ›› 60% of all households with 3+ children are STRUGGLING or MIXED.

## ✓ ILLNESS:

- › 49% of STRUGGLING report medical conditions requiring ongoing treatment (1.6x avg);
  - ›› 63% of all residents with these medical conditions are STRUGGLING or MIXED
- › 49% of STRUGGLING have a chronic illness like diabetes, heart disease, cancer: (1.8x avg);
  - ›› 68% of all residents with a chronic illness are STRUGGLING or MIXED
- › BMI: Class 3 obese (2.8x);
  - ›› 79% of all Class 3 obese are

STRUGGLING or MIXED (1.5x avg)

## ✓ POOR MENTAL HEALTH DAYS:

- › 95% of STRUGGLING report 2+ poor mental health days/month (1.6x avg);
  - ›› 69% of all residents with 2+ poor mental health days are STRUGGLING or MIXED
- › 83% of ‘STRUGGLING’ report 7+ poor mental health days/month (2.9x avg);
  - ›› 91% of all residents with 7+ poor mental health days are STRUGGLING or MIXED

## ✓ DOMESTIC VIOLENCE:

- › 6% of STRUGGLING report being in an unsafe intimate relationship (2.2x)
  - ›› 83% of all residents in unsafe relationships are STRUGGLING or MIXED (1.5x avg)

## ✓ HOMELESS OR UNSTABLE HOUSING:

- › 18% of STRUGGLING are unsheltered or homeless (2.8x);
  - ›› 86% of all homeless/unsheltered are STRUGGLING or MIXED (1.6x avg)

## ✓ BILL PAYMENT WORRIES:

- › 39% of STRUGGLING report utility bill payment issues (2.3x avg);
  - ›› 84% of all residents with bill payment



## APPENDIX C: DEMOGRAPHIC AND HEALTH PROFILE OF VALDEZ RESIDENTS WHO ARE “STRUGGLING” OR “MIXED” (Cont.)

issues are STRUGGLING or MIXED (1.6x avg)

### ✔ COVID:

- › 50% of all STRUGGLING have children home from school (1.7x);
  - ›› 59% of all residents with children home from school are STRUGGLING or MIXED
- › 9% lost a friend or co-worker to Covid (1.3x avg)
- › 12% of all STRUGGLING reported job furloughs (1.7x avg);
  - ›› 77% of all with furloughs are STRUGGLING or MIXED (1.4x avg)
- › 6% of all STRUGGLING missed a house / rent payment (2.2x avg),
  - ›› 89% of all who missed payments are STRUGGLING or MIXED (1.6x avg)
- › 9% of all STRUGGLING lost friend or coworker to Covid (1.3x avg);
  - ›› 73% of all who residents who lost a friend/coworker to Covid are STRUGGLING or MIXED (1.4x avg)
- › 17% of all STRUGGLING have suspected or confirmed Coronavirus (2.0x avg);
  - ›› 62% of all with Coronavirus are STRUGGLING or MIXED.



# APPENDIX D: VALDEZ, AK VS. SNOHOMISH COUNTY, WA BENCHMARK COMPARISON (CHR 2020)

	Valdez-Cordova (VC), AK <span style="color: red;">X</span>	Snohomish (SN), WA <span style="color: red;">X</span>
<b>Health Outcomes</b>		
<b>Length of Life</b>		
Premature death	7,300	5,400
<b>Quality of Life</b>		
Poor or fair health <span style="color: grey;">●</span>	12%	14%
Poor physical health days <span style="color: grey;">●</span>	3.1	3.7
Poor mental health days <span style="color: grey;">●</span>	3.2	3.7
Low birthweight	5%	6%
<b>Health Factors</b>		
<b>Health Behaviors</b>		
Adult smoking <span style="color: grey;">●</span>	17%	13%
Adult obesity <span style="color: grey;">●</span>	35%	29%
Food environment index <span style="color: grey;">●</span>	7.2	8.4
Physical inactivity <span style="color: grey;">●</span>	19%	18%
Access to exercise opportunities	100%	86%
Excessive drinking <span style="color: grey;">●</span>	25%	19%
Alcohol-impaired driving deaths	71%	24%
Sexually transmitted infections <span style="color: grey;">●</span>	366.5	328.6
Teen births	15	13
<b>Clinical Care</b>		
Uninsured	15%	6%
Primary care physicians	1,030:1	1,900:1
Dentists	2,290:1	1,380:1
Mental health providers	480:1	310:1
Preventable hospital stays		2,918
Mammography screening		37%
Flu vaccinations		49%
<b>Social &amp; Economic Factors</b>		
High school graduation <span style="color: grey;">●</span>	67%	86%
Some college	53%	70%
Unemployment	7.4%	3.8%
Children in poverty	12%	9%
Income inequality	4.7	3.8
Children in single-parent households	18%	25%
Social associations	16.2	7.1
Violent crime <span style="color: grey;">●</span>	316	205
Injury deaths	118	62
<b>Physical Environment</b>		
Air pollution - particulate matter		8.1
Drinking water violations	Yes	Yes
Severe housing problems	20%	17%
Driving alone to work	64%	74%
Long commute - driving alone	4%	47%

# Thank You

For more information, contact

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