
# Southern Kenai Peninsula, Alaska

# Community Health Needs Assessment

## Executive Summary

## March 2014

## MAPP of SKP Partners

*AK Family Violence Prevention Project*
*AK Small Business Development Center*
*Best Beginnings Homer*
*Big Brothers Big Sisters*
*Bunnell Street Arts Center*
*Center for Alaskan Coastal Studies*
*City of Homer*
*Cook Inlet Council on Alcohol and Drug Abuse (CICADA)*
*Cook Inletkeeper*
*Homer Community Food Pantry*
*Homer Chamber of Commerce*
*Homer Council on the Arts*
*Homer Downtown Rotary Club*
*Homer Foundation*
*Homer - Kachemak Bay Rotary Club*
*Homer Medical Center*
*Homer United Methodist Church*
*Homer News*
*Homer Police Department*
*Homer Public Health Center*
*Homer Senior Citizens, Inc.*
*Hospice of Homer*
*Independent Living Center*
*Kachemak Bay Campus/Kenai Peninsula College*
*Kachemak Bay Conservation Society*
*Kachemak Bay Family Planning Clinic*
*Kachemak Bay Research Reserve*
*Kachemak Heritage Land Trust*
*Kenai Peninsula Youth Court*
*Kenai Peninsula Borough School District*
*Nature Rocks Homer*
*Ninilchik Clinic*
*Ninilchik Health and Wellness Club*
*Ninilchik Indian Housing*
*Ninilchik Senior Center*
*Ninilchik Tribal Council*
*NoFAS (Fetal Alcohol Syndrome) Alaska*
*Pratt Museum*
*ReCreate REC*
*Refuge Chapel*
*South Peninsula Behavioral Health Services (SPBHS)*
*South Peninsula Haven House*
*South Peninsula Hospital (SPH)*
*Sprout Family Services*
*Sustainable Homer*
*SVT Health and Wellness Center (SVT)*

## MAPP coordinator

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## INTRODUCTION

Community Health Needs Assessments provide data and information on a broad spectrum of quality of life issues among residents within communities. Conducting a comprehensive Community Health Needs Assessment (CHNA) is an important step in strategically identifying and addressing socially complex, community issues. The CHNA is intended to inform the development of a Community Health Improvement Plan (an implementation strategy to address identified unmet health-related needs). Building on the first area-wide assessment conducted in 2009, the following describes the process and observations of the second Southern Kenai Peninsula Community Health Needs Assessment.

**The main objectives of this second community health needs assessment were to:**

1. **Accurately depict the Southern Kenai Peninsula community's health status**
2. **Identify community issues that will inform prioritization of strategic action for collective impact**
3. **Build upon the first, 2009 CHNA and further refine the breadth and depth of CHNA data**
4. **Fulfill federal requirements for non-profit hospitals to complete a Community Health Needs Assessment every three years (part of the Patient Protection and Affordable Care Act)**

## COMMUNITY PROFILE

The target population for this collaborative community health improvement effort includes all residents within the Southern Kenai Peninsula, a vast rural area in south central Alaska and part of the Kenai Peninsula Borough (Figure 1). This includes residents of Seldovia, Port Graham, Nanwalek, Homer and Anchor Point and the surrounding areas which include Fox River, Happy Valley, Kachemak City, Fritz Creek, Diamond Ridge, Halibut Cove, and four small Russian "Old Believers" communities: Nikolaevsk; Kachemak Selo; Voznesenka; and Razdolna.

Communities of the Southern Kenai Peninsula (SKP) are at the end of a 220-mile road that leads south from Anchorage. Anchorage is the largest city in Alaska, with a population of 291,826, representing 41% of the state's total population of 710,231. Major hospitals and specialty clinics are located in this urban area which is about a 5-hour drive from the Southern Kenai Peninsula. Winter conditions exist for almost seven months of the year, presenting hazardous driving conditions with ice, snow and frequent avalanches resulting in far longer driving times. There are small aircraft connections several times a day from Homer to Anchorage that take about one hour in good weather.

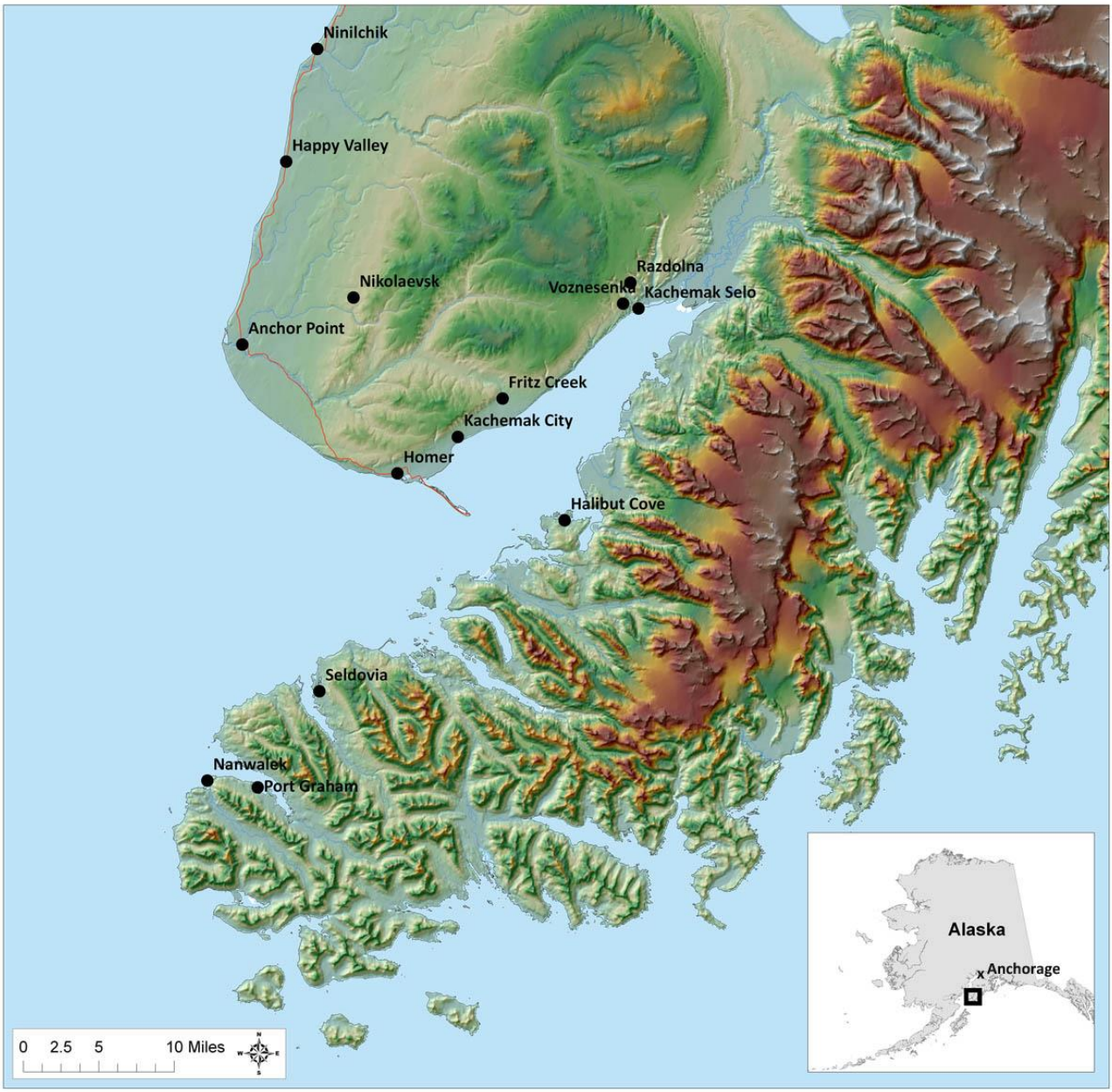



Figure 1. Map of the Southern Kenai Peninsula communities

The SKP hub for health care services is in Homer. For most of the SKP communities, access to Homer's health care services is by road with a maximum driving distance of about 45 miles. Transportation to Homer for communities across Kachemak Bay - Seldovia, Port Graham, Nanwalek, and Halibut Cove - is one to one and a half hour by boat or a 20-minute small aircraft flight. Round trip from Homer to communities across the bay can cost anywhere from $46 to $120. Planes, boats, and roads are severely impacted by weather conditions that often leave people stranded away from home for days. A few organizations provide transportation assistance to clients via shuttle or taxi vouchers, however, there

are no public busses, subways, or shuttles available to assist people in getting to services. It is hard to get around in this area.

Healthcare services in the service area are fairly comprehensive given our remote rural location and most needs are locally met. A 22-bed community owned critical access, acute care hospital is the hub of medical practice in Homer, offering trauma level IV emergency care seven days a week, acute, surgical, lab, imaging, orthopedic and primary care. Three primary care practices are located close to the hospital, and three outlying clinics are in remote locations. Three of the six are owned and operated by the respective native tribal council of that area, two are private practice and one is hospital owned.

Local based providers include but are not limited to: multiple general surgeons, one orthopedic surgeon, one part-time ob/gyn, multiple dentists, one optician, one ophthalmologist, and multiple chiropractors. Visiting specialists who provide care on a weekly or monthly basis include an oncologist, cardiologist, urologist, ENT, lipids and cholesterol specialist, podiatrist and pulmonologist.

The three local primary care clinics currently offer a combined twelve general practice physicians and seven mid-level providers, though some work only on a part-time basis. The community behavioral health center offers a part-time psychiatrist and numerous mid-level providers and services. We are home to a local office of the regional council on drug and alcohol abuse and a local chapter of alcoholics anonymous. There is a local family planning clinic and a women's services agency and shelter. Six midwives practice in the community. The local public health clinic employs four public health nurses and offers regular local clinics as well as visits to remote communities.

The immediate community has a twice weekly V.A. clinic, hospice, adult day care, over 100 assisted living / senior housing units, an active senior center and a hospital-owned long term care. There are two home health agencies, one sleep center, two durable medical equipment supply companies and one equipment loan program.

There are at least eight physical therapists, four occupational therapists, a speech/language pathologist and an audiologist providing services from four different clinics, plus additional rehabilitation providers offered through the school system. Complimentary medicine includes acupuncture, naturopathy, massage therapy, and functional medicine. There are two retail pharmacies in the community, both open daily.

Located in Homer are the State of Alaska Office of the Division of Family & Youth Services, Office of Public Assistance and Women/Infant/Children Office. Numerous social services and non-profit agencies, wellness and recreational programs, educational, cultural, and spiritual offerings complete the growing list of services that support our broad definition of health in the community.

The providers in the community change quite rapidly. Providers join the community attracted by the quality of life and passionate about the lifestyle that Alaska offers. However, they often leave in short order when they realize the challenges of living so far from family, enduring long winters, accessing professional development opportunities, and receiving uncompetitive wages. The service needs remain constant which creates a challenge for all service providers to maintain a consistent baseline level of care.

**DEMOGRAPHICS**

The estimated number of year-round residents within the Southern Kenai Peninsula is about 14,000, which includes several small, culturally diverse communities. In addition, the community sees a large influx of seasonal residents who are not tallied in these numbers and the area attracts over 100,000 visitors each year. Close to half of the population is largely in or in close proximity to the service and commerce hub of Homer. The city of Homer has a population of 5,050 and is about 91% Caucasian (2008-2012 American Community Survey estimate). It is often referred to as "the end of the road," since it is the official northern end of Coastal Highway 1. The remaining half of the population is scattered in small neighborhoods throughout a vast region encompassing 8,317 miles and 491 miles of built roads.

The communities within the SKP have distinct and unique identities. The southern boundary of the SKP communities includes three villages across Kachemak Bay (7x19 miles long) that are only accessible by boat or plane. Two of the villages, Port Graham and Nanwalek (population 177 and 254, respectively), are Alaska Native villages with the Suqpiaq culture and the third community, Seldovia (population 420), is a blend of Aleut, Yupik, Alutiiz, Athabascan and Caucasian. The northern boundary of the SKP communities is on the road system 45 miles north, marked by the village of Ninilchik. Ninilchik's population of 883 represents a blend of Aleut, Alutiiq, Athabascan and Caucasian ethnicities. Four Russian Old Believer communities also inhabit the area at each of end of the highway (population 318+ - only one of four communities has Census data).

Population data from the US 2010 Census show that the area has experienced a 10% population increase within the past ten years. Within this same timeframe, the number of 55-59 year olds in our

borough has increased by 106%. The Kenai Peninsula Borough estimates a continuation of that trend with the senior population (65+) expected to grow 87% between 2008 and 2018. As the population ages, it is likely that healthcare needs will also increase, resulting in an expected increase of health care usage in the immediate future.

| **Table 1. 2010 Southern Kenai Peninsula Population Estimates** | | | |
|---|---|---|---|
| **2010 Population Estimates – U.S. Census Bureau Sub Areas** | | **% AK Native Population** | **Median Age** |
| Anchor Point | 1,930 | 4% | 47.1 |
| Diamond Ridge | 1,156 | 3% | 45.6 |
| Fox River | 685 | 0% | 19.2 |
| Fritz Creek | 1,932 | 3% | 42.3 |
| Halibut Cove | 76 | 7% | 47.5 |
| Happy Valley | 593 | 6% | 51.3 |
| Homer | 5,003 | 4% | 44.1 |
| Kachemak City | 472 | 4% | 54.2 |
| Kachemak Selo | * | * | * |
| Nanwalek | 254 | 80% | 20.7 |
| Nikoleavsk | 318 | 4% | 31.3 |
| Ninilchik | 883 | 15% | 51.8 |
| Port Graham | 177 | 71% | 30.3 |
| Razdolna | * | * | * |
| Seldovia | 420 | 26% | 48.5 |
| Vosnesenka | * | * | * |
| **Total** | **13,823+** | *** = Census data not available for these sub areas** | |

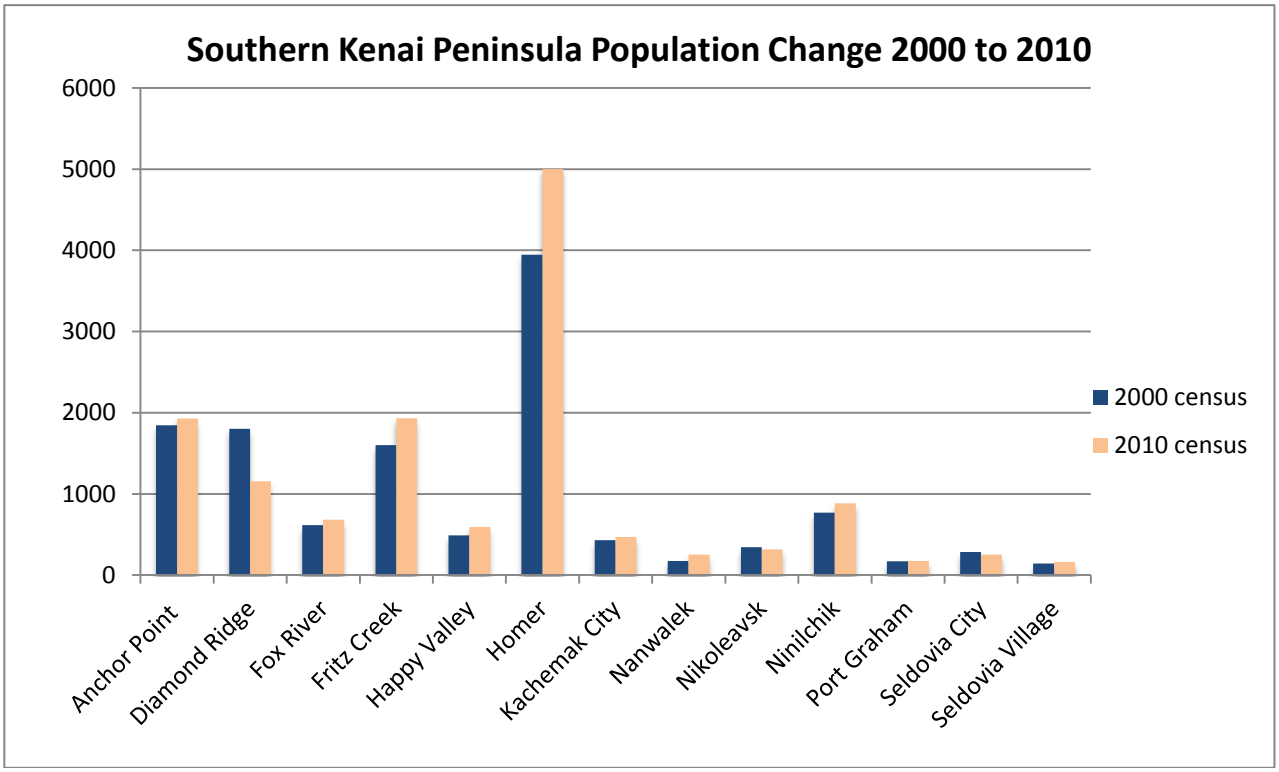


Figure 2. 2000 to 2010 Southern Kenai Peninsula population.

**Table 2. Southern Kenai Peninsula Socioeconomic Snapshot and Comparisons**

| Socioeconomic Snapshot and Comparisons | | | | |
|---|---|---|---|---|
| | Southern Kenai Peninsula | Kenai Peninsula | Alaska | United States |
| Mean household income | (Avg) $59,799 | $74,933 | $86,208 | $73,034 |
| Median household income | (Avg) $48,787 | $59,421 | $69,917 | $53,046 |
| Persons living below poverty (AK 125%) | 16.8% at 125% (unknown at 100%) | (9.1% at 100%) | 15.2% at 125% (9.6% at 100%) | (14.9% at 100%) |
| Persons w/ a high school diploma or higher | 92.4% | 92.8% | 91.6% | 85.7% |
| College graduates | 27.0% | 23.5% | 27.5% | 28.5% |
| Mean travel time to work (min) | 18.5 min | 19.2 min | 18.6 min | 25.4 min |
| Source: US Census Bureau, American Community Survey 2008-2012 estimates (SKP is 2007-2011 estimates) | | | | |

**BACKGROUND: MAPP of the Southern Kenai Peninsula**

Spearheaded by the South Peninsula Hospital, forty organizations gathered in November 2008 to conduct the first collaborative, area-wide health needs assessment, with the goal of identifying opportunities for health improvement and to serve as a catalyst for community action. During this initial gathering, a coordinator with a public health background was hired and a steering group was formed that included the South Peninsula Hospital, South Peninsula Behavioral Health Services, Seldovia Village Tribe Health and Wellness, and the Kachemak Bay Campus. Health was defined broadly to include physical, mental/emotional, cultural, economic, educational, spiritual, and environmental health. With consultation and technical assistance from the State of Alaska Section of Public Health Nursing, the "Mobilizing for Action through Planning and Partnership" (MAPP) framework was selected to structure the community health needs assessment (developed by the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO)) (Figure 3). The participating partners elected to define the community geographically as the Southern Kenai Peninsula and this matched the service area of the organizations at the table. This includes the northern community of Ninilchik south to the villages across the bay, and with Homer as the hub housing most services (Figure 1). The partners set a project timeline to complete the four MAPP assessments over the 2009 calendar year and move into action steps during 2010. Results from the four MAPP assessments were discussed in three facilitated community meetings and three priority issues arose for workgroup actions:


Figure 3. MAPP Framework

1) Addressing Substance Abuse and Domestic Violence
2) Healthy Lifestyle Choices (healthy food focus)
3) Connecting Community Resources

A vision, “Proactive, Resilient, and Innovative Community” was identified, in addition to nine overarching goals:

- Healthy and safe individuals and families
- Community-wide support for diverse healthy behavior choices
- Collaborative, accessible, prevention and intervention-focused, holistic health network
- Premiere cultural, educational, artistic opportunities and systems
- Local, sustainable, equitable economy
- Multi-use, intergenerational, accessible community opportunities and resources
- Local, affordable, safe, sustainable diverse food, energy and water systems
- Resilient, biodiverse functioning ecosystems
- Affordable, sustainable, accessible transportation system

The steering committee and each workgroup established action plans (through a logic model format) and these were combined to form the first Community Health Improvement Plan (CHIP). Many successes resulted from these collaborative efforts (see overarching successes below) and some workgroup strategies continue to this day. While some collaborative efforts born out of the first iteration are still underway, MAPP of the SKP is transitioning into the ‘identifying strategic issues’ and ‘formulating goals and strategies’ phases of the MAPP framework now that it has completed the second CHNA.

**BUILDING ON COMMUNITY STRENGTHS and PREVIOUS SUCCESSES**

A critical component of effectively implementing the MAPP process and addressing community issues is to identify and build on our community strengths. One goal of this second CHNA was to refine the breadth and depth of the first CHNA, seeking qualitative and quantitative data that would focus on root causes to community issues. Thus, less priority was placed on gathering new community strengths this round as many were previously identified (through Community Themes and Strengths Assessment).

Identified strengths of the SKP community include:

- People help each other
- Respect for other viewpoints
- Caring/nice people
- Community comes together on things
- Beautiful environment, nature, recreational opportunities
- Art, music, creative community
- Alternative healthcare
- Access to local foods
- Good place to raise kids, safe community, friendly and social
- Strong families and engaged/active youth community
- Opportunity for personal/family growth, interest in prevention
- Professional development opportunities
- Public schools, churches, restaurants
- Sustainability
- Our history, strong political voice, liberal, activist
- Support from government, road system
- No box stores
- Small and rural, and simple and active lifestyles
- Diverse business base (fishing, tourism, construction, arts, etc.)
- Attractive to professionals and retirees
- Community demonstrates incredible resources and commitment to action

The first assessment and action cycle over the past four years has supported a multitude of successes for our community. We will continue to build on these successes and the lessons learned through this iterative MAPP process.

**SUCCESSES**

MAPP of the Southern Kenai Peninsula community successes range from specific issue-level to overarching cultural shifts occurring in our community. See Appendix D for a comprehensive list of successes.

The following examples reflect broad-based system and cultural changes that have been catalyzed by MAPP of the Southern Kenai Peninsula community efforts:

- Initiated and coordinated a health needs assessment utilizing the MAPP framework in 2009 and a second iteration in 2012, which included identifying gaps in available data that the community identified as important
- Developed and implemented a Community Health Improvement Plan based on priority themes identified by the community
- Created a vehicle for ongoing strategic collaboration
- Established a neutral and ongoing force for positive community outcomes
- Supported and supports the ability to obtain new grant dollars into the community, promoting collaboration over competition
- Is engaging community leaders
- Promotes broad, non-traditional partnerships
- Is increasing community awareness of the value and importance of data for decision-making
- Is increasing awareness of organizational issues
- Observed an increase in community members' participation based on trust that their input will contribute to reaching a shared vision

**OVERVIEW OF THE SECOND COMMUNITY HEALTH ASSESSMENT**

Building on the lessons-learned and results from the first CHNA, the second CHNA is composed of three of the four separate assessments:

I. Community Themes & Strengths Assessment

Qualitative input from community members to identify the issues they feel are important

a. Perceptions of Community Health Survey

b. Key Informant Survey

II. Community Health Status Assessment

Quantitative community health data (representing cultural, economic, educational, environmental, mental, physical, and spiritual health) that identifies priority health and quality of life issues

III. Forces of Change Assessment

Identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate

IV. Local Public Health Assessment

*This assessment was not conducted during the second CHNA based on input from a NACCHO MAPP navigator. Given that a three-year cycle for CHNA is short for identifying measurable changes in much of the data, and in this case our small, rural community did not form a workgroup to focus on the Local Public Health System following the first assessment, the likelihood of change in results for the Local Public Health Assessment (LPHA) was minimal.*

The Local Public Health Assessment measures how well different local public health system partners work together to deliver the Essential Public Health Services.

Using the combined results/observations from all three assessments, and bringing forward information from the fourth (LPHA) for review, community issues will be prioritized to help direct collective community efforts over the next few years.

**METHODS AND FINDINGS FROM EACH ASSESSMENT**

**I. THEMES and STRENGTHS ASSESSMENT: Perceptions of Community Health Survey**

**METHODS**

The data team revised questions from the first community survey while trying to maintain comparability. Consideration was also given to available Census data and creating questions and response options that would elucidate the respondents' community representation. In order to encourage community participation in the survey, the paper survey was limited to one sheet (two

sided), an online version was made available, and questions were primarily multiple-choice questions with free response options.

The survey was open for community response in November and December 2012. Surveys were handed out at the November 10th Rotary Health Fair, distributed through the Homer News and Homer Tribune, made available online (*mappofskp.net* and *pop411.org*), handed out to community organizations to distribute to their clients/patrons, distributed at 'Share the Spirit', and made available at City Hall, the Homer Public Library, and Ulmer's Drug & Hardware store. To compile paper and online results, all paper surveys were entered into survey monkey. Data team members assigned all free responses to their corresponding categories in order to determine the volume of responses addressing specific topics. The results of this survey were made available on the MAPP website and announced within Homer News and Tribune letter to the editors.

**RESULTS**

Approximately 1,212 community members from thirteen Southern Kenai Peninsula communities provided input to the survey. The percentage of respondents from each community reflected the population size in relation to the total SKP population (Figure 5). The majority of respondents were from households with two individuals (41.6%) and between 46-64 years old (43.9%). Respondents' age, income, and household size closely mirrored that of the Southern Kenai Peninsula (Figures 5 and 6).

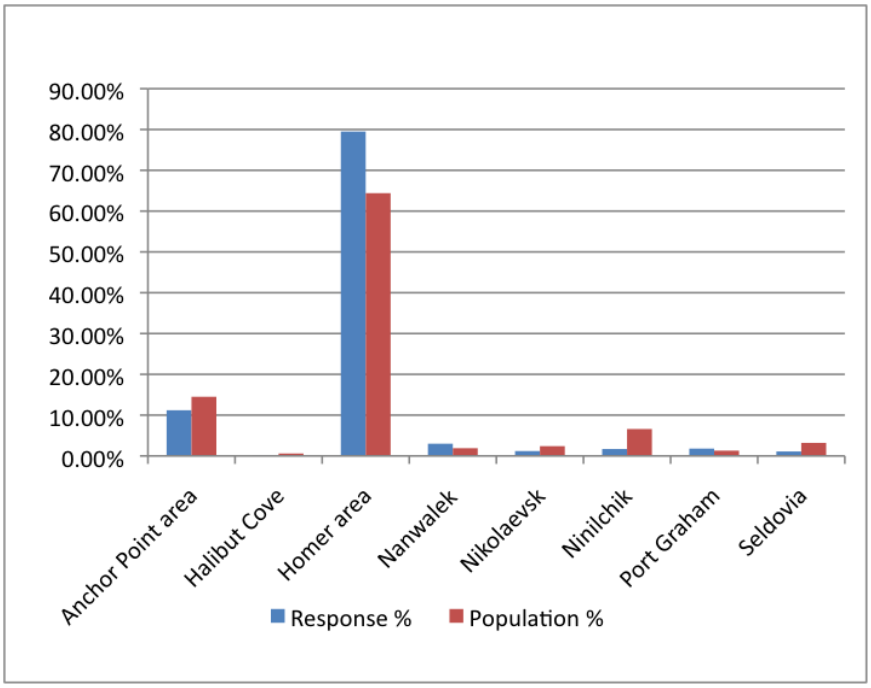



Figure 4. Comparison between community composition of survey respondents to Southern Kenai Peninsula community composition

75.4% of 2012 respondents reported having some form of health insurance (73% of respondents reported having some form of health insurance in the 2008 survey).

| Age | Survey % | SKP % |
|---|---|---|
| 13-18 | 4.6% | 6.7% |
| 18-25 | 5.5% | 4.4% |
| 26-45 | 29.8% | 21.7% |
| 46-64 | 43.9% | 35.7% |
| 65+ | 16.3% | 12.0% |

Figure 5. Age comparison of survey respondents to Southern Kenai Peninsula age composition (age brackets vary slightly between survey options & census categories)

| Income | Survey % | SKP % |
|---|---|---|
| <$25,000 | 23.90% | 24.7% |
| $25,000-33,000 | 12.30% | 11.4% |
| $33,000-51,000 | 18.60% | 11.4% |
| $51,000-76,000 | 20.90% | 20.1% |
| $76,000+ | 24.20% | 31.9% |

Figure 6. Income comparisons of survey respondents to Southern Kenai Peninsula population (income brackets vary slightly between survey options & census categories)

The top five greatest community strengths identified in 2012 were:

1. Natural beauty (78.9%)
2. People help each other (68.1%)
3. Healthy environment (53.4%)
4. Good schools (47.6%)
5. Diverse cultural / arts opportunities (47.1%)

When asked to rank the issues most affecting themselves and their families, the top three 2012 responses were:

1. Economic Costs (selected by 72.9% respondents)
2. Physical Health (selected by 68.4% respondents)
3. Mental / Emotional Health (selected by 46.9% respondents)

When asked to rank the issues most affecting 'the community', the top three 2012 responses were:

1. Substance Abuse (selected by 79.3% respondents)
2. Economic Costs (selected by 54.4% respondents)
3. Mental / Emotional Health (selected by 51.6% respondents)

Similar responses and order were observed in the 2008 community survey.

The top five services 2012 respondents found most lacking were:

1. Teen activities (53.5%)
2. Transportation (50.0%)
3. Shopping (35.3%)
4. Housing (28.0%)
5. Substance abuse treatment (27.4%)

In 2008, the top five responses for lacking services were (an open-ended question):

1. Medical specialists (43%)
2. Clinic services (18%)
3. Shopping (16%)
4. Teen activities (8%)
5. Transportation (5%)

Responses that identified additional categories beyond what was provided:

- Trails (5 responses)
- Teen resources (5 responses)
- Affordable indoor recreation (5 responses)
- Economic opportunities / jobs (4 responses)
- Vocational education (4 responses)
- Emergency services (housing) (3 responses)
- Law enforcement (2 responses)
- Community outreach / education (2 responses)
- Resources for special needs (2 responses)
- Affordable legal services (1 responses)
- Mental health services (1 response)
- Domestic violence services (1 response)

When asked what specific services or activities to provide or improve upon, 473 respondents provided free response suggestions that addressed multiple topics. These responses were categorized and are listed in the order of number of responses (highest to lowest):

- Public transportation (109 comments)
- Teen / Youth resources (55 comments)
- Teen activities (51 comments)
- Affordable indoor recreation (45 comments)
- Recreational activities (40 comments)
- Economic opportunities / jobs (37 comments)
- Substance abuse treatment (36 comments)
- Trails (34 comments)
- Access to healthy, whole foods (23 comments)
- Childcare (19 comments)
- Shopping (18 comments)
- Medical specialists (18 comments)

- Housing (17 comments)
- Educational opportunities (17 comments)
- Clinic services (13 comments)
- Mental health services (12 comments)
- Community outreach / education (12 comments)
- Emergency housing (9 comments)
- Health insurance (9 comments)
- Parent services (8 comments)
- Elder activities (8 comments)
- Law enforcement (8 comments)
- Winter maintenance of roads/sidewalks/trails (8 comments)
- Domestic violence services (7 comments)
- Digital connectivity (7 comments)
- Vocational education (7 comments)
- Elder care (6 comments)
- Arts and culture (5 comments)
- Environmental monitoring (5 comments)
- Business support (5 comments)

The top five responses for what kept respondents from accessing services were:

1. Cost (46.5%)
2. Schedule conflicts (41.5%)
3. Not enough time (35.7%)
4. Transportation (20.4%)
5. Lack of anonymity (14.0%)

<u>2008 responses included:</u>

1. Cost (34%)
2. Lack of anonymity, confidentiality, distrust agency or provider (8%)
3. Transportation (8%)

**Key Informant Survey**
**METHODS**

Key informant input was collected through four questions on an online survey or an optional interview. The survey was sent to 100+ SKP community leaders within broad community health perspectives: cultural, economic, educational, environmental, mental, physical, and spiritual. The 2009 list of key informant participants was initially used and updated to address staff changes and to reflect additional community perspectives that were under-represented. MAPP steering committee members contacted all key informants via phone before the survey was distributed to give context for and encourage participation in the survey online or in an interview. A SurveyMonkey link was then emailed out through MailChimp, allowing for anonymous response. Nine respondents elected the option to be interviewed. Public Health Nurses conducted an additional ten interviews while traveling to outlying

communities. A two-week time period was given for survey participation, although additional time was required to conduct interviews.

To ensure anonymity, free responses were summarized by the key informant data team. The data team discussed and further refined root causes identified by respondents.

**RESULTS**

A total of 86 participants provided input to the survey. Although this survey was anonymous, ~50 key informants verified that they completed the survey which enabled health sector representation to be gauged. Confirmed participation was the following: alternative healthcare (1), arts (3), business (3), clergy (1), early education (1), education (5), environment (4), environmental education (2), government (4), law enforcement (2), health care provider (4), military (2), senior (1), social service (11), and youth (2).

The total timeframe for survey participation was March 1st – April 19th, 2013. New issues brought forth in this round of key informant input included: lack of intergenerational families, transient community, associating individual/family issues with Adverse Childhood Experiences (including end of life emotional issues), city government working cross-purposes to business development and the non-profit sector, and lack of incentives from employers. The majority of identified changes that are presently affecting organizations/industries were financial in nature: funding cuts, economic downturn, decreases in grant opportunities, rises in the cost of living, and more. Economics are becoming a more sophisticated issue, thus complicating our efforts if we don't work together. One positive change identified by many is our community's improved collaboration, community-building, & coordination. The majority (63%) of respondents felt the 14 community issues described during the first local CHNA still accurately captured existing issues today. Additional suggestions were provided that ultimately fell within a category provided, but were more specific in nature. From the list of 14 themes identified in the first CHNA, the key informants selected these five issues as most affecting the populations they serve: Economic Issues (62%), Substance Abuse (52%), Mental Health Issues (47%), Family Issues (37%), and Insurance / health care coverage (31%). Interconnected and circular in nature, these five issues were also consistently identified as root causes by the majority of respondents.

**COMBINED RESULTS FROM COMMUNITY and KEY INFORMANT SURVEYS**

The Institute of Social and Economic Research (ISER) analyzed and ranked the priorities identified in the Perceptions of Community Health and Key Informant surveys (results in Appendix C). The top five responses from the Perceptions of Community Health survey questions were assigned a total rank (5

through 1) and then added to the rank (5 through 1) of each key informant question. This ensured equal weighting of each survey and resulted in a prioritized list of top issues identified by the community:

1. **Economic Costs**
2. **Substance Abuse**
3. **Mental/Emotional Health**
4. **Public Transportation**
5. **Family Issues (5a)**
   **Teen Issues/Resources (5b)**

Identifying these priority six issues created focus areas for quantitative data collection. Determining what data are available elucidates whether or not we have adequate information to determine the local 'status' and, when adequate, is important in comparing the 'status' against the community perception. Observations compiled from the broad CHNA data collection are available within the Health Status results section below. Additional data collection aimed at answering these specific issues is recommended to ensure appropriate/adequate status reporting.

**II. Forces of Change Assessment**

**METHODS**

A group Forces of Change brainstorm session was conducted during the February 1st, 2013 MAPP Community meeting with 31 participants. The group brainstormed ideas and captured them on an overhead screen. Then the group was divided into six individual tables, with each one taking a portion of the trends to further identify challenges and patterns associated with each external force. Notes from each individual group's discussion were then combined into one document that was taken to MAPP workgroups for further discussion.

The MAPP coordinator used the trends of change identified by the Key Informant interviewees (Q1) to assign categories and group/order issues within the Forces of Change matrix. The issues were ordered according to highest to lowest number of related issues.

**RESULTS**

Themes of Change (in order of number of issues identified per category – themes identified by about one hundred 2013 Key Informant survey respondents within the Southern Kenai Peninsula area):

- Changes in natural resources & management
- Economics
- Improved collaboration, community-building, & coordination
- Demographics
- Technology
- Lack of shared vision
- Changes in drug-use
- Health care issues

**III. Community Health Status Assessment**

**METHODS**

In order to include the diverse quality of life issues that affect our community, the data collected for the second Community Health Status Assessment continued to be broad in nature. This presents a challenge to balance both having a wide range of community-level data available for users to answer specific (user-driven) questions with presenting community data in a manner that elucidates meaningful understanding of specific health needs or community priorities. The challenge still exists to create parameters in which data collected balances these two needs.

The identified priorities for data collection included:

- Updating data obtained for the first assessment, providing an opportunity to see changes over time
- Updating and retrieving data provided by local organizations
- When Southern Kenai Peninsula data available, prioritizing its representation over Kenai Peninsula or State of Alaska data to better understand local needs
- Highlighting data that informs priorities identified by the community
- Improving consistency in reporting measures across organizations to enhance community-level understanding (versus organizational understanding)
- Using and locally tracking data prioritized by Healthy Alaskan 2020 (top 25 health indicators released in September of 2013)
- Improving data quality, reporting, and focus of collection

Giving consideration to these priorities, this assessment puts forth sub questions to support the overarching question of "What is the Health Status of our Southern Kenai Peninsula community?" These sub questions are based on priority indicators and issues established by the County Health Rankings, Healthy Alaska 2020, and the Southern Kenai Peninsula community.

The sub questions are:

What are the population demographics of the Southern Kenai Peninsula community and how have they changed from 2000 to 2010?

What are the top five leading causes of death in the Southern Kenai Peninsula area and what data are available that track key risk factors for these causes of death?

How does the Southern Kenai Peninsula compare to the state and nation on Healthy Alaska 2020's top 25 leading indicators of health?

What quantitative data do we have on qualitative issues raised by community members?

- Economics / Affordability
- Substance Abuse
- Mental Health
- Transportation
- Family Issues / Adverse Childhood Experiences
- Teen Resources / Activities

What data are available to track the 'healthy vision' defined by the community in 2010?

In order to support initial analyses, these questions were primarily addressed by available Southern Kenai Peninsula community-level data – US Census 2000 and 2010, American Community Survey results combined for all Southern Kenai Peninsula communities, and State of Alaska vital statistics and behavioral risk factor survey data. A thorough analysis is not provided, but data is provided to support discussion and selection of issues that will be prioritized for further analysis.

The graphs shown in the Health Status Assessment are predominantly secondary data that meet the greatest number of data quality dimensions and depict Southern Kenai Peninsula community-level data:

- US Census, 2000 and 2010 for the Southern Kenai Peninsula community
- American Community Survey, 2007-2011 5-year estimates for the Southern Kenai Peninsula community
- Alaska Behavior Risk Factor Surveillance System for the Southern Kenai Peninsula community
- Alaska Youth Risk Behavior Survey for Southern Kenai Peninsula schools
- Alaska Bureau of Vital Statistics

Primary and secondary data collected and compiled at the local level (individual efforts, organizations, and communities within the Southern Kenai Peninsula) are highly valued in our MAPP process. This process is informed by the five conditions of Collective Impact (Common Agenda, Shared Measures, Mutually Reinforcing Activities, Continuous Communication, and Backbone Support) to guide its shared community efforts. A critical component of Collective Impact is creating, prioritizing, tracking, and evaluating shared measures. Local level data improves our community's ability to achieve consistent data collection for priority issues and better understand specific community strengths, needs, and changes. The process and communication surrounding consistent and shared local-level data collection reinforces our collective impact in addition to improving our ability to strategically address existing needs. Local organizational data collected for this assessment is available in Appendix A and on the MAPP of the SKP website (www.mappofskp.net) under the 'Community Vision' tab.

**LOCAL COMMUNITY DATA**

MAPP of the Southern Kenai Peninsula asked local community members and organizations to share their data that reflected important community health information. Many organizations contributed and a great deal of local-level, organizational data are integrated into the Community Health Assessment. When applicable to specific health status lenses, lists of available local data are included in a table and the actual data are included in Appendix A and available online.

In October 2012, MAPP of the Southern Kenai Peninsula was awarded a capacity-building grant by the Alaska Community Foundation that supported the purchase of strategic management software, Insightvision. This online tool provides a framework for housing, organizing, and tracking community data and is embedded on the MAPP website (www.mappofskp.net). This online tool makes the

majority of health status data more accessible to the community and supports efficient ongoing updates in the future.

**OBSERVATIONS**

The following observations highlight Southern Kenai Peninsula-level data presented in the assessment. Healthy Alaskans 2020 has identified the top 25 health indicators for Alaskans and the Southern Kenai Peninsula is able to track most of these measures at the community level. However, three-year trends for SKP-level data are not yet available. The observations below do not include observations from local organizational data presented in Appendix A (e.g., Cook Inletkeeper, Homer Police Department, and South Peninsula Haven House data).

- There was an increase of 1,237 residents within the SKP between the 2000 and 2010 census (10% increase → population overall is growing, however birth rate is stable).
- There is a greater percentage of residents aged 45 and older than in other regions in AK and the entire US (49% of SKP population 45+, whereas Kenai Peninsula 44%, Alaska 36%, and US 40%).
- The percentage of SKP population 65+ changed from 8.4% male (2000) to 13.3% (2013) and 4.2% female (2000) to 12.2% (2010).
- The Southern Kenai Peninsula's top 3 leading causes of death (#1 Cancer, #2 Heart Disease, and #3 Unintentional injury) are similar to the Kenai Peninsula, Alaska, and US (#1 heart disease, #2 cancer).
- While the SKP seems to be on par with rest of the US and AK in many areas, this is concerning since the status of US health is overall unhealthy and getting both worse and more costly (examples are the number of individuals with back pain or diabetes mellitus).
- Binge drinking amongst SKP teens is consistently higher than statewide rates which is very concerning. Adult binge drinking is also high.
- There is a wide spectrum of substance abuse services that are not available in the Southern Kenai Peninsula geographic region.
- SKP youth and adult obesity and overweight data are alarmingly high, trending similarly to AK and the US.
- Due to the high suicide, alcohol-induced deaths and rape rates statewide (and lack of comparable local data), these issues at regional levels continue to be a focus for data collection.

- Alaska is 38th out of 50 states for completion of 19-35 month old children's immunizations, an important indicator according to the CDC. A statewide registry in AK (VacTrAK) to assure complete updated records regardless of multiple providers is still in its infancy.
- Alaska is consistently the #1 or #2 state for chlamydia incidence nationwide.
- Economics and affordability have been raised as a top concern for the community (in the community themes and strengths assessment), however there is a lack of identified community-level data on economic statistics/data (e.g., Homer's recent Google award for number of online businesses, yet this is not tracked locally). This might be compounded by the way in which the city and borough limits are defined and the absence of a borough-level economic synthesis in recent years.
- Almost half (44.4%) of SKP households make up the extreme ends of the income spectrum – with 24.7% in the lowest income bracket and 19.7% in the highest income bracket.
- SKP households have lower mean and median incomes in comparison to Kenai Peninsula, AK, and US (SKP mean household income 25% lower than Kenai Peninsula, 44% lower than AK, and 22% lower than US).
- The cost of SKP housing is below that of Anchorage, but all other costs of living (transportation, fuel, clothing, and food) are higher.
- The generally accepted definition of affordability is for a household to pay no more than 30% of its annual income on housing. 38.8% of households (with mortgage) and 48% of SKP renters pay more than 30% of household income on housing – thus, many residents fit the definition of 'cost burdened'.
- According to adult behavioral risk survey responses, the adult leisure exercise is declining.
- There continues to be an overall increase in the number of SKP K-12 homeless students.
- The Kenai Peninsula has alarmingly high numbers of individuals engaged in intimate sexual violence, physical violence, or both (2013 UAA Justice Center).
- The community survey responses highlight the perception that there is lack of teen/youth activities, however, there are many activities available – there are other issues or barriers (awareness / support / cost) at play that creates a disconnect between services/activities available and access.
- However, with the above bullet in mind, an important youth/family resource, the Homer Boys & Girls Club, has been closed in the last year.

- There is a lack of transportation, environmental, prevention, arts, and culture data for the assessment, thus half of our community goals have little information for comparison / status evaluation.
- Climate Change continues to impact and alter our environment through changes in water availability, increasing temperatures, number of frost-free days, and more. There is a lack of community-level conversation around climate adaptation, however, there are many opportunities (such as the City of Homer's Climate Action Plan) on which community efforts could build.
- The number of collaborative community (and non-traditional) partnerships has increased since the last health needs assessment.
- There is a lack of shared measurement around public transportation and community needs. This issue could be further explored as it is connected to many other community issues. This is a nation-wide issue, observed even within densely populated urban areas that have larger tax bases and smaller geographic distance to cover. Our community would be wise to explore the many factors that contribute to transportation needs in a large, sparsely populated geographic area that has many low income pockets within (we know there is a need, but don't have tax base to cover the need).

**RECOMMENDATIONS FOR THIRD CHNA DATA COLLECTION**

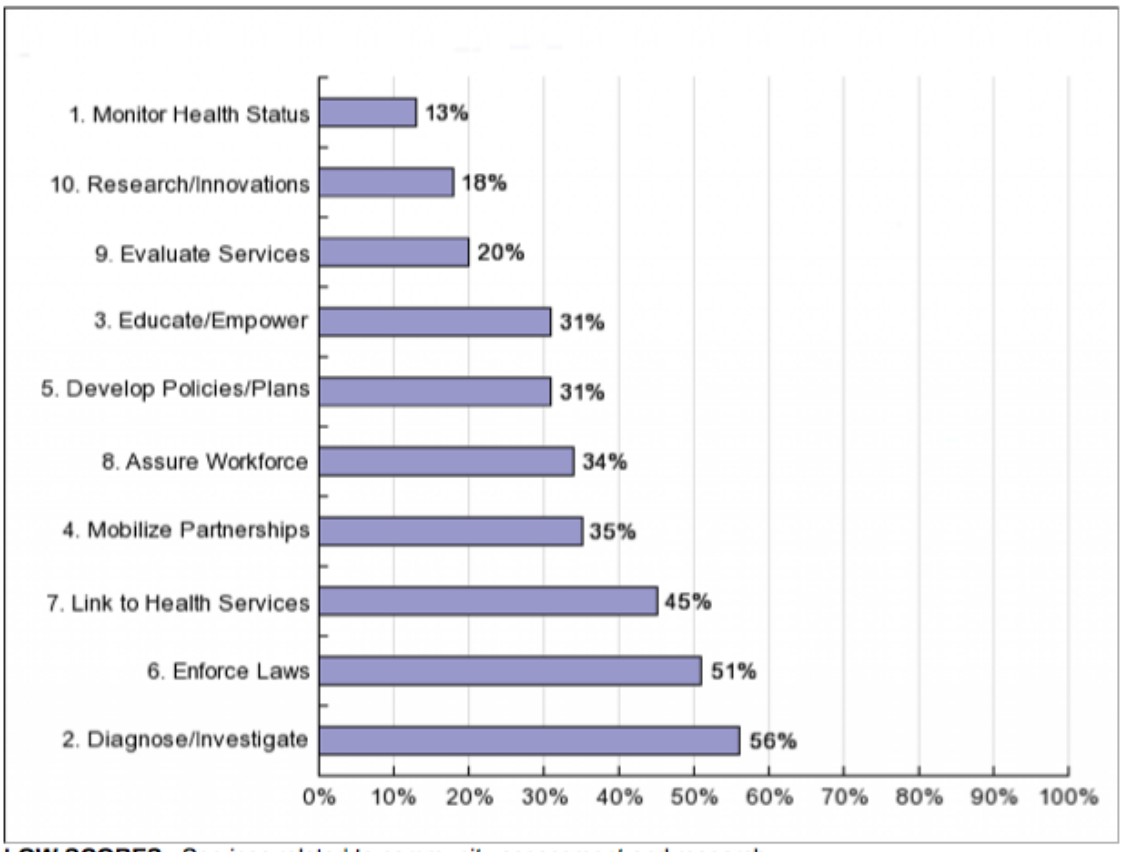
Through the iterative assessment process, our understanding of community health issues can become more refined and focused. With refined understanding also comes the awareness of information/data needed to better illuminate specific community needs and strengths. For a variety of reasons, the following areas were not meaningfully represented (or represented at all) during this second CHNA and are recommended for data collection in the third CHNA to support increased understanding of priority community issues:

- Transportation assistance
- Vaccine coverage rates area wide
- High school graduation rates
- Number of seasonal homeowners
- Demographics of residents moving to Southern Kenai Peninsula (age, income)
- Number of tourists
- Home-buying / building (building permits)
- HEA new service connections
- Cancer data collection and consistency in reporting

## IV. LOCAL PUBLIC HEALTH ASSESSMENT

Results from 2009 assessment included here in the absence of new data.

**Southern Kenai Peninsula Scores in the Ten Essential Services**




**LOW SCORES**: Services related to community assessment and research
The fact that we are completing a comprehensive community assessment through the activities of the SKP Community Project automatically will raise our scores, should we complete the NPHPSP tool in the future.
**MEDIAN SCORES**: Services related to client education/empowerment, mobilizing partnerships, policy development, and assurance of a competent public health workforce.
**HIGH SCORES:** Services related to reportable disease and enforcement of laws and regulations. In addition, we scored well the service that links people to needed personal health services; however, we scored much lower on the model standard that addressed transportation, cultural/linguistic services, and the actual coordination of services for vulnerable populations.

## UPDATED OBSERVATIONS

- While there was not a workgroup formed around the results on this report card, some of the needs were incorporated into either core values or workgroup functions – for example increasing data collection to monitor the health status of our population.
- Improved collaboration and non-traditional partnerships were acknowledged in the Community Themes & Strengths Assessment.
- It is anticipated in the next round of assessment that more meaningful specifics could be shown by updating this important public health tool.

**CHANGES IN PROCESS BETWEEN FIRST AND SECOND COMMUNITY HEALTH NEEDS ASSESSMENTS**

- There is an increasing priority (sometimes requirement) for evidence-based interventions and health outcome criteria, thus there has been an increased value placed on data collection/reporting.
- There is an increased value nation-wide for community coalitions to solve community issues, therefore an increased need for Community Health Needs Assessments (CHNA). Organizations are recognizing this and participating more broadly.
- CHNAs are now a federal requirement for some community health organizations.
- Having established a framework for collaboration, MAPP of the SKP attracted support of statewide agencies for data collection, sharing (AK Public Health, AK Bureau of Vital Stats, and more) and analysis (Institute of Social and Economic Research).
- This, in combination with increased data availability, has contributed to the second CHNA having access to more Southern Kenai Peninsula community-level data:
    - Healthy Alaska 2020 top 25 indicators were released in September 2013, providing guidance on key measures and supporting the request for SKP-level data for comparison
        - 13 of the 25 indicators have SKP-level data available and are comparable
    - Behavioral Risk Factor Surveillance System (BRFSS) and some Youth Risk Behavior Survey (YRBS) available at the SKP level
    - 2010 US census data available, thus comparisons to 2000 within SKP could be made and 2010 comparisons could be made between the SKP, the Kenai Peninsula, Alaska, and US
    - US Census American Community Survey data (2007-2011 estimates) were available for most Southern Kenai Peninsula communities, thus could be compiled to obtain SKP community-level statistics
    - Alaska Bureau of Vital statistics were obtained for multiple SKP community-level measures
    - The Kenai Peninsula Borough School District (KPBSD) is partnering with the Alaska Division of Public Health to collect and analyze Body Mass Index data on KPBSD students and has shared these data with the SKP community
- Physical health organizations are now collaborating to provide shared measures for some key risk factors and access to care info

- Software to show interactive community data on website - this format is more readily updated as we continue.
- Increased community input on community open-ended questions in Community Themes & strengths assessment (indication of increased community awareness of health improvements underway).
- Key informant interviews were structured to build on and add focus to the issues identified in the 1st CHNA, particularly focusing on root causes of community issues.
- Key informant input was predominantly answered as an online survey and was anonymous.
- CHNA data group was smaller and had one consistent core. These members also participated on the steering committee, thus this presented a challenge for resources/time.
- Having conducted the first CHNA, updates to previously submitted data were easier.
- Established partnerships on which to build and engage new participants.
- Increased awareness of the importance of identifying and reducing the impact of Adverse Childhood Experiences (ACEs) on individuals and families. This awareness has led to statewide initiation of ACEs questions being asked in the 2014 BRFSS to better understand adult health.
- Workgroups established in the first round of MAPP identified gaps and began collecting some primary local data that is now being reported.
- Consistent financial support was available for the MAPP coordinator position, including contributions from several local partners and ongoing hospital service area board funding.
- There is an increased understanding of how to define useful data (sustainable, ongoing, reliable, importance to story told…).

**CROSS-CUTTING ISSUES (WHERE THE 2013 ASSESSMENTS OVERLAP)**

Per the MAPP process guidelines, cross-cutting issues help identify themes that would be strategic for the community to consider addressing. Additionally, prior recommendations for improving the "ten essential services" from the previous (2009) Local Public Health System Assessment will apply to any strategic issues the community chooses.

The following themes were prominent in all three of the current assessments:

- Economic and Affordability Issues
- Adverse Childhood Experiences / Family Issues
- Access to care and services
- Aging population
- Quality of life
- Substance abuse
- Climate Change

As is the case with complex social issues, these topics that surfaced from each assessment have components that are interrelated, influence, or compound one another. Additionally, most of these issues function as root causes to what commonly become physical health problems. Thus, in order to support the community vision of a, "Proactive, Resilient, Innovative Community," the cross-cutting issues below should be taken into account when developing strategies and actions to improve community health. *Bullets below are not inclusive of all data, but provide an overview.*

**a. Economic and Affordability Issues**

- Community Themes and Strengths assessment
  - #1 community concern communicated in community surveys
  - Example concerns include health care costs, reduced organizational budgets, high cost of living, changes in tax base, lack of job opportunities with living wages, and more
- Community Health Status assessment
  - Census data show low household incomes compared to region, state, and nation
  - McDowell report demonstrates higher cost of living in Homer compared to Anchorage
  - American Community Survey data show that for more than a third of home owners with a mortage and renters, housing costs that are greater than 30% of their monthly income
  - Continual cuts in food stamp benefits increase local health inequities, widening the gap between rich and poor
- Forces of Change assessment
  - Changes in federal budget and federal sequestration
- High food and fuel prices
  - Availability of living wage jobs

**b. Adverse Childhood Experiences (Family Issues)**

- Community Themes and Strengths assessment
  - #5 community concern communicated in community surveys
  - Key informant surveys identified ACEs or family issues as a root cause to many client issues
- Community Health Status assessment
  - Data from BRFSS on ACEs-related questions shows comparable responses of Southern Kenai Peninsula (SKP) residents to statewide statistics

        - Data from Haven House, Homer Police, Office of Child Services, South Peninsula Behavioral Health Services, and more reflect concerning family issues in the Homer service area
    - Forces of Change assessment
        - An increased community awareness and understanding of ACEs is named with the opportunity to focus on resiliency / strengths

**c. Access to Care and Services**

- Community Themes and Strengths assessment
    - Transportation identified as one of the major services lacking in this community (#4 priority identified from community surveys)
    - Changes in health care and the Affordable Care Act
    - Teen services seen as lacking in the community, however it appears that there are many services, but also many barriers to accessing them (e.g., awareness, transportation, supportive parent, cost, etc)
- Community Health Status assessment
    - BRFSS results show percentages of adults that could not afford to see a doctor in the last year
    - Many youth services available in community, but a perception that there is a need
- Forces of Change assessment
    - Questions with how the affordable care act will impact access to health care
    - Changes in technology might affect access to certain sectors of the population, information overload, and more

**d. Demographics – Aging Population**

- Community Themes and Strengths assessment
    - Lack of elder services and activities, senior housing, and other issues related to aging
    - Observed increases in elder population
- Community Health Status assessment
    - Census demographics show stable birth rates but increasing 45+ year old population
- Forces of Change assessment
    - Borough tax breaks given to seniors reduces property tax revenues (for school funding and more)

- Increased population on fixed income
- Diminished work force
- Increased health care needs
- Opportunities for volunteer pool, special areas of expertise, and new businesses to meet needs

e. **Quality of Life** – people selecting to live here for the natural beauty, sense of place, and intrinsic value
   - Community Themes and Strengths assessment
     - Many respondents identified natural beauty and people helping one another as community strengths
     - People live here because they want to be here (indicates a deliberate, intentional connection to place)
     - Community participates in and values philanthropy and volunteerism
   - Community Health Status assessment
     - Seasonal housing statistics show evidence of area's attractiveness
   - Forces of Change assessment
     - Increasing seasonal population, changing demographics

**f. Substance Abuse**
   - Community Themes and Strengths assessment
     - #2 community concern communicated in community surveys
     - Perception that substance abuse treatment is still lacking in the community
   - Community Health Status assessment
     - Data from BRFSS responses show concerning rates of youth and adult binge drinking response
     - Substance abuse services are lacking in the SKP region according to the American Society of Addictive Medicine Continuum of Care.
     - Homer Prevention Project has collected additional and more specific data on underage and adult drinking in the Anchor Point and Homer communities
   - Forces of Change assessment
     - Changes in drug use and availability

**g. Climate Change**

- Community Themes and Strengths assessment
  - Conflicting support for non-renewable resource development and use in Alaska with the need to develop adaptive and sustainable measures/practices
- Community Health Status assessment
  - Number of frost-free days trending upwards since the early 1900s in Homer, Alaska
  - Increasing stream temperatures in salmon streams within the Cook Inlet watershed (data available specifically for Anchor River within Appendix A)
- Forces of Change assessment
  - Not as prevalent in national / state conversations but acceptance that climate change exists. Evidence that AK is 'ground zero for climate change', such as relocating villages due to rising sea levels and increased flooding during storms and ice flows
  - Increased storm frequencies, increased maintenance – unpredictability
  - Broad and hard to communicate relevance
  - Economy versus biology – climate change impacts to fisheries

**CONCLUSION**

This executive summary provides an overview of the methods and observations from each current assessment (Community Themes and Strengths, Community Health Status, and Forces of Change), thus providing a great deal of information to support the selection of strategic issue(s) for community action. The next step in utilizing this CHNA will be engaging community members in selecting (a) strategic issue(s) and developing a Community Health Improvement Plan (CHIP). This document could include: 1. Recommendations from this CHNA; 2. The process by which community needs are prioritized; 3. Ranked order of community priorities; and 4. Next steps and opportunities (short and long-term goals). While the CHIP will focus on specific actions for collective action, there are many ways in which to improve community health. All community members are encouraged to use the information provided within this CHNA to build on individual and group strengths that support and address community health improvement. It takes every one of us!