SOUTHERN KENAI PENINSULA COMMUNITIES PROJECT

Community Strengths and Themes Assessment Report

Homer, Alaska
December 2009

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With thanks also to our Core Group, who provided year-long leadership for the project, as well as serving in various capacities for each of the 4 individual assessments:

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Special thanks to these other project contributors: Jayne Andreen, Linda Chamberlain, Kris Curtis, Paul Eneboe, Michael Hawfield, Sara Karnos, and Randy Magen

And a big thank you to residents area-wide, who participated by sharing their hopes, dreams, concerns and solutions over this past year.

Lastly, we want to acknowledge the creativity and passion that so many have brought to our meetings and to specific committee workgroups; this project is truly a joint collaboration. The following is a list of member organizations:

Alzheimers Resource Agency of Alaska
Armageddon Café and Refuge Chapel
Bunnell Street Arts Center
The Center
City of Homer
Cook Inlet Council on Alcohol and Drug Abuse (CICADA)
Cook InletKeeper
Food Pantry
Homer Chamber of Commerce
Homer Downtown Rotary Club
Homer Foundation
Homer - Kachemak Bay Rotary Club
Homer Medical Clinic
Homer Police Dept
Homer Public Health Center
Homer Senior Citizens, Inc.
Independent Living Center
Kachemak Bay Campus - Kenai Peninsula College
Kachemak Bay Conservation Society
Kachemak Bay Family Planning Clinic
Kenai Public Health Center
Kenai Peninsula Borough School District
Kenai Peninsula Youth Court
Ninilchik Senior Center
Ninilchik Clinic
NoFAS (Fetal Alcohol Syndrome) Alaska
South Peninsula Haven House
South Peninsula Hospital
Sustainable Homer
Seldovia Village Tribe (SVT) Clinic

INTRODUCTION TO MAPP PROCESS

Developing and sustaining a healthy community requires participation from many diverse organizations and individuals who live and work and play in our community. The Southern Kenai Peninsula Communities Project came together in November of 2008, spearheaded by South Peninsula Hospital, to create just such a partnership. We gathered 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. We defined health very broadly, to include not only physical, but mental, spiritual, emotional, cultural and environmental health. This report is the culmination of 4 assessments conducted using the "Mobilizing for Action through Planning and Partnership" (MAPP) framework to structure our process. MAPP…is a tool that helps communities improve health and quality of life through community-wide and community driven strategic planning."[1] This framework was developed by the CDC (Centers for Disease Control and Prevention) and National Association of City and County Health Organizations (NACCHO). The State of AK Section of Public Health Nursing provided consultation and technical assistance to our local MAPP project.

[1] Achieving Healthier Communities through MAPP: A User's Handbook, Centers for Disease Control and Prevention (CDC), and National Association of City and County Health Organizations (NACCHO), 2008.

In the MAPP model, the 4 assessments are the key content that drive the process leading to development of a Community Health Improvement Plan.

The model below describes the entire MAPP process. The four assessments collect information to convey a broad description of health and the local public health system--beyond the traditional measures of illness and death rates. The center shows how the combined assessment assists communities in community-wide planning. Working together from a co-created vision statement fosters collaboration toward action steps unique to the health and quality of life in our area.

Southern Kenai Peninsula Communities Project

When a group of organizations met and there was consensus on readiness to conduct an assessment, we began organizing a partnership. We looked area-wide and obtained representation from health and social service workers, education, city government and the environment to collaborate and maintain broad perspectives on the issues. We built on the many partnerships already in existence in our community, inviting new members and sometimes specific expertise throughout the process. Business and the arts were invited and have participated, as have representative of other disciplines over the year. We sought out youth, village residents and representatives from senior and veteran groups for their input specifically. Our intention has been to collect primary as well as secondary data from many sources on core health indicators, to make

available for all organizations to use, with cyclic updates. In this way, the report can become a living document to improve upon as we discover gaps in local data collection and potential new ways to document the issues of concern to our residents. We expect to use the data from these assessments to foster ever-broadening collaboration and to harness funds for creative community action to improve the quality of life in our area.

Our public health partnership elected to define the community geographically as the Southern Kenai Peninsula. This includes Ninilchik in the north, south to the villages across the bay, and with Homer as the hub housing most services. This means that the following communities are represented in this report: Ninilchik, Happy Valley, Anchor Point, Nikolaevsk, Homer, Kachemak City, Voznesenka, Razdolna, Kachemak Selo, Halibut Cove, Seldovia, Port Graham and Nanwalek. Demographics and services to outlying areas vary greatly, so we appreciate the specific input we received from each community in the region. Our data is compiled together thus far, but communities will have access to the data we have collected for this report.

As we defined our community, the group also selected a name, "Southern Kenai Peninsula Communities Project." We also consensed on a vision: "vision to action for a better life." The group set a project timeline to complete the four assessments over the calendar year of 2009, and move into action steps at the beginning of 2010. Sub-committees formed and the work began.

COMMUNITY STRENGTHS AND THEMES ASSESSMENT

This is the community input portion of our data collection. It is qualitative in nature, and seeks to answer the following questions:
-"What is important to our community?"
-"How is quality of life perceived in our community?"
-"What assets do we have that can be used to improve community health?"

Background

Although several formal and informal surveys have been conducted in the past by local organizations, either no compilation was available, or the results were specific to the conducting organization's goals. Our group decided to seek our own broad input, in the form of community surveys (one at the Homer Health Fair and another community-wide, with an on-line component), and interviews with community leaders or "key informants." We collected 1441 completed surveys (610 from the Health fair and 831 from the Community-wide) and 99 key informant interview transcripts.

Surveys

We conducted our first survey in Homer, at the annual Rotary Health Fair in Nov. 2008. We offered surveys to each person who entered the door, and held drawings for door prizes, which provided an incentive to complete the survey as participants left. (Entrance into the drawing was contingent on turning in a completed survey). Questions were based upon health and general quality of life issues. (See our survey tool in Report Appendix, p.18.)

The Community-wide survey (Appendix, p. 20) went to area residents as an insert in the weekly "Homer News," and was available at several central locations in town – the public library, City Hall, the Chamber of Commerce, and Ulmer's/True Value Hardware. Our members also took surveys with them throughout Dec. and into Jan., to meetings, client home visits, civic groups and social gatherings. Several holiday fundraisers had tables available with surveys to complete, and organizations sent a link to our on-line version in their e-newsletters. Parents gave the online link to their teenage children. Many organizations had 1:1 help for clients to complete the survey in person. Public Health Nurses took them into villages, where they sought local help to distribute and collect them. In short, we distributed them as widely as our members could imagine, with tremendous community support for gathering broad input. We felt that the health fair had reached a more limited audience, so we actively sought larger representation area-wide in our second survey.

The second survey was re-worded by our growing number of partnership members, who broadened some of our questions from more traditional health language. Consequently, some of our results are reported separately here, while we combined results for questions that remained the same.

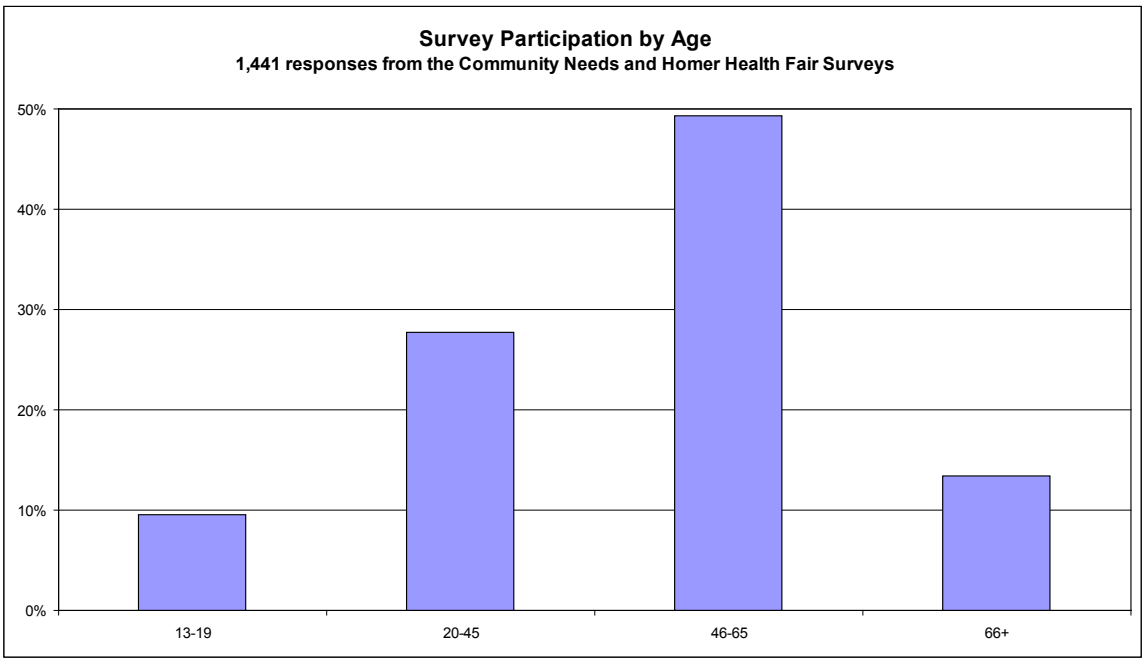
Limitations

With a total community population of approximately 13, 072, our 1441 surveys represent an 11% sampling. Our age and geographic breakdown closely reflects the population at large, given we did not sample children under 13. (See demographics, p. 12). We did not seek a random sample, and when population numbers are this small, the confidence interval is wide, which does make data unstable. In this assessment, MAPP uses surveys to gather general themes from residents, and the reader is encouraged to use caution in widely generalizing from our data.

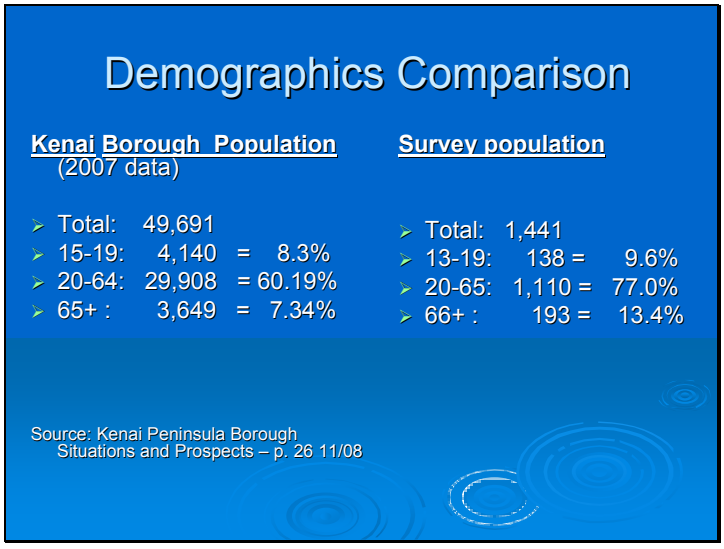
Our constraints included meeting Rotary guidelines for the health fair's shared page and later, Surveymonkey guidelines. We matched the written and online versions in the Community-wide survey. Some questions were indented on the page, which produces an effect of their appearing less important, and thus those questions were skipped by some participants. In compiling results, we tallied all responses given, and therefore our graphs in all cases represent numbers of responses, rather than number of participants. (Some people picked more or fewer choices than were requested.)

Finally, open-ended questions do not tell the whole story; some people do not complete them, and we cannot assume from this that they have no response. This is the nature of qualitative study. We present the information here to identify some of our community's perceived strengths and challenges; we hope our work will stimulate an ongoing dialog about community health and quality of life issues, as well as serve as a call to action.

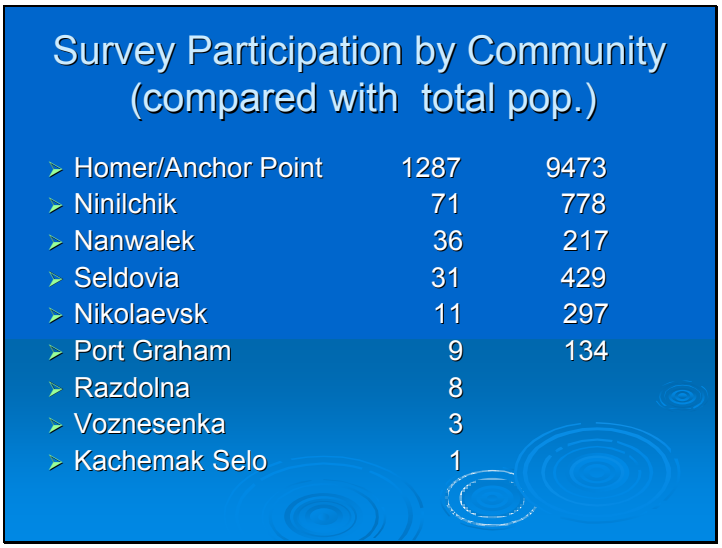
COMBINED SURVEY RESULTS
(See survey tools in Report Appendix, p. 18-23)



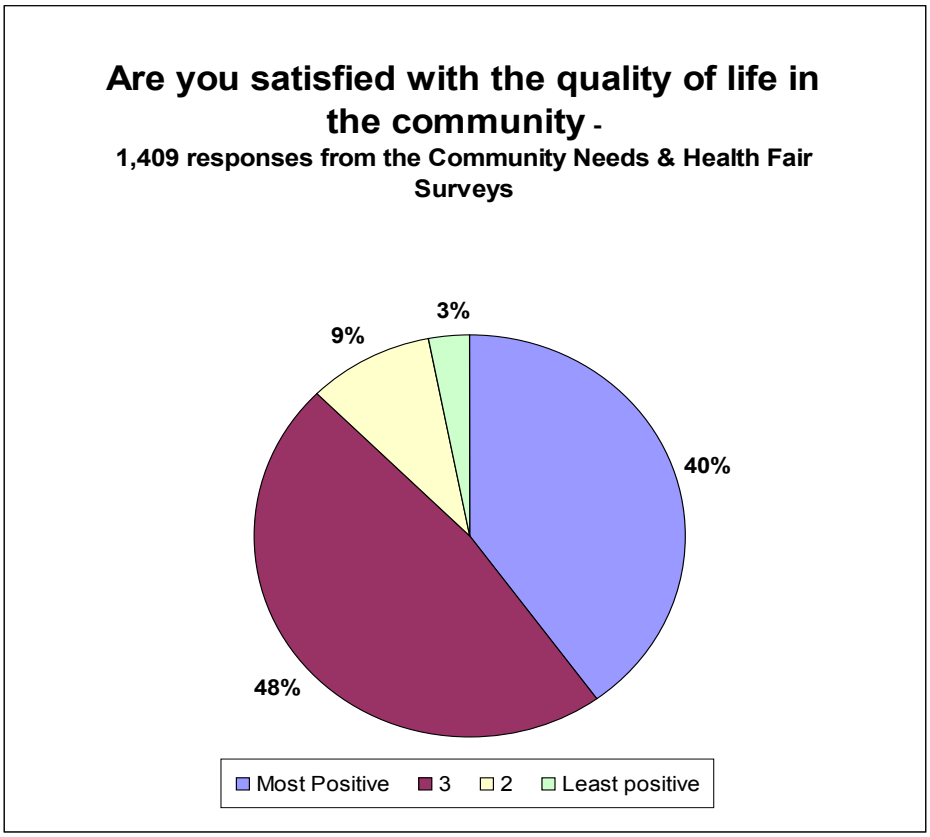
Our largest group of responses was from ages 46-65.



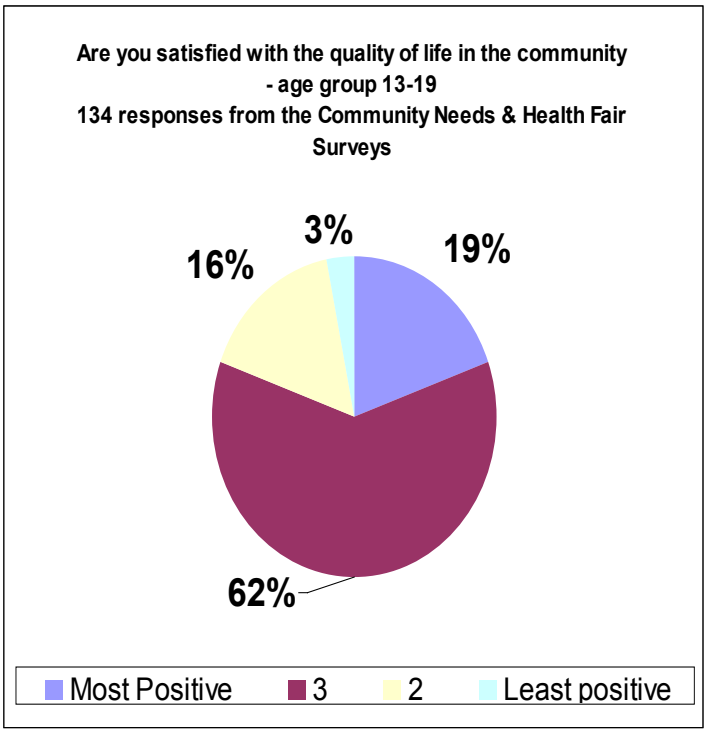
Our survey population did closely resemble the borough age breakdown proportions, noting that their age categories differed slightly from ours. Also, our total population equals 100%, since we did not survey under 13 year olds.

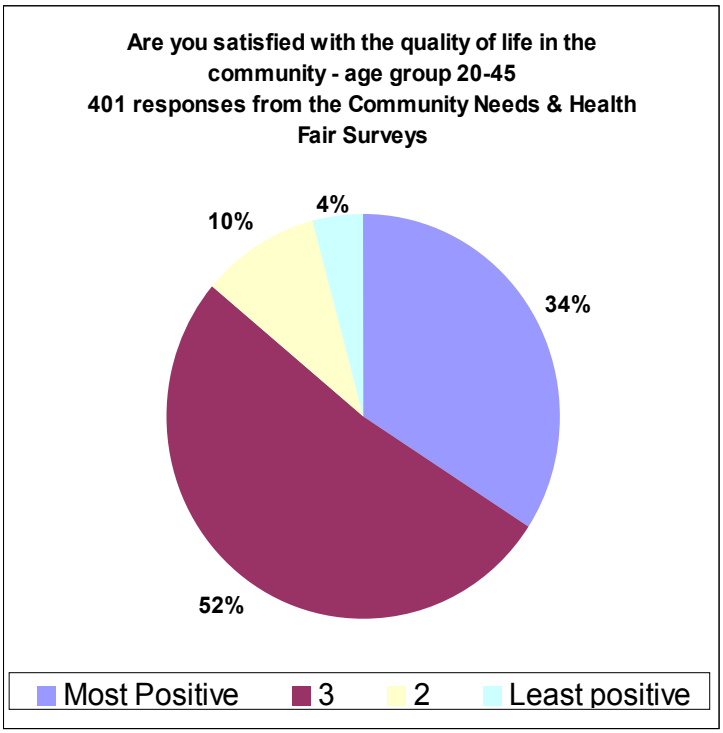


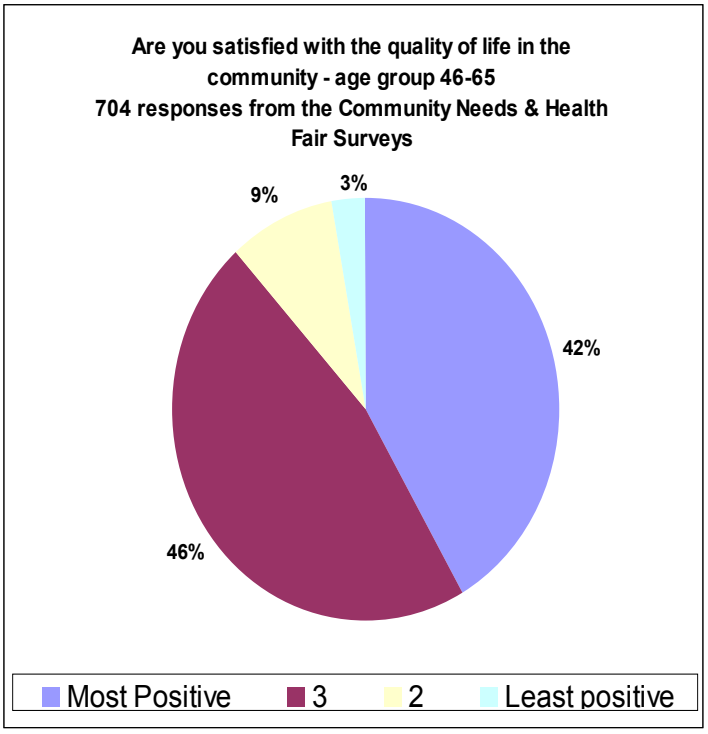
We were fortunate to discover that the proportion of people surveyed in each community (9 to 15%) roughly mirrors the population proportions as of 2007, according to census data from “Kenai Peninsula Borough Situations and Prospects,” Nov. 2008. Nikolaevsk is the one exception. (Census data is not available for Razdolna, Voznesenka and Kachemak Selo.)

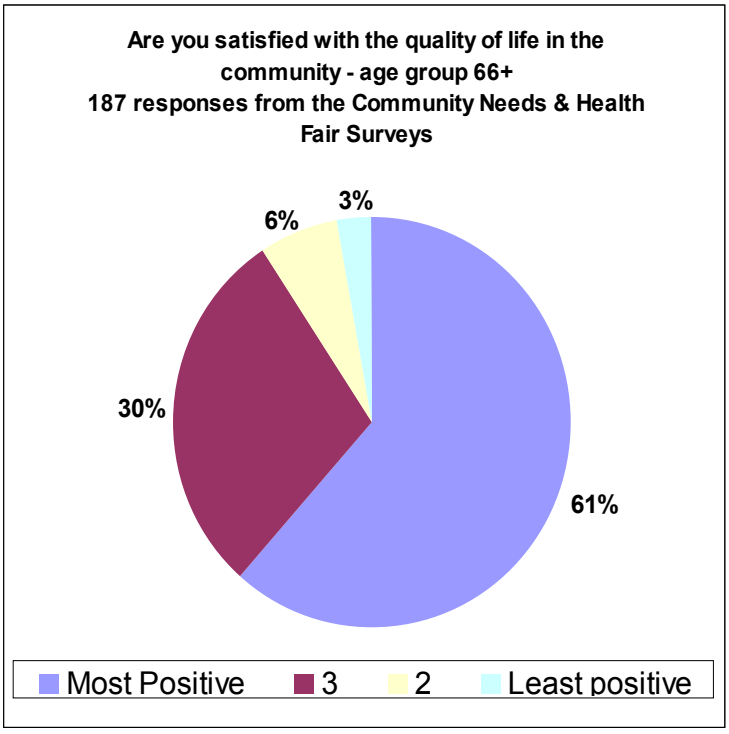


Most people reported satisfaction with the quality of life in the community.

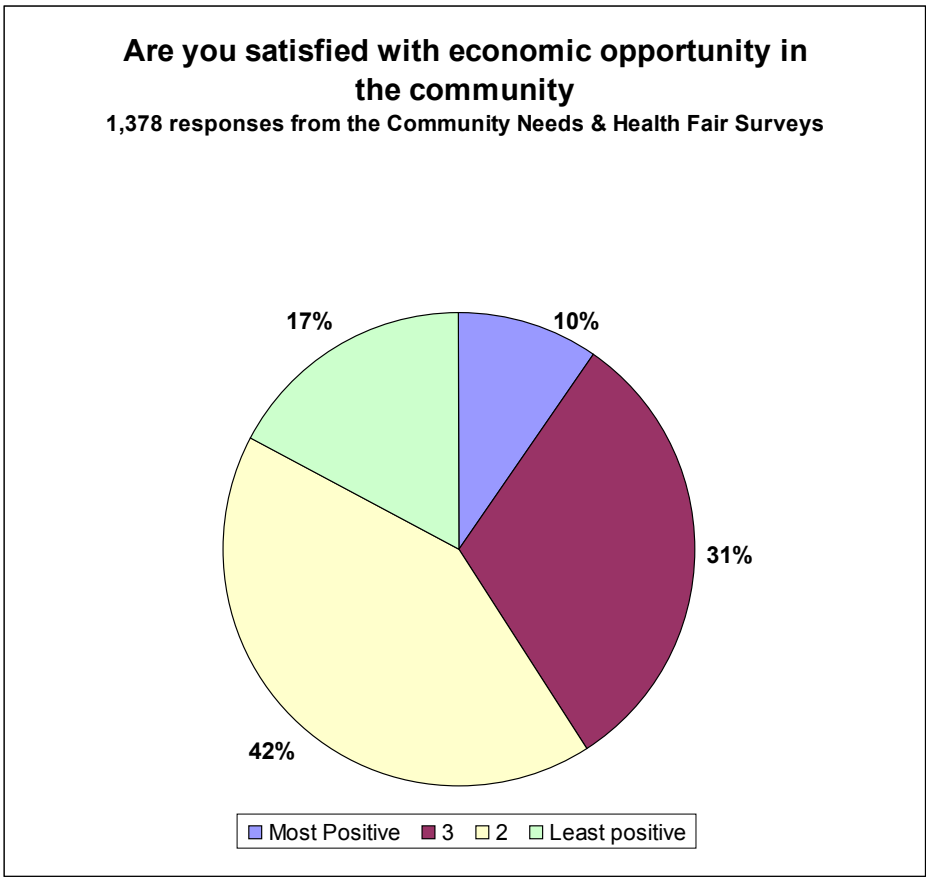




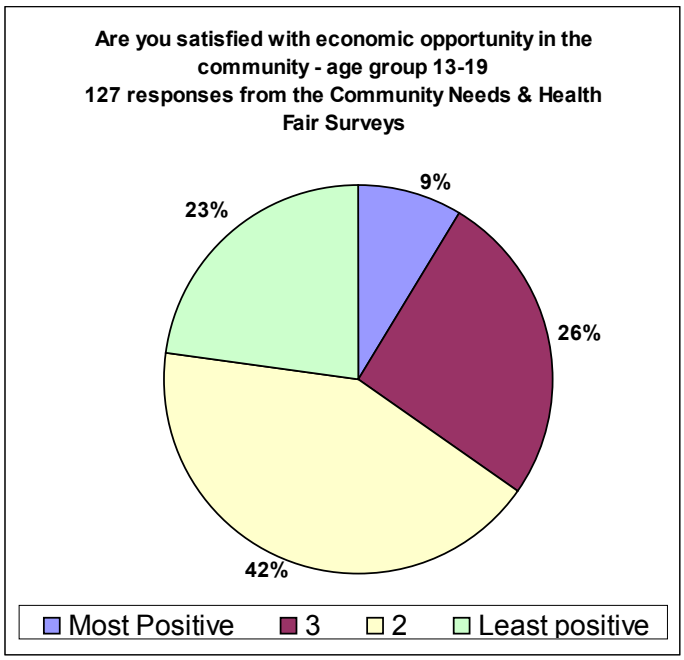


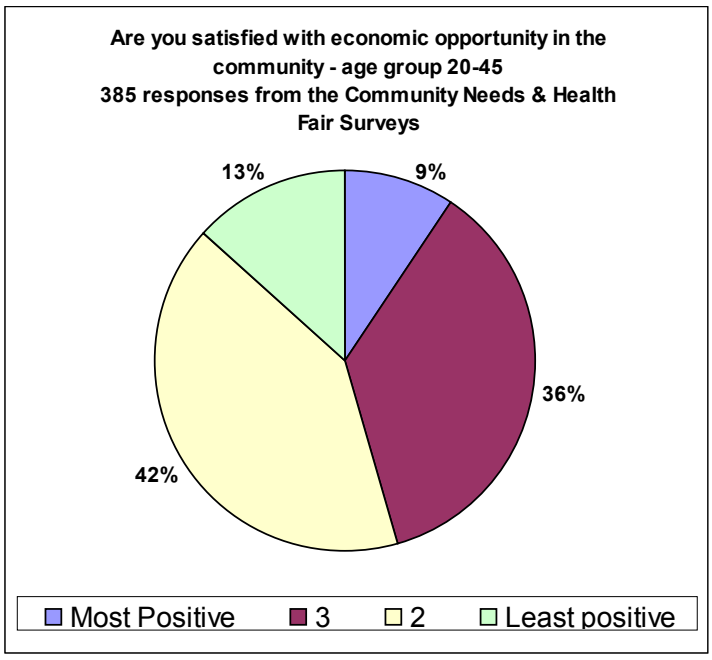


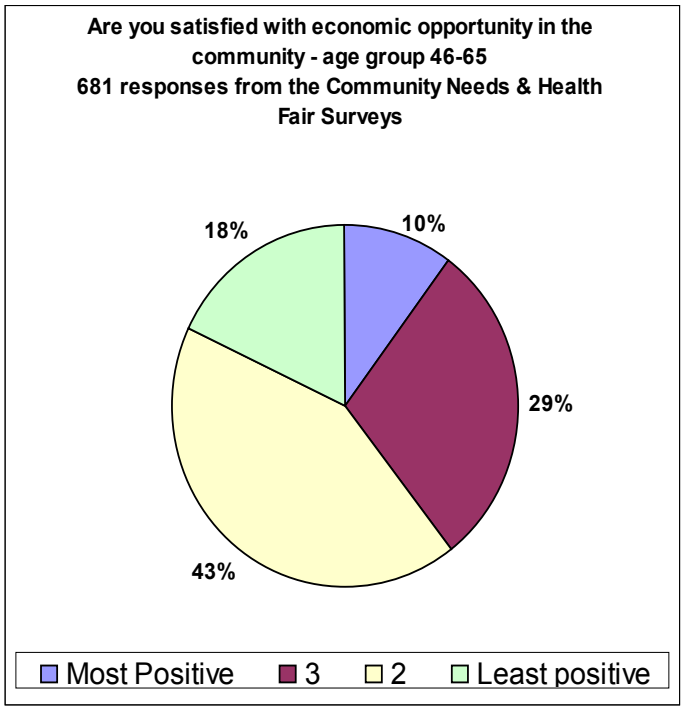
This holds true in all age groups, with the over 65 year olds slightly more satisfied.

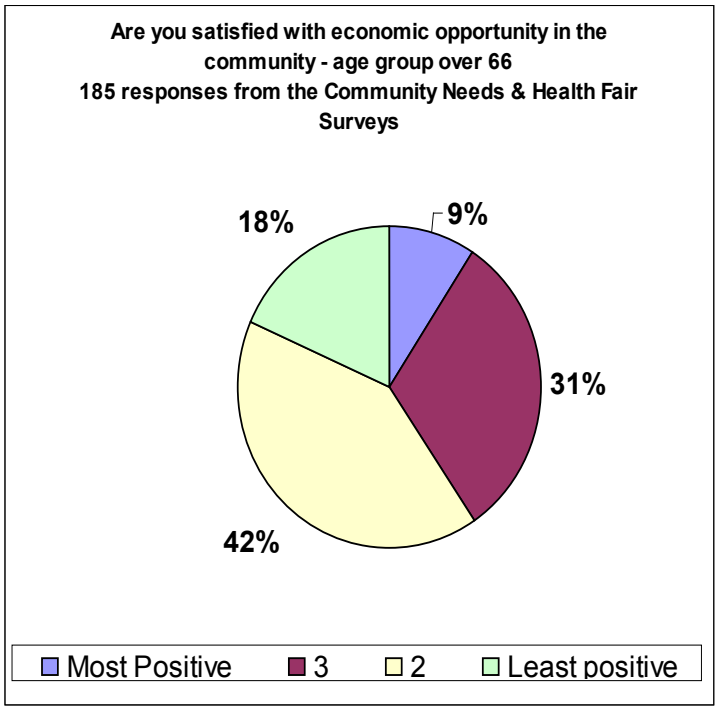


About 40%, across age groups, say they are positive about economic opportunity in our community.

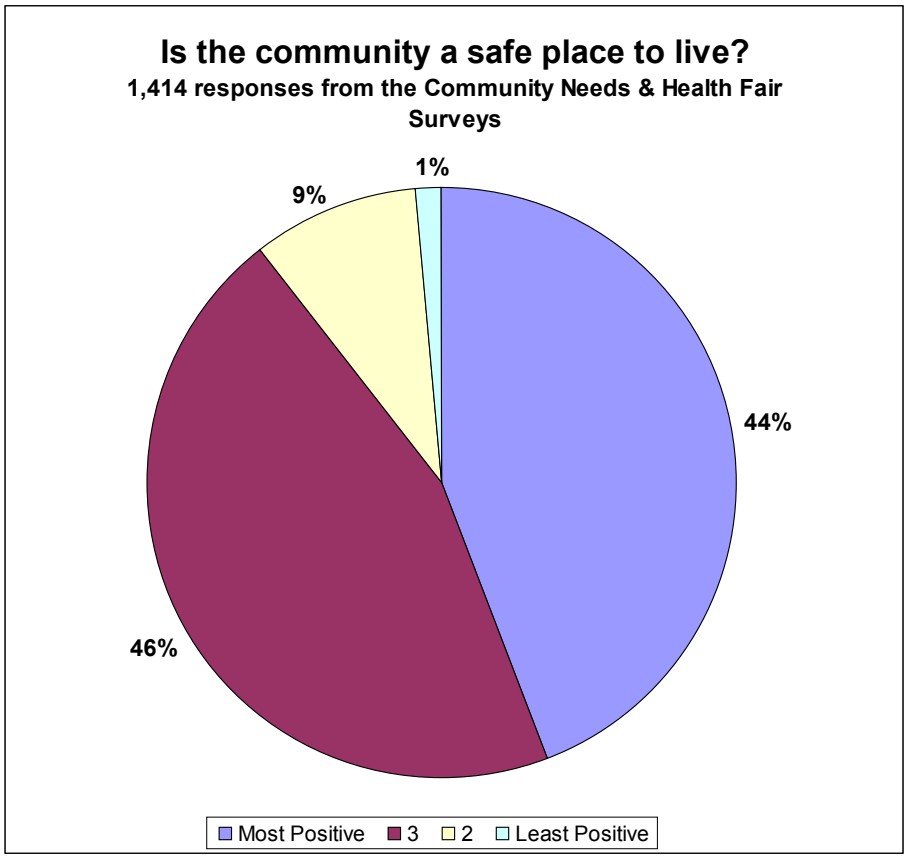




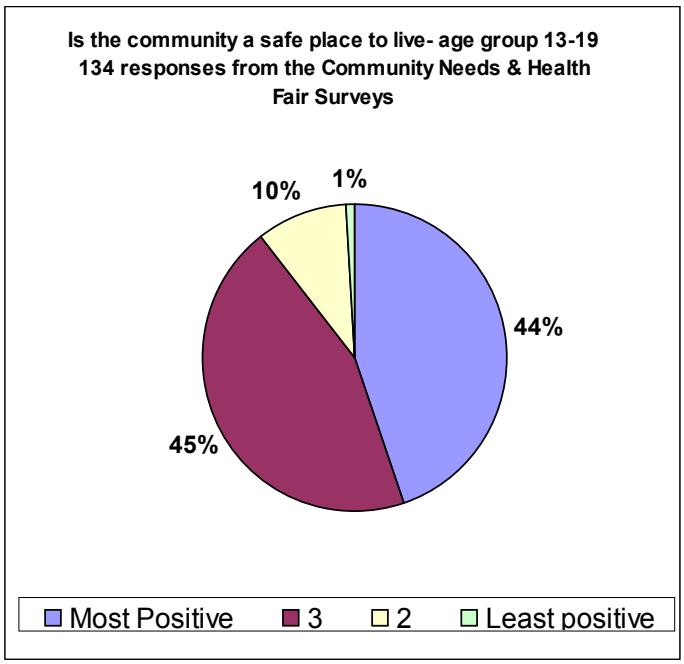


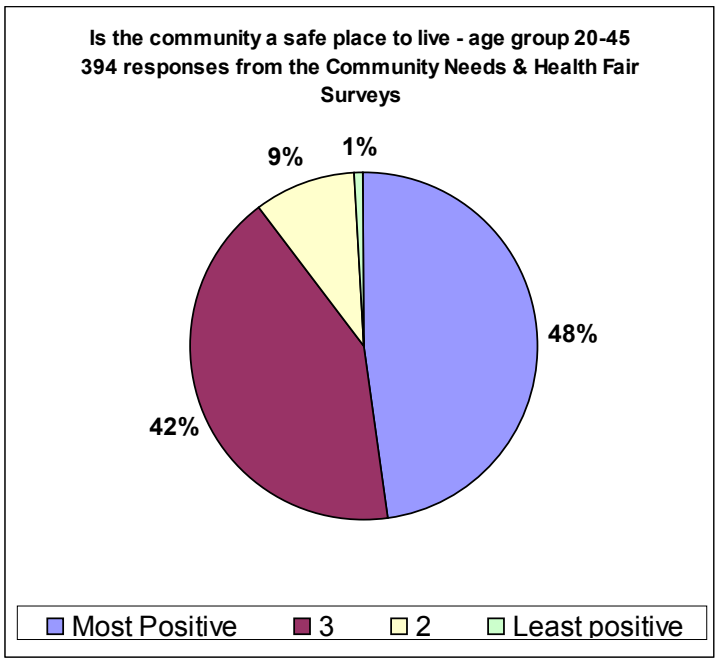


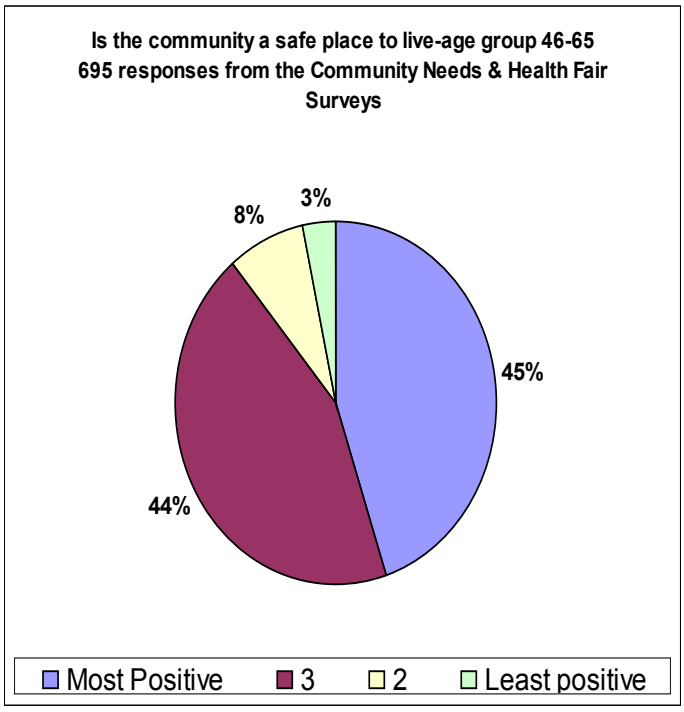
Teens reported the least satisfaction about economic opportunity in our community.

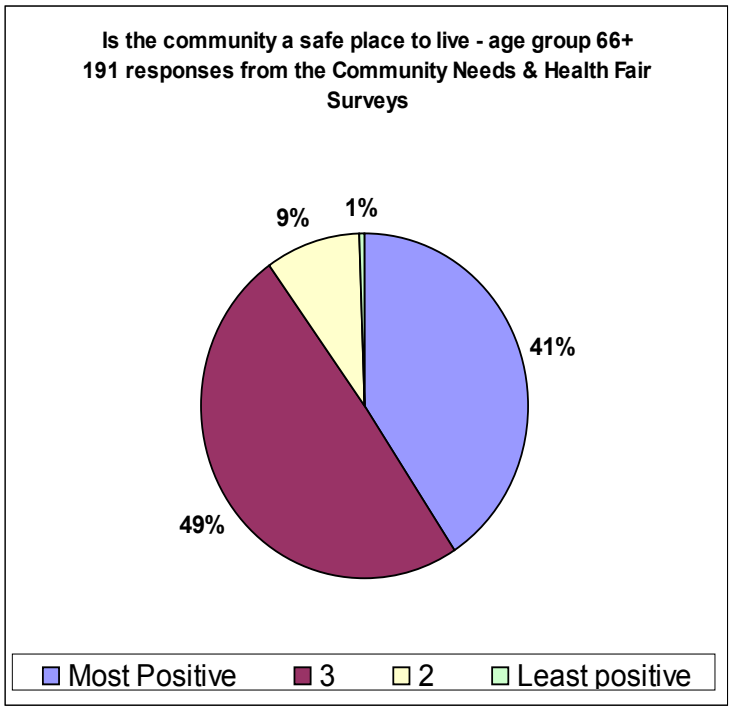


Most reported the community is a safe place to live.

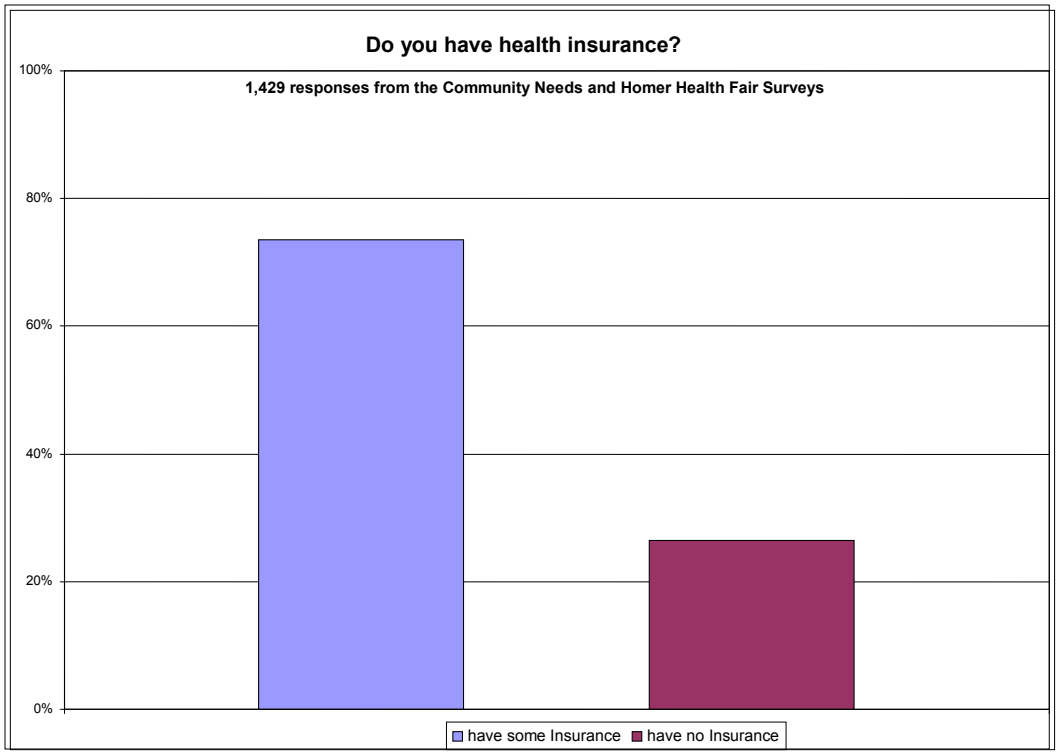


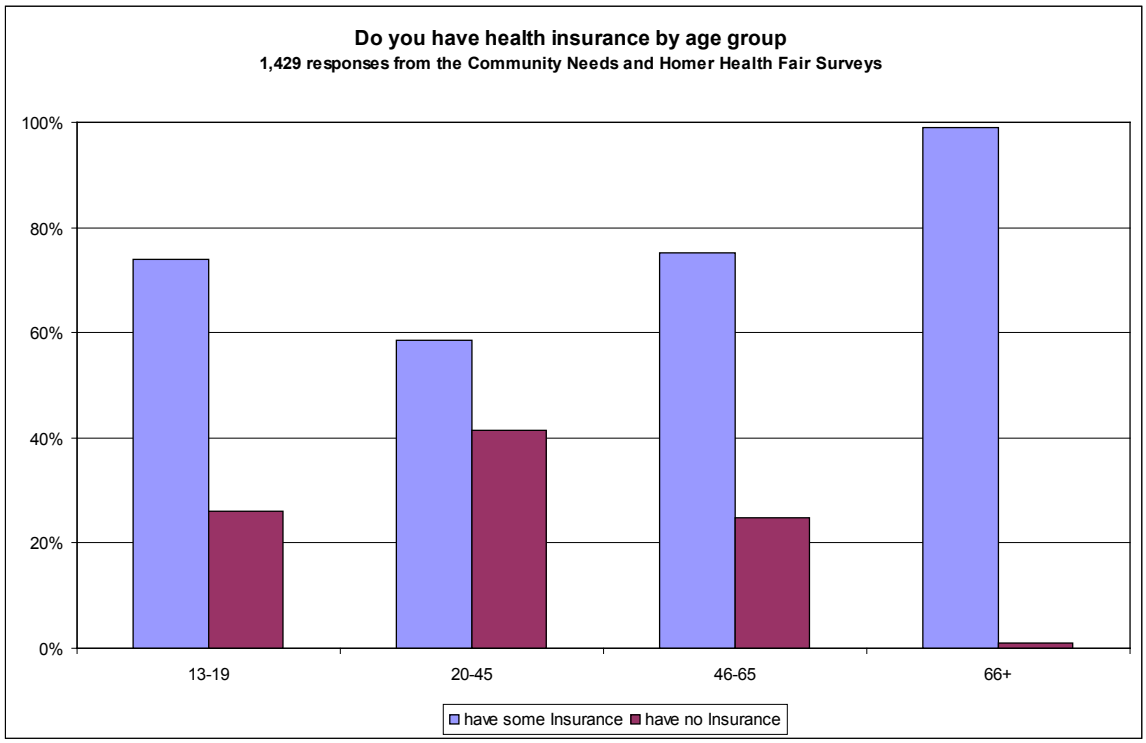






People in all age groups agreed.

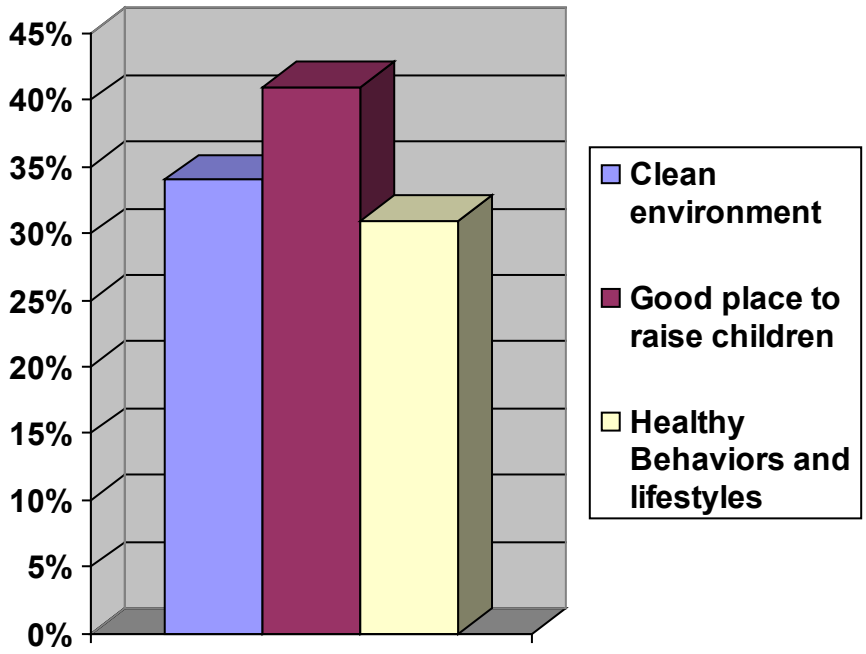




About 27% of our survey population reported no health insurance. This finding is consistent with statewide survey and local clinic data, reported elsewhere in this assessment. Respondents aged 20-45 report the lowest numbers with health insurance. (Note that those over 65 are all eligible for Medicare).

ROTARY HEALTH FAIR SURVEY RESULTS

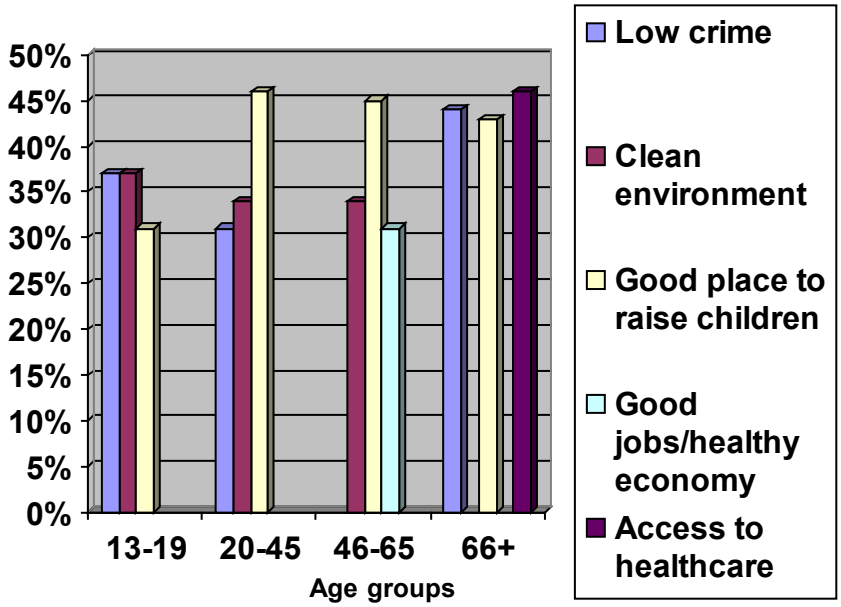
What do you think are the three most important factors for a healthy community?



Overall, these three factors were the most important to respondents.

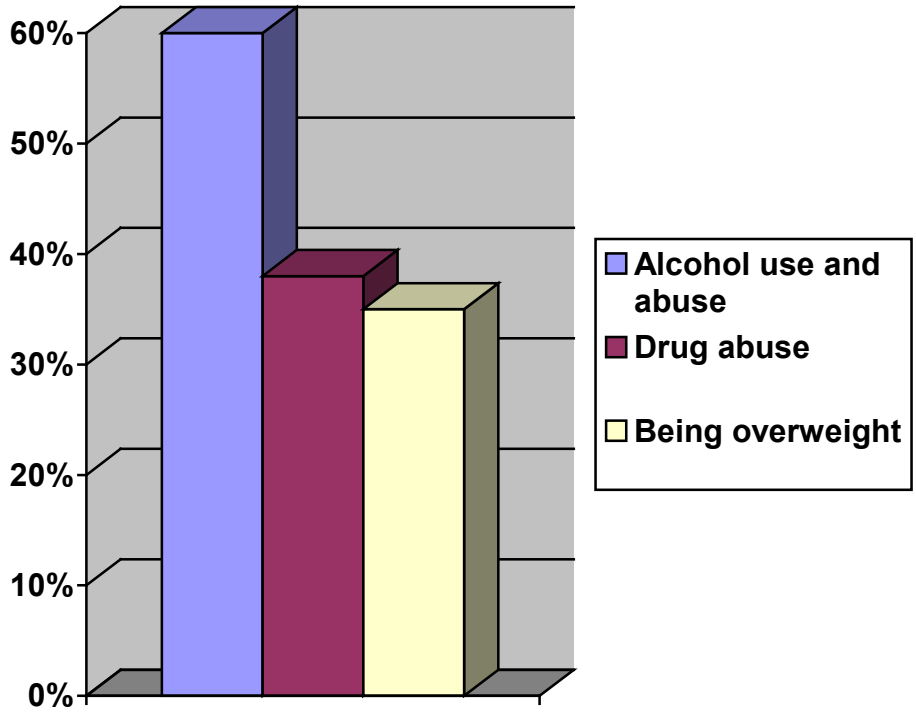
When separated out by age groups, the responses were different:

What do you think are the three most important factors for a healthy community?
(Top three responses for each age group)



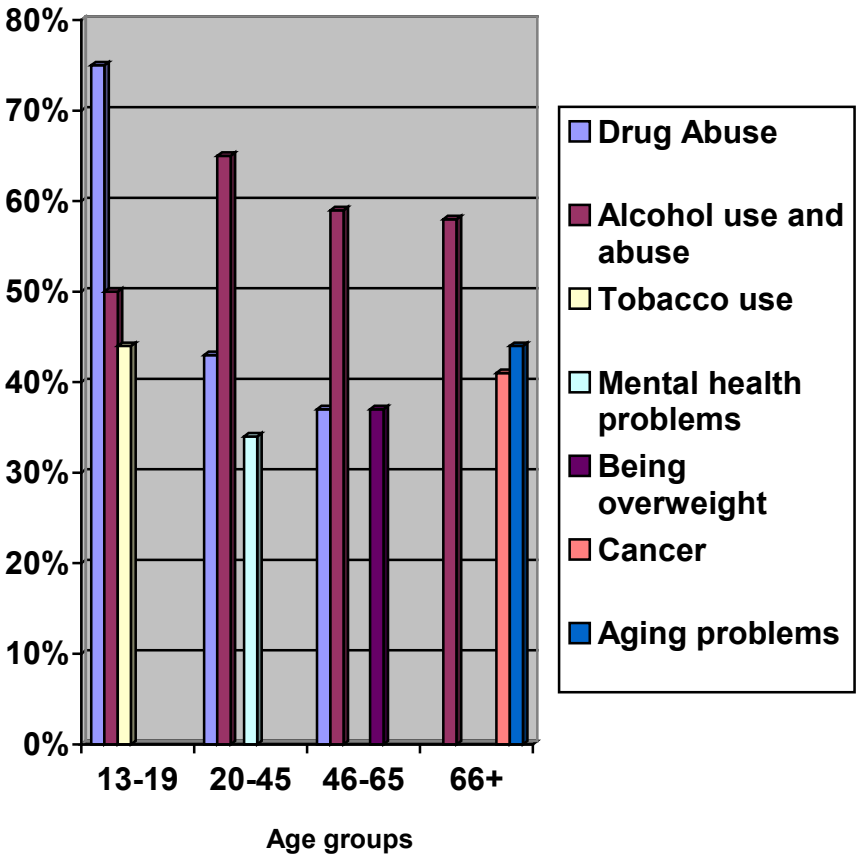
Note: The different numbers of respondents in each age group accounts for the difference in overall top 3 choices in the previous graph. (The 46-65 age group is a large proportion of the total respondents in this survey.) Young people ranked a clean environment first, whereas it was replaced by access to healthcare in the over 65 group. Good jobs and a healthy economy ranked in the top 3 only for the 46-65 group.

What do you think are the five most important “health problems” in the community?
(Top three responses--All ages combined)



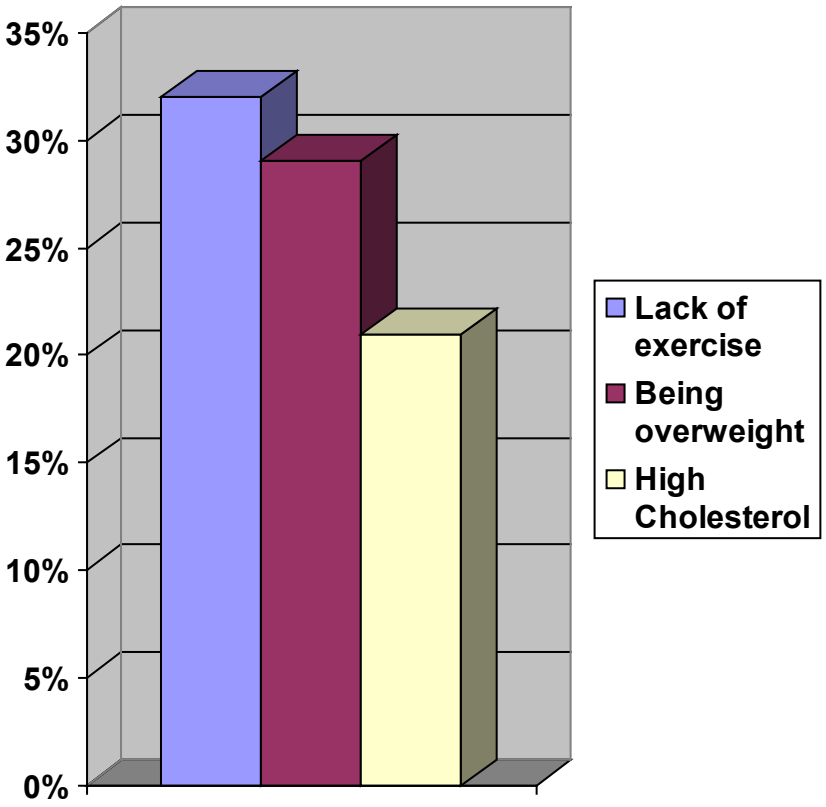
Substance abuse ranked high as a community health problem.

What do you think are the five most important "health problems" in the community?
(Top three responses for each age group)



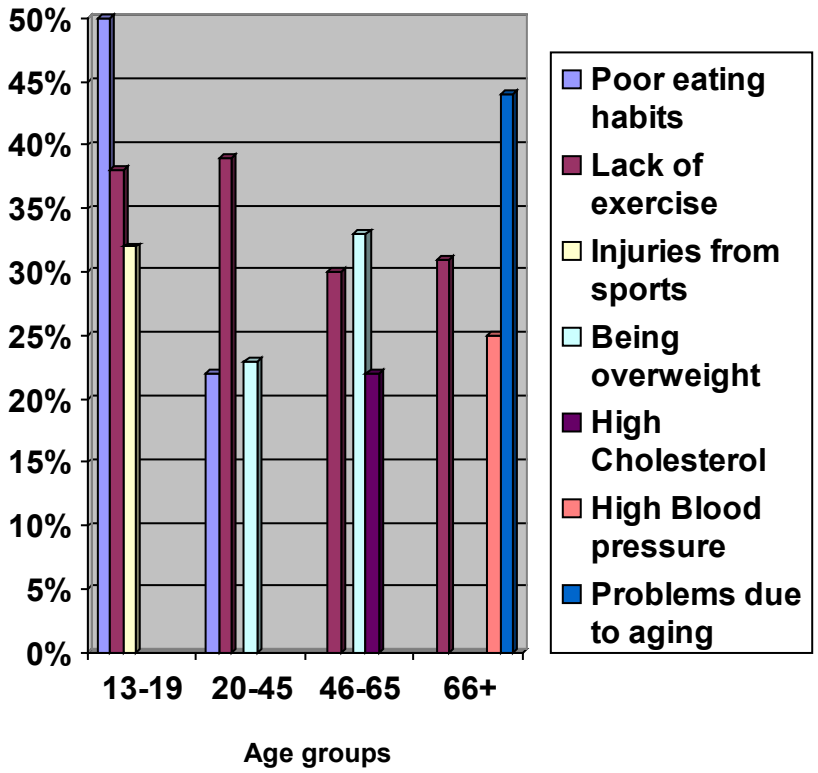
For the most important health problems in the community, teens chose all substance abuse issues. Alcohol use and abuse was in the top 3 for all groups. Mental health was in the top 3 for 20-45 year olds, and cancer in the over 65 year olds. Drug abuse was prioritized by all but the over 65 year olds.

What do you think are the five most important “health problems” in your family?
(Top three responses--All ages combined)



Most important problems named were very different for “your family,” compared with “the community.”

What do you think are the five most important “health problems” in your family?
(Top three responses in each age group)



The age groups also responded differently from each other in this question.

Have there been any health related services you or a member of your household have needed but have not been able to find in your community?

Yes 167 No 363

Of those people who answered “Yes”, the top 5 services named (no choices provided):

Cardiac related 28
Cancer related 21
Dermatology related 17
Mental Health related 14
Joint/orthopedic related 13

Note: Many people did not answer either part of #6, but we can’t infer that as a “no.” Further exploration of this issue is needed, since we do know that at least 167 respondents needed services not available here.

What prevents you from using any health related services that are already here in this area (no choices provided)?

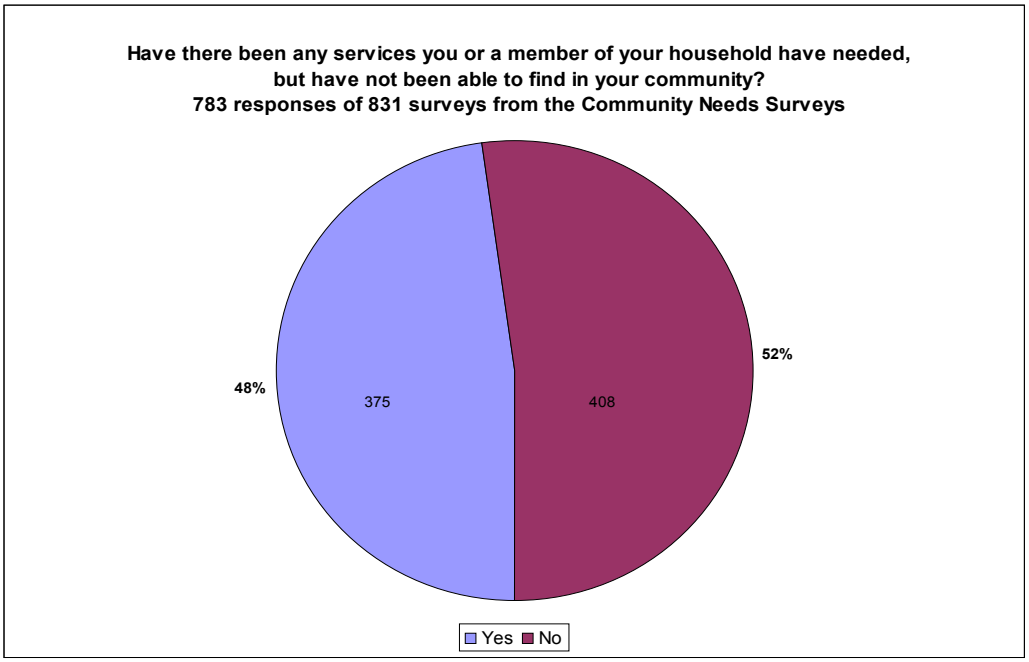
1. Cost/Money = 140
2. Nothing = 84
3. Lack of/not enough health insurance = 37

What do you see as the strengths and opportunities we have in our community to build upon in the future (no choices provided)?

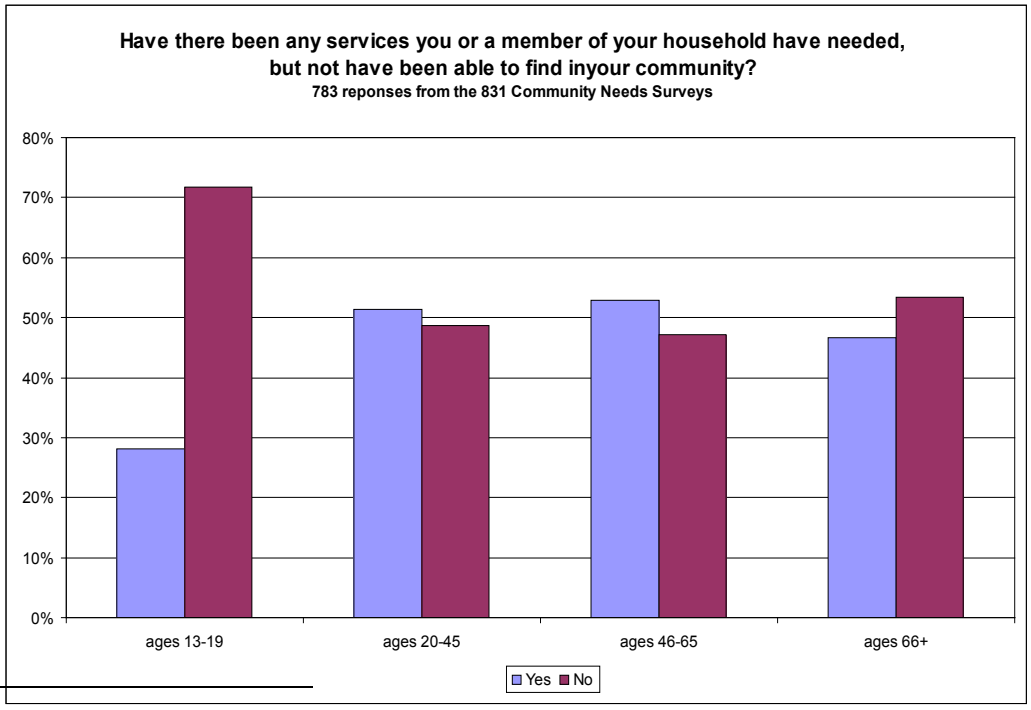
Top three answers:

1. Caring/nice people = 37
2. Hospital = 20
3. Community comes together on things = 14

COMMUNITY–WIDE SURVEY RESULTS[2]

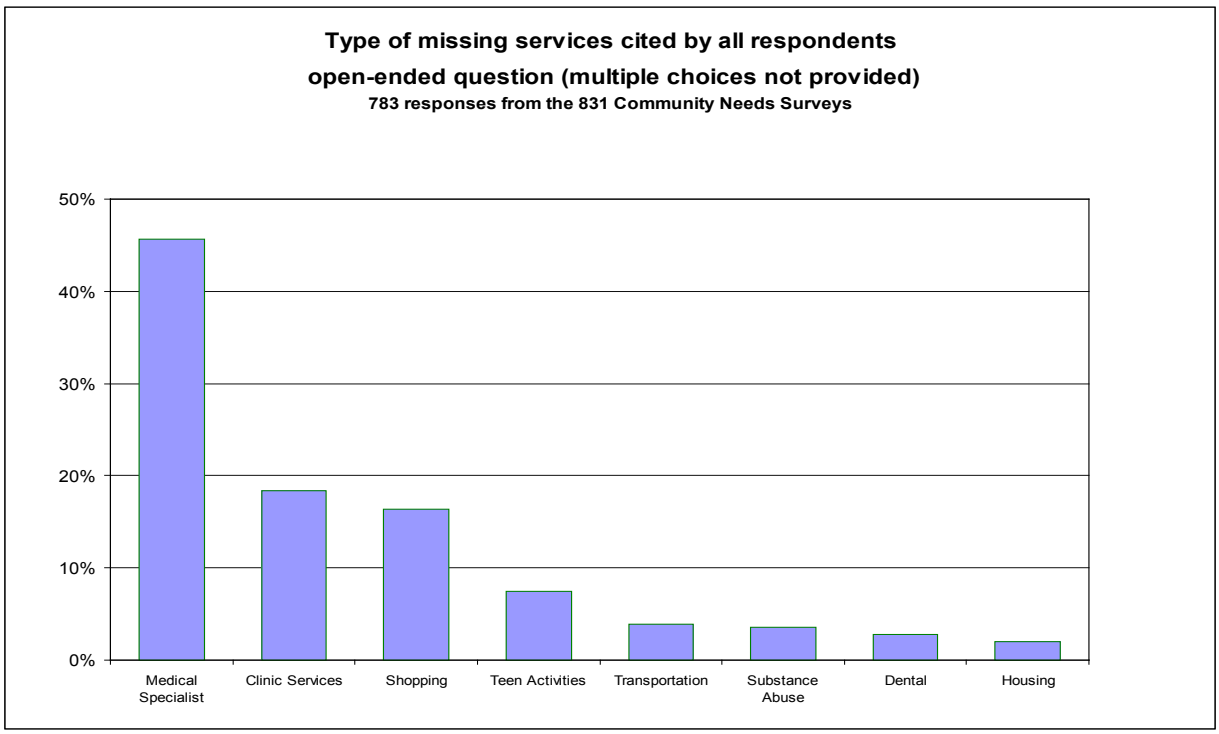


In this survey, nearly half of our respondents said yes.



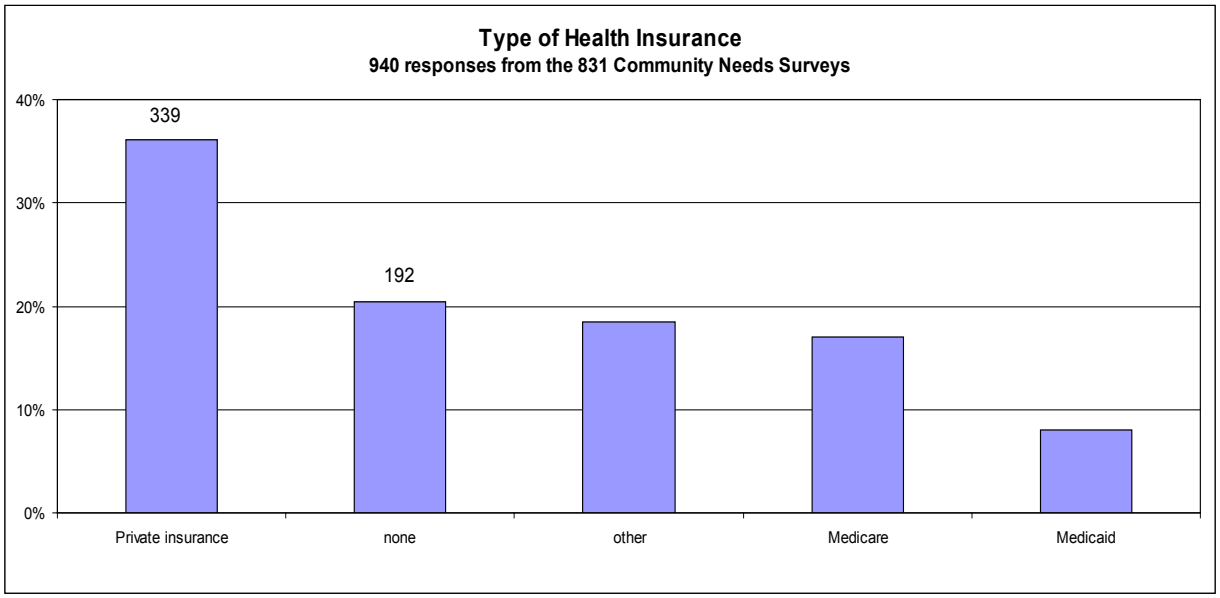
[2] These remaining Community-Wide survey results are not combined with the Health Fair results, because the group improved upon (changed) earlier questions. Our intention was to obtain more specific input and to broaden the community's definition of health.

Broken down by age group, teens were the least likely to report not being able to find services they needed.
The graph below shows write-in answers, tallied where possible.

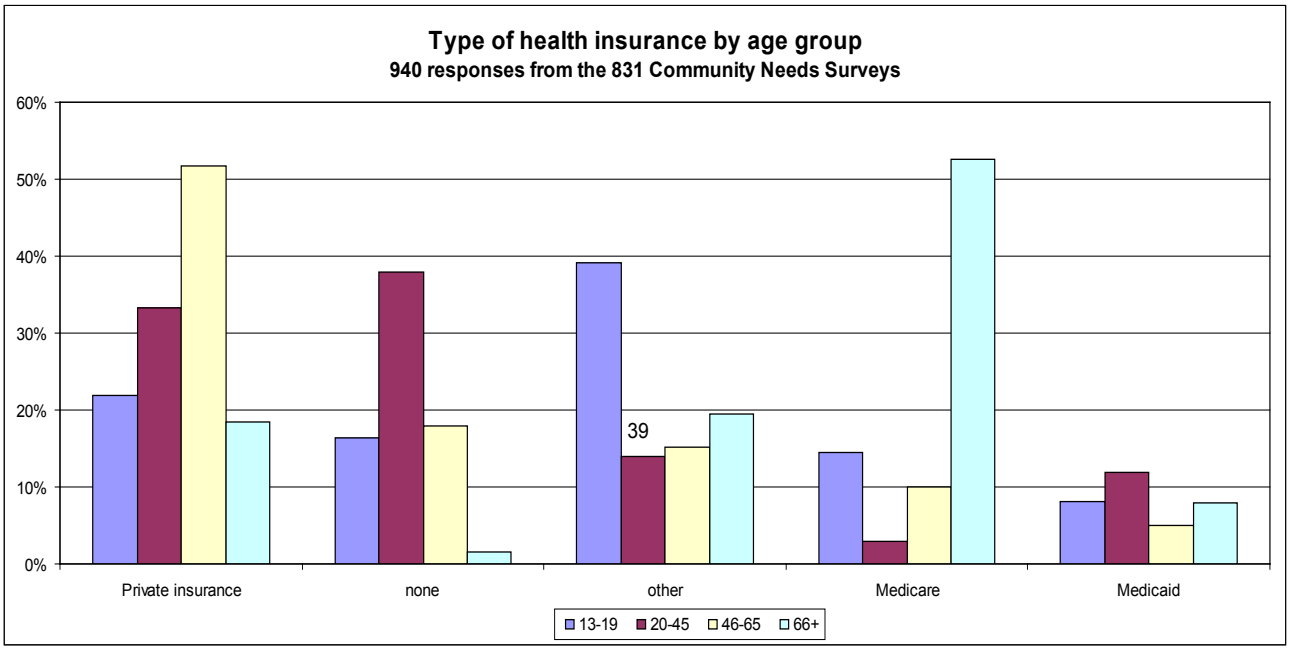


Using the word “services,” instead of health services (as we did in the Rotary Health Fair survey), brought a larger range of answers. Had we used the word “activities,” we might have also elicited prevention, recreation and education-oriented answers.

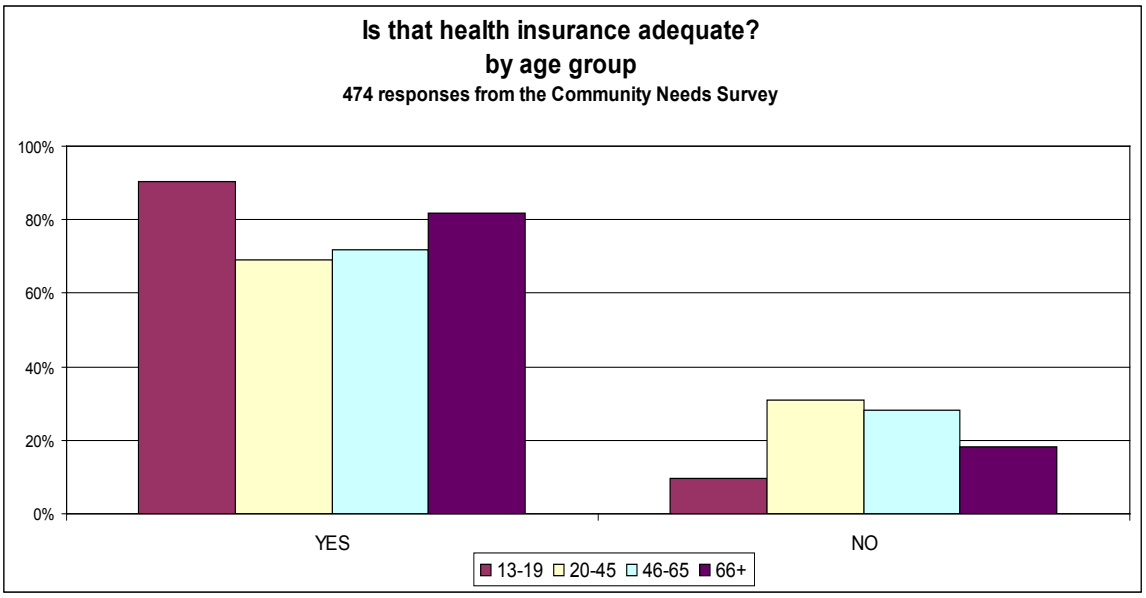
Twenty-seven percent (27%) of our survey population reported no health insurance.

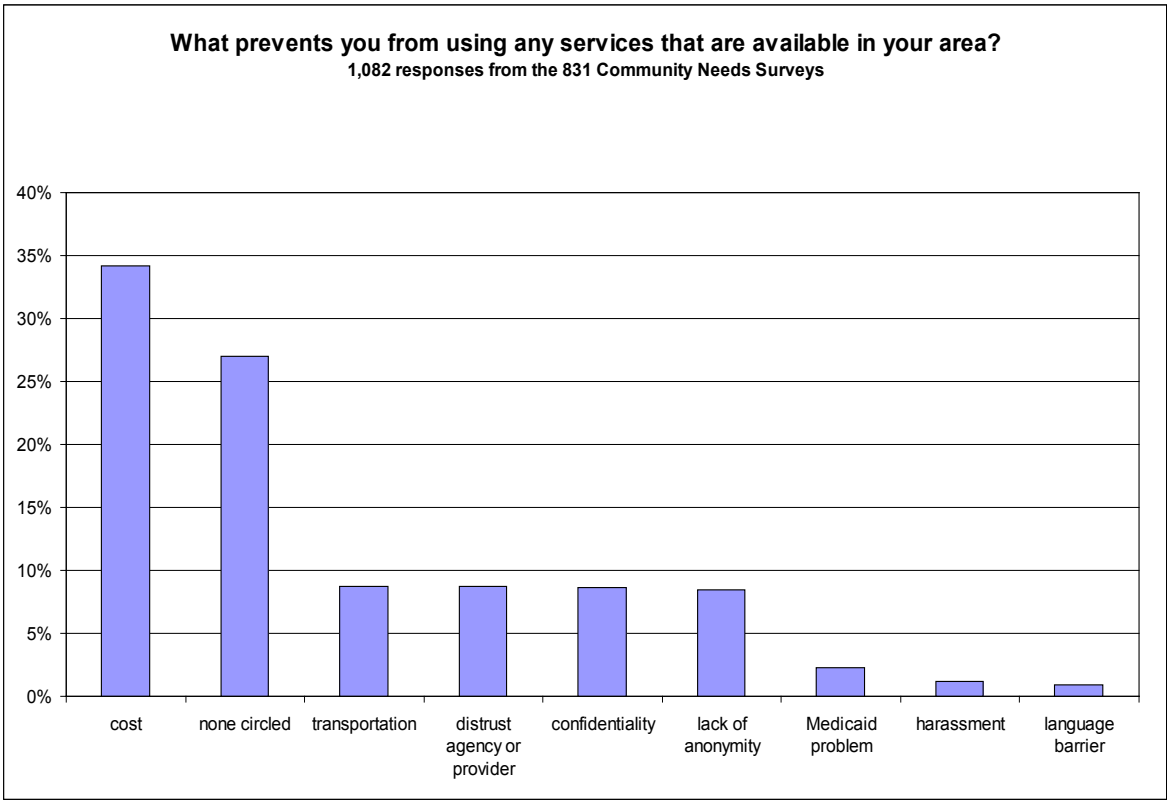


Our question did not differentiate between private insurance with full coverage and high-deductible (catastrophic) policies. We added an “other” category in this survey, and nearly 20% responded from that category.

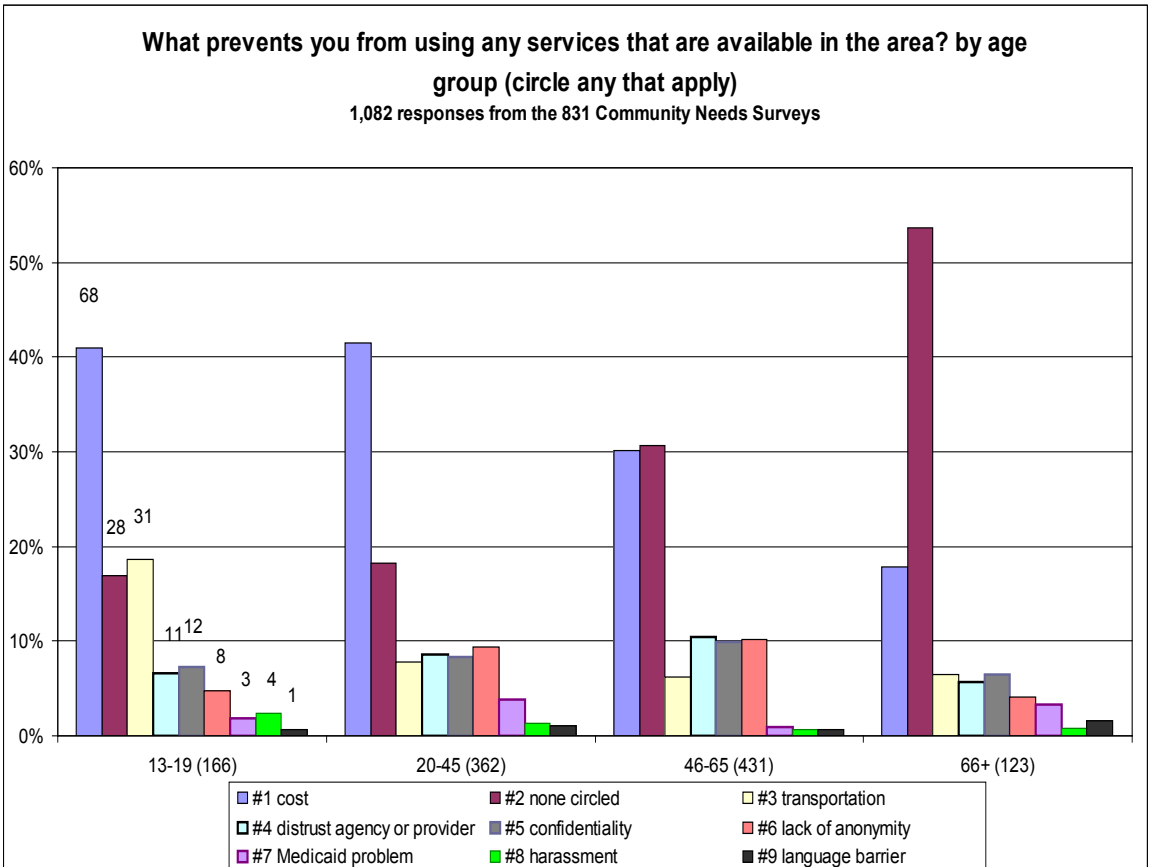


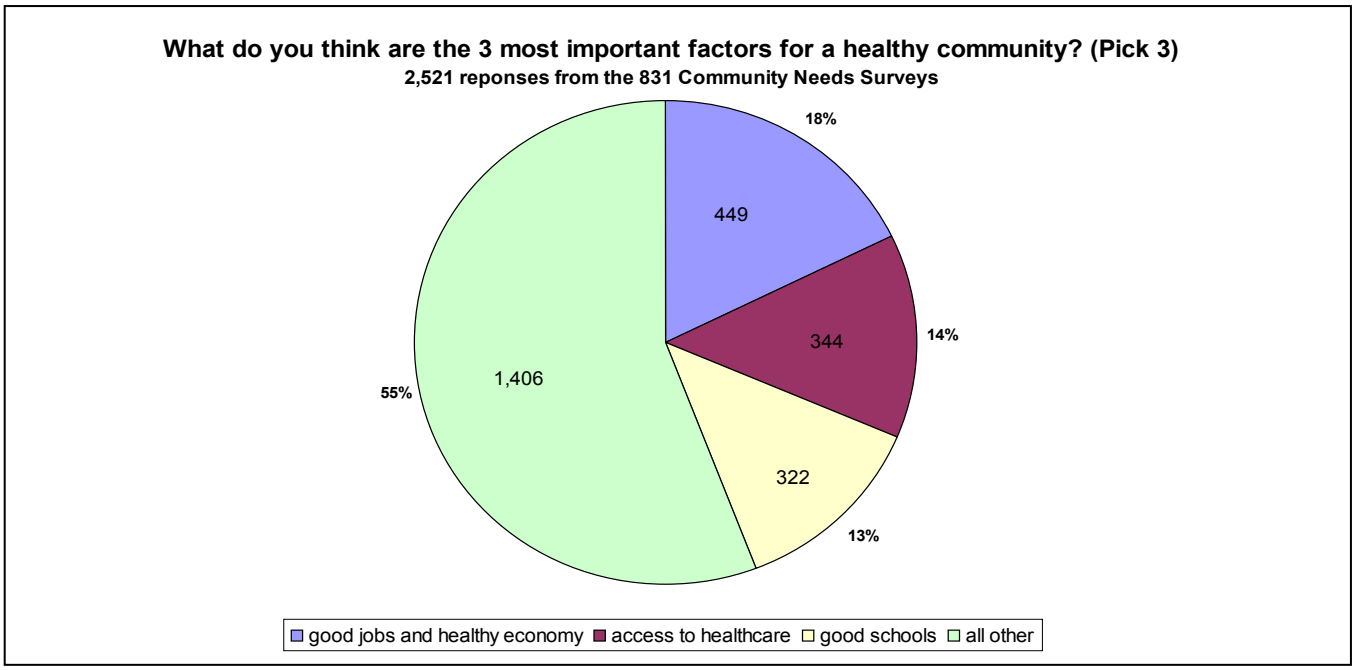
More than half of those who responded said their health insurance is adequate.



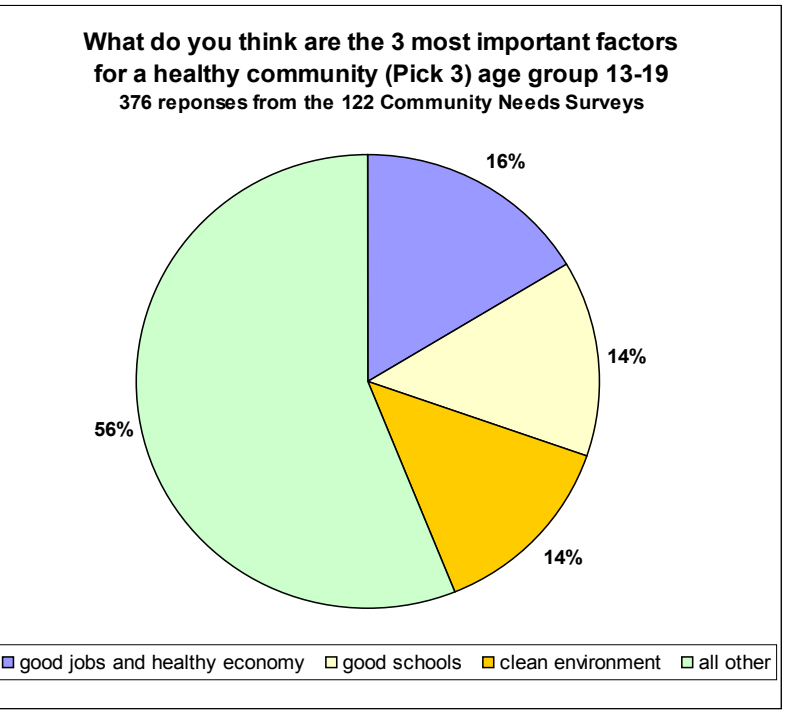


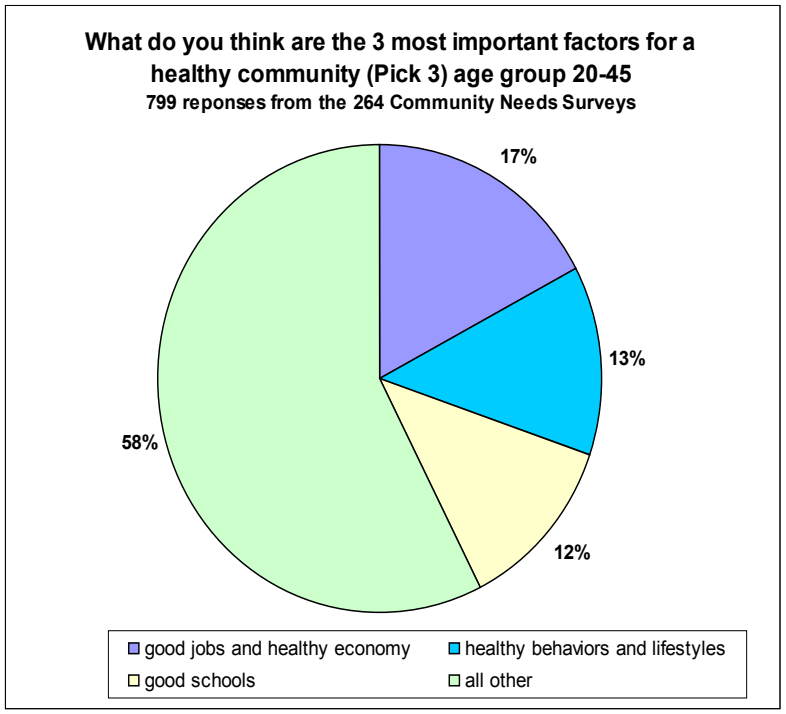
This was a multiple choice question, based on answers most often written in on the Rotary Health Fair survey. Cost was identified as preventing the most respondents in all age groups from using any services that are currently available in the area. Note that only 8% named distrust of a local agency or provider.

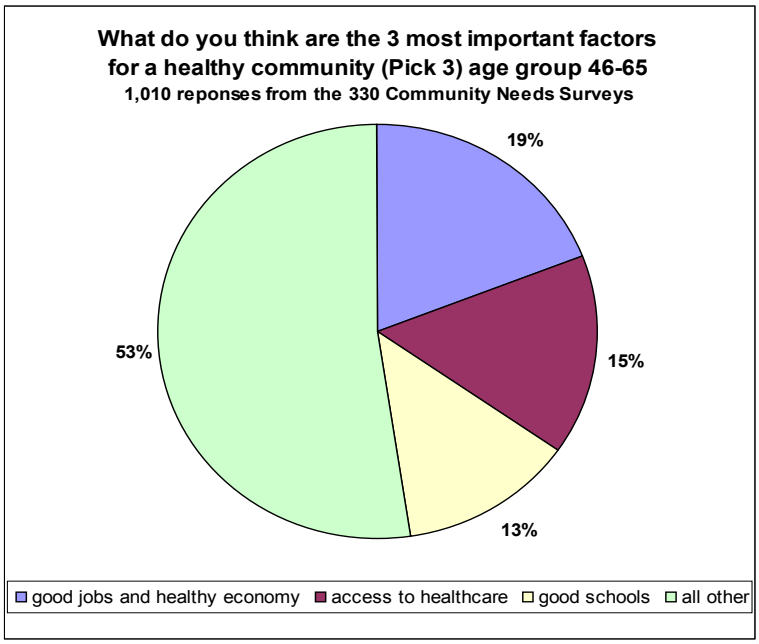


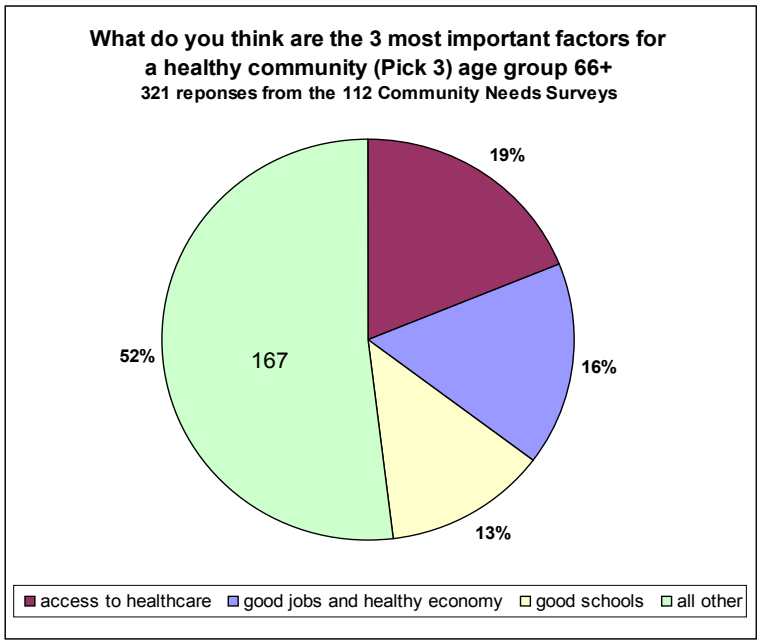


The top three factors chosen represent 45% of responses.

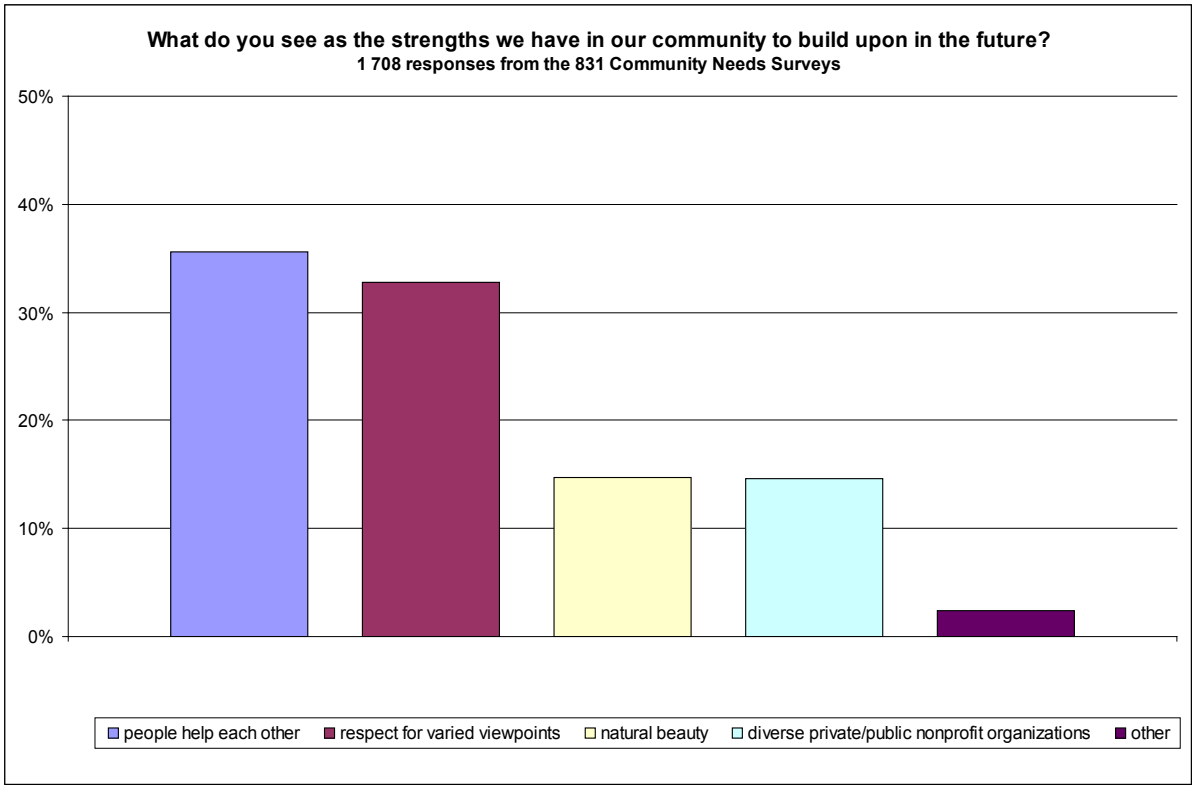


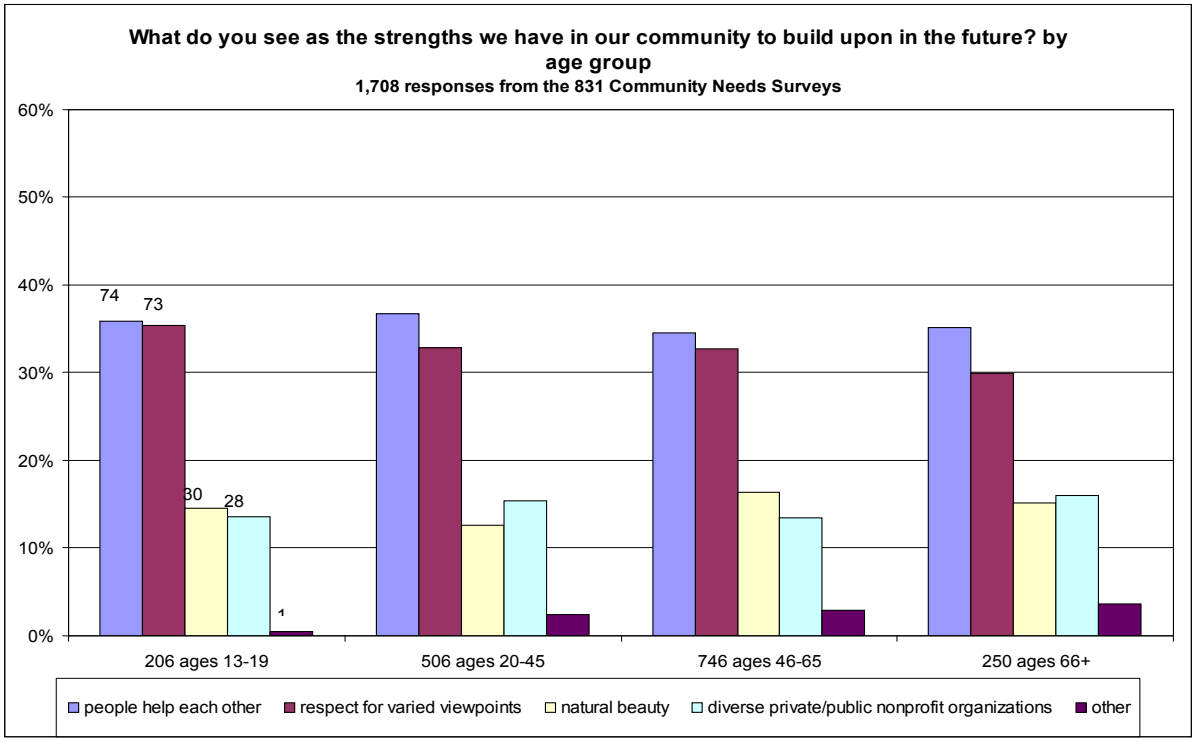




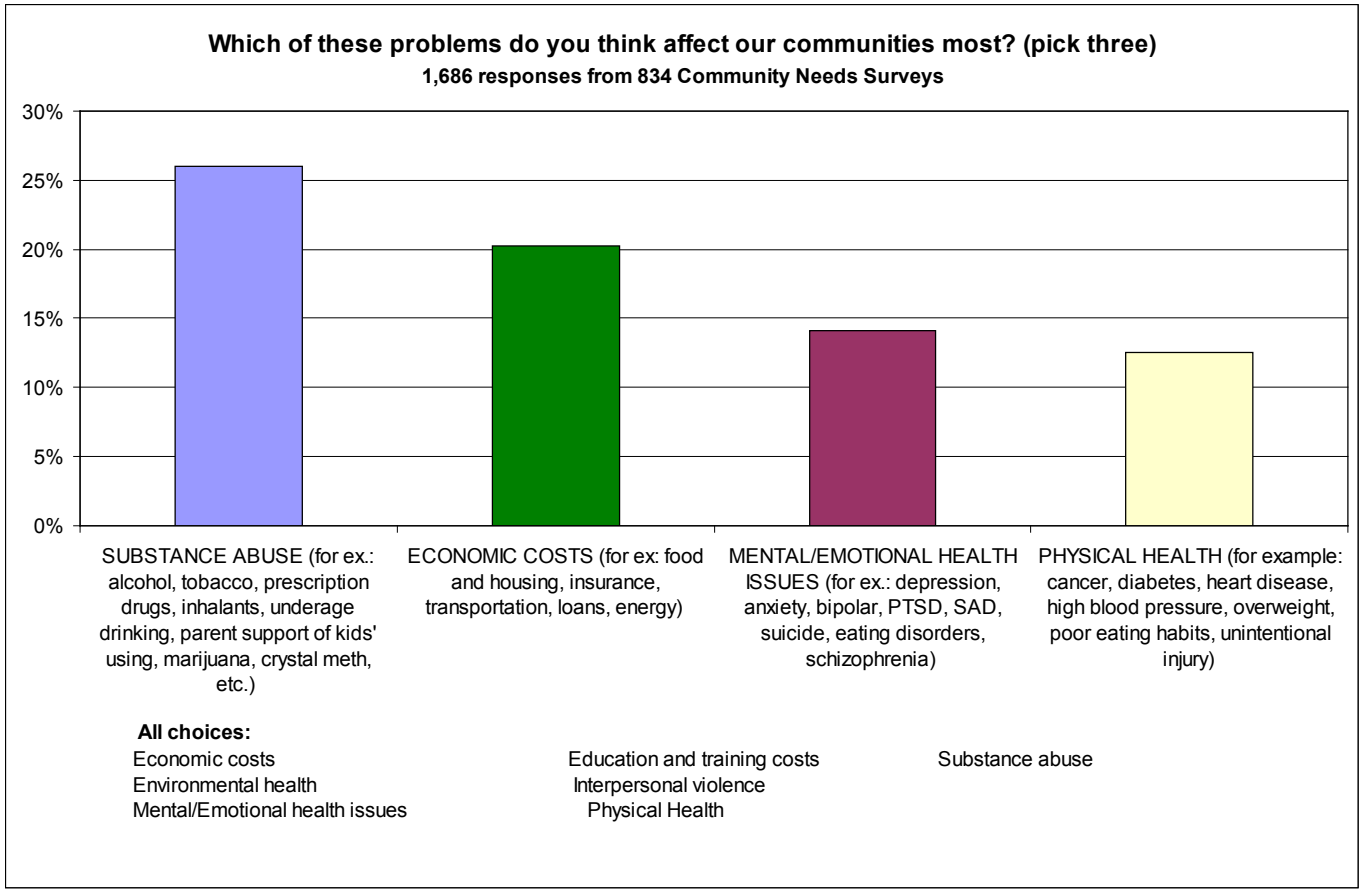


In this survey, all age groups named “good jobs and healthy economy” in their top 3 choices. This differs from the Rotary Health Fair survey results. Teens again named “a clean environment,” whereas 20-45 answered “ healthy behaviors and lifestyles,” and 46 and older chose “access to healthcare.” (See tools in the Report Appendix, p. 18-23 for changes in the choices of answers).


What do you see as the strengths we have in our community to build upon in the future?
1 708 responses from the 831 Community Needs Surveys
50%
40%
30%
20%
10%
0%
people help each other
respect for varied viewpoints
natural beauty
diverse private/public nonprofit organizations
other

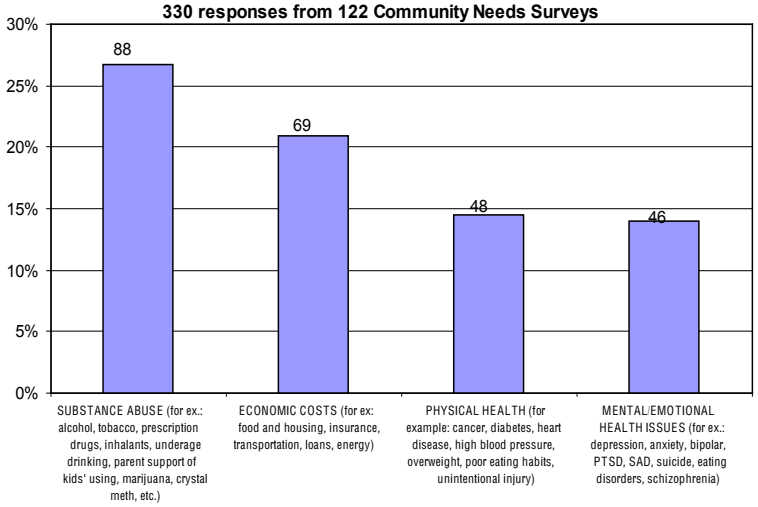

What do you see as the strengths we have in our community to build upon in the future? by age group
1,708 responses from the 831 Community Needs Surveys
60%
50%
40%
30%
20%
10%
0%
74
73
30
28
1
206 ages 13-19
506 ages 20-45
746 ages 46-65
250 ages 66+
people help each other
respect for varied viewpoints
natural beauty
diverse private/public nonprofit organizations
other

In this question, we provided choices based on the most common responses in the Health Fair survey, because many people did not answer it as a write-in. Responses were similar in all age groups.



Substance abuse and economic costs ranked highest among the choices provided.

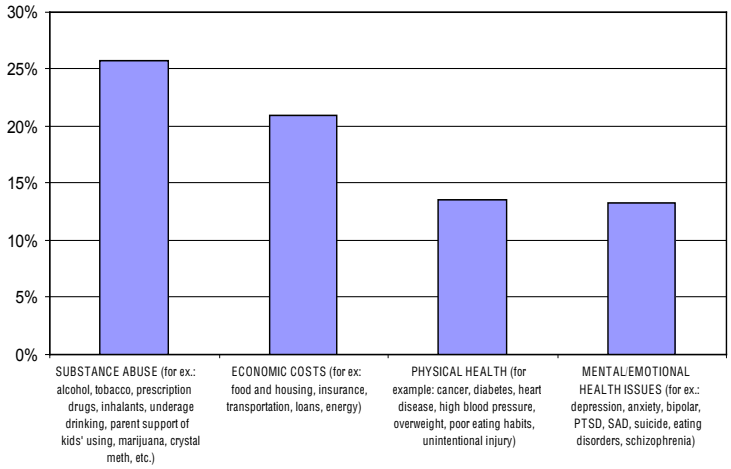
Which of these problems do you think affect our communities most? (pick three) age group 13-19
330 responses from 122 Community Needs Surveys



All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

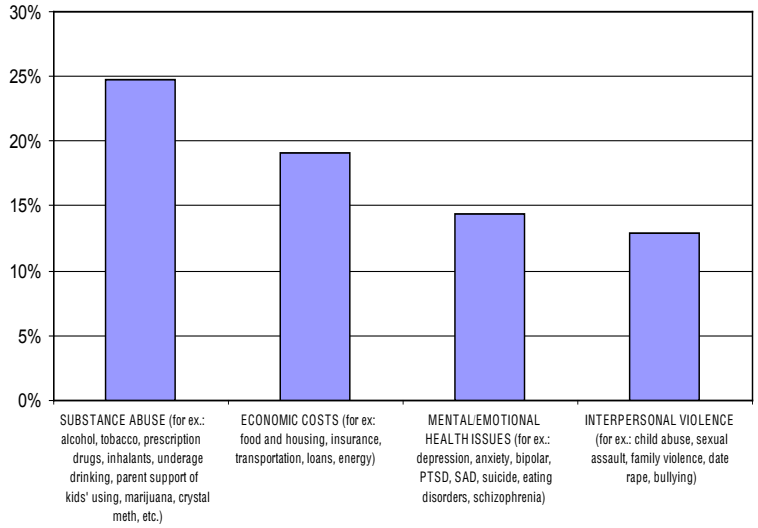
Which of these problems do you think affect our communities most? (pick three) age group 20-45
727 responses from 267 Community Needs Surveys



All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

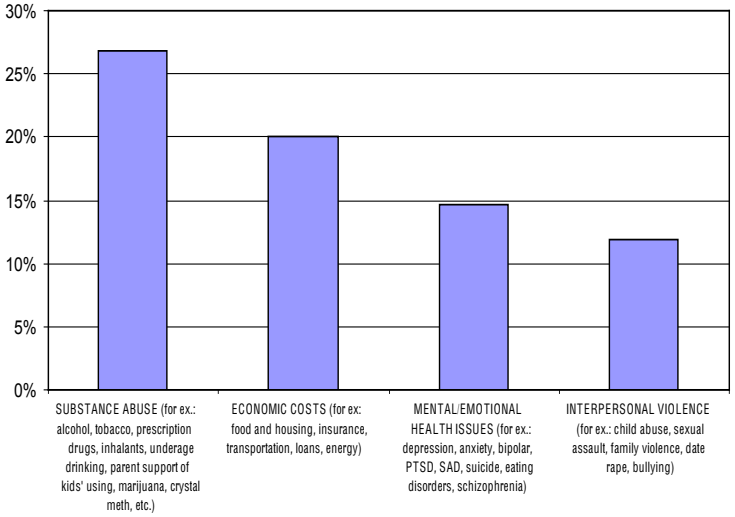
Which of these problems do you think affect our communities most? (pick three) age group 46-65
949 responses from 330 Community Needs Surveys



All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

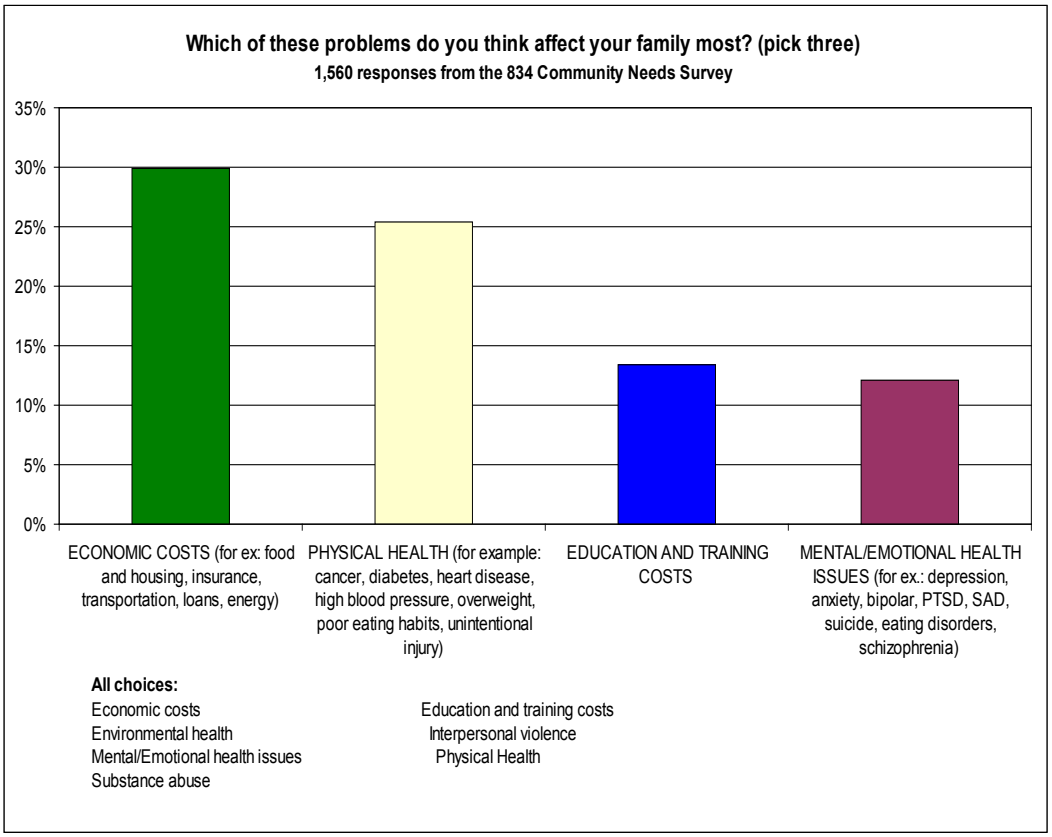
Which of these problems do you think affect our communities most? (pick three) age group 66+
320 responses from 112 Community Needs Surveys



All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

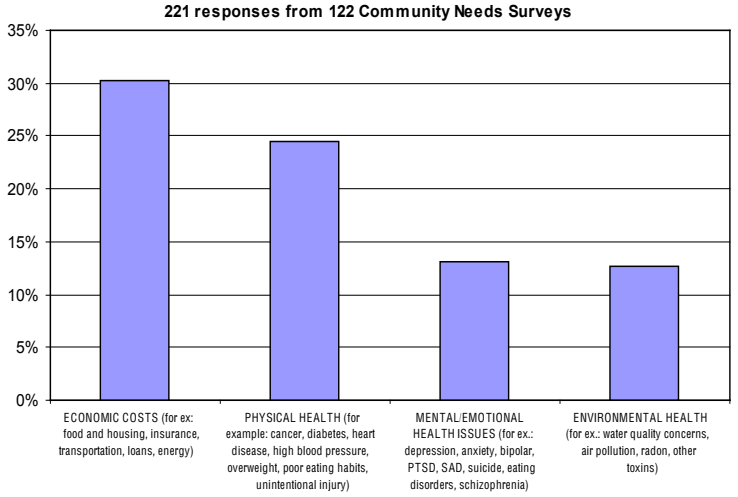
The top 2 choices remained the same across age groups; choices 3 and 4 varied between age groups.



For problems that "affect your family the most," the choices were very different. Substance abuse did not appear in the top 4 chosen, and economic costs rose to the top; note very different results overall, when the same question was asked about affecting your family vs. affecting our community.

Which of these problems do you think affect your family most? (pick three) age group 13-19

221 responses from 122 Community Needs Surveys

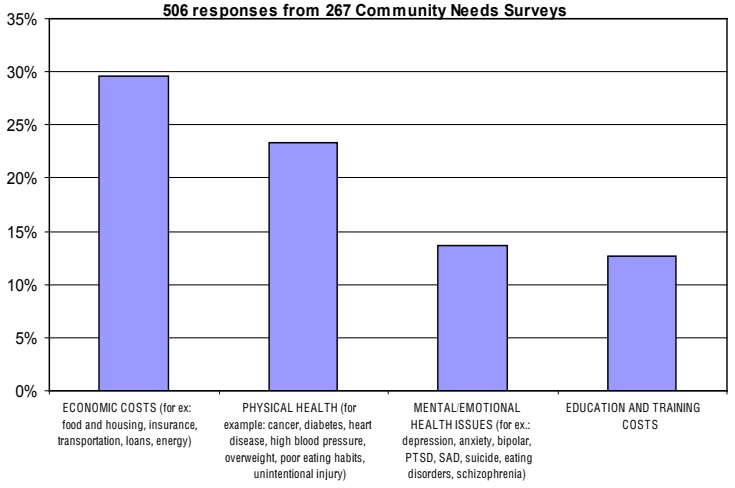


All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

Which of these problems do you think affect your family most? (pick three) age group 20-45

506 responses from 267 Community Needs Surveys

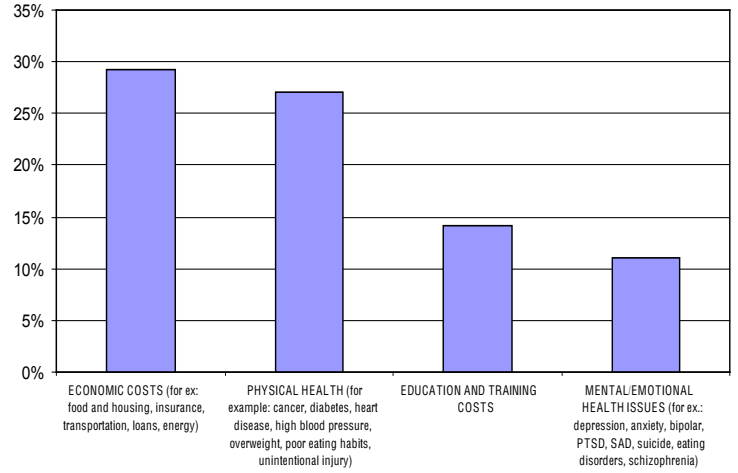


All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

Which of these problems do you think affect your family most? (pick three) age group 46-65

627 responses from 330 Community Needs Surveys

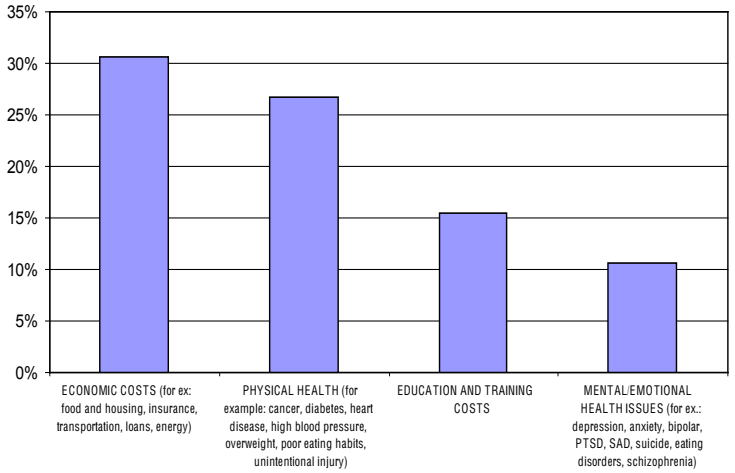


All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

Which of these problems do you think affect your family most? (pick three) age group 66+

206 responses from 112 Community Needs Surveys



All choices:

Economic costs
Environmental health
Mental/Emotional health issues
Substance abuse
Education and training costs
Interpersonal violence
Physical Health

Economic and physical health problems remain #1 and #2 choices across age groups. Mental and emotional health issues are in the top 4 for all ages. Teens once again report concern about the environment, while the 4th choice in all other age groups is education and training costs.

KEY INFORMANT INTERVIEWS

Methods

Our goal with this tool was to gather in-depth opinions from various perspectives in the community, and then summarize these into strengths, challenges, possible solutions (and identified potential barriers). The Core group initially identified about 150 key community leaders from all walks of life, citizens to represent important voices from every arena. Subsequently, we shortened our list to 110 and ultimately compiled 99 transcripts from area-wide interviews between March and April. We selected informants from healthcare, social service agencies, alternative health, education, government, business, environmental education and activism, arts, youth, vets, clergy, and law enforcement/court. We asked people to respond from the organization/group we identified, since many people in our community serve in several different roles. In addition, we offered the chance for all physicians and any Chamber of Commerce members in attendance at their March meeting to be interviewed.

We asked questions to identify perceived community strengths, priority issues, and best solutions. The responses are categorized below. We have summarized the responses to a fourth question, about perceived barriers to the solutions they offered. We also solicited their input on a vision for our community in 5-10 years; that input will serve as a beginning for visioning, when we use the four assessments to begin strategic planning in January of 2010.

Our Themes Committee reviewed the interview responses at length, to categorize responses while staying true to the respondents' words. We included responses in as many categories as applied. We brought these raw tallies to a monthly meeting of our whole group, seeking feedback on our choice of categories and any themes that they would identify. Our results reflect the consensus of our committee and a collaborative process between the community-wide partners.

Results and discussion

Question 1: What strengths and assets do you see in this community, on behalf of your organization and/or the clients that you serve?

Broad categories of responses:

1. Collaboration
2. Spirit of volunteerism
3. Caring/generous residents and businesses
4. Support service organizations – committed, professional staff
5. Diversity/tolerance
6. Supportive media
7. High educational level
8. Quality of life
9. Stewardship/environmental

Leaders were exuberant in expressing their love for this community, praising its many strengths. Our community strengths and assets focused on three areas: the people, the many support service organizations, and the quality of life. There was an overall sense of choosing to live here, in "the cosmic hamlet," for the benefits of strong community and quality of life - even if all is not perfect. People resources were mentioned most: innovative organizations with a personal touch, enlightened and resourceful residents, a strong community spirit, and a sharing of resources. An openness to new ideas and informed debate were mentioned often, along with a community value placed on lifelong learning.

Support service organizations mentioned are highlighted for their committed and professional staff, considered innovative, diverse, confidential, supportive of villages, progressive and sometimes providing services at a reduced fee or at no cost. Providers find their work meaningful and take pride

in the services they offer, including primary care, children's and recreational activities. Fifty-eight individual organizations or programs were specifically mentioned for kudos. Many interviewees noted that local media are assets and supportive of the community.

Respondents viewed residents and businesses as caring and generous. They noted that the enlightened citizenry is supportive of vulnerable populations, young people and seniors. People respond in times of crisis and pull together, and are philanthropic, contributing both financially and with civic duty. Their spirit of volunteerism further appears in fundraising and getting involved, whether with emergency services, youth and/or adults. People want to be here. They have a strong sense of community identity, pride and spirit, and are independent and responsible.

People were also commended for their diversity and tolerance, both socially and economically, and on the tendency toward informed debate. They are seen as open to new ideas and change, non-judgmental, and willing to talk about personal agendas. They seek problem-solving through dialog and consensus.
Collaboration and hands-on cooperation between providers continues to improve. People are getting along better and breaking down barriers. Service providers network, are helpful, share resources and partner, with each other and with schools. This Communities Project is a good example.

A total of 45 quality of life indicators were named, including:

Beautiful environment, nature, recreational opportunities
Art and 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

Question 2 and 3 are paired responses.
From the perspective of your work in the community, what are the most important issues that affect your organization and/or the clients that you serve?
and
In your professional opinion, how could these issues best be addressed?
In the following table, the issues identified are presented in categories, with examples of specific issues and specific solutions offered. (Note: the issues in each column are not paired with solutions column; this table simply contains samples of issues and solutions offered under each category).

A note about qualitative research: the hope is to consider each of these broad categories below, regardless of numbers of examples given for each. In qualitative research, the goal is not to quantify. Some categories below define areas within our system that are problematic, and that we have the vocabulary to describe. Others name areas that are under-addressed in our present systems, where we may not have a common vocabulary to define or address them quickly. Sometimes knowing what could be done was communicated in a single word or phrase; i.e., prevention, or expose kids early. We simply have more vocabulary for systems currently in place. Perhaps new systems will rise out of the vision we create together, as we take these ideas into our community-wide planning process.

Notice the vision behind the creative ideas and solutions offered below, as you notice which resonate with your own experience of our community.

KEY INFORMANT INTERVIEW THEMES
QUESTIONS 2 AND 3 – Important Issues and Ways to Address Them
(NOTE: paired for category, not matched by individual item in each column)

ISSUE/SOME EXAMPLES	EXAMPLES OF SOLUTIONS OFFERED
1. LACK OF SHARED VISION - -stuck in disagreement; need to agree and go forward, stop talking indefinitely about same issues -mixed message to kids about substance use and abuse of alcohol and marijuana; mixed message to law enforcement about same -no vision for sustainable economic development while protecting our environment	-need for strategic planning / follow through -need a city center -explore pervasive impact of interpersonal violence -community food cache for disasters -legislative advocacy, educating our legislators -dialog on justice, also punishment vs. therapy/rehab -dialog on economic development and make a plan; strong leadership
2. ACCESS TO CARE -perceived disparity among different group, e.g. disabled, unaccompanied youth, AK Natives, seniors, low income, fragmentation by govt. systems (vets, Natives) -perception of no low-cost care if not on Medicaid (vs. provider perception that care is available, exceptions always made) -lack of access to alternative healthcare -no access to substance abuse services locally -no treatment available locally -transportation	-collaboration with all providers on issues around continuity of care between SVT and other local providers: call, records sharing barriers, lack of consistent providers at SVT -SVT board that doesn't represent their population -consider an "umbrella" approach/partnership for all services -take services to outlying areas, or let all populations have access to services that are available in Homer -public transportation -extended hours for all clinics -shared database/electronic records
3. LACK OF TRUE COLLABORATION -duplication of services -prescription over-filling by use of different pharmacies -perception of orgs. as silos, increasing costs and not treating whole person	-collaboration with all providers on issues around continuity of care between SVT and other local providers: call, records sharing barriers, lack of consistent providers at SVT, and board that "doesn't represent their population". -admin level of collaboration; ongoing follow-thru of this assessment; rotating board? -inform media of what services exist -task force to address prescription drug concerns - regionally -clinics' partnering with local tribes -focus groups/engage new residents/listen to each other -add youth shelter into what exists, e.g. Haven House, not another new place. -local insurance co-op -raise awareness that some "silos" protect some clients

4. INSURANCE/HEALTHCARE COVERAGE -under and un-insured -splintered coverage -higher AK rates -small business cannot afford to provide -Medicaid/Medicare reimbursement to providers is too low -substance abuse under-funded -denial of SSI for disabled Denali Kid Care understaffed – long wait, while eligibility period shortened	-legislative changes to Medicaid -simplify and centralize billing -a national plan could resolve much -Chamber of Commerce group healthcare plan -increase mental health coverage -single payer system -Insurance companies to cover preventive care
5. INTERPERSONAL VIOLENCE -much doesn't get reported -ACE effects are pervasive in our culture -crime	-train village residents -education for whole community -intervene earlier
6. MENTAL HEALTH ISSUES -family anxiety -no village services -another psychiatrist and neurological service -Christian-based services	-legislative advocacy -increase insurance coverage, staffing, care to children
7. LACK OF PREVENTION /WELLNESS/RECREATION ACTIVITIES -fragmentation -lack of substance abuse ed/prevention in schools -lack of fluoride -too much paperwork/reduces wellness activities -Russian culture promotes hi-carb/dairy diet -system of punishment, not therapy in legal system -no funding for prevention/screening -hospital requires up-front funding, e.g. for lab -not enough focus on health, personal responsibility -teen isolation, boredom - no recreation	-outdoor recreation activities -focus on health -document trends -encourage individual responsibility for health -emphasize lifestyle changes, like diet and exercise (vs. pills) -long-term funding for diabetes prevention -substance abuse prevention for youth, for all -make sex education less covert -mall, gaming arcade, teen center -expose youth early to diverse, enjoyable pursuits (art, music, sports, etc.)
8. FAMILY ISSUES -single parent homes -low income -lack of parent involvement in programs -disconnected families -bullying supported by families -lack of childcare -parents facilitate and tolerate substance use by youth -lack of parenting skills -lack of senior housing -no low cost trans -housing for dementia -end of life care - large senior population—property taxes a hardship	-safe, sober housing -family residential substance abuse treatment program -flexible job schedules and daycare -focus on strengths -community center -therapeutic foster homes/shelters -youth shelter -all services under one roof -substance abuse education -mall or arcade -drug education in grade school -continue youth court -job mentoring -planning for LTC -more safe walking area -more h/c providers with senior focus -assisted living facility in villages -educate about senior issues

9. ECONOMIC ISSUES -poverty, need for more services in economic downturn -lack of winter jobs -aging population -city budget deficit -lack of diversity in industry -insurance is less often offered as a benefit -limited retail -lack of affordable housing -lack of winter jobs -low wages -outward migration in ages 30-40 -reduced revenue, reduced services -rising utility costs -increased crime, due to poverty and substance abuse -lack of population density -high housing prices prevent locals from owning -too much growth; bay is at capacity	-create an incubator group to grow the economy year-round -broaden our economic base -partner with tribal orgs. for workforce training -recruitment and retention in general -plan for less in winter -local food solutions on a personal level -voc rehab and life skills training -find funds for AHFC housing projects -job bank for day labor needs -adapt economic model to look at real costs of different kinds of growth -get prepared for economic changes -actively develop something, e.g. port container delivery, organic farming, university town, natural gas lines -art for the soul and economy -seek state help to recruit industry -consolidate electrical assn. -city to prioritize essential services to fund
10. ENVIRONMENT -over-dependence on fossil fuels -consumption without thought of consequences -over-fishing -climate change -Exxon Valdez impact -ongoing water quality issues -Pebble Mine -lack of sidewalks and walking/bike paths	-grow local foods -educate politicians on climate change and ocean acidification -workshops and forums focused on action -lower the speed limit to 55 -personal change like reusable bags, stopping over-consumption-Look at real costs of growth -zoning for quality of life
11. ORGANIZATIONAL HEALTH /SYSTEMS -complicated billing/disparity between private/public clinic reimbursement -lack of support for law enforcement -need for new tech; low pop density, so trickle down funds don't match needs -student loan repayment only to public clinics -no user board at SVT -needing to provide a lot of free care -seasonal influx of revenue -lack of awareness of services -no state champion for making changes -aging workforce	-change tribal board; Local board to represent patient pop. -create a voice for unempowered to communicate with legislators -SVT admin and tribal change, to retail local providers -lower DKC workload -legislative funding for substance abuse in families -do not use ER as a clinic -access local data breakdown from KPB -political action -govt to listen to voters, live within its means SPH to live within its budget -recruit for primary care replacement, not specialists for profit -higher salaries -use PFD to fund ed and health -reward providers for keeping folks out of the hospital -get village reps on different boards -services to villages -public prior notification of major neighborhood projects
12. SUBSTANCE ABUSE -more highly addictive new drugs	-safe, sober housing

-law enforcement is under-funded -no ed or treatment services in schools -stigma in seeking help -no local residential treatment/rehab -CICADA is not invested in Homer -irreversible brain damage from FASD, crack and meth -issues sometimes perceived as moral -contributes to crimes -over-prescribing Rxs by physicians -trauma, secondary to sexual assault -easy access to drugs -boredom	-Medicaid should decrease funding for narcotics -adhere to new rules for opiate dispensing -task force to address Rx drug abuse -get new physician who understands addiction -family residential treatment program -open schools to substance abuse education -start substance abuse ed at an earlier age -raise awareness on sobriety vs. "acceptable" use of alcohol – both possible, valid lifestyle choices/messages to youth -involve church to find spiritual solutions -prevention -D.A. to prosecute more -state-funded facility -train village residents to be counselors -drug ed in grade school -expose youth at an early age to diverse, enjoyable pursuits -look to fund other agencies in the community besides CICADA
13. EDUCATION -high schools dumb down -cost of professional education is high -lack of funding for environmental ed -no voc rehab -support vs. punishment -over-crowded school and no school library -fear-based, extreme messages instead of education; lack of ed on moderation and responsibility -public school policy prevents issues being addressed -lack of funds for schools -few resources to address learning disabilities -lack of local voc ed -lack of job skills -knowledge on alternative medicine -lack of life skills -misconception re library	-use PFD to fund education and health -increase funding for schools -parenting classes -talk to school principal -grow your own food class/instruction -tap community resources like the arts, for more resources in schools -training for physicians from someone they would listen to -more ed about personal issues -voc rehab life skills training -increase higher education opportunities -mentoring and tutoring activities -publish pamphlet on how to find a human service agency -follow Cuban model for creating doctors -offer different level of medical certification in state -provide different paths for different learning styles -raise awareness on issues that result in funding -educate legislators on health related issues -cool, not preachy speakers at school -teach preventive oral health -educate about non-motorized outdoor activities -educate in violence and sexual assault
14. LACK OF TOLERANCE /DIVERSITY -racism in media's reporting (subtle and overt) -liberal denial of racism	-media publicity on village events -bring English Bay band to Homer -get village reps on boards -empower villagers, disabled, Advocacy for domestic partnerships, diversity, youth -listen to others

	-increase opportunities for youth involvement -provide different paths for different learning styles

QUESTION 4: What are the challenges or barriers, if any, in addressing these issues?
What follows is a summary of the perceived barriers that interviewees offered, regarding solutions they had proposed to the major community issues they identified. Those barriers fell into three major categories: challenging community attitudes and perceptions, organizational challenges, and systems issues (seemingly beyond our local influence).

Polarities in our community came out in this part of the interviews: they were seen as a possible detriment to real change, in this case. People said that the community isn't always open to change, to listening, to trying new things. There is a desire to help and include everyone, while there is also a fear of socialism, in many cases. There are "us vs. them" judgments between groups, that get in our way and seem to stay in place. Again, it was mentioned that the community needs to put aside its assumptions and find common ground. The absence of personal responsibility for our lifestyle choices was also named as a barrier. These are all issues that we as a community could possibly address, if it emerges as a priority.

For organizational challenges, collaboration at all levels was a perceived challenge; getting youth involved and getting information out are closely related. The lack of rural services and the need for more grant-writing (especially collaborative) was named. The changing environment and economics were mentioned as barriers, with an overuse of the legal system to resolve problems better solved elsewhere. Again, these are challenges that could be incorporated into future planning.

In the systems arena (also more fully explored in the "Forces of Change" Assessment, p. 7-9), the issues themselves are a given, but we have choice in how we meet them. There is a splintering of funding to different groups (especially non-Medicaid, low income and immigrant populations), geographic isolation, a small tax base, and bureaucracy that interferes with partnership. People see there are regulations that fail to honor localized needs of a particular community. Interviewees said that these economic times bring more anxiety and depression, and the lure of technology keeps people inside. There are reimbursement issues, and our population is aging. The challenge is ours to meet these large issues proactively as a community.

OVERARCHING THEMES FROM THIS ASSESSMENT

Our survey and interview results consistently point to ample assets for addressing our challenges. For every problem raised, participants named eloquent solutions. We discuss emerging themes by the categories of our interview findings, while weaving in the threads from survey results from all ages. The input ranges from simple things that can be changed quickly, to more abstract concerns that suggest multi-level, long-term approaches. A can-do perspective is pervasive through all the ideas expressed. We invite the reader to consider all ideas first, before limiting one's thinking only to what seems easy through one's own perspective. Observed in the interviews is that this community demonstrates incredible resources and commitment to action.

Visioning
There is a perception that the community is good at tolerating disagreement, but gets stuck there and stops short of agreeing on a vision for the future; we need to identify what works, not just what does not. From an economic perspective, there is much frustration about the inability to agree enough to

move forward for more year round economic viability. This unique willingness to disagree can be used as a way to listen more deeply and find consensus, to take action as never before.

Many creative solutions are offered, such as listening to one another, visioning together, and creating a town center. Mentioned are advocating for government systems and education that foster an identified direction for growth, including formerly excluded groups (i.e. outlying communities and veterans sometimes separated by govt. funding programs); diversifying or specializing in one area (we have several already underway), and agreeing to lend our community support to just that. Several areas have a good start on this, including becoming a college town, a retirement community, organic farm center, larger boat harbor development, and tidal/alternative energy leader. The community could still decide to have some kinds of development off limits. Most are satisfied with life in our community, and report it is a safe place to live.

Regarding community values, youth and law enforcement both noted that our community sends mixed messages about values around substance use and abuse. Many families provide marijuana and alcohol to youth, reportedly, making it difficult to enforce laws and difficult for youth to understand what is healthy use, or to learn healthy lifestyle choices. Providers report that both a lifestyle of sobriety and one of use (not abuse) is possible, and this is not clearly understood by youth, nor role modeled well by adults. The lack of any local family treatment perpetuates this problem, as there could be a visible presence of successful recovery if treatment were an option here. Survey respondents did report substance abuse as their number one concern in the community, although they identified economic problems as tops when considering their families. Substance abuse problems fell below the top four when considering their families. Economics are a large health determinant always, and more so in times of recession; people reported concern that we are likely to see more substance abuse and legal problems if economic uncertainty grows. Perhaps there is ongoing cultural stigma in acknowledging substance abuse issues, or denial is at work. Either way, the problem likely affects everyone, and we do not have adequate prevention or services in place at present.

Provision of healthcare is fragmented, some by govt. regulation (VA and tribal) which could change through systems advocacy. Other fragmentation is from a splintering of care that could change through true local collaboration. Many expressed a shared vision in creating a local “umbrella” of care, breaking down barriers between current providers. An example of this would be after-hour medical care, which is in all cases provided on-call (except ER on weekends). This is a problem for all providers, and true solutions would require consensus between all medical providers, yet the benefits to consumers and providers alike would be great. While federal decisions on national healthcare are still under debate, most providers express an intense frustration with “drowning in paperwork,” from the splintered system of insurances and separate records. There is a strong commitment to sitting down together and finding local solutions. It remains to be seen whether the timing and thoroughness of a national program will resolve things, or whether taking local action is timely. Either way, a focus group could be a productive next step.

<u>Collaboration and Access to Care</u>

These two issues are tied in that many providers believe that they see anyone who has a need, while other providers perceive that they cannot get their clients in to other area services when they refer. The 50+ organizations in our community are seen as caring and skilled, but also as standing separately like “silos.” There is much discussion about these economic times, inviting us to work more closely together, and that people feel it serves the client better, when treated as a whole person with perhaps several issues. Transportation is an issue mentioned by providers as well as consumers. At least four organizations have mechanisms for transporting their own clients in some situations. Still, finding solutions for equal access would require even greater collaboration that we currently have. In many cases greater legislative advocacy emerges as a theme, saying that state legislators can’t make good decisions on healthcare without more education in specific areas.

There are many opinions that tribal facilities have not fit in with the other clinical providers of healthcare, especially for the round-the-clock needs. Still those facilities are seen as valuable, filling a

need in the community. Interviewees stated that they are willing to meet and resolve these issues locally due to a common goal of providing quality healthcare efficiently to everyone.

Cost is identified as the largest factor preventing people from accessing services that do exist here. Consistent with statewide data, our survey respondents reported 25-30% have no health insurance at all. Almost half reported that they couldn't find some services they needed here, though more questions are needed to understand if people want specialty services here (vs. traveling elsewhere), and what cost they might be willing to pay, if so.

Mental Health and Violence

All age groups ranked mental health concerns in the top four community problems, as well as problems affecting their family. Increased services were recommended, especially in villages where services have had funding cuts. Interpersonal violence was not named as a top four problem affecting their family, however it was named as a top four community problem by the 46-65 and the 66+ age groups.

Substance Abuse

One bumper sticker sums it up: "Homer, Alaska – a quaint little drinking village with a fishing problem." The community perception is that we have a drinking problem; this was heard from all directions, as follows:

- Youth leaders say kids receive mixed messages, about alcohol and marijuana especially
- Law enforcement says it is difficult to enforce laws when parents do not sometimes support them
- Many say schools should be more open to substance abuse education, using resources that are offered from the community
- Youth leaders say that drug education should begin in grade school, before kids are faced with the choices when they are at school
- Many say that we don't make a clear definition between alcohol use that is safe, vs. abuse, or that for some, sobriety is the only choice, and a choice worth community respect.
- Without a local family residential treatment center, our community doesn't get to see that recovery works, because people must leave
- Prescription drug abuse is growing, and so is the interest in taking action on prevention
- There are not enough local resources addressing the substance abuse concerns that exist.

Multiple Problems Requiring Multiple Solutions

Many people are dealing with more than one health concern, and many suggestions noted that more emphasis be on treating the whole person. Fragmented care exaggerates problems, and it's hard to keep up with what services are available. The long-term effects of early exposure to violence are only beginning to be understood; trauma scores suggest that multiple factors increase risk in an individual and in families. In 2007, the Governor of Alaska's Healthcare Strategies Planning Council identified seven goals, one of which "is definitely the larger-order problem, meaning if we can solve it, many of the other problems will be alleviated". That problem is the lack of prevention and personal responsibility."[3] Prevention and wellness are a thread throughout our project's community input, although it is noted that is does not get funded because the system is problem-oriented and there is no way to bill for wellness. Providers expressed frustration at the lack of time to educate within the insurance payment structure, which mandates large amounts of time documenting for different billing systems. There is no funding for screening programs, and outcomes are not easily measurable. However, many also said we know it is the right thing to do. It is worthwhile to note that Healthy People 2010 is gathering ongoing information on lifestyle and behavior risk factors, because they play a major role in all the leading causes of death. (See Community Health Status Assessment Report).

[3] Final Report, Alaska Health Care Strategies Planning Council, December 2007.

Youth leaders here encouraged us to expose kids early to diverse enjoyable pursuits (arts, music, sports, etc.) as well as nutrition and exercise. It was mentioned that we as a community could provide more outdoor opportunities and activities for kids, and healthy lifestyles could provide an alternative to the need for many medications. Alternative medicine is available and well-utilized in our community, and there are opportunities for more partnerships and increased understanding between different types of healthcare providers.

Families

Homer has often been described as polarized, and that is evidenced in our community input: on one hand, the quality of life issues mentioned included caring about one another, engaged and active youth, strong families and a good place to raise kids, a safe place to live. On the other hand, there were great concerns about bullying, children's couch-surfing, a lack of youth activities, and the need for parenting classes. Childcare and life skills training are identified as much-needed supports. Many mentioned the need for a teen shelter, which could over time show a diversity in the types of needs that may present, but with all sharing the common need to ensure the safety of our children, it could provide time to differentiate specific needs later. Mentioned was that this could be incorporated into already existing facilities, avoiding another silo. Family anxiety, loneliness, and a need for more senior housing were named; the lack of affordable housing for all ages is reported as a growing concern.

Environment

With climate change so prominent in the news, few dispute human activity as a cause; Homer has a long history of safeguarding its clean waters and natural beauty, and that value has only increased with the growing awareness of ocean acidification and other impacts. Water quality issues were named at the level of city systems, as well as in terms of challenges posed by resource development. A recent, city-sponsored brainstorming on economic development brought out a concern regarding the long-standing reputation of Homer as "a place that does not want development," or fears that development would mean degrading our environment. Many there spoke of a desire to purse economic diversity, or some specific economic developments, while also considering issues of sustainability and protection of the environment. In our interviews, we heard an emphasis on both, the need to diversify our economy and also to consider the costs of different kinds of growth, to plan for them. Homer seems ready to move beyond environment vs. economics, and into a strategy that embraces the future while not being afraid to articulate what we are willing to pay for it. In our surveys, young people spoke of their concern for the environment, while in all age groups, only 40% reported satisfaction with the economic opportunity in Homer. Economics and the environment were often discussed together in our interviews; perhaps there is an opportunity now for more diverse partnerships that consider both, and move forward in decision-making. In the City's brainstorm, Kenai-Soldotna was reported as more progressive, creating "business incubator groups" to explore and support new possibilities.

Education

People expressed widespread belief in the power that can come from education and from raising community awareness, and that attitudes and perceptions can be changed with education. The community sees itself as open to new ideas, lifelong learning, and creative thinking; people stand ready to roll up sleeves and make new, more efficient systems. They pointed to the Homer Foundation, numerous non-profits and sports facilities that exist, and the success of small groups of people in creating great change here. The awareness of different learning styles and the need to honor all of them, and re-vitalizing vocational education and voc-rehab, have surfaced often as goals. The use of the resources at Kachemak Bay Campus of Kenai Peninsula College to further diversify our culture, our workforce and response to changing health needs has been mentioned often. Diverse programming—from mentoring to grow-your-own food, to parenting, to sustainable development practices—have all been suggested as examples.

Tolerance

People on both sides of the Bay identified racial issues that need healing. More focus on including different communities/community members in media reports, hiring locally, and celebrating together

could all foster an embracing of our diversity. People with disabilities, youth, veterans, single parents – many groups were named as lacking community-wide support. Bullying in our schools was mentioned by several of our youth. Focusing on these issues may help us address more of the root causes of all of our community issues, and bring forth a truly shared vision that includes equal access for all.

The community has given a tremendous amount of information about what it sees as our greatest strengths and opportunities for improving health and the quality of life in our community. We are invited to take this information and set priorities to take action now, with this plethora of creative directions as a beginning.

A P P E N D I X

COMMUNITY STRENGTHS & THEMES ASSESSMENT REPORT
Homer, Alaska
December 2009

SOUTHERN KENAI PENINSULA COMMUNITIES PROJECT

REPORT

A P P E N D I X

CONTENTS

Project Timeline

TIMELINE FOR MAPP 2009

Jan. Mar. June Oct. Dec
|----------|

Data |----------|
Catalog or compile Sort/seek other identified

Forces of change
|-----| |----|

CS& T*
|---------| |----------|
surveys 1:1/focus (if group decides)

LPHA (inventory of services)
|----------|

Writing of Report |------|

Identify Strategic Issues and develop goals/strategies **|-------|**

Share results with the community Jan. 2010?

*CS& T = Community Strengths and Themes – community input 1/13/09

LEADING HEALTH INDICATORS
Priorities for Action

The Leading Health Indicators are a set of 10 high-priority public health issues in the United States. The indicators are intended to help everyone more easily understand how healthy we are as a Nation and which are the most important changes we can make to improve our own health as well as the health of our families and communities. The Leading Health Indicators are:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

Each indicator will be tracked, measured and reported on regularly throughout the decade.

LEADING HEALTH INDICATORS:
A Critical Link to Healthy People 2010

Healthy People 2010, a broad-based collaborative effort among Federal, State, and Territorial governments, as well as hundreds of private, public, and nonprofit organizations, has set national disease prevention and health promotion objectives to be achieved by the end of this decade (www.healthypeople.gov). The effort has two overarching goals: to increase the quality and years of healthy life and to eliminate health disparities. *Healthy People 2010* features 467 science-based objectives and 10 Leading Health Indicators, which use a smaller set of objectives to track progress toward meeting *Healthy People 2010* goals.

SEEING THE WHOLE PICTURE

Each Leading Health Indicator is an important health issue by itself. Together, the set of indicators helps us understand that there are many factors that matter to the health of individuals, communities and the Nation. Each of the indicators depends to some extent on:

- The information people have about their health and how to make improvements
- Choices people make (behavioral factors)
- Where and how people live (environmental, economic and social conditions)
- The type, amount and quality of health care people receive (access to health care and characteristics of the healthcare system)

Realizing improvements for the set of indicators will require effective public and private sector programs that address multiple factors.

MAKING CONNECTIONS ACROSS INDICATORS

Identifying changes to improve any one of the Leading Health Indicators is good; identifying changes that will cut across and improve several indicators simultaneously is also important. Thinking "outside the indicator" means that we can look at how one contributing factor or one important change may affect several indicators. The indicators can also provide the foundation for new partnerships across health issues and new thinking about how to address the many health concerns we face.

An example of this type of innovative thinking is collaboration among those who want to increase the amount of physical activity individuals do and promote weight loss to reach a healthy weight. Other cross-cutting action ideas are:

TAKING ACTION TO IMPROVE EVERYONE'S HEALTH

The Leading Health Indicators are intended to motivate citizens and communities to take actions to improve the health of individuals, families, communities and the Nation. The indicators can help us determine *what each one of us can do and where we can best focus our energies*—at home, and in our communities, worksites, businesses, or States—to live better and longer.

Some possible actions are:

- *Adopt the 10 Leading Health Indicators as personal and professional guides for choices about how to make health improvements.*
- *Encourage public health professionals and public officials to adopt the Leading Health Indicators as the basis for public health priority-setting and decision-making.*
- *Urge our public and community health systems and our community leadership to use the Leading Health Indicators as measures of local success for investments in health improvements.*

- Combining education for parents into a "healthy home" program that addresses injury prevention, nutrition, and the impact of environmental tobacco smoke on children and other family members.

- Designing worksite wellness programs to address several indicators simultaneously, such as physical activity, overweight and obesity, and tobacco use.
- Using existing communications and outreach efforts for immunization to promote enrollment of children in health insurance programs.

In short, the Leading Health Indicators can be a tool to develop comprehensive health activities that work simultaneously to improve many aspects of health.

FEDERAL RESOURCES

More information on the Leading Health Indicators, including links to Federal Web sites with data, planning tools, scientific information, and details about various programs are available at www.healthypeople.gov/LHI.

U.S. Department of Health and Human Services
Office of Disease Prevention and Health Promotion
1101 Wootton Parkway, Suite LL100
Rockville, MD 20852
Voice: 240-453-8280
Fax: 240-453-8282

This is the html version of the file
http://www.eed.state.ak.us/TLS/SCHOOLHEALTH/pdf/HealthyAK_Dec2007.pdf.

2007 Alaska YRBS – Weighted Data

In 2003 **Alaska** became the first state with active parent consent required for participation in school surveys like the **YRBS** to ever collect enough responses to yield usable data on a statewide level, and with your help we did it again in 2007! **Alaska** needed 60% of all students selected for the survey to actually participate in the survey to achieve usable (representative) data and 60% is exactly what **Alaska** managed to collect. Had any of the participating schools chosen not to participate, or had the participating schools not worked so hard to collect signed permission slips, **Alaska** would have fallen short in its efforts.

The **YRBS** represents Alaska's most comprehensive and reliable source of information on the prevalence of risk behaviors in Alaska's youth that contribute to the leading causes of death and disease in Alaskans. Countless health agencies, families, and school districts rely on the **YRBS** data when applying for competitive grants and also to measure whether or not their current intervention and prevention programming is working. **Alaska** now has usable data from 2007, 2003, and 1995 which allows it to understand and measure trends in youth risk behaviors across more than a decade. Great work!

Alaska YRBS Comparison & Trends

The 2007 **Alaska YRBS results** are very similar to the **results** of the 2003 **Alaska YRBS**. This is not surprising since changes are usually gradual. Over the last 12 years the prevalence of many risk behaviors has decreased. The prevalence of smoking cigarettes, drinking alcohol, using marijuana, and physical fighting seem to be going down. The percent of students that have ever had sexual intercourse or reported having sexual intercourse in the past three months has stayed about the same. Percentage of students taught about AIDS or HIV infection in schools has gone down. The 2007 **Alaska YRBS results** are very similar to the national **YRBS** data from 2005 (which is the last available data – 2007 national survey **results** will be released next summer). Fewer students in **Alaska** reported being in a physical fight in the past 12 months compared to the national **results** (29.2% vs. 35.9%) but more students in **Alaska** reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the past 12 months (12.4% vs. 9.2%). The percent of Alaskan high school students attending daily PE is lower than the national average with only 17.7% of high school students attending daily PE in **Alaska** compared to 33% of those in the national 2005 **YRBS** survey.

2007 Alaska YRBS results are posted online at
http://hss.state.ak.us/dph/chronic/school/yrbsresults.htm

Leading Causes of Death and YRBS Results

Suicide is the leading cause of death of **Alaska** youth (ages 15-19). The **Alaska YRBS** data indicates that 14.1% have made a plan about how they would attempt suicide and 10.7% actually attempted suicide one or more times in the past 12 months. Motor vehicle crashes are the second leading cause of death

among **Alaska** youth. 23.5% of **Alaska** youth report having driven in a car by someone who had been drinking and 9.7% reported driving a car when they had been drinking.

Key Findings
The survey asked students to report certain risky behaviors. Key findings are listed below.

Alcohol and drug use:
- ❖ 39.7 percent of high school students had consumed alcohol within the past 30 days;
  - ➢ Compared to 38.7 percent in 2003 and 47.5 percent in 1995;
- ❖ 20.5 percent of high school students reported using marijuana in the past 30 days;
  - ➢ Compared to 23.9 percent in 2003 and 28.7 percent in 1995; and
- ❖ 25.1 percent of students were offered, sold or given an illegal drug by someone on school property during the past 12 months;
  - ➢ Compared to 28.4 percent in 2003 and 34.1 percent in 1995.

Violence and suicide:
- ❖ 29.2 percent of high school students had been in a physical fight during the past year;
  - ➢ Compared to 27.1 percent in 2003 and 35.8 percent in 1995;
- ❖ 12.4 percent had been physically hurt by a boyfriend or girlfriend in the past year;
  - ➢ Compared to 10.8 percent in 2003 (1995 numbers were not available);and
- ❖ 10.7 percent reported attempting suicide in the past 12 months;
  - ➢ Compared to 8.1 percent in 2003 and 9.4 percent in 1995.

Obesity:
The obesity epidemic in **Alaska** and the nation contributes to the risk of heart disease, stroke, diabetes, and other chronic diseases. Health habits such as good nutrition and being physically active are the key to maintaining a healthy weight.
- ❖ 84.3% of high school students do not eat the recommended daily servings of fruits and vegetables.
- ❖ 57.5% did not get the recommended 60 minutes of physical activity per day for most days of the week.
- ❖ 82.3% did not attend daily PE classes.
- ❖ 27.3 percent were overweight or at risk of being overweight.

Other behaviors that increase the risk of health problems:
- ❖ 45.1 percent of high school students have had sexual intercourse;
  - ➢ Compared to 39.6 percent in 2003 and 47.2 percent in 1995; and
- ❖ 17.8 percent of high school students smoked in the past 30 days;
  - ➢ Compared to 19.2 percent in 2003 and 36.5 percent in 1995.

Methodology

The Behavioral Risk Factor Surveillance System (BRFSS) is conducted by the Alaska Division of Public Health in cooperation with the National Centers for Disease Control and Prevention (CDC). It is a monthly telephone survey that utilizes a standard protocol and interviewing methods developed by the CDC.

Sample Design

Although the main purpose of the BRFSS is to estimate the prevalence of behavioral risk factors in the general population, interviewing each person is not economically feasible. Thus, a probability (or random) sample is selected in which all persons have a known chance of selection. The BRFSS in Alaska uses a stratified random sampling design. The Alaska sample is stratified into five regions based on common demographics. An equal number of interviews are conducted from each region, which purposely oversamples the nonurban areas of Alaska.

Sample Size

Each month over 200 Alaska residents age 18 and older are interviewed over the telephone regarding their health practices and day to day living habits, to reach an annual sample size of 2,500 (500 per region). The data are collected from January through December, for each year.

Sampling Process

From 1990 - 1998, the telephone sample was generated by the University of Alaska Anchorage, Institute of Social and Economic Research (ISER). The method preferred by the CDC for generating a random sample of telephone numbers works efficiently when telephone prefixes are heavily saturated with working residential telephone numbers. Since most of the prefixes in Alaska have less than 500 residential numbers, the probability of reaching a working residential number is low. For this reason, the Institute of Social and Economic Research used a combination method of computer random generation (using the RANDY method) for large exchanges and random selection from a database of entered directory numbers for small exchanges. In 1997, this strategy was re-evaluated and in 1998 ISER modified its methods to include more random numbers from small exchanges. In addition, GENESYS ID services were purchased each month for the generated sample, in order to eliminate as many business and non-working lines as possible.

Beginning in 1999, and presumably for the future, the BRFSS began to rely on CDC for its telephone sample purchased from GENESYS. This aimed to improve and calculate the probability that all households in Alaska with telephones would have a chance of inclusion in the study. The sample currently used is a Disproportionate Stratified Sample Design (DSS). Disproportionate stratified random sampling is a variation of cluster sampling. For DSS, information obtained from other sources is used to classify 100 number blocks of telephone numbers into two strata based on the presumed density (high or low) of residential telephone numbers (strata that are either likely or unlikely to yield residential numbers). Telephone numbers in the "likely" strata are sampled at a higher rate than numbers in the unlikely strata.The GENESYS sample is divided into zero banks and one-plus banks. These values are

determined by analyzing all possible 100 blocks for an area. The recommended sampling ratio between one-plus blocks and zero blocks is 4:1. Since the rural region of Alaska has as many as 80% of phone banks that are zero blocks, the sampling ratio is 8:1 in Region 4. This ratio was determined in consultation with BSB. In 2003, zero blocks were dropped from the random sample.
Because Alaska has such a low number of active residential lines, Alaska requires a large amount of phone sample each month to operate successfully. In addition, GENESYS is electronically identifying business and non working numbers through its ID services and has modified its ID services to detect non working numbers in rural Alaska through its Super ID services which has made technological adjustments to improve the process and increase the survey efficiency for Alaska.

Survey Instrument
The BRFSS instrument is a standardized questionnaire which consists of three sections:

- the core (which includes demographics),
- a set of optional modules and
- state specific questions.

The questionnaire covers such topics as Health Status, Health Care Access, Nutrition, Physical Activity, Diabetes, Tobacco Use (including Smokeless Tobacco), Alcohol Use, Demographics, Women's Health, Injury Prevention, and HIV/AIDS Awareness.
Participation is random, anonymous and confidential. Respondents are randomly selected from among the adult members of the household. Only those living in households are surveyed. Those living in institutions (i.e., nursing homes, dormitories) are not surveyed.

Data Collection
Interviews are conducted by trained college interns and administrative clerks. The interviews are conducted everyday including evenings and weekends.
Data are collected via computer using Ci3 CATI (Computer Assisted Telephone Interviewing) software. Monthly data files are sent to the Centers for Disease Control and Prevention.

Data Analysis
The Behavioral Risk Factor Surveillance System (BRFSS) data contains information on Alaskan adults only (aged 18 and above).
Data collected by BRFSS are edited using PCEdits software produced by the CDC. Edit reports are produced monthly and corrections made. Corrected data files and edit reports are sent to the CDC monthly. At the end of each survey year, data are compiled and weighted by CDC, and cross tabulations and prevalence reports are prepared.

Weighting:
Unweighted data are the actual responses of each survey respondent. The data are weighted or adjusted to compensate for the overrepresentation or under-representation of persons in various subgroups. The data are further weighted to adjust the distribution of the sample data so that it reflects the total population of the sampled area.

Data Reporting:

Data are analyzed by the CDC for Alaska by gender, race, age, marital status, education, income and employment and standard tables are produced.

Special Note:
For 2000 and 2001, health care coverage results for Alaska are further analyzed by the Alaska Division of Public Health, Bureau of Vital Statistics. This analysis adjusts for survey respondents who report they have no health care coverage and then in a follow up question report to be covered by a health care plan. This explains the reason that prevalence estimates may not match those published by the CDC.

Comparisons
All prevalence comparisons made to the National BRFSS Ranges and the National BRFSS Median are comparisons made to the 50 states participating in the Behavioral Risk Factor Surveillance System.

Limitations
The BRFSS uses telephone interviewing for several reasons. Telephone interviews are faster and less expensive than face to face interviews. Calls are made from one central location (Juneau) and are monitored for quality control.
The one main limitation of any telephone survey is that those people without phones cannot be reached and are not represented. In Alaska, about 97% of households have phones; about 98% of all U.S. households have phones (2000 US Census, Summary File 4). The percentage of households with a telephone varies by region in Alaska . In general, persons of low socioeconomic status are less likely than persons of higher socioeconomic status to have phones and are undersampled. However, national BRFSS results correspond well with findings from other surveys conducted in person.
With surveys based on self-reported information, the potential for bias must be kept in mind when interpreting results. Survey response rates may also affect the potential for bias in the data.
The reliability of a prevalence estimate depends on the actual, unweighted number of respondents in a category or demographic subgroup (not a weighted number). Interpreting and reporting weighted numbers that are based on a small, unweighted number of respondents can be misleading. The degree of precision increases if the sample size is larger and decreases if the sample size is smaller. Prevalence estimates are not usually reported for those categories in which there were less than 50 respondents and are rounded to the nearest whole percent when the denominator is less than 500.

For more information:

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More details on methodology at:
http://www.hss.state.ak.us/dph/chronic/hsl/brfss/2008/BRFSS08.pdf

Community Town Hall Visit Grant
Report on April 29-May 1, 2009 Outreach to Homer
Project Overview

The Alaska Mental Health Trust Authority (AMHTA) provided funding for the Alaska Mental Health Board (AMHB) and Advisory Board on Alcoholism and Drug Abuse (ABADA) to conduct a series of town hall style outreach events in rural communities around Alaska. The objective of these visits is to obtain feedback about how behavioral health services are serving the community, what needs exist and whether there are gaps in services, as well as to find out what is going well in these communities. Rebecca Busch, AMHB/ABADA Planner, is coordinating this project.

The Team
This visit was staffed by the following:
Robert Coghill, Board Member ABADA
Nina Allen, Board Member, AMHB
Melissa Stone, Director, Division of Behavioral Health
Rebecca Busch, AMHB/ABADA Planner

Homer
Homer was identified as the third of five communities to be visited for this project. Homer is located at the end of the road system on the Kenai Peninsula along Kachemak Bay. In the 1890's Homer was an active coal mining community. The community was named after Homer Pennock, a gold mining promoter in the 1890's. Gold mining turned out to be unsuccessful in the area. The local economy is shaped by tourism, sport and commercial fishing, logging, art and entertainment. Employment is frequently seasonal.
Homer has an estimated population of 5,691 people, of whom 4.8% report being Alaska Native (2007 census). Homer is served by an array of social services. There are over 40 providers who serve the Homer community. During the community visit there was a conflict with a United Way grant review which also required agency's attendance. The following providers participated in the community visit:

- Homer Public Health Center
- Head Start
- Alcoholics Anonymous and Narcotics Anonymous
- The Center (South Peninsula Behavioral Health Services)
- Cook Inlet Council on Alcohol and Drug Abuse (CICADA)
- South Peninsula Hospital (SPH)
- Friendship Place Senior Services
- Office of Public Assistance
- Haven House

Preparation

Planning for the visit to Homer began with identifying the team and contacts for the community, followed by making the arrangements for meeting spaces. Nina Allen, a member of AMHB, a Homer resident and executive director of The Center offered great guidance for the visit, providing background information, insight on current local issues, and hosting the provider meeting. The Center's staff assisted greatly in planning for the visit as well. Carol Barret, also from The Center, helped with up to date local contacts, identifying appropriate meeting spaces, and helping with many logistics. Thank you, Nina and Carol!

Service providers were contacted by email, phone and/or fax with information and an invitation to participate in the community meetings, as well as to encourage their program participants to attend as well. Public meetings were advertised by posting flyers around town (thanks to Center staff and Nina), public service announcements on the local radio stations, and articles in the local print and online newspapers.

The Schedule of Events

April 29 Arrive in Homer
Provider Meeting (brown bag lunch)
Community Town Hall Meeting
April 30 Two Consumer Meetings
May 1st Team Meeting
Depart

Public Meetings

The community meetings were well attended overall, with very productive participation. Around 40 community members attended the various meetings. The provider meeting and town hall meeting were equally well attended, which speaks to the dedicated services available in the area. The town hall meeting at City Hall assembly chambers drew around 20 people. There was low turnout for the consumer meetings. Even so, the feedback we received was very informative.

What We Learned: Successes in the Community

The Center is a resource to the community that provides a wide variety of services. It is a significant employer in the community, with 54 full time employees and 80-100 part time employees. The Center seems to be successful in retaining its full-time staff, due in part due to offering benefits. The Center employs a full time psychiatrist. Dr. Burgess has a wonderful rapport with the community and was spoken of very highly during our visit.

The Center provides adult and children's mental health, substance abuse and developmental disability services that include emergency 24/7 on call services. The Center provides skills trainers in the Homer schools to work with youth who have additional needs, challenging behaviors, or developmental delays. This collaborative relationship between the school system and behavioral health system encourages a strong support system for youth.

CICADA offers substance abuse assessments, education, outpatient treatment, level 2 groups, intensive outpatient, aftercare services, referrals to residential facilities, gender specific groups, and an adolescent program. CICADA and the Center work together to serve people experiencing co-occurring disorders.

An incredible asset to the community is the "Southern Kenai Peninsula Community Project," a community-wide health needs assessment project initiated and funded by South Peninsula Hospital. The project is coordinated by Sharon Whytal. It is a year-long process that seeks to not only take a look at how the Homer community delivers health care, but also how the community comes together to work for itself. One goal of this project is to develop a strategic plan for serving Homer's overall health which can then be used to attract or seek funding to fill identified needs. It is intended to be a tool for all community agencies to use to strengthen their strategies for serving the community by expanding on the strengths already present and to create solutions by developing resources (without duplication) to address the needs of the community. It is hoped that the project will produce a matrix of all community resources, include data and develop working logic models for particular goals like prevention. The project is a collaboration of more than 15 core agencies, while over 30 agencies participated in the planning. The project will produce a reporting document in the Fall of 2009 and begin strategic planning.

South Peninsula Hospital is undergoing remodeling and expansion which will increase current acute care beds by 12. In addition, the hospital is also working toward becoming a Designated Evaluation and Stabilization (DES) hospital. The hospital and the Center have a good collaborative working relationship, utilizing their individual areas of expertise well and serving on each other's boards.

What We Learned: Needs Work

Prevention was brought up several times by meeting participants. Many agreed prevention efforts should be prioritized in order to slow the growing need for care and treatment.

Many meeting participants, consumers and providers alike, reported a need to increase access for services. A very successful and positive aspect is the number of people already engaged and accessing services. The flip side is that local providers work very hard to meet the needs of the community but report that there seems to be more need than capacity to serve, which can delay access.

The Center seems to be successful in retaining its workforce and this is in part due to offering benefits to full time staff. Unfortunately, the agency is small and cannot afford to offer the same to part time staff. While many choose to work part time and this fits more with some lifestyles, the availability of benefits might reduce part-time staff turnover.

Staff from the Friendship Center, the senior adult day services provider, expressed interest in receiving more training in how to address mental health and substance abuse needs of aging Alaskans. Senior populations are the fastest growing population in Alaska and there is more need for training in these areas. As a small staff, it is difficult for them to leave the area to receive training. It would be helpful if training opportunities were offered in Homer or local expertise was shared to minimize the impact of staff having to travel for training.

Meeting participants noted a need for improved transition planning for youth returning home from a residential psychiatric treatment centers in Alaska or an out of state facility. Many commented on experiences when a child is released without adequate planning and preparation, which inhibits the success of reuniting and re-entering the various familial, social, and school environments. Also discussed were how limited foster care and therapeutic foster care are in Homer.

There was discussion around many populations served. Discussed at length were the groups who fall through the cracks. While many people are able to receive behavioral health services through Medicaid, private insurance, or self-pay, there are many who don't qualify for Medicaid, do not have health care coverage or have the ability to pay on their own. This population does not receive services.

While there are options for receiving treatment for substance abuse in Homer through CICADA, it was said that the wait list for an evaluation is around a month. CICADA does offer substance abuse treatment for adolescents within their program, but the adolescent provider position has been unfilled for several months. CICADA has a smaller office in Homer than their office in Kenai. There seems to be a need to expand staff and program capacity in the office in Homer in order to adequately administer the existing programs and meet the demand of Homer's need. One area identified for expansion was offering case management to clients with co-occurring disorders to help coordinate services and assist in navigating the system. (CICADA has applied for a SAMHSA grant to add peer navigation as a part of the services they have available.) Another needed resource identified by meeting participants was women's vocational job skills training or educational programs.

Stigma remains a problem in Homer. Meeting participants noted bumper stickers characterizing the town as "Homer - A quaint little drinking village with a fishing problem." This common characterization of the community is concerning for many reasons, but primarily because it minimizes such a serious issue. A participant at the Town Hall meeting shared how there seems to be a double standard for mental health and substance abuse. Areas for improvement are the stigmas associated with people experiencing behavioral health concerns as well as those associated with receiving treatment and care for behavioral health concerns. This would encourage earlier interventions and be more apt to prevent chronic conditions.

What We Learned: Unmet Needs

Lack of Services

As mentioned in other communities, it was brought up at the Town Hall meeting that a clearinghouse for resources would greatly assist anyone who was seeking services. This resource could also educate consumers on services available and the process to access them. For example, it could dispel the idea that a person must see a psychiatrist in order to have an assessment or receive care. Several people mentioned a long wait time to be able to see the psychiatrist, while there seemed to be varying expectations of what a psychiatrist should provide verses a clinician. A clearinghouse type of a resource could help guide expectations of appropriate levels of care from clinicians and providers.

There are no psychiatric DES (Designated Evaluation and Stabilization) beds in Homer. The expansion of the hospital includes consideration for a potential room with a focus on mental health care, but at the time of the visit it was not a clearly defined plan in place.

While substance abuse treatment is available in the Homer area, there is not a program that provides inpatient treatment. As with many other communities, there is no formal detox facility in Homer. Responsibility for providing detox and sleep off services falls to the hospital and law enforcement. Last year, the hospital reported 34 cases requiring detox services and care. While the hospital responded to these cases, the community need for detox exceeds what the hospital can address. It is important to note also there is no mechanism in place to hold a criminal securely while they detox, Troopers are not staffed for this nor is there an appropriate facility. This is a need that is apparent in many areas around the state.

It can take up to six months for someone ready for treatment to be accepted or admitted to residential treatment in Anchorage or Soldotna. There is no intensive outpatient care specific for women with children available. At this time there is no funding to expand programs CICADA offers.

There is no residential assistive care for seniors or residential care for seniors with dementia or Alzheimer's disease, or for seniors with challenging or assaultive behaviors. Housing for seniors with

specific care needs is a great concern for the state, as without these services it makes it very difficult to stay in their community with their support systems.
Homer does not have a group home or residential care for youth. When a young person requires a level of care outside of the home, they must leave the community. Parenting classes or intensive in home support for families who have youth at risk of being placed in residential care or at risk of placement in the custody of the Office of Children's Services (OCS) would be a great resource and could potentially reduce the need to be placed outside Homer. Parents who had experienced having to place their child outside the community shared the need for more support. During the provider meeting it was discussed there was a need for a small facility to provide residential services to youth locally. There were questions about the process for documenting the need for this level of care.

What We Learned: Issues of Policy
During the Town Hall meeting there were questions regarding the process and potential of utilizing "Surrogate Guardianship." AS 13.52.030(b) allows a surrogate to make a decision regarding emergency mental health treatment for an adult if there is no other agent or guardian appointed for that adult and the adult has been determined to lack capacity to make the decision himself by a physician and psychiatrist or other mental health clinician. Melissa Stone and Rebecca Busch followed up with the participants specifically interested in this issue, providing more information about the procedures for a surrogate to make health care decisions. However, this discussion shows the need for greater public education about the ways families can support and care for people with mental health needs.
Another policy issue identified by participants was the perception that the Chronic and Acute Medical Assistance (CAMA) program does not cover psychiatric services at a community mental health center. CAMA is a state funded program designed to help needy Alaskans who have specific illnesses get the medical care they need to manage those illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Medicaid benefits, have very little income, and have inadequate or no health insurance. CAMA does cover psychiatrist services as long as the insured's eligibility for CAMA is based on chronic mental illness. CAMA will not cover psychiatric services unrelated to the basis for eligibility, or if they are delivered in an inpatient setting. Additional information on CAMA covered services and eligibility was provided after the community visit.
As mentioned by providers in other communities, Homer providers described frustration with not being able to bill Medicaid for working with families if the enrolled youth is not in the session. After the community visit, information clarifying under what circumstances family therapy and services are Medicaid reimbursable was provided. (The enrolled client must be present for at least half of the session; participation of the client's family and/or "social network" is permissible.)
The State of Alaska has an FASD Waiver Demonstration Project which aims to address the variety of needs of youth with an FASD in conjunction with a clinical mental health diagnosis. This project has the ability to identify and enroll up to 25 participants. As of earlier in the process of beginning the project the number of providers to be enrolled was limited. The Center has not been enrolled as a provider but will be working with the Division of Behavioral Health staff to become an enrolled provider.
Meeting participants discussed a need for statewide electronic medical records as a way for clients' records to transfer more easily and prevent delay in access to services. AKAIMS (Alaska's Automated Information Management System) has grown in its ability to serve in that capacity, and the system continues to evolve toward offering electronic data interchange. Currently there are around 30 community mental health agencies using AKAIMS for record keeping. The Center is an agency doing this now.

A parent shared her experience when her daughter was released from a residential psychiatric treatment center prior to having reached therapeutic stability and without adequate discharge planning. This parent shared how her daughter reached a level where she was no longer a danger to herself or others, and was then prepared for release without a prolonged period of stability. The parent did not feel her daughter was ready to leave residential care but was told that Denali KidCare would not cover any further care. Her daughter was discharged without any planning and without follow-up care. The parent's recommendation was to increase the communication between the family, funding entities, and the residential care facility so that decisions can be a collaborative process.

Follow-Up

Thank you notes and emails have been sent directly to all community agencies, those who attended the community meetings and provided contact information, and to the Homer community at large via the newspaper. Team members (or their staff) have begun to contact participants for follow up on specific questions or interests. Melissa responded to questions about surrogate decision making and FASD waiver programs. Rebecca connected Friendship Center staff with the Trust Training Cooperative for additional training to address behavioral health needs of their program participants. Nina will coordinate local training opportunities with the Friendship Center. Rebecca provided information on billing requirement for family therapy and CAMA coverage.

Some Other Helpful Links

City of Homer Comprehensive Plan, 2009 Update:
http://homercompplan.com/

City of Homer Climate Action Plan
http://www.ci.homer.ak.us/CLPL.pdf

Kenai Peninsula Borough Situations and Prospects, latest quarterly report:
http://www.borough.kenai.ak.us/Econ/2009/Q2/0209%20Quarterly%20Report.pdf

Homer Chamber of Commerce Economic and Tourism Survey
http://www.homeralaska.org/membership/documents/HCOCEcocTourismSummaryReport3.09.PDF

PLEASE COMPLETE AND RETURN TO THE BOOTH AT THE EXIT DOORS TO ENTER INTO DOOR PRIZE DRAWINGS!

Rotary Health Fair Survey 2008

1. Age range: 13-19 20-45 46-65 66+
2. Have you been before? Yes No If yes, # of Health Fairs attended_____
3. How did you hear about the Rotary Health Fair? Newspaper □ radio □ word of mouth □ poster □
4. Why did you come to the Rotary Health Fair? Blood work □ booths □ other (state reason) _____
5. List up to 3 things that you liked at the Health Fair: 1) _____
   2) _____3) _____
6. What other health areas would you like included in a future Health Fair?

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Community Health Needs Assessment Survey:

Over the next months, area groups will be asking for your views on life in the Homer area and beyond. Please take a minute to complete this first survey. We want your input!

1. Please circle the number 1 to 4 that reflects your answer **1 - least positive and 4 - most positive**

A. Are you satisfied with the quality of life in our community?	1	2	3	4
B. Is there economic opportunity in the community?	1	2	3	4
C. Is the community a safe place to live?	1	2	3	4

2. Do you have health insurance? Yes No
If yes, do you have: Private insurance □ Medicare □ Medicaid □

3. In the following list, what do you think are the three most important factors for a healthy community?

Check only 3:

□ Good place to raise children
□ Low crime/ safe neighborhoods
□ Low level of child abuse
□ Low adult death and disease rates
□ Access to health care
□ Parks and recreation
□ Affordable housing
□ Excellent race relations
□ Good jobs and healthy economy
□ Strong family life
□ Healthy behaviors and lifestyles
□ Good schools
□ Low infant deaths
□ Religious or spiritual values
□ Clean environment
□ Arts and cultural events
□ Other _____

4. What do you think are the five most important "health problems" in the community?

Check only 5:

- □ Aging problems
- □ Contagious diseases
- □ Cancer
- □ Alcohol use and/or abuse
- □ Injuries from sports and recreation
- □ Child abuse/neglect
- □ Being overweight
- □ Diabetes
- □ Lack of exercise
- □ Domestic Violence
- □ Mental health problems
- □ Motor vehicle injuries
- □ Drug abuse
- □ Rape/sexual assault
- □ Poor eating habits
- □ Respiratory / Lung disease
- □ Tobacco use
- □ HIV/AIDS
- □ Firearm related injuries
- □ Teenage pregnancy
- □ High Cholesterol
- □ Heart disease and Stroke
- □ Seasonal Affective Disorder (SAD)
- □ Tobacco use
- □ High blood pressure
- □ Unsafe sex
- □ Not using seat belts/child safety seats
- □ Post Traumatic Stress Disorder (PTSD)

□ Other _____

5. What do you think are the most important "health problems" in your family?

Check all that apply:

- □ Problems due to aging
- □ Contagious diseases
- □ Cancer
- □ Alcohol use and/or abuse
- □ Injuries from sports and recreation
- □ Child abuse/neglect
- □ Being overweight
- □ Diabetes
- □ Lack of exercise
- □ Domestic violence
- □ Mental health problems
- □ Motor vehicle injuries
- □ Drug abuse
- □ Rape/sexual assault
- □ Poor eating habits
- □ Respiratory / Lung disease
- □ Tobacco use
- □ HIV/AIDS
- □ Firearm related injuries
- □ Teenage pregnancy
- □ High Cholesterol
- □ Heart disease and Stroke
- □ Seasonal Affective Disorder (SAD)
- □ Tobacco use
- □ High blood pressure
- □ Unsafe sex
- □ Not using seat belts/child safety seats
- □ Post Traumatic Stress Disorder (PTSD)

□ Other _____

6. Have there been any health related services you or a member of your household have needed but have not been able to find in your community? Yes No

If you answered "yes" to the above question, list these services

7. What prevents you from using any health related services that are already here in this area?

8. What do you see as the strengths and opportunities we have in our community to build upon in the future?

For any questions about the Community Health Needs Assessment or to volunteer to distribute later surveys to a group or organization you belong to, call Sharon Whytal, RN at 399-4027

RETURN TO THE BOOTH AT THE EXIT DOORS TO ENTER INTO DOOR PRIZE DRAWINGS!

South Peninsula Survey

1.

Please take 10 minutes to give us your input about living on the S. Kenai Peninsula. Our goal is to improve the community's health and wellbeing, broadly defined to include the arts, business, the environment, as well as health services - everything that contributes to our quality of life and health.

*** 1. What is your age?**

- ◯ Under 13
- ◯ 13-19
- ◯ 20-45
- ◯ 46-65
- ◯ 66+

*** 2. Where do you live?**

- ☐ Homer
- ☐ Anchor Point
- ☐ Ninilchik
- ☐ Port Graham
- ☐ Nanwalek
- ☐ Seldovia
- ☐ Nikolaevsk
- ☐ Razdolna
- ☐ Voznesenka
- ☐ Kachemak Selo

Other (please specify)

3. Please choose the number that best reflects your answer, with 1 being the least positive and 4 the most positive.

	1	2	3	4
Are you satisfied with the quality of life in our community?	◯	◯	◯	◯
Is there economic opportunity in the community?	◯	◯	◯	◯
Is the community a safe place to live?	◯	◯	◯	◯

4. Have there been any services you or a member of your household have needed, but have not been able to find in your community?

- ☐ no
- ☐ yes

If yes, what services would you like to see provided here?

South Peninsula Survey

5. Do you have health insurance? If yes, please identify which kind.

- [ ] no
- [ ] yes
- [ ] private insurance
- [ ] Medicaid
- [ ] Medicare

Is it adequate?

6. What prevents you from using any services that are available in the area? (Choose all that apply)

- [ ] transportation
- [ ] Medicaid problem
- [ ] cost
- [ ] don't trust a provider
- [ ] language barrier
- [ ] harassment
- [ ] confidentiality

Other (please specify)

7. What do you think are the 3 most important factors for a healthy community? (Pick 3)

- [ ] good schools
- [ ] diverse cultural/arts opportunities
- [ ] religious or spiritual values
- [ ] access to healthcare
- [ ] access to job training and higher education
- [ ] good support for families
- [ ] good jobs and healthy economy
- [ ] public transportation
- [ ] healthy behaviors and lifestyles
- [ ] clean environment
- [ ] parks and recreation
- [ ] cultural diversity
- [ ] affordable housing

Other (please specify)

8. What do you see as the strengths we have in our community to build upon in the future?

- [ ] people help each other
- [ ] residents' willingness to disagree
- [ ] a clean and beautiful environment

Other (please specify)

South Peninsula Survey

9. Which of these problems do you think affect us the most--in our community and in your family. (Pick 3 in each column).

	In the community	In your family
PHYSICAL HEALTH (for example: cancer, diabetes, heart disease, high blood pressure, overweight, poor eating habits, unintentional injury)	☐	☐
MENTAL/EMOTIONAL HEALTH ISSUES (for ex.: depression, anxiety, bipolar, PTSD, SAD, suicide, eating disorders, schizophrenia)	☐	☐
SUBSTANCE ABUSE (for ex.: alcohol, tobacco, prescription drugs, inhalants, underage drinking, parent support of kids' using, marijuana, crystal meth, etc.)	☐	☐
INTERPERSONAL VIOLENCE (for ex.: child abuse, sexual assault, family violence, date rape, bullying)	☐	☐
ECONOMIC COSTS (for ex: food and housing, insurance, school, transportation needs, loans, energy costs)	☐	☐
ECONOMIC OPPORTUNITY NEEDS (for ex.: education, job training, low paying jobs, unstable economy)	☐	☐
ENVIRONMENTAL HEALTH (for ex.: water quality concerns, air pollution, radon, other toxins)	☐	☐

10. Do you have any additional comments or suggestions?

"Vision to Action for a Better Life"
SKP Communities Project

Key Informant Interview Questions

1. What strengths and assets do you see in this community, on behalf of your organization and/or the clients that you serve?

2. From the perspective of your work in the community, what are the most important issues that affect your organization and/or the clients that you serve?

3. In your professional opinion, how could these issues best be addressed?

4. What are the challenges or barriers, if any, in addressing these issues?

5. What are the local, regional, state, national and/or global occurrences or external factors, now or anticipated, that might affect your agency or the people that you serve?

6. What would you like to see for your organization and/or for the people who you serve in five to ten years?

2/25/09

Question #6. Services needed and not found.
Yes services needed=167 No services needed+363
Of those who answered "yes", this was their response.

Service wanted	**Total**	**Age grp. 13-19**	**Age grp. 20-45**	**Age grp. 46-65**	**Age grp. 66+**
Dentistry	4		1	2	1
Cancer related service	21		3	16	2
Dermatology	17		2	14	1
OB/GYN	11		5	6	
GI	8		3	5	
Eye care	4		2	2	
Increased quality of services	5		3	1	1
Neurology	10		2	7	1
Urology	5		3	2	
Cost	4		2	2	
Cardiac	28			24	4
Joint/ortho	13			10	3
Pediatric	6		4	2	
Mental health	14		4	10	
Cosmetic	1				1
Respiratory	1		1		
Alternative health	2		1	1	
Other surgery	5		1	4	
Rheumatology	2			2	

Question #7 What prevents you from using any health related services that are already here in this area?

#	Response
84	"Nothing"
135	"Cost/Money"
37	"Lack of/not enough health insurance"
9	"time"
10	"privacy"
21	"lack of competent providers"
22	"services elsewhere"
1	"negative experience"
2	"VA"
4	"good health"
1	"lack of experience"
2	"lack of specialist"
1	"fear"
1	"not open to men with kids"
1	"don't know providers"

2	“distance”
1	“alternative treatments”
3	“lack of choice”
1	“MRI too small”

Question #8 What do you see as the strengths and opportunities we have in our community to build upon in the future?

#	**Response**
4	“intelligence”
1	“facility condusive to education”
20	“hospital”
2	“sliding scale SVT”
1	“Denali kid care”
1	“alternative energy sources”
4	“recreation”
3	“more docs/professional growth”
1	“Obama”
8	“alternative health” “expanding traditional and nontraditional health/wellness”
1	“hospice”
2	“nonprofits”
1	“less churches”
1	“motivated”
1	“tolerance”
2	“Youth enthusiasm”
6	“Health fair”
6	“Arts”
12	“Community spirit”
20	“Caring community”
14	“Community comes together on things”
2	“Free thinking/open”
8	“Professional resources”
2	“Quality of life”
12	“Clean air/environment”
7	“volunteers”
5	“good place to live”
1	“Air transportation/road”
1	“Free health care”
1	“young people”
2	“Schools”
2	“positive attitudes”
6	“People take responsibility for own health and prevention”
1	“forward thinking community”
17	“nice/caring people”
4	“involved community”

3	“support group”
1	“Hard working people”
1	“housing”
1	“variety of services”
1	“vehicle safety”
1	“education”
1	“jobs”
1	“Health behaviors”
7	“natural beauty”
3	“diverse/well informed”
1	“museums”
1	“church”
1	“expand spit”
1	“medical system”
1	“small caring community”
1	“great place for retirees”
2	“Youth leading/involvement”
1	“initiative”
1	“Christian values”
1	“solid values”
2	“universal health care”
1	“SPH not on provider list”
1	“environment education”
1	“outreach”
1	“services driven for the community”
2	“open minds”
1	“lust for life”
1	“current services”
1	“healthy community”
1	“educated people”
1	“gym”
1	“Rotary”
1	“family”
1	“opportunity”
1	“hope”
1	“sliding scale”