



2019–2022 Community Health Needs Assessment

Adopted: June 21, 2019

PeaceHealth Ketchikan Medical Center Community Health Board



PeaceHealth
Ketchikan Medical Center

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I. Executive Summary and Key Takeaways from 2019 CHNA

Overview

PEACEHEALTH

Caring for those in our communities is not new to PeaceHealth. It has been a constant since the Sisters of St. Joseph of Peace, PeaceHealth's founders, arrived in Fairhaven, Washington, to serve the needs of the loggers, mill workers, fishermen and their families in 1890. Even then, the Sisters knew that strong, healthy communities benefit individuals and society, and that social and economic factors can make some community members especially vulnerable. The Sisters believed they had a responsibility to care for the vulnerable, and that ultimately, healthier communities enable all of us to rise to a better life. This thinking continues to inspire and guide us toward creating a better future for the communities we serve.

Today, PeaceHealth is a 10-hospital, integrated, not-for-profit system serving communities in Alaska, Washington and Oregon. PeaceHealth is a Catholic healthcare ministry with a Mission to *carry on the healing mission of Jesus Christ by promoting personal and community health, relieving pain and suffering, and treating each person in a loving and caring way.*


PeaceHealth has embraced the Community Health Needs Assessment (CHNA) process as a means of realizing our Mission and engaging and partnering with the community in identifying disparities and prioritizing health needs. We also align our work to address prioritized CHNA needs.

PEACEHEALTH KETCHIKAN MEDICAL CENTER

PeaceHealth Ketchikan Medical Center (PeaceHealth Ketchikan) is a 25-bed critical access hospital servicing rural, remote, and extensive native southern Southeast Alaska patient populations. It also operates a 29-bed long-term care unit. The hospital provides inpatient medical and surgical services (general surgery, gastroenterology, orthopedics and urology), a behavioral health clinic, diagnostic imaging, a 24/7 emergency room, a childbirth center, a sleep center, rehabilitation (PT, OT, ST), respiratory therapy, telehealth and visiting clinics, and home health.

2019 CHNA PROCESS

PeaceHealth Ketchikan conducted its 2019 CHNA process in the context of state, regional and local community health planning in Alaska, Southeast Alaska, the Ketchikan Gateway Borough and Prince of Wales - Hyder Census Area.



For this CHNA, both primary and secondary data were collected and analyzed. The input of key informants was sought, and a community convening was held in which the needs were identified and prioritized. At various times throughout the nearly eight-month CHNA process, data, findings and input were shared with PeaceHealth Ketchikan's Community Health Board.

Key themes, gaps and needs that emerged during the process included:

- **Behavioral health:** More services and outreach were identified as needed, especially related to screening. As per the community input, there is need for a local detox program; substance use in schools is increasing; and there is a shortage of providers, especially those that accept Medicaid.
- **Affordable housing, homelessness and housing insecurity:** There is a visible homeless population and housing is expensive.
- **Healthcare delivery and inclusion / equity:** There are equity issues with certain groups. Expansion of community collaborations to coordinate resources was also defined as a need.
- **Family and child wellbeing / children and families and youth behaviors:** Trends in unhealthy youth behaviors (drinking, smoking, suicide) are concerning. The increased rate of vaping and juuling is a growing youth issue. There are promising efforts underway to change the smoking age in the community. There also appears to be a growing sense of hopelessness and weakening of social connection among youth. Food insecurity is a problem among a growing number of children and families, and nutrition education is needed.

II. Prior CHNAs: Implementation Plan Progress and Accomplishments

This 2019 CHNA is the third CHNA developed by PeaceHealth Ketchikan since the implementation of the Affordable Care Act's CHNA requirement. The problem of healthcare access and lack of insurance coverage was identified in all PeaceHealth communities in 2013 as a major need and was therefore chosen as a major focus area in the 2013 CHNA implementation plans. In its 2013 CHNA, in expectation of healthcare reform, PeaceHealth Ketchikan anticipated working with the community to actively inform and support enrollment. Medicaid expansion did not begin in Alaska until September 2015; since that time, PeaceHealth Ketchikan has actively worked to assist eligible residents in signing up for Medicaid.

There is limited data available at the local Ketchikan Borough/Prince of Wales Census Area level, because Medicaid data is compiled by regions, not boroughs. PeaceHealth Ketchikan's service area is part of the Southeast Region excluding Juneau. The state's most recent Medicaid dashboard indicates that statewide, the Medicaid/CHIP enrollment has nearly doubled since 2015. At the same time, the state has seen a 26% reduction in the uninsured rate

The Southeast Region has a total of 20,400 enrollees and 5,516 associated with expansion. By any and all measures, and as depicted in Figures 1 and 2 below, these efforts were extremely successful, and continue to benefit the community.

Map 1: State of Alaska By Regions

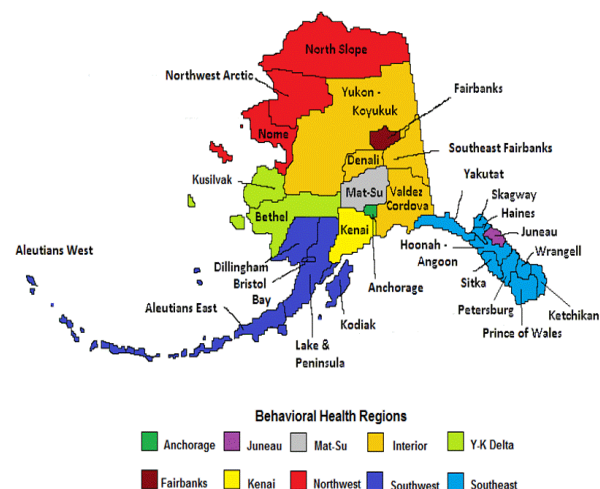


Figure 1:
Alaska State Medicaid Enrollment

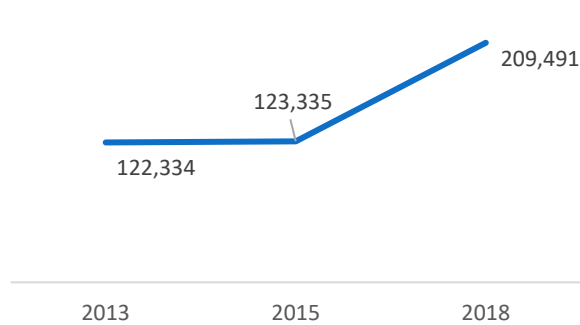
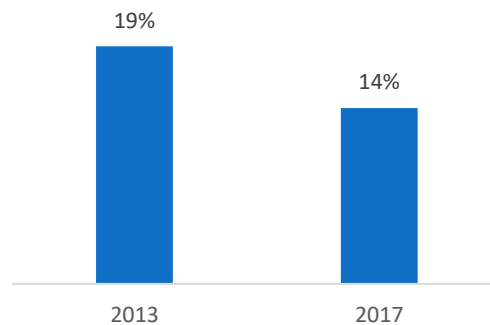


Figure 2:
Percent Uninsured, State of Alaska



Source: Health insurance.org

In its 2016 CHNA, PeaceHealth Ketchikan selected four focus areas:

- Behavioral Health
- Housing and Support Programs and Emergency Shelter
- Cultural Humility and Inclusion
- Maternal Child Health and Childhood Development

In adopting its implementation strategies, the PeaceHealth Ketchikan Community Health Board (CHB) considered the size of the population impacted, the needs in relation to hospital competencies, and the types of community partnerships that would be required to advance the need and available resources. Note that in developing the implementation plan, the priority needs and identified initiatives under the care coordination focus area were targeted towards children, so those initiatives were rolled into the Maternal Child Health and Childhood Development focus area.

The final 2016 Implementation Plan is restated in Table 1. For each need, a set of initiatives was noted, as was a listing of potential partners. The expected degree of PeaceHealth engagement was framed in terms of “lead,” “co-lead” or “support.” While the work is ongoing, progress and accomplishments to date are summarized in Table 1.

Table 1: PeaceHealth Ketchikan 2016 CHNA - Selected Priorities and Initiatives

	Initiatives	Target Population	Potential Partners and PeaceHealth Role	Accomplishments and Activities
Behavioral Health	Complete regional substance abuse assessment that builds on CHNA findings and develop local improvement plan.	People with substance use disorders.	City and members of the task force; private physicians; Akeela Behavioral Health; PHMG; Community Connections. <i>PeaceHealth Ketchikan Role: Co-lead.</i>	PeaceHealth Ketchikan supported MAT training for primary care providers is tracking use of opioids in care provided and supported the integration of behavioral health screening in primary care. Also supported the evaluation of sobering facility (analysis indicated not sustainable).
	Develop Detox Center initiative.	People who abuse opioids.		
	Develop Medication Assisted Treatment (MAT).	People who abuse opioids.		
	Primary care behavioral health integration project.	People presenting in a primary care setting with mental health and substance use disorders.		
Care Coordination for Complex Patients	Develop access initiative focused on increasing the numbers of people in the community who are covered by health insurance, including Medicaid.	Seasonal and part time workers; Native Alaskans; Filipino Americans; people with high deductibles.	Insurance brokers; Public Health; SNAP program/ Foodbank of Alaska/DHSS. <i>PeaceHealth Ketchikan Role: Co-lead.</i>	CNA training with the goal of addressing access and care coordination.
	Further develop a care management system that links ED, primary care and specialty care.	High utilizing, more difficult to serve people who are uninsured or covered by Medicaid.	PHMG; KIC; private community PCPs and Coast Guard. <i>PeaceHealth Ketchikan Role: Lead.</i>	Increased integrated care across management systems and providers.
Cultural Humility and Inclusion	Seek an operational reset with Ketchikan Indian Community (KIC).	PeaceHealth Caregivers and KIC team members	System "Inclusion" team. <i>PeaceHealth Ketchikan Role: Lead.</i>	Adoption of PeaceHealth Statement of Commitment to Inclusivity, Respect for Diversity and Cultural Humility. Completion of leadership training in 2017.
	Increase the diversity of our workforce at all levels of the organization.	Native Alaskans.	Native Alaskan community leaders. <i>PeaceHealth Ketchikan Role: Lead.</i>	
	Develop a Community Health Worker program connecting ED and primary care.	Filipino Americans.	Ketchikan Indian Community (KIC) <i>PeaceHealth Ketchikan Role: Co-Lead.</i>	
Maternal Child Health & Childhood Development	Advocate for and support school based early identification and intervention programs.	At risk middle school children.	Ketchikan School District Public Health. <i>PeaceHealth Ketchikan Role: Co-lead.</i>	

III. State, Regional and Community CHNA Context

PeaceHealth Ketchikan's 2019 CHNA process was undertaken within the context, and with the knowledge of other existing, recent or concurrent community health improvement planning efforts in the state, region and boroughs, including:

Alaska's state health improvement plan, *Healthy Alaskans 2020* (HA2020) brings together partners from many sectors across the state to improve health and ensure health equity for all Alaskans through shared understanding, united efforts, and collective accountability. Led jointly by the State of Alaska Department of Health and Social Services and Alaska Native Tribal Health Consortium, HA2020 is a framework of 25 health priorities for Alaska. Each priority has its own target for improvement to reach by 2020. This framework is based on the latest scientific evidence and the input of Alaskans from communities across the state. The 2030 Plan is being developed at this time.



While The **Ketchikan Wellness Coalition's Community Health Improvement Plan** was last updated in 2014, it has developed strategic plans for several of its current initiatives including its ***Behavioral Health Initiative*** which seeks to reduce stigma by providing:

- Mental Health First Aid – Provide this evidence-based training to our community members and businesses.
- Media and Community Conversations – Share positive stories from people living with mental illness, provide information to our community on how to support your mental health.
- Navigator – Develop a program that will be the “go-to” for information about community services and how to access them for behavioral health.

The coalition also has a *Building Healthy Task Force*, whose priorities include: childhood obesity, healthy eating, increasing fitness and family activities; a *Substance Abuse Task Force* is dedicated to finding avenues to reduce substance use in Ketchikan; and a *Building Cultural Unity Task Force* that focuses on social justice and understanding among the different cultural, ethnic and social groups within our community.

In 2015, the **Alaska Native Tribal Health Consortium** (ANTHC) was awarded a five-year Wellness Strategies for Health Program grant from the Centers for Disease Control and Prevention (CDC). The goal of this grant is to reduce the health impacts of heart disease, diabetes and stroke among Alaska Native and American Indian people in the state of Alaska.



The **Ketchikan Indian Community** (KIC) was included in ANTHC's grant as a sub-awardee to plan, implement and evaluate interventions for improving community health. The population targeted by this effort includes nearly 3,000 Alaska Native people who live in the Ketchikan Gateway Borough. The community identified two priorities: Improving chronic disease management and reducing tobacco use. These priorities were selected based on need for improvement and potential for improvement (including feasibility of changes).

IV. Overview of the PeaceHealth Ketchikan Service Area

DEMOGRAPHIC AND SECONDARY DATA¹

PeaceHealth Ketchikan is located within the Tongass National Forest, the largest national forest in the United States at 16.7 million acres. Composed of a network of waterways and remote island communities, Ketchikan and the surrounding areas are known for their salmon runs, stunning scenery and rich Alaska Native culture. Over 70% of PeaceHealth Ketchikan's inpatients come from Ketchikan Gateway Borough and Prince of Wales – Hyder Census Area. At approximately 14,300 combined square miles, the vast service area has a population of over 20,000 residents and is a popular tourist destination with over one million visitors annually. The service area's total population was largely flat over the past decade; however, it is aging, the 65+ grew by 64% over the same timeframe.

Social determinants of health include access to social and economic opportunities; resources and supports available at home, neighborhoods and communities; the quality of schooling; the safety of workplaces; the cleanliness of water, food, and air; and the nature of social interactions and relationships. In the service area the social determinant data demonstrates that the two communities comprising the service area Ketchikan Gateway and Prince of Wales are different, with Prince of Wales experiencing lower graduation rates, higher poverty rates and less access to nutritious food. In turn, Ketchikan Gateway has higher rates of substance use and housing burdens due to cost.

SERVICE AREA CURRENT DEMOGRAPHIC PROFILE

1,183 (5.9%) are preschoolers under 5 years old (compared to 3.8% statewide)

3,872 (19.2%) are 5-19 years old (compared to 22.1% statewide)

11,673 (58.0%) are adults age 20-64 (compared to 59.8% statewide)

2,777 (13.8%) are seniors age 65+ (compared to 10.8% statewide)

4,075 (20.2%) are Alaska Native and American Indian (compared to 19.6% statewide)

1,055 (5.2%) are Hispanic or Latino (compared to 6.8% statewide)

[1,177 (5.8%) are Asian, (8.3%) Filipino (compared to 6.2% statewide, 3.5% are Filipino)

¹ Some data is only available by region, however, where possible, data was provided by borough.

Table 2 provides data by each of the boroughs in the service area, demonstrating disparities between boroughs on the social determinants of health throughout the service area.

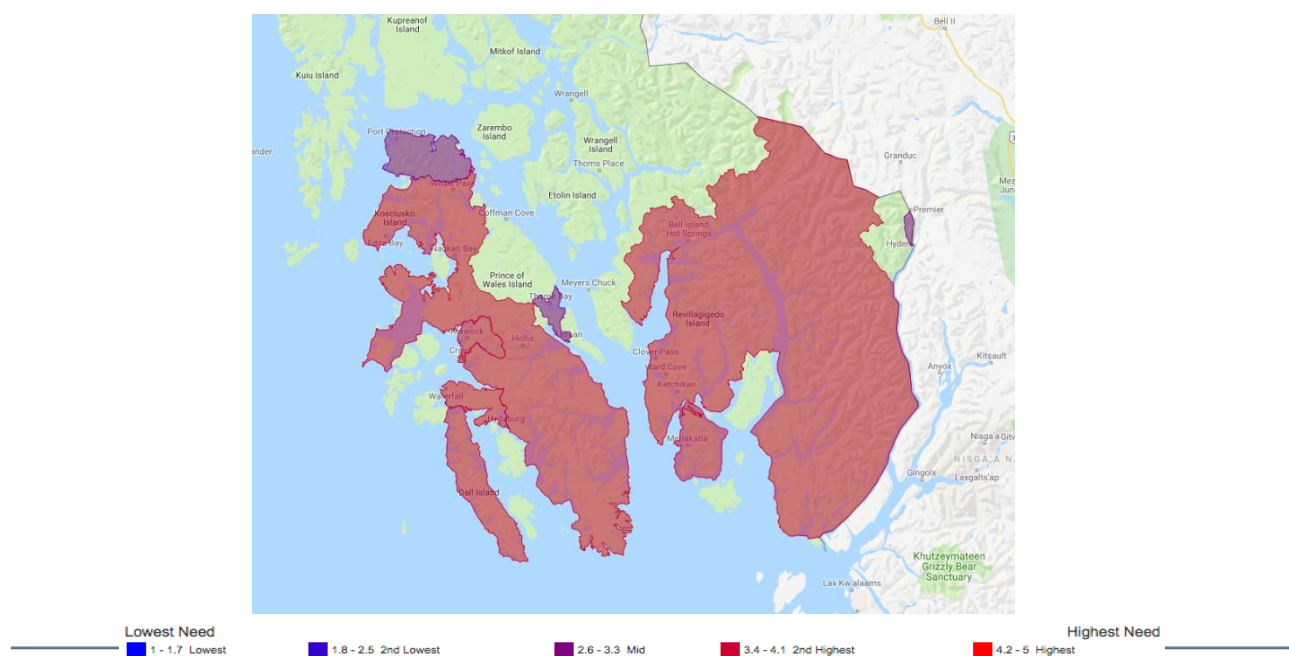
Table 2: Sociodemographic Profile by Borough

Sociodemographic	Ketchikan Gateway Borough	Prince of Wales - Hyder Census Area	Alaska State
High school diploma (%)	77.0%	71.0%	76.0%
Individuals living below the FPL (%)	10.6%	16.0%	10.2%
Median household income	\$67,321	\$52,114	\$76,114
Food environment Index (Access to healthy foods, scale 1-10)	8.2	6.4	6.5
Opioid prescriptions per 100 persons	77.4	38.9	52.0
Severe housing cost burden (%)	13.0%	7.0%	12.0%

Source: Centers for Disease Control (CDC) and Prevention 2016-2017 Prescription Data

The Community Need Index (CNI), a tool created by Dignity Health, measures a community's social and economic health on five measures: income, cultural diversity, education level, unemployment and health insurance, and housing. The CNI demonstrates that within the service area, the majority of the Borough and Prince of Wales census area both have high needs.

Map 2: Ketchikan Gateway Borough and Prince of Wales – Hyder Census Area, Community Need Index Map, 2018





Source: Dignity Health

V. Health Status

The Health Status indicators identified in this section are from primary data from Robert Wood Johnson Foundation's (RWJF) *County Health Rankings*. RWJF's county health rankings data compare counties within each state on more than 30 factors. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Counties are ranked relative to the health of other counties in the same state.

This is a nationally recognized dataset for measuring key social determinates of health and health status. RWJF measures and reports this data annually. The remaining data in this section is organized into four areas defined as priorities by the PeaceHealth System in 2018. These include:

- Family and Childhood Wellbeing including Nutrition and Food Insecurity.
- Affordable Housing including Service Enriched Housing.
- Healthcare Access and Equity.
- Behavioral Health including the Opioid Epidemic.

Data in this section is supplemented and expanded with sources from state, regional and local sources, including Behavioral Risk Factor Surveillance System; Youth Risk Factor Surveillance System; Alaska Department of Health and Social Services, US Census Bureau; Alaska Department of Education and Early Development; Feeding America; Centers for Medicare and Medicaid Services; and Community Commons.

KETCHIKAN AND PRINCE OF WALES RWJF RANKING

The data in Table 3 tracks Ketchikan and Prince of Wales's progress on the RWJF's metrics. Of the 19 boroughs and six city-boroughs (for a total of 25 distinct geographies) in Alaska, Ketchikan generally does better in some of these rankings than Prince of Wales.

Table 3: Ketchikan and Prince of Wales's County Health Rankings

<i>Measure</i>	<i>Borough</i>	'11	'12	'13	'14	'15	'16	'17	'18	'19	<i>Ranking Change 11-19</i>
Health Outcomes <i>Mortality and morbidity</i>	Ketchikan	10	13	12	14	9	5	7	7	9	1 ↑
	Prince of Wales - Hyder	12	8	16	17	17	14	NA	11	12	0
Length of Life <i>Premature death</i>	Ketchikan	6	8	9	9	11	12	7	4	6	0
	Prince of Wales - Hyder	11	11	11	11	17	13	NA	2	19	-8 ↓
Quality of Life <i>Poor or fair health, poor physical health days, poor mental health days, low birthweight</i>	Ketchikan	17	18	13	14	10	4	9	9	15	2 ↑
	Prince of Wales - Hyder	18	9	14	17	19	16	NA	18	5	13 ↑
Health Factors	Ketchikan	9	9	12	11	6	6	11	12	10	-1 ↓
	Prince of Wales - Hyder	16	19	18	18	18	18	NA	16	16	0
Clinical Care <i>Uninsured adults, primary care providers rate, preventable hospital stays, diabetic screenings</i>	Ketchikan	3	6	5	14	6	5	7	8	6	-3 ↓
	Prince of Wales - Hyder	12	21	21	20	21	23	NA	20	22	-10 ↓
Health Behaviors <i>Adult smoking, adult obesity, binge drinking, motor vehicle crash deaths, chlamydia, teen birth rate</i>	Ketchikan	14	13	13	9	7	11	12	15	12	2 ↑
	Prince of Wales - Hyder	15	17	18	16	16	17	NA	16	16	-1 ↓
Social and Economic Factors <i>High school graduation rate, college degrees, children in poverty, income inequality, inadequate social support</i>	Ketchikan	10	6	9	8	4	7	8	8	8	2 ↑
	Prince of Wales - Hyder	18	21	17	18	17	17	NA	17	17	1 ↑

Child and Family Wellbeing, Nutrition and Food Insecurity



WHAT IS CHILD AND FAMILY WELLBEING?

Child and Family Wellbeing is a key pillar of a healthy community. Circumstances in pregnancy through early childhood are key predictors of health and wellbeing later in life. Wellbeing is envisioned as a community where all pregnant women, infants, children, adolescents and families are well-fed, safe, and equipped with resources and knowledge to succeed in school, from kindergarten to high school graduation and through the rest of their lives.

WHAT IS FOOD INSECURITY?

The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life. Hunger and food insecurity are closely related, but distinct, concepts. Hunger refers to a **personal, physical sensation** of discomfort, while food insecurity refers to a **lack of available financial resources** for food at the level of the household. Poverty and food insecurity are closely related. In 2017, an estimated 1 in 8 Americans were food insecure, including more than 12 million children.

According to Feeding America, children who do not get enough to eat — especially during their first three years — begin life at a serious disadvantage. When they're hungry, children are more likely to be hospitalized and they face higher risks of health conditions like anemia and asthma. And as they grow up, children struggling to get enough to eat are more likely to have problems in school and other social situations; they are more likely to repeat a grade in elementary school, experience developmental impairments in areas including language and motor skills and have more social and behavioral problems.

Children struggling with food insecurity and hunger, come from families who are struggling, too. In order to provide enough to eat, 84% of households Feeding America serves report buying the cheapest food — instead of healthy food.

HOW DO KETCHIKAN AND PRINCE OF WALES FARE?

In social and economic factors, including the percentage of adults who have completed high school and have some college education, as well as the percentage of babies born to single mothers, Ketchikan ranks 7th and Prince of Wales ranks 8th of the 25 geographies in Alaska. In terms of adult behavioral health indicators such as excessive drinking and smoking, Prince of Wales ranks higher (worse) than Ketchikan.

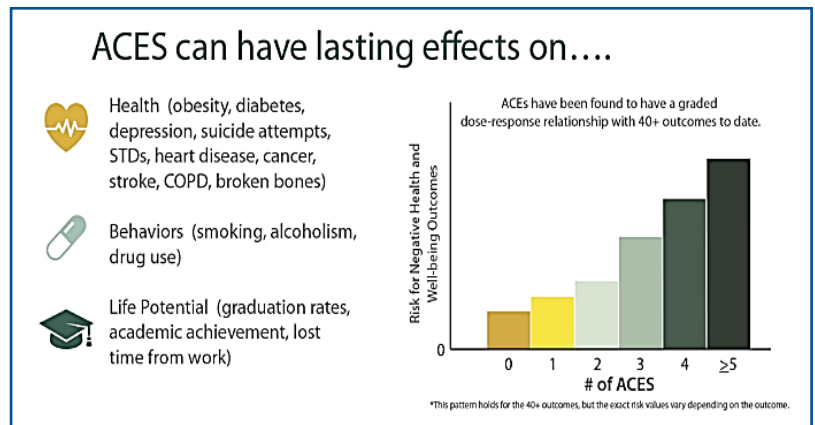
According to Feeding America, 44% of households in Ketchikan are below the SNAP threshold of 200% poverty and 57% on Prince of Wales. Food insecurity is higher in Prince of Wales than either Ketchikan or the State (17% vs. 13% for the State and Ketchikan).

Deeper Dive

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

Adverse Childhood Experiences, or ACEs, are traumatic events that occur in childhood and cause stress that changes a child's brain development. Exposure to ACEs has been shown to have a dose-response relationship with adverse health and social outcomes in adulthood, including but not limited to depression, heart disease, COPD, risk for intimate partner violence, and alcohol and drug abuse. ACEs include emotional, physical, or sexual abuse, emotional or physical neglect, seeing intimate partner violence inflicted on one's parent, having mental illness or substance abuse in a household, enduring a parental separation or divorce, or having an incarcerated member of the household.

Figure 3: Association between ACEs and Negative Outcomes

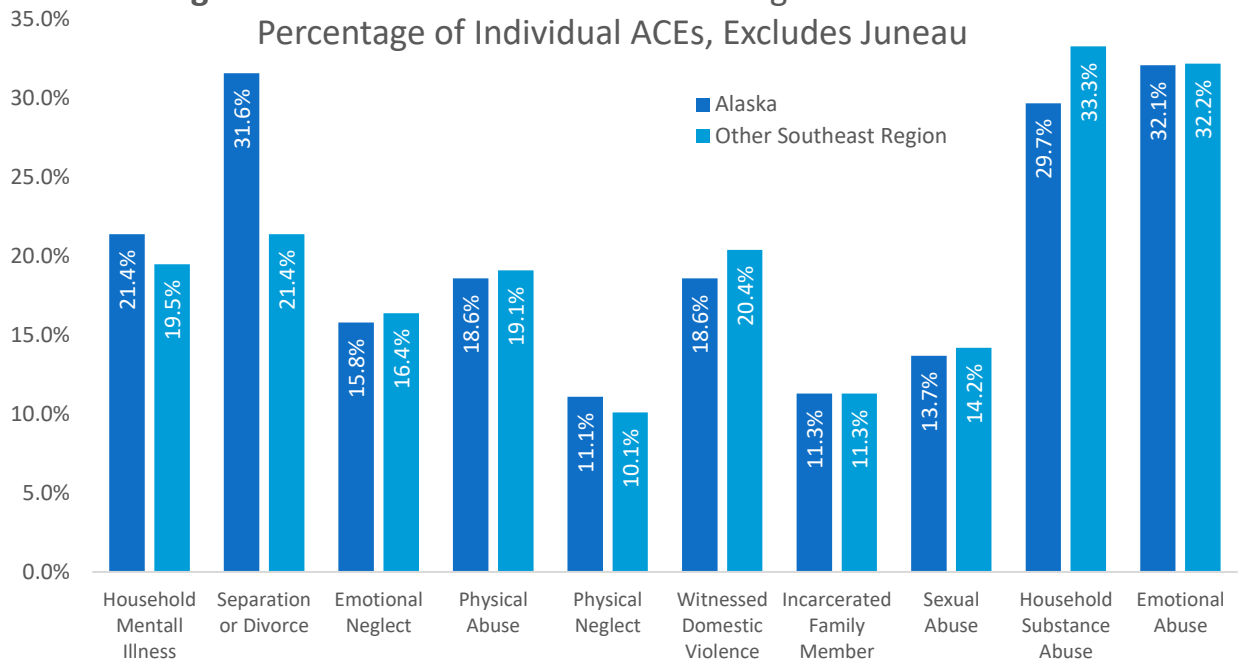


Source: Centers for Disease Control and Prevention, "Association between ACEs and negative outcomes"

From 2013 through 2015 Alaskan adults were asked about their exposure to childhood adversity. The data was compiled at the regional level and compared to the State. This data identifies ways that childhood trauma affects the life cycle. By reviewing indicators self-reported by adults, a relationship between poor health, social outcomes and ACEs indicators can be seen.

As Figure 4 demonstrates, for the ten measures on which data was collected, the Southeast Alaska region excluding Juneau, performed better on half the measures, though it did have higher (worse) rates of substance abuse and domestic violence.

Figure 4: Other Southeast Behavioral Region and Statewide Percentage of Individual ACEs, Excludes Juneau



Source: Alaska 2013-2015 Behavioral Risk Factor Surveillance System Survey, Division of Public Health, Section of Chronic Disease and Health Promotion

OBESITY AND RELATED CHRONIC DISEASES

There is a clear connection between food insecurity and high levels of stress, poor nutrition and chronic diet-related diseases, like obesity and diabetes. Looking at data collected over the past 7 years, a declining trend in the amount of fruits and vegetables (5+) eaten per day has prevailed among 10th grade youth. The data has also shown this trend in eating a full 3 meals a day, with 10th grade youth often skipping breakfast.

Ketchikan has a 9% diabetes rate and Prince of Wales has a 10% diabetes rate compared to an 8% statewide rate. In addition, both Ketchikan and Prince of Wales also have higher rates of obesity compared to the state with more than a third of the population being obese. Obesity and diabetes imperil the health of residents, lower their life span, and put enormous pressure on families and the healthcare system to provide long-term care for aging relatives with avoidable chronic disease. Heart disease, a common comorbidity of obesity is expressed in a higher mortality rate in the Southeast Alaska region (152 per 100,000) compared to the state (139 per 100,000). Additionally, County Health Ranking data shows a high percentage of poor or fair health in Ketchikan and Prince of Wales compared to the state.

Data from the 2015 and 2015 Healthy Youth Surveys demonstrate an improvement in obesity and fruit and vegetable consumption in Ketchikan. Comparable data is not available for Prince of Wales. The level of physical inactivity has increased.

Figure 5: Healthy Youth Survey, 2015 and 2017, select measures

Metric	Borough	2015	2017
Physical Inactivity	Ketchikan	77.8%	79.9%
	Prince of Wales - Hyder	N/A	N/A
Obesity	Ketchikan	17.5%	16.6%
	Prince of Wales - Hyder	N/A	N/A
Fruit and Vegetable Consumption	Ketchikan	85.8%	90.0%
	Prince of Wales - Hyder	N/A	N/A

Note: no data for Prince of Wales reported due to small 'n'.

Affordable Housing, Housing Insecurity, Homelessness and Enriched Services



Safe and stable housing is a key component of financial wellbeing and helps form the basis of good health. Housing challenges occur alongside poverty and food insecurity, together imperiling the well-being of affected households and the community as a whole. Good health depends on having homes that are safe and free from physical hazards. When adequate housing protects individuals and families from harmful exposures and provides them with a sense of privacy, security, stability and control, it makes vital contributions to health.

WHAT IS HOUSING INSECURITY?

More than 19 million households in America (or about 30 percent of all renters) pay more than half of their monthly income on housing. This is a key factor in what the government now refers to as “housing insecurity” — a condition in which a person or family’s living situation lacks security as the result of high housing costs relative to income, poor or substandard housing quality, unstable neighborhoods, overcrowding (too many people living in the house or apartment for everyone to live safely, and/or homeless (having no place to live, sleeping on the streets or in shelters).

HOW IS HOMELESSNESS DEFINED?

There are a number of definitions. For this CHNA, the U.S. Department of Health and Human Services (HHS) definition used, which is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation.

WHAT IS SERVICE-ENRICHED HOUSING?

Service-enriched housing is permanent, basic rental housing in which social services are available onsite or by referral through a supportive services program or service coordinator. Programs often support low income families, seniors, people with disabilities and veterans.

WHAT DEFINES SEVERE HOUSING PROBLEMS?

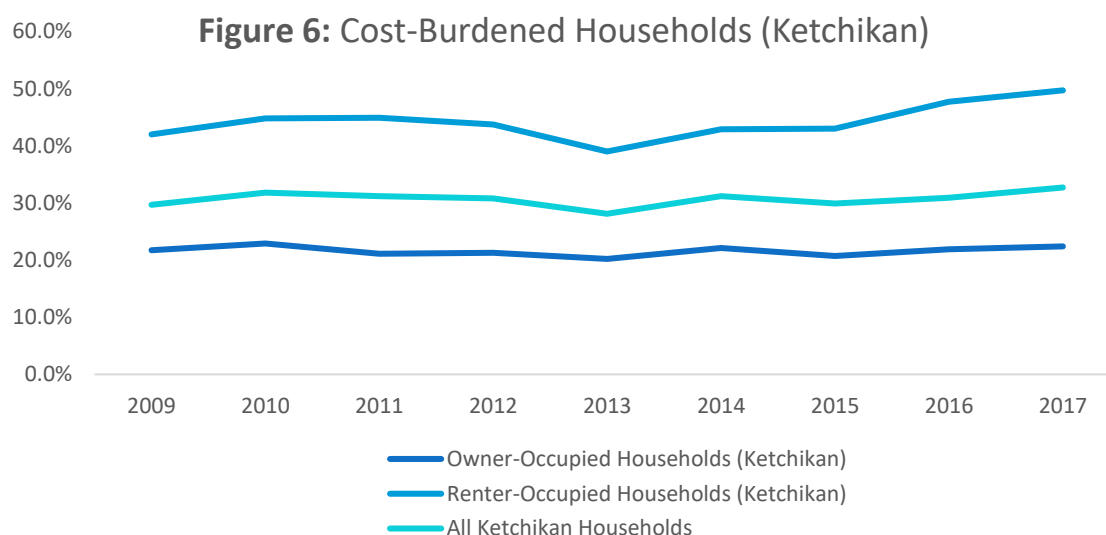
Severe housing problems are measured as an overall score, but includes four different types of housing problems:

- Overcrowding.
- High housing costs.
- Lack of kitchen facilities.
- Lack of plumbing facilities.

HOUSING AVAILABILITY AND AFFORDABILITY PROFILE

In Ketchikan, from 2009-2013, households experiencing a severe cost of housing burden (those that spend more than 30% of income on housing) ranged between 28%-30%, higher than the average of the State of Alaska (29%). Since 2013, this percentage has grown to 33%. The burden is also greater for renters and is now nearly 50%.

The cost-burdened households in Prince of Wales is less (overall about 17%). However, the renters have a greater burden and about 30% of households in Prince of Wales meet the definition of a cost burdened household.



Households with 'severe housing problems,' including cost-burdened housing: 15% for Ketchikan and 18% for Prince of Wales (=AK: 21%)

Deeper Dive

ADULT HOMELESSNESS

Data from the First City Homeless Services Shelter (which opened in October 2017) reported that 314 individuals were assisted 8,596 times (227 men and 87 women). Out of these, 40.5% were American Indian/Alaska Native and 4.5% were under 18 years old. The Overnight Warming Center served 82 persons for a total of 968 housing events (59 men, 23 women).

The 2018 point-in-time count for Ketchikan indicated that there was a total of 65 individuals; 46 in emergency shelters and 19 unsheltered.

Healthcare Access and Equity



Access to quality, affordable, comprehensive care throughout the life course is an important facet of community wellness. We envision a community where all people have access to quality, affordable, preventive and acute care, including mental health and dentistry, throughout the life course. Many disparities in health are rooted in inequities in the opportunities and resources needed to be as healthy as possible. The determinants of health include living and working conditions, education, income, neighborhood characteristic, social inclusion, and medical care. An increase in opportunities to be healthier will benefit everyone but more focus should be placed on groups that have been excluded or marginalized in the past.

WHAT IS HEALTHCARE EQUITY?

The RWJF states that health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and healthcare.



Fig 1: Equality and Equity. Credit to: Robert Wood Johnson Foundation

HOW IS HEALTHCARE ACCESS DEFINED?

Access means ensuring that all people have the opportunity to get the medical, public health and social services they need to live healthier lives. Access includes affordability.

HOW DO KETCHIKAN AND PRINCE OF WALES FARE?

Healthcare delivery factors including the ratio of physicians, dentists and mental health providers to the population, as well as certain measures of access to care (percentage of Medicare recipients receiving mammograms and flu shots).

Table 4: Health Equity System Profile

Health Equity Profile			
Topic	Ketchikan	Prince of Wales - Hyder	Alaska
Primary Care Ratio	(1,250:1)	(1,269:1)	(1,112:1)
Dentist Ratio	(1,386:1)	(2,148:1)	(1,013:1)
Mental Health Ratio	(396:1)	(1,289:1)	(263:1)
Uninsured Rate	17%	24%	16%
Uninsured Adults	18%	28%	18%
Uninsured Children	12%	15%	10%
Children in Poverty	13%	24%	15%
Children Eligible for Free or Reduced-Price Lunch	40%	66%	44%
Unemployment Rate	6.3%	11.4%	7.2%
Mammography Screening	27%	N/A	33%
Income Inequality Ratio ²	4.2	4.6	4.0
Linguistic Isolation	4.5%	0.2%	5%

Deeper Dive

INSURANCE AND ACCESS TO CARE

People without health insurance are less likely to receive preventative care and services for major health conditions and chronic diseases. The total number of uninsured adults in Ketchikan is consistent with the state level. For Prince of Wales adults; the uninsured rate is 10 percentage points higher (28%). For children in both Ketchikan and Prince of Wales, residents have higher percentages of uninsured children than the state.

PREVENTABLE HEALTH MEASURES INEQUALITIES

Access to preventive healthcare, such as vaccines and disease screenings, can prevent some conditions altogether and leads to earlier detection and treatment of disease, better outcomes for patients with those conditions, and reduced financial burdens on patients and their families.

² This measures the ratio of household income at the 80th percentile to income at the 20th percentile.

By utilizing these services, severe health complications can be avoided, and preventable hospitalizations can be minimized.

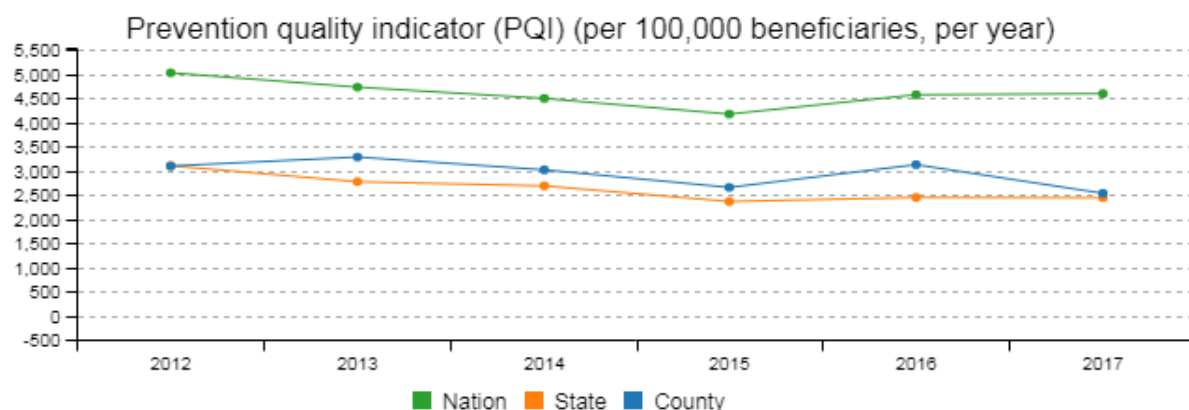
Ketchikan fares better than the state of Alaska in overall flu vaccination rates (36% in Ketchikan vs. 32% in Alaska), but Ketchikan's rate of mammography screening, at 27%, is below the Alaska state mammography screening rate of 33%.

PREVENTABLE HOSPITAL STAYS

Hospitalization for ambulatory-care sensitive conditions, which can be diagnosed and treated in outpatient settings, suggest a lack of access to quality preventive/primary care, and also represent overuse of hospitals as a main source of care. Understanding preventable hospitalizations can help us identify gaps in primary care.

According to the U.S. Department of Health & Human Services, the Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions" (ACSC). These are conditions for which good outpatient care prevents disease complications and the need for hospitalization. A higher PQI rate indicates a greater rate of hospitalizations for ACSC, and poorer access to quality primary care. Ketchikan has a rate of preventable hospitalizations that is lower than the national average but is now on par with the state, suggesting that clinical care is a relative strength of the Ketchikan community.

Figure 7: Overall Composite Prevention Quality Indicator (PQI)
(per 100,000 beneficiaries, per year)



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities, PQI-90 Composite Score

Behavioral Health, Substance Use and the Opioid Epidemic



WHAT IS BEHAVIORAL HEALTH?

Behavioral health is an umbrella term that includes mental health (life stressors and crises, stress, depression, etc.) and alcohol and substance abuse conditions and, opioid misuse. Behavioral health needs can and do negatively impact physical health, leading to an increased risk of some conditions.

HOW DO KETCHIKAN AND PRINCE OF WALES FARE?

In health behaviors, which include substance use (drugs/alcohol/smoking) and overdose rates, Ketchikan and Prince of Wales residents use alcohol and smoke at slightly higher rates than the rest of the state. This data is consistent with CDC data that shows the percentage of youth electronic vapor products statewide to be 16% which is higher than the national average (13%). Community representatives were concerned that this data underrepresents the local experience. The data, which was collected in the spring of 2017, is currently the most recent data available.

The Youth Risk Behavior Survey was developed by the CDC and implemented by the Department of Education & Early Development and the Department of Health and Social Services in cooperation with public high schools. In spring 2017, the department surveyed 1,332 students from 40 high schools that were scientifically selected to represent all public high schools and the results are representative of Alaska's high school students in grades 9-12 in traditional public high schools.

Statewide, alcohol continues to be the most abused substance in Alaska. According to a State of Alaska Epidemiology Bulletin dated May 7, 2018, Alaskans experience higher rates of alcohol attributable mortality compared to most other states, and twice as many deaths are alcohol attributable each year, when compared to methamphetamine and opioid deaths combined. The abuse of alcohol also continues to be a prominent factor in violence against persons, suicide and accidental death.

In addition, according to the Ketchikan Behavioral Health Community Needs Assessment, 17% of Ketchikan residents report emotional difficulty daily and 32% experience emotional difficulty at least a few times per week. More than 60% report stigma as a reason for not seeking services.

Ketchikan and Prince of Wales Behavioral Health Profile

Ratio of care providers to residents:

- Mental health: 396:1 (Ketchikan) and 1,289:1 (Prince of Wales) (>AK: 263:1)
- Adult excessive drinking: 21% (Ketchikan) and 20% (Prince of Wales) (> AK: 19%)
- Adult smoking: 20% (Ketchikan) and 23% (Prince of Wales) (> AK: 19%)
- Youth smoking cigarettes: 13.4% (up from 8.6% in 2015 – Ketchikan) (>AK: 8.9% and trending down)
- Youth drinking: 29.8% (up from 19.9% in 2015 – Ketchikan)
- Youth smoking: 13.4% (up from 8.6% in 2015 – Ketchikan)
- Youth vaping: 16.3% (up from 13.5% in 2015 – Ketchikan)

Deeper Dive

Growth of opioid use disorder

WHAT ARE OPIOIDS?

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine and many others. When used correctly under a healthcare provider's direction, prescription pain medicines are helpful. However, misusing prescription opioids risks dependence and addiction.

According to Alaska's 2018-2022 *Statewide Opioid Action Plan*, the highest number of opioid-related deaths identified statewide in one year was 108 in 2017 (preliminary data); of which, 100 (93%) were due to overdose. During 2010–2017, with 623 identified opioid overdose deaths, the opioid overdose death rate increased 77% (from 7.7 per 100,000 persons in 2010 to 13.6 in 2017). From 2012–2017, the rate of out-of-hospital naloxone administrations by Emergency Medical Service (EMS) personnel more than doubled, from 8.0 to 17.7 administrations per 1,000 EMS calls in 2012 and 2017, respectively. Note that data for the service area and for race/ethnicity is suppressed due to low volumes. While the data is suppressed, a report published by the Northwest Tribal Epidemiology Center in Portland, OR, during 2013-2015, found that the rate of fatal opioid overdoses was nearly three times higher among American Indian and Alaska Natives, when compared to whites.

The rates of opioid-related inpatient hospitalizations were 28.5 per 100,000 persons in 2016 and 26.0 per 100,000 persons in 2017, with total inpatient hospitalization charges exceeding \$23 million.

Despite the escalating rate of opioid overdose deaths and high hospitalization rates, there are several encouraging findings. Preliminary data suggest a possible reduction in the number of deaths during the first six months of 2018. Additionally, the percentage of traditional high school students who report using heroin at least once dropped in 2011 and 2013 and has not increased since. The rate of Medicare Part D patients who received opioid prescriptions has decreased annually since 2015, suggesting more judicious prescribing in Alaska. Furthermore, naloxone use is increasing; this is likely due in part to the increased statewide availability of this life-saving overdose reversal medication.

In 2017, Alaska providers wrote 52.0 opioid prescriptions for every 100 persons. The average U.S. rate in the same year was 58.7 prescriptions per 100 persons. According to the CDC, the prescribing rate in Ketchikan Gateway in 2017 was 91.5 and in Prince of Wales 56.4. This data should be closely monitored to determine if the higher rate in Ketchikan was an anomaly): <https://www.cdc.gov/drugoverdose/maps/rxcounty2017.html>.

VI. PeaceHealth Defined System Level Gaps

In 2018 the PeaceHealth System identified four primary pillars of a healthy community, that appear universal in the communities across the three states in which PeaceHealth provides care. These needs were confirmed through key informant interviews which allowed feedback from the individuals “on the ground” in providing community health initiatives. While these do not supplant the local CHNA process they are insightful and provide insight into potential focus areas and identify needs.

The four areas and their impact on community health are summarized below. Possible action steps for PeaceHealth are summarized below.

Family and childhood wellbeing, nutrition and food insecurity

More than 215,000 individuals in the PeaceHealth three-state, 10 County service area are food insecure, and 25% of them earn too much to qualify for assistance. Making food insecurity a systemwide community health priority is crucial to ensuring the wellbeing of the communities served and fulfills PeaceHealth’s Mission and Core Value of Social Justice.

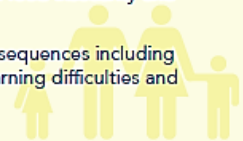


PeaceHealth is taking action by:

1. Expand successful partnerships in the area of food insecurity and nutrition, broadening PeaceHealth’s participation wherever possible.
2. Identify program gaps to make a meaningful difference.
3. Empower caregivers to be community-based and trained with skills to identify food and nutrition related issues.
4. Partner with others to improve nutrition and nourish the community.
5. Advocate for programs that provide nutritional assistance and education.
6. Educate and engage through access to emergency assistance to the PeaceHealth family and community.

Impact on Community Health

- There is a clear connection between food insecurity and diet-related disease.
- Children can suffer a lifetime of consequences including a higher risk of chronic diseases, learning difficulties and social and behavioral problems.



DIABETES



HYPERTENSION



HEART DISEASE



OBESITY

Affordable housing, housing insecurity, homelessness and enriched services



Overall, individuals living in PeaceHealth areas of service are unable to secure a stable basic household budget due to the lack of affordable housing options. Low-income households that spend more than 50% of their income on housing costs are spending 41% less on food and describe their health as fair or poor. Social determinants, including poverty and housing instability, make up 60% of health outcomes.

Taking action:

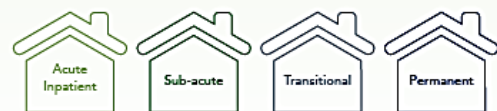
1. Partner with others to provide emergency and transitional housing along with prescriptions, medical equipment and transportation assistance.
2. Collaborate to reduce the housing costs for families and patients seeking treatment.
3. Contribute to supporting the cost of resident services.

Deeper Dive

Unaffordable housing impacts other areas of health, with research showing:

- As a state's average rent increases, the food insecurity rate also increases.
- Low-income households that spend more than 50% of their incomes on housing costs spend 41% less on food each month than similar households.
- Adults living in unaffordable housing are more likely than other adults to describe their health as fair or poor.
- Living in unaffordable housing is associated with higher levels of stress, depression and anxiety.
- Stable housing is a key intervention for people who experience serious mental illness.

What are the different types of housing in play?



Healthcare access and equity

Many of the patients served by PeaceHealth have difficulty managing care at home due to a lack of adequate support. To bridge the gap between providers and patients, community health workers (CHWs) offer support. CHWs assist patients in developing the skills and relationships needed to manage their own health and navigate the healthcare system, which makes for more equitable access to care.



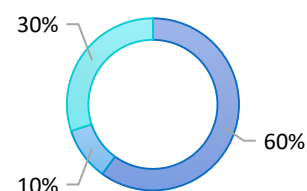
Impact on Community Health

CHWs are frontline public health workers who are trusted members of the community with shared experiences and a close understanding of those they serve. They are effective in bridging care because they are able to respond creatively to the unique needs of diverse individuals and communities. This results in:

- **Improved health outcomes;**
- **Reduced readmissions and emergency room visits; and**
- **Educated and empowered patients and families.**



Determinants of Health



■ Social ■ Health Care ■ Genetics

Taking action:

1. Employ patient health navigators, care management, behavioral health, and caregivers.
2. Contract with community connector programs and care navigators.
3. Connect patients to contacts that will assist in setting appointments and other health needs.
4. Partner with community services to collaborate on health, dental, and social services for children, families and pregnant women



Behavioral health and the opioid epidemic

PeaceHealth is using a multidisciplinary approach to halt the opioid epidemic and heal patients and families suffering from substance use disorders and chronic pain. Focusing on prevention through “fire proofing,” PeaceHealth is implementing a strategic plan to curtail opioid use and treat behavioral health disorders stemming from substance use.



Taking action:

1. Create standard guidelines and alternatives to opioids such as acupuncture and yoga for the treatment of chronic pain.
2. Implement new tools to document and report opioid usage.
3. Hold physicians and prescribers accountable with peer reviews.
4. Prevent and treat by creating Narcan (naloxone) policies and procedures, treatment programs and prescribing suboxone to treat addiction.
5. Partner with behavioral health centers for treatment of substance use disorders.

The Need

“The current opioid epidemic is the deadliest drug crisis in American history.” — *The New York Times*, 10/26/2017

- Overdoses, fueled by opioids, are the leading cause of death for Americans under 50 years old.
- Declared a public health emergency in October, 2017, this epidemic impacts every segment of our society — young and old, rich and poor, urban and rural.
- It has its roots in the over-prescription and misuse of opioid painkillers, and now the availability of inexpensive, illegal opioids (like heroin and fentanyl), is rapidly adding fuel to this fire.

Facts & Faces of Opioid Addiction

4.3 million

Americans use opioids for non-medical purposes.

— National Survey on Drug Use and Health

78 people

die each day from prescription painkiller overdose.

— Centers for Disease Control

21.2 years

is the average age for first-time use of prescription painkillers in the past year.

— National Survey on Drug Use and Health

77%

21–35 year olds represent the majority of opioid use disorder patients entering treatment.¹

70%

of patients with dependency on opioids, opiates or heroin entering treatment are male.²

1.6x

likelihood that a patient in treatment for opioid use disorder has chronic pain.³

^{1, 2, 3} MAP Health Management analyzed data for 30 substance abuse treatment facilities nationwide, including 734 individuals entering treatment during 2015–16.

VII. Community Input and Convening

Community input was secured in two ways. First, interviews of key informants were conducted. Secondly, PeaceHealth Ketchikan held a community convening in early April.

KEY INFORMANT INTERVIEWS

PeaceHealth Ketchikan surveyed community leaders from organizations throughout the service area representing perspectives from public health and medically underserved and vulnerable groups. The key informant interviews were designed to collect input on the following:

- Health needs and gaps of the community.
- Feedback on the 2016 CHNA priorities and accomplishments to date.
- Secondary data gathering for 2019 CHNA.

Table 5 details the organizations that participated in the key informant interviews

Table 5: Key Informant Interview Participants by Organization, 2019 CHNA

Organization
State of Alaska Public Health Department and Ketchikan Public Health Center
Ketchikan Gateway Borough School District
Prince of Wales Health network
Akeela Behavioral Health


COMMUNITY CONVENING

PeaceHealth convened a community meeting on April 8. In which 14 community leaders and providers attended. As with the key informant interviews, participants were guided through a three-part process:

1. A look back to the 2016 CHNA and progress to date.
2. A review of updated primary and secondary data gathered for the 2019 CHNA including a summary of the PeaceHealth system defined unmet needs and key informant interview themes.
3. Input requested for priorities and importantly on anything that may have been missing.

The top needs/gaps identified in the key informant interviews and community convening, in order of priority, with a specific focus on children and youth include:

- **Behavioral health:** More services and outreach were identified as needed especially related to screening. As per community input, there is a need for a local detox program; substance use in the schools is increasing; and there is a shortage of providers, especially those that accept Medicaid.

- 
- **Affordable housing, homelessness and housing insecurity:** There is a visible homeless population and housing is expensive.
 - **Healthcare delivery and inclusion/equity:** There are equity issues with certain groups. Expansion of community collaborations to coordinate resources was also defined as a need.
 - **Family and child wellbeing/children and families and youth behaviors:** Trends in unhealthy youth behaviors (drinking, smoking, suicide) are concerning. The increased rate of vaping and juuling is a growing youth issue. There are promising efforts underway to change the smoking age in the community. There also appears to be a growing sense of hopelessness and weakening of social connection among youth. Food insecurity is a problem among a growing number of children and families, and nutrition education is needed.

VIII. Next Steps

Consistent with 26 CFR § 1.501(r)-3, PeaceHealth Ketchikan will adopt an implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA is adopted, or by Nov. 15, 2019. Prior to this date, the implementation plan will be presented to the CHB for review and consideration. Once approved, the implementation plan will be appended to this CHNA and widely disseminated. It will serve as PeaceHealth Ketchikan's guidance for the next three years in prioritizing and decision-making regarding resources and will guide the development of an annual plan that operationalizes each initiative.