

Healthy Alaskans 2030 State Health Assessment

August 2019



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Acknowledgements

Special thanks to the Division of Public Health Section of Public Health Nursing, the Alaska Native Tribal Health Consortium Community Health Aide program and the Anchorage Health Department for contributing valuable qualitative data to the state health assessment.



Healthy Alaskans 2020 and 2030 is a partnership between the Alaska Department of Health & Social Services and the Alaska Native Tribal Health Consortium.

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Healthy Alaskans 2030 State Health Assessment

Introduction

The State of Alaska, Department of Health and Social Services, in equal partnership with the Alaska Native Tribal Health Consortium, leads the state health improvement plan (SHIP), Healthy Alaskans 2020 (HA2020). Healthy Alaskans 2020 is composed of 25 leading health indicators, or priorities, each with established targets to achieve by 2020. Through a comprehensive and inclusive process, organizations and communities of all levels have agreed to the HA2020 indicators and targets for the past decade. HA2020 is aimed at improving the health of all Alaskans and has a vision of Healthy Alaskans in Healthy Communities. To support this vision, HA2020 provides a framework supporting the work of partners and stakeholders statewide who are actively engaged in improving the health of Alaskans. To build this framework, specific steps have been followed, including the completion of a statewide health assessment, the prioritization of health objectives and targets for the decade for Alaska, and the identification of strategies and actions to reach those targets.

The state health improvement plan is updated every 10 years and as the decade ends, it is time to develop the next iteration of the state health improvement plan, Healthy Alaskans 2030. To develop the new SHIP, a new comprehensive state health assessment identified the most important health issues impacting Alaskans and the health improvement needs of the state. The state health assessment will inform the careful selection of leading health indicators and targets that organizations and communities will be working on for the next decade. The state health assessment will ensure Healthy Alaskans 2030 contains and focuses on health priorities that are shaped by data about the health status of Alaskans, the effectiveness of Alaska's public health system in providing essential services, and input given by Alaskans regarding health issues impacting them and their communities. This document presents the findings of the most recent state health assessment and includes a description of Alaska's demographics, health issues of specific population groups with particular health issues and disparities or inequities, factors that contribute to the state population's health challenges, and community resources and assets to address health issues.

The success of HA2030 is dependent upon many strategic decisions, including those related to the design of the organizational structure, creation and support of partnerships, and compilation and presentation of the best available data on health status, health factors and health priorities. The purpose of this document is to provide a clear snapshot of the health status of Alaskans and perceptions about health that are important to addressing health issues for all Alaskans.

State Health Assessment Process

During 2018-2019 the Alaska state health assessment was conducted using a hybrid of the Healthy People and Evidence Based Public Health planning models with additional guidance for participatory methods from the Association of State and Tribal Health Officials, the National Public Health Performance Standards Program, and the Community Toolbox. Many stakeholders actively participated in part or in the entire state health assessment process, including the Healthy Alaskans Core and Advisory Teams, Healthy Alaskans 2030 Leading Health Indicator Development Teams, public health nurses throughout the state, the Anchorage Health Department, and all Alaskans who responded to surveys, participated in community listening sessions, gave input during outreach events, and commented on the state health assessment draft report during the public comment period.

Included in this state health assessment report is comprehensive, broad based data and information from a variety of sources that summarizes key health information for Alaska, including:

- 1) A summary of health status in Alaska, including the impact of the social determinants of health;
- 2) A summary of the health concerns of Alaskans from survey responses, community listening sessions, interviews, and other qualitative data methods;
- 3) A summary of key findings from an evaluation of Healthy Alaskans 2020; and
- 4) A summary of results of Alaska's Public Health System Assessment ("Community Capacity Review") that used the National Public Health Performance Standards State Assessment tool.

The state health assessment is an important compilation of data that will assist in the thoughtful, evidence-based selection of health priorities for HA2030 that public health system partners and stakeholders will work on for the next 10 years. The selection of HA2030 leading health indicators, targets, strategies and actions involves a comprehensive process with a diverse set of participants. The process is led by the Healthy Alaskans Core Team. The Core Team is the small group of staff from both partner entities who have overseen the planning and implementation of the entire initiative. Additional stakeholder groups, called Leading Health Indicator Development Teams, were created to provide different levels of input and feedback on health issues in Alaska. The Advisory Team will be presented with recommendations from the Leading Health Indicator Development Teams, along with data related to health status indicators, and will use that information, along with their expertise, to recommend statewide health priorities to be included in Healthy Alaskans 2030. The Steering Team, composed of leaders from the two partner organizations supporting this initiative, will make the final decision on the leading health priorities for HA2030 based on data and recommendations presented to them. Other critical teams referred to in this document include the Data Team, which has collected and rated the existing health status data in the state; Alaska stakeholders who provided the public input at several stages of the process and the Target-setting Teams, which will determine targets for sets of Leading Health Indicators (LHIs). The demographic description provides the context for decision-making on health priorities.

Understanding Alaska - Demographics

Alaska is an extreme frontier state with 1.2 persons per square mile spread throughout 362 communities; by comparison, U.S. population density is 87.4¹. The state population of 739,795² is spread across an area larger than California, Texas and Montana combined, equal to 1/5 the landmass of the entire U.S. One quarter of the population lives in communities with less than 2,500 people. Alaska has about 200 villages that are reachable only by air or boat along rivers, coastline and islands. Alaska is a challenging environment to provide public health and preventive services due to its highly dispersed population, high transportation costs, and limited local public health infrastructure.

¹ US Census, 2010. Accessed 11-5-2013, <http://www.census.gov/2010census/data/apportionment-dens-text.php>.

² American Fact Finder, American Community Survey, July 2017 estimate. Accessed 11-1-2018, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2017_PEPANNRES.

Three different systems provide health care in Alaska: the private sector; the military and Veterans' Administration health system; and the Alaska Tribal Health System. The "private sector" can be defined as any services provided outside of the military or tribal systems. It includes hospitals (both nonprofit and for-profit); the offices of physicians, dentists and mental health professionals; and various types of clinics such as Federally-Qualified Health Centers. Additionally, limited public health services are provided by state Public Health Nurses at clinics and itinerantly and two communities in the state also have local health departments. Alaska is unique in being the only state that does not have any managed care organizations in the private sector, and formal provider networks are minimal.

Alaska has a very diverse population. According to the 2010 U.S. census, 7.3% of Alaskans are identified as having more than one race. Alaska's 2017 population estimates by race—which classify races both alone and in combination—classify 66.9% of Alaskans as White; 18.5% as American Indian or Alaska Native; 9.7% as Asian or Pacific Islander; and 4.9% as African American.³ In addition, 6.5% of Alaskans identify as being of Hispanic origin, regardless of race. Almost half of the state's population resides in Anchorage. Within the Anchorage School District, the state's largest school district, minority students comprise more than 50 percent of the student population, and 100 languages are spoken. The most common of these are Spanish, Hmong, Samoan, Filipino and Yup'ik.⁴ Outside of Anchorage, the state is similarly diverse, and many rural and remote communities are predominantly Alaska Native. In Alaska there are at least 20 distinct indigenous languages spoken among Alaska Native people.⁵

Alaska's population is also very "young." According to 2017 population estimates, the median age of Alaskans is 35.2 years, with 11.2% of the population older than 64 years,⁶ compared with a U.S. median age of 37.7 and 14.5% age 65 or older.⁷ Similar to the national pattern, however, the percentage of Alaska's population age 65 or older is expected to continue rising over the coming decades, reaching an estimated 15.8% of the population by 2045.⁸

Approximately 18.9% of the population of Alaska (and 26.2% of those under 18 years) lives below 125% of the Federal Poverty Level.⁹ Among all Alaskans, 12.6% percent are without health insurance coverage, compared to 8.8% in the U.S. Thirty percent of Alaska adults do not have one person they consider their personal health care provider, and 14% report being unable to seek health care services in the past 12 months due to cost.¹⁰ American Indian and Alaska Native tribal members generally have access to tribal health services even if they do not have other health care coverage.

³ Alaska Department of Labor and Workforce Development, Research and Analysis Section, Alaska Population by Age, Sex, Race (alone or in combination), and Hispanic Origin, 2010 to 2017, July 2017. Accessed 11-1-2018, <http://live.laborstats.alaska.gov/pop/index.cfm>.

⁴ Anchorage School District website, About ASD, Accessed 11/1/2018, <https://www.asdk12.org/aboutasd/>.

⁵ University of Alaska Fairbanks, Alaska Native Language Center website, Languages, Accessed 11/1/2018, <http://www.uaf.edu/anlc/languages/>.

⁶ Alaska Department of Labor and Workforce Development, Research and Analysis Section, Alaska Population by Age, Sex and Borough/Census Area, 2010 to 2017, July 2017. Accessed 11-1-2018, <http://live.laborstats.alaska.gov/pop/index.cfm>.

⁷ U.S. Census Bureau, 2012-2016 American Community Survey. Accessed 11-1-2018, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_5YR_DP05.

⁸ Alaska of Labor and Workforce Development. Population projections: 2017 to 2045. August 2018. Accessed 11-1-2018, <http://laborstats.alaska.gov/trends/aug18art2.pdf>.

⁹ U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement.

¹⁰ Alaska Behavioral Risk Factor Surveillance System, 2017.

The Health of Alaskans

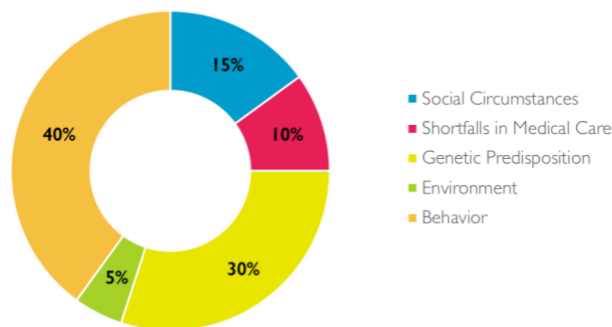
Several types of indicators can be used to gain a picture of the health status of Alaskans. Broad categories of these indicators include: 1) causes of death (mortality); 2) causes of illness and injury (morbidity); 3) behaviors that increase risk of illness or injury; 4) access to health care and preventive services; and 5) other social and economic determinants of health. No picture of health status is complete without an examination of health inequities across all of these sets of indicators. The following section provides an overview of the health of Alaskans according to the above listed categories of health indicators.

Mortality

Population health is determined by a number of factors. The following figure depicts the extent each factor impacts premature death in the U.S. According to the National Cancer Institute Dictionary, premature death is any death that occurs before the average age of death in a certain population (NCI, n.d.).¹¹ The CDC states that in the United States, the average age of death is about 78 years. The average life expectancy for Alaska Native people is 70.7 years, according to a recent report by the Alaska Native Epidemiology Center

(http://anthctoday.org/epicenter/healthData/factsheets/Life_Expectancy_statewide_2_1_2017.pdf)

Impacts of Various Domains on Premature Deaths in the US



Source: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Affairs*.

Behavioral risk factors, often referred to as lifestyle factors, are responsible for approximately four out of 10 U.S. premature deaths. Chief among these risk behaviors are tobacco use, poor diet, and inactivity, the combination of which account for 69% of preventable deaths in the U.S.¹²

¹¹ National Institute of Health's National Cancer Institute. NCI Dictionary of Cancer Terms. Retrieved from <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/premature-death>

¹² Mokdad AH, Marks JS, Stroup DF, Gerberding JL (2000). Actual causes of death in the United States. *JAMA*. 2004;291(10):1238-45.

Alaska's mortality data come from the Division of Public Health's Health Analytics and Vital Records Section. In Alaska, as in the U.S., the majority of deaths each year are due to chronic diseases. In 2017, the most recent year for which data are available, 4,415 Alaskan residents died.¹³ The following figure shows the 10 leading causes of death in Alaska and compares that ranking with U.S. deaths.

Leading Causes of Death, Alaska Residents and US 2017

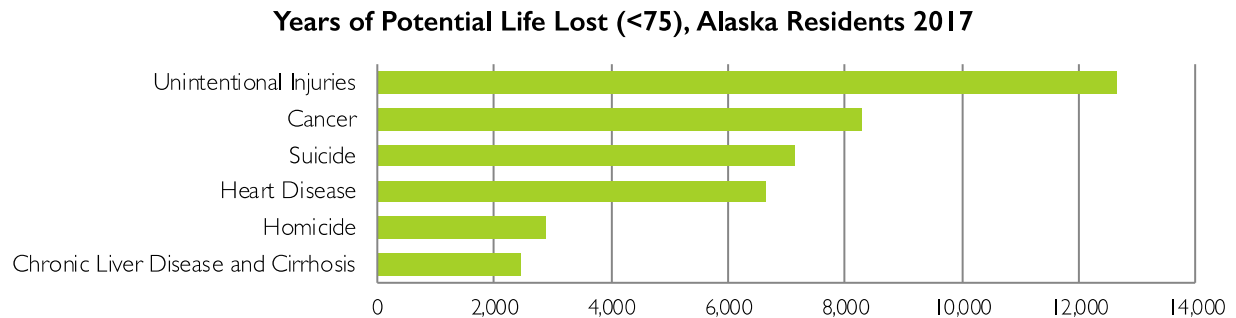
Cause of Death	Deaths	AK Age-Adjusted Rate	US Age-Adjusted Rate	US Rank
1. Cancer	908	136.2	183.9	2
2. Heart Disease	799	133.4	198.8	1
3. Unintentional Injuries	427	63.0	52.2	3
4. Chronic Lower Respiratory Dis.	203	36.0	49.2	4
5. Suicide	197	26.9	14.5	10
6. Stroke	187	34.8	37.6	5
7. Diabetes	125	18.6	21.5	7
8. Chronic Liver Dis. And Cirrhosis	120	14.9	12.8	11
9. Alzheimer's Disease	97	22.2	37.3	6
10. Homicide	76	10.4	6.2	n/a

Source: Alaska Division of Public Health, Vital Statistics, Mortality; NCHS (2017)

Unlike in the U.S. overall, cancer is the leading cause of death in Alaska; heart disease is second. Perhaps more striking is the difference in rates of unintentional injury and suicide in particular—between Alaska and the U.S. The Alaska age-adjusted rate of death from unintentional injuries is 63.0 per 100,000, compared to 52.2 per 100,000 in the U.S. overall. The age-adjusted suicide rate, which only just makes the top 10 list in the U.S., is 26.9 per 100,000 in Alaska, approximately 86% greater than the U.S. rate (14.5 per 100,000). Another notable Alaska-versus-U.S. difference is the rate of death due to homicides, which are not in the U.S. top 10 leading causes of death: the Alaska age-adjusted rate is 10.4 per 100,000 compared to only 6.2 per 100,000 in the U.S.

¹³ Alaska Division of Public Health, Health Analytics and Vital Records Section (2018a). Alaska Vital Statistics 2017 Annual Report.

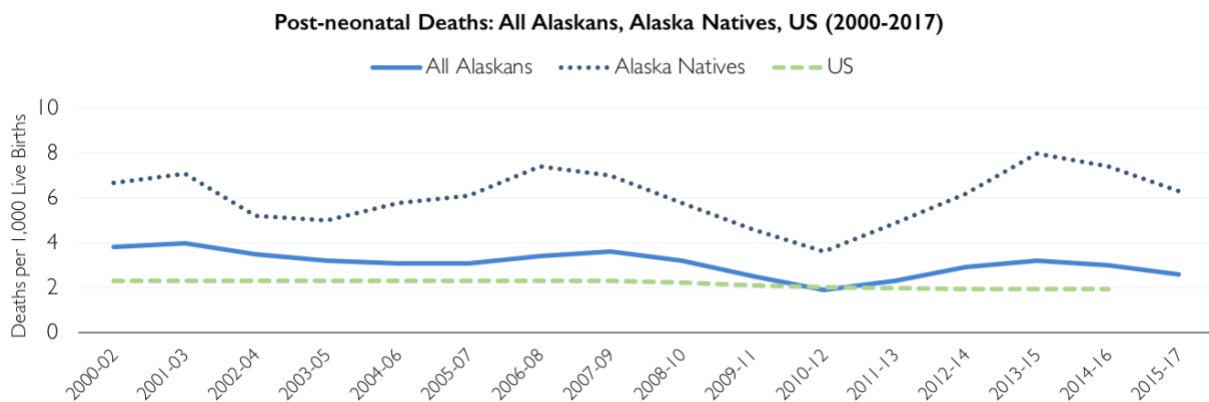
Rates of death reveal only part of the picture of mortality in Alaska. Since certain causes strike down the youngest Alaskans, it is also important to consider the years of potential life lost due to specific causes of death. This is defined as the number of years lost prior to an Alaskan's 75th year, aggregated by cause. The following graph shows the six leading causes of death based on the total years of potential life lost among Alaskans.



Source: Alaska Division of Public Health, Vital Statistics, Mortality

Unintentional injury death in Alaska had the largest toll in terms of years of potential life lost, followed by cancer and suicide being second and third, respectively.¹⁴

Another important indicator of the health of a population is the rate of death for those ages 28 days to 1 year. The graph below shows that trends in post-neonatal mortality rate for Alaska Natives and Alaska as a whole are much higher in comparison to U.S. data which were available for the period 2000 through 2017.



Source: Alaska Division of Public Health, Vital Statistics, Mortality; NCHS (2017)

¹⁴ Alaska Division of Public Health, Health Analytics and Vital Records Section (2018b). Alaska Vital Statistics 2017 Annual Report, NCHS (2017)

Morbidity

Several sources of Alaska data, including disease and injury registries, hospital discharge records, and telephone-based behavior surveys, provide information about morbidity, or the presence of illness or injury among Alaskans. The following table shows the top reasons for hospitalization in Alaska (2017) by percentage of discharge diagnoses. The relative cost of those diagnoses is also shown. Childbirth of live newborns, followed by septicemia, or sepsis, are the most frequent reasons for hospitalization. Sepsis is the body's extreme response to an infection that happens when an infection a person already has triggers a chain reaction throughout the body that can lead to tissue damage, organ failure and death.¹⁵ The top five reasons for hospitalization account for over a quarter of all discharges and 20% of hospital charges.

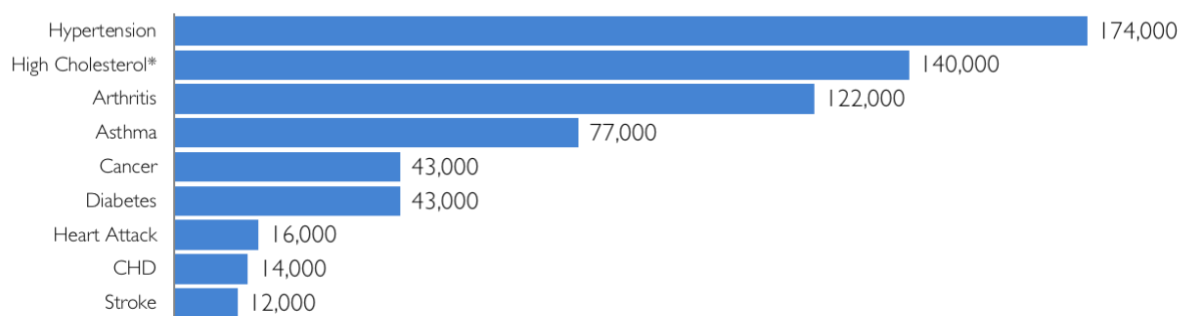
Top Five Reasons for Hospitalization

Alaska - 2017	Percentage of Discharges	Percentage of Charges
Live born	13%	6%
Septicemia (except in labor)	5%	7%
Mood disorders	4%	2%
Osteoarthritis	3%	4%
Other birth complications	3%	1%

Source: Alaska Division of Public Health, Health Facilities and Data Reporting Inpatient Database v10
Note: The reasons for hospitalization were generated using Clinical Classification Categories. Charges do not reflect what was paid for the services or negotiated discounted rates.

Self-reported data from adult Alaskans regarding their history of being diagnosed with chronic conditions is shown below. Hypertension and high cholesterol impact an estimated 174,000 and 140,000 Alaskans, respectively.

Alaska Adults Diagnosed with Select Chronic Diseases, 2017



Source: Alaska Division of Public Health, Behavioral Risk Factor Surveillance System *Of those screened last 5 years.

These data do not show the impact of multiple chronic conditions. Many individuals in Alaska, as in the U.S., are simultaneously dealing with more than one chronic condition. Having multiple chronic conditions negatively impacts quality of life¹⁶ as well as health care costs.¹⁷

¹⁵ CDC, Diseases and Conditions Definitions (2018). What is Sepsis? Retrieved from <https://www.cdc.gov/sepsis/what-is-sepsis.html>.

¹⁶ Anderson G (2010). Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation.

¹⁷ Centers for Medicare and Medicaid Services (CMS). State level Chronic Condition Reports. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CCStateReports.html> (Report 2). Accessed 12-20-2013.

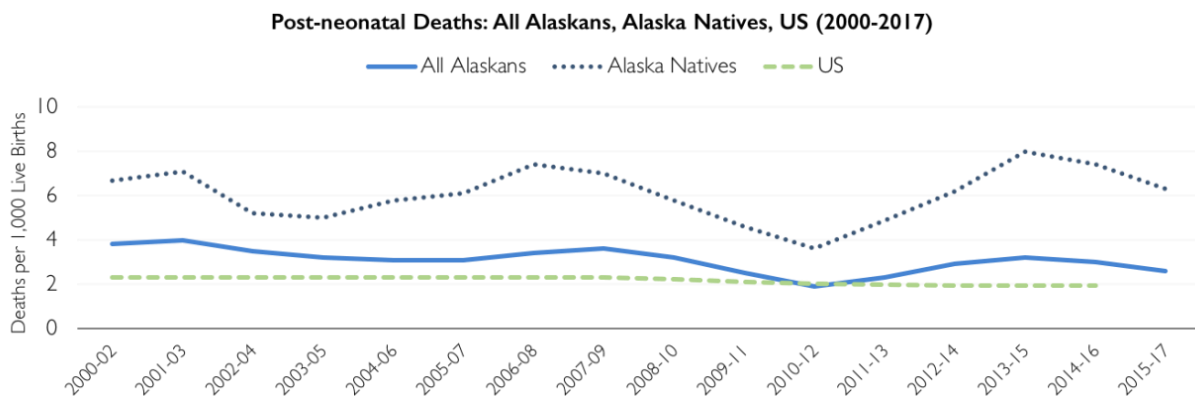
The Alaska Cancer Registry provides a significant amount of information regarding cancer incidence in Alaska. The following table shows the top five cancers in Alaska in 2016. Breast cancer (among women) ranks first in terms of both cases and age-adjusted rates of cancer incidence, followed by prostate cancer.

Counts and Incidence Rates for Top 5 Cancers, Alaska Adults 2016

Rank*	Cancer Site	Number of Cases	Age-Adjusted Cases per 100,000
1	Breast (women only)	411	115.6
2	Prostate (men only)	363	95.1
3	Lung and Bronchus	362	55.7
3	Colon and Rectum	270	39.0
5	Urinary Bladder	124	19.4

Source: Alaska Division of Public Health, Alaska Cancer Registry. *Based on counts

A database maintained by DHSS, Office of Children's Services is used to monitor reports of child maltreatment. Child abuse and neglect are long-standing issues in Alaska, with rates historically significantly higher than in the U.S. overall. The following graph shows improvement in the Alaska and U.S. rates (per 1,000 children) of substantiated child maltreatment over the past five years; however, the Alaska rate remains more than 50% higher than the U.S. rate.



Sources: Alaska DHSS, Office of Children's Services; DHHS, Administration for Children and Families.

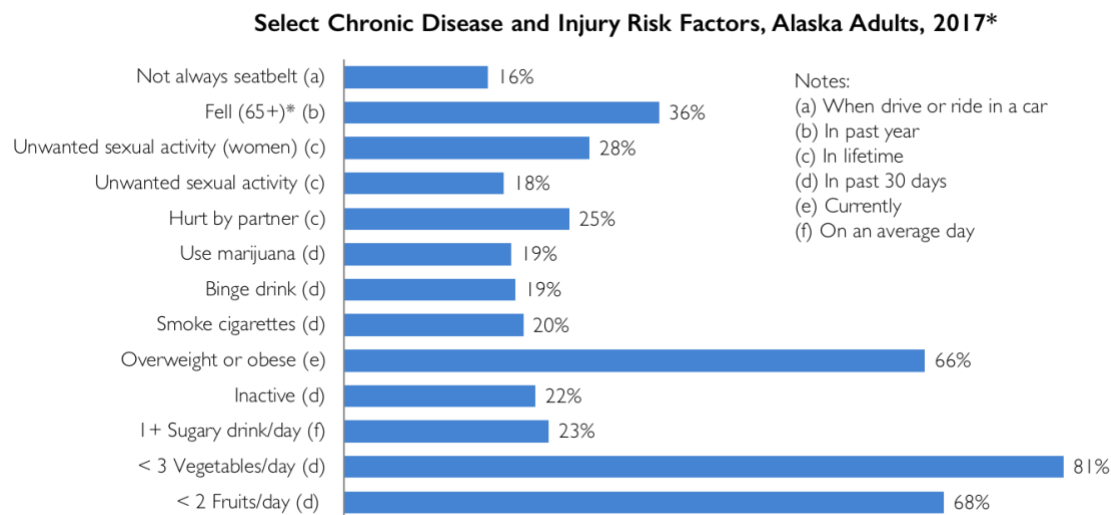
Self-reported data from the Behavioral Risk Factor Surveillance System (BRFSS) can be used to assess quality of life and level of disability experienced by Alaska adults. More than one in 10 Alaskan adults report being in poor mental health during about half of the prior month; a similar percentage report being in poor physical health for that many days.

Quality of Life Indicators (past 30 days) Alaska Adults, 2017			Source: Alaska Division of Public Health, Behavioral Risk Factor Surveillance System
16%	12%	8%	
14+ days not good mental health	14+ days not good physical health	Activity is limited due to health problems	

Contributing Factors to Alaska's Health Challenges

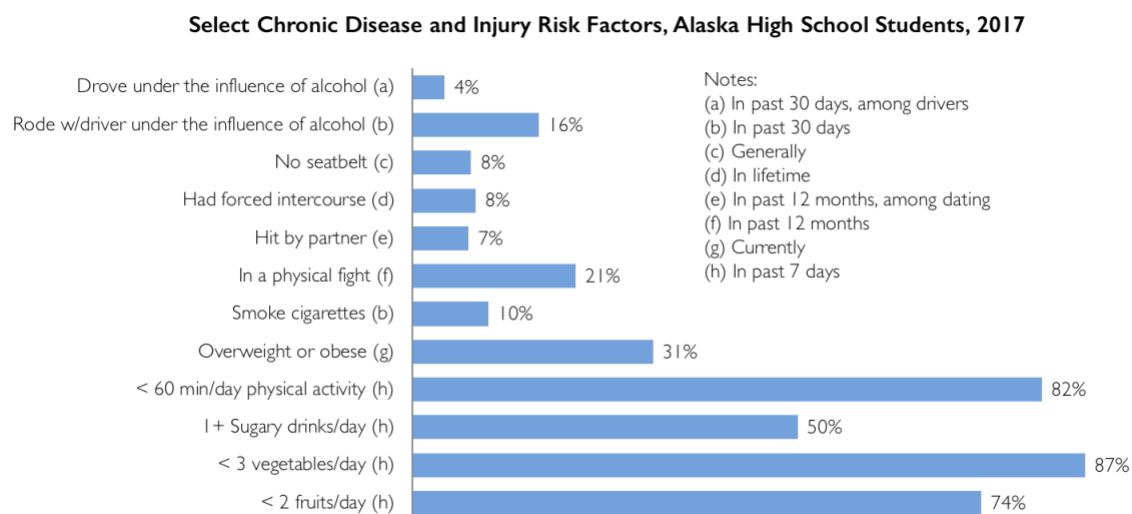
Risk Factors

Many behaviors and experiences put individuals at risk for negative health outcomes and associated personal and financial costs. The following graph shows the prevalence of selected risk factors for chronic disease and injury among adults in Alaska.



Source: Alaska Division of Public Health, Behavioral Risk Factor Surveillance System *Except 2016, where noted

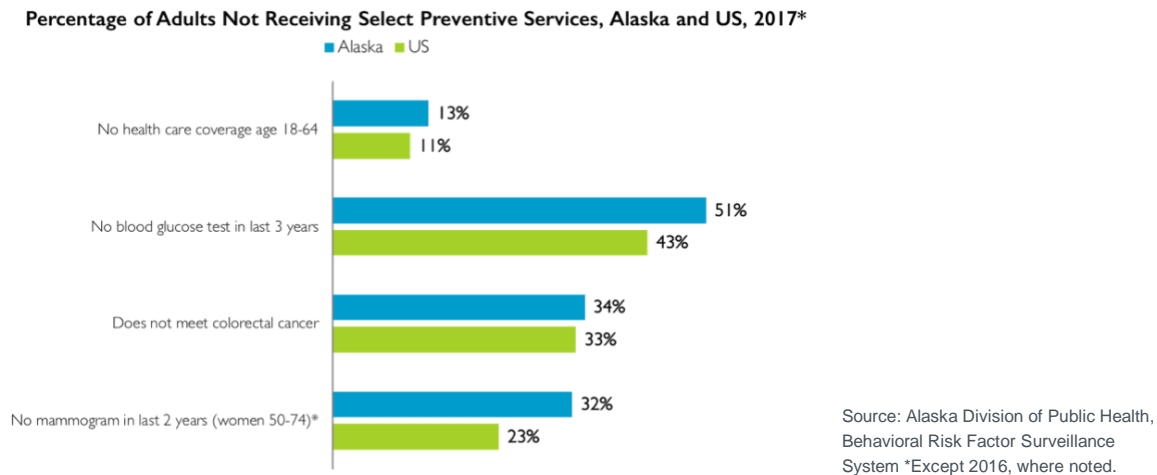
Alaska youth are also engaging in behaviors that put them at risk for negative health outcomes. The following graph shows the prevalence of selected risk factors for chronic disease and injury among high school students in Alaska.



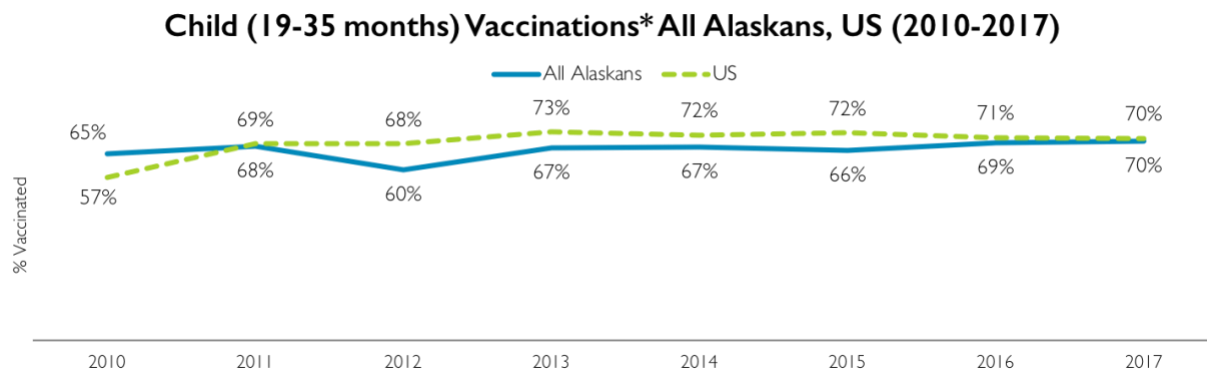
Source: Alaska Division of Public Health, Youth Risk Behavior Survey

Access to Health Care and Preventive Services

Routinely collected Alaska data was also examined to give an indication of the status of access to health care and preventive services, such as screenings for certain diseases and preventative health exams. The following graph shows the percentage of Alaska and U.S. adults who have not received selected age- and sex-specific preventive services.

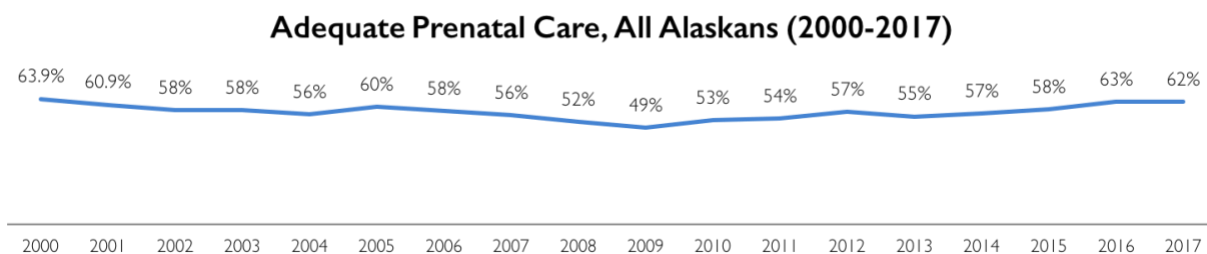


Data from the National Immunization Survey indicate that Alaska's vaccine coverage rate for children 19 to 35 months is low compared to other states. The following graph shows the trend in Alaska and U.S. rates of children being vaccinated with the recommended childhood immunization schedule.



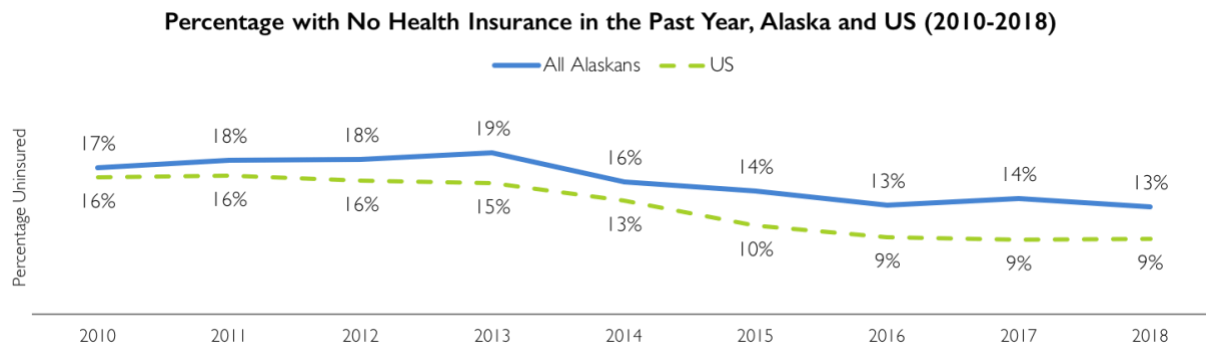
Source: Centers for Disease Control and Prevention, National Immunization Survey *4:3:1:3:3 series of DTaP, polio, MMR, Hib, Hep B

The percentage of live births born to women who received adequate prenatal care (as defined by an Adequacy of Prenatal Care Utilization Index of 80 or greater) has declined by 23% from 2000 to 2009, but has been steadily rising to levels similar to what was seen in 2000.



Source: Alaska Division of Public Health, Vital Statistics, Natality

The percentage of Alaskans without health insurance coverage increased slightly from 2010 to 2013. In 2014, uninsurance began to decrease, following the pattern seen in the U.S. overall. By 2017, the Alaska rate of uninsurance had decreased by almost 27% since 2010, but was 43% higher than the national rate.



Source: US Census Bureau, Current Population Survey Note: Year of data collected reflects health insurance coverage in the previous year.

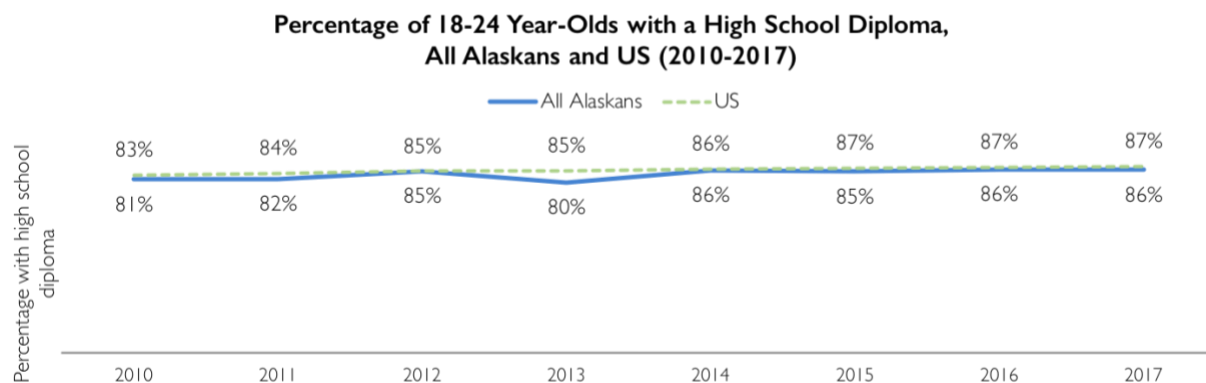
Social Determinants of Health

Health is determined by a complex set of interdependent factors, including individual behavior, biology, genetics and access to health services, as well as the physical and social environment. The combined impact of these factors both drives and is influenced by health outcomes.

Social determinants of health refer to the social, economic, and political resources and structures that influence health outcomes. Specific examples of social determinants include education, employment, physical environment, income and social support assets.

Social Determinant: Education

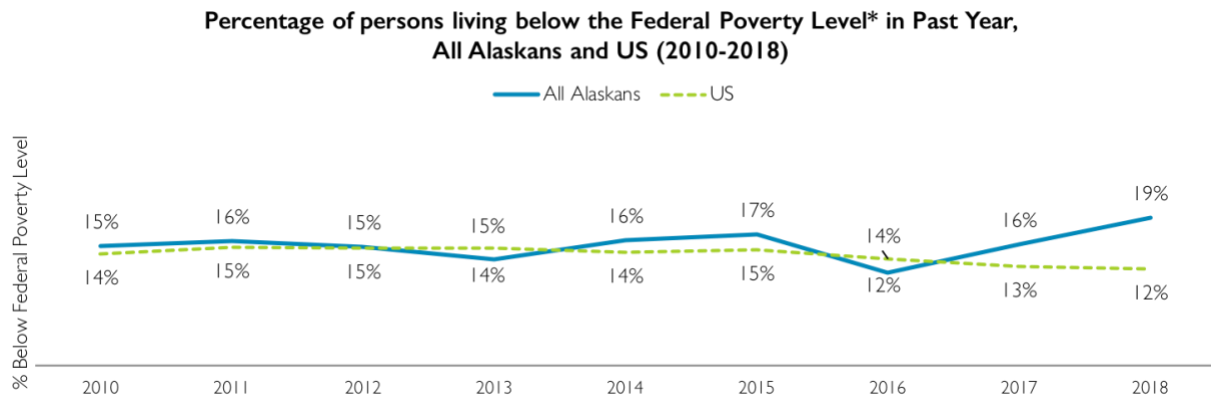
The U.S. Census provides state-level estimates of several of these social determinants. The following figure shows the Alaska and U.S. trends in educational attainment as assessed by the percentage of 18 to 24-year-olds who have obtained a high school diploma. The Alaska rate very closely mirrors the U.S. rate on this indicator.



Source: US Census Bureau, American Community Survey

Social Determinant: Poverty

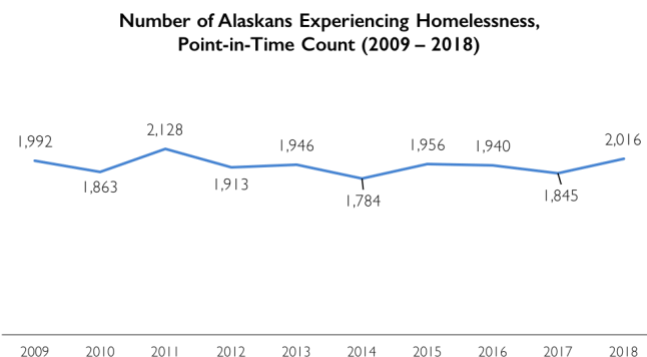
Poverty, which considers household income level as well as household size, is another critical social determinant of health. Due to the higher cost of living in Alaska compared to the U.S. overall, poverty status for Alaska is defined as 125% of the federal poverty threshold. The Alaska rate shows more variability than the U.S. rate over the past eight years; however, in 2012, the percentages of Alaskans and U.S. residents who met this definition of being in poverty were similar.



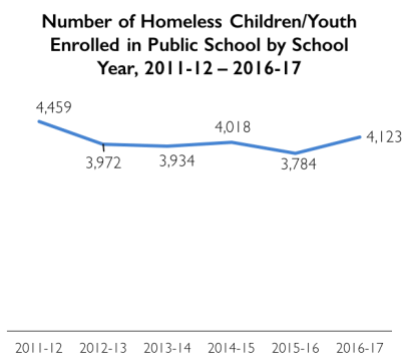
Source: US Census, CPS; *below 125% of FPL for Alaska (below 100% of FPL for US)

Social Determinant: Housing

Homelessness continues to be a significant public health problem throughout Alaska. Point-in-time (PIT) Counts reported to the U.S. Department of Housing and Urban Development (HUD) indicate that there has been little change in the number of homeless Alaskans since 2009. The PIT count is a count of sheltered and unsheltered homeless persons on a single night in January. The Alaska Department of Education reports on homeless students enrolled in Alaska public schools according to the criteria of the McKinney Vento Act, which labels children homeless if they do not have fixed, regular and adequate nighttime residence. Children and youth who share the housing of others, live in hotels, shelters, public spaces, abandoned buildings, or who regularly couch surf meet their definition for homelessness. Like the PIT count, Alaska Department of Education estimates of homelessness have remain fairly consistent during the last decade.



Source: Institute for Community Alliances Development

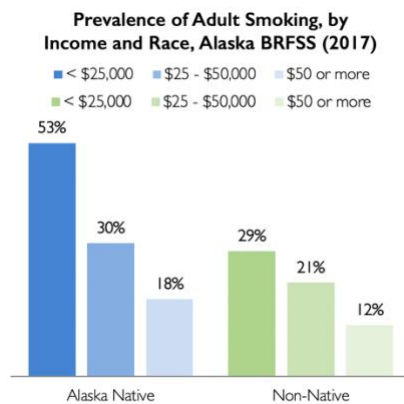


Source: Alaska Department of Education & Early

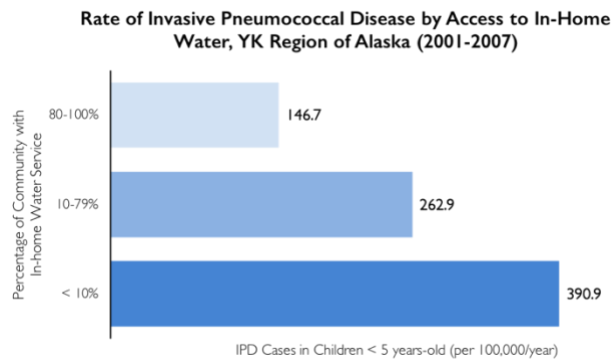
Social Determinant: Physical Environment

The following figures are just two examples of the link between social determinants and health outcomes in Alaska. Both household income level and race are associated with smoking prevalence. Smoking prevalence decreases with rising income levels in both Alaska Natives and non-Natives; however, at every income level Alaska Native adults smoke at a higher rate compared to non-Natives.

The following figure depicts the relationship between rates of invasive pneumococcal disease (IPD) in children under 5 (in the Yukon-Kuskokwim region of Alaska) and access to in-home water service. High IPD rates in Alaska are associated with lack of in-home piped water (controlling for household crowding and per capita income).

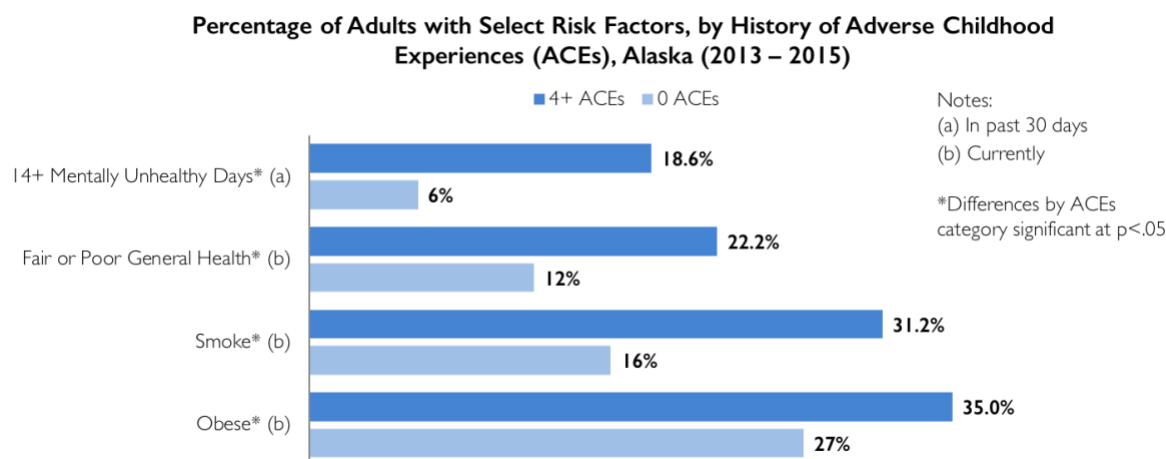


Source: Alaska Division of Public Health, Behavioral Risk Factor Surveillance System



Source: Wenger, Zulz, Bruden et al. (2010). Invasive Pneumococcal Disease in Alaskan Children: Impact of the Seven-Valent Pneumococcal Conjugate Vaccine and the Role of Water Supply. *Pediatric Infectious Disease Journal*. 29(3) p: 251-256.

Social Determinant: Adverse Childhood Experiences



Source: Behavioral Risk Factor Surveillance System

Adverse Childhood Experiences, or ACEs, are a set of traumatic childhood experiences, such as maltreatment and neglect, that have been found to be risk factors for the leading causes of poor quality of life, illness and death. The higher the number of ACEs, the more likely a person will experience one or more of a wide variety of poor health consequences.¹⁸ In Alaska, 20% of adults report having experienced four or more ACEs before they were 18 years of age.¹⁹ The following figure shows that, compared to those with no ACEs, Alaska adults with four or more ACEs are more likely to smoke, be obese and generally have poorer mental or physical health.

Because the social determinants of health impact individual skills and behaviors, social participation, lifestyle, knowledge and overall health status, they have a major role in creating—or mitigating—inequities in health across population subgroups.

Inequities in the Health of Alaskans

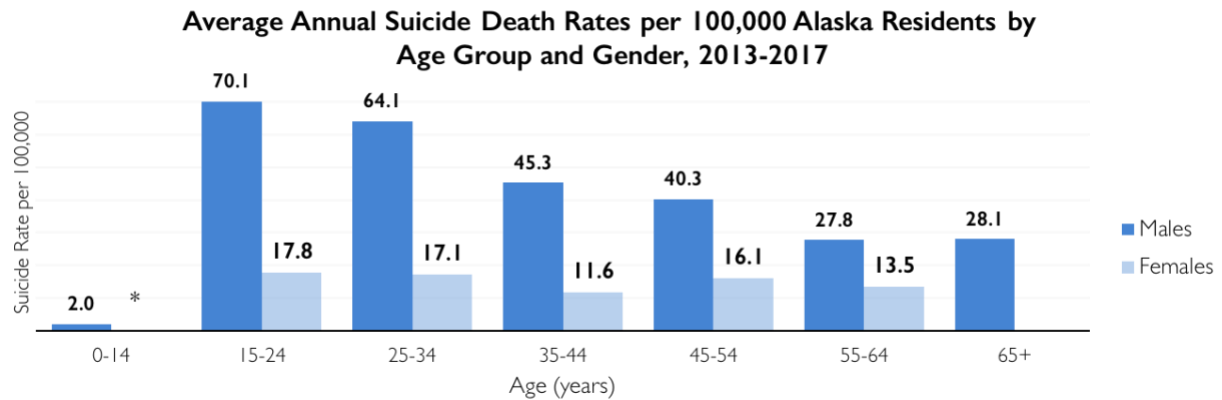
Various Alaska populations suffer from disparities in health caused by systematic and avoidable social and economic circumstances that create barriers for achieving full health potential and lead to poor health outcomes. According to the National Institute of Health, “Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.”²⁰ In Alaska, these disparities exist among populations of different racial or ethnic backgrounds, education, income, geographic location and gender, among others. Health equity and the elimination of health disparities are part of the overarching goals of the CDC Healthy People 2030 initiative. In addition, one of the objective selection criteria for HA2030 is that, “Objectives should address healthy equity and differences in health status and services across different population sub-groups, including racial, socioeconomic, age, gender, disability status, and geographic groups.”

¹⁸ U.S. Centers for Disease Control and Prevention (CDC, 2019). Adverse Childhood Experiences (ACE) Study. Accessed November 21, 2018, <http://www.cdc.gov/violenceprevention/acestudy/index.html>

¹⁹ Alaska Department of Health and Social Services (2017). Informed Alaskans. Accessed July 8, 2019. <http://ibis.dhss.alaska.gov/indicator/view/xace4cnt.HA.html>

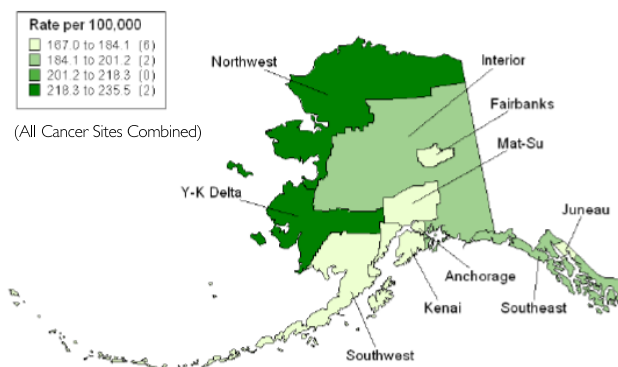
²⁰ National Institutes of Health. Addressing health disparities: The NIH program of action. 2000. Accessed July 8, 2019. <http://healthdisparities.nih.gov/whatare.html>

Health inequities are seen across all types of indicators previously discussed, including mortality, morbidity and risk factors. Although American Indian/Alaska Native people (AI/AN) and non-Native people in Alaska share most leading causes of death, AI/AN mortality rates are significantly higher for many leading causes including cancer, heart disease, unintentional injury, homicide and suicide.²¹ Mortality rates also differ by age groups and gender, such as suicide mortality rates, with Alaskan males aged 15-24 years suffering disproportionately from the highest rates.



Source: Alaska Division of Public Health, Vital Statistics, Mortality *Less than 3 deaths, no rates calculated

**Age-Adjusted Cancer Mortality Rates per 100,000
Alaska Resident by Behavioral Health Systems Region, 2005-2014**



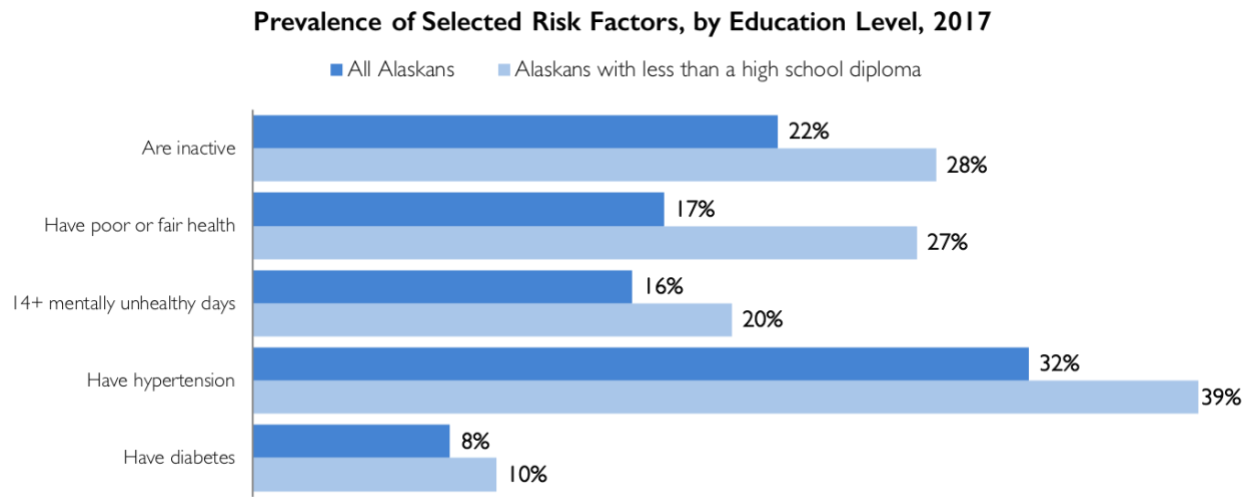
Source: Alaska Division of Public Health, Alaska Cancer Registry

Regional disparities also exist, with some regions experiencing significantly higher mortality rates and/or morbidity rates for certain conditions. For example, cancer mortality rates are generally highest in the Northwest and Y-K Delta behavioral health regions in Alaska.

²¹ Alaska Native Epidemiology Center (2014). Statewide Data: Leading Causes of Death. Accessed July 8, 2019. http://www.anthctoday.org/epicenter/assets/data/statewide/leading_causes_of_death_statewide_12_31_13.pdf.

In addition to experiencing higher cancer mortality rates, AI/AN people also have the highest incidence rates of colorectal cancer of any group in Alaska and the United States. Although AI/AN diabetes prevalence rates have historically been lower than the rates for U.S. Whites, rates have increased significantly over the past twenty years, along with the prevalence of overweight and obesity among AI/AN people.^{22,23} American Indian/Alaska Native people have higher prevalence rates of certain risk behaviors when compared to the non-Native population in Alaska, including adolescent and adult smoking²⁴ and adult binge drinking (Alaska Department of Health and Social Services, n.d.b.).²⁵ The Alaska Native prevalence of smoking is higher than for non-Natives at all income levels.

There are also disparities in the prevalence of risk factors and disease morbidity among other Alaska populations. For example, selected risk factor prevalence is higher for people with less than a high school education compared to the total Alaska population. Alaskans who have not completed high school report higher rates of physical inactivity, poor or fair self-rated health status, and have higher prevalence of frequent mental distress, hypertension and diabetes. Differences in risk factors and disease morbidity also exist for certain age groups, geographic areas, disability status and income groups, often related to the social determinants of health. In 2017, Alaska adults living under 125% of federal poverty guidelines were more than twice as likely to be smokers as those living above the threshold.²⁶



Source: Alaska Division of Public Health, Behavioral Risk Factor Surveillance System

²² Alaska Native Epidemiology Center (2014). Statewide Data: Diabetes. Accessed July 8, 2019.

http://anthctoday.org/epicenter/healthData/factsheets/diabetes_prevalence_statewide_1_5_2017.pdf

²³ Alaska Department of Health and Social Services (n.d.a). Informed Alaskans. Accessed September 25, 2019.

<http://ibis.dhss.alaska.gov/indicator/view/DiabPrev.HA.html>

²⁴ Alaska Department of Health and Social Services (n.d.b). Alaska Tobacco Facts - 2018 Update. Accessed July 8, 2019.

http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/2018_AKTobaccoFacts.pdf

²⁵ Alaska Department of Health and Social Services (n.d.c). Informed Alaskans. Accessed July 8, 2019.

http://ibis.dhss.alaska.gov/indicator/complete_profile/AlcConBinDri.html

²⁶ Alaska Department of Health and Social Services (n.d.c). Informed Alaskans. Accessed July 8, 2019.

http://ibis.dhss.alaska.gov/query/result/BREFF23/BREFF_CM/XSMOKER.html

Health Concerns of Alaskans

In assessing the health of Alaskans, it is important to consider the concerns and viewpoints of the population in addition to epidemiological data. While health data and statistics can tell us what health outcomes or risk factors may be of concern from a population view, these may differ from the concerns at a local community or individual level. With that in mind, public input was solicited from Alaskans through both an online survey and a series of listening sessions and interviews across Alaska to understand what health issues are of the greatest concern to Alaskans.

The online survey provided an opportunity for members of the general public to participate in HA2030 and inform the Advisory Team in selecting LHIs. It asked Alaskans about health priorities in their own lives and in their communities, asking about priorities within each of the following five domains of health-related topics: health behaviors, clinical and preventive access to care, social and economic factors, the physical environment, and health outcomes. A total of 1,688 Alaskans from across the state completed the survey, which was open from October 2018 through February 2019. Survey respondents were able to rate each health topic independently on a 5-point scale indicating they were ‘not at all concerned’ to ‘extremely concerned’ about each one, but were also able to rank health priorities within each of the five large domains.

Considering rankings within each of the five domains, the health topics of highest concern to respondents were:

- Health Behaviors: Substance use (other than alcohol), followed closely by violence
- Clinical and Preventive Access to Care: Inability to pay for health care
- Social and Economic Factors: Community safety (including violent crime and homicide rates, homelessness, and ACEs), followed closely by affordability of housing
- Physical Environment: Health-promoting environments (including having safe places to walk/bike; physical activity opportunities; and access to healthy food, clean water and wastewater services, and)
- Health Outcomes: Quality of life and well-being (including mental health/depression, suicide and substance-related death)

Regardless of domain, specific topics that 75% or more of respondents identified as very or extremely concerning included: substance use other than alcohol, violence, the cost of healthcare, and alcohol use.

To supplement the online survey results, outreach was conducted in rural areas and with underrepresented populations through additional qualitative methods such as community listening sessions, interviews and a brief questionnaire completed by respondents at local conferences attended by rural residents. These additional data provided some insights from those that were underrepresented in the online survey.

Community listening sessions were conducted by public health nurses in several rural areas including Northway, Tok, Dot Lake, Seldovia and Petersburg. In addition, a group of Community Health Aides representing rural communities across the state participated in a listening session. This group included participants from rural clinics operated by Bristol Bay Health Corporation, Yukon-Kuskokwim Health Corporation, North Slope Borough Health Department, Norton Sound Health Corporation, Maniilaq Association, Copper River Native Association, Kodiak Area Native Association, Chugachmiut and the McGrath Regional Health Center. The data from these sessions suggest that the most important health concerns are in the healthy behaviors category with diet and exercise as the most common specific concern. The listening session data also indicated that mental health was the greatest community health challenge. Services in the areas of suicide prevention, substance abuse and misuse prevention and treatment were noted as a great need. Quality of clinical care and addressing diet and exercise were the most common responses when participants were asked in what health areas their communities were doing well.

Short, open-ended surveys were used to collect information from three other groups 1) the elderly/seniors, 2) people experiencing homelessness and food insecurity, and 3) attendees at public health and environmental conferences and events. A common theme across each population was the identification of drug and alcohol misuse and abuse, mental/behavioral health concerns, suicide and cancer as key health priorities. Affordability of and access to health care and treatment were also significant concerns among seniors. Conference attendees noted tobacco, domestic violence, and sexual assault as significant challenges, as did respondents engaged at homeless shelters and soup kitchens. Local environmental issues, healthy eating and nutrition, and homelessness were also frequently cited as priorities by respondents in all three short survey groups.

The Healthy Alaskans Advisory Team will use these qualitative data at various stages in the recommendation making process to inform their selection of the Healthy Alaskans 2030 leading health indicators.

Alaska's Public Health System Assessment: Community Capacity Review

State Assets, Resources, and Limitations

The Alaska Department of Health and Social Services (DHSS) and the Alaska Native Tribal Health Consortium (ANTHC) convened 59 people from across Alaska to participate in this public health assessment. The Community Capacity Review, a convening of public health system partners, was conducted using the National Public Health Performance Standards State Assessment Instrument in March 2019. Representatives from multiple sectors and geographic regions of Alaska were brought together to engage in a structured dialogue to evaluate the strengths and identify the gaps of Alaska's public health system. The results of the state public health system assessment illustrate the assets, resources, and limitations that exist in Alaska to address health issues. The assessment focused on answering the following questions:

- What are the components, activities, competencies and capacities of our statewide public health system?
- How are the Ten Essential Services (ES) of Public Health provided throughout Alaska?

The National Public Health Performance Standards (NPHPS) State Assessment instrument was used to evaluate the state's current performance against a set of optimal standards within four broad areas, called Model Standards. The standards, when applied across the Ten Essential Services, assured that the full scope of public health action was evaluated. Participants considered the activities of all public health system partners, thus addressing the activities of the full range public, private and voluntary entities that contribute to public health in Alaska.

The aggregate scores for the Essential Services, expressed on a scale of 0-100%, where 0% means no activity and 100% means optimal level of activity, were:

Essential Services	scale
ES 1: Monitor health status to identify and solve community health problems	67%
ES 2: Diagnose and investigate health problems and health hazards in the community	73%
ES 3: Inform, educate, and empower people about health issues	47%
ES 4: Mobilize community partnerships to identify and solve health problems	48%
ES 5: Develop policies and plans that support individual and community health efforts	60%
ES 6: Enforce laws and regulations that protect health and ensure safety	49%
ES 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable	42%
ES 8: Assure a competent public and personal health care workforce	46%
ES 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services	30%
ES 10: Research for new insights and innovative solutions to health problems	44%

The aggregate scores across the Ten Essential Services of Public Healthy Model Standards were:

Ten Essential Services of the Public Healthy Model Standards	scale
Planning and Implementation	54%
State-Local Relationships	53%
Performance Management and Quality Improvement	40%
Capacity and Resources	54%

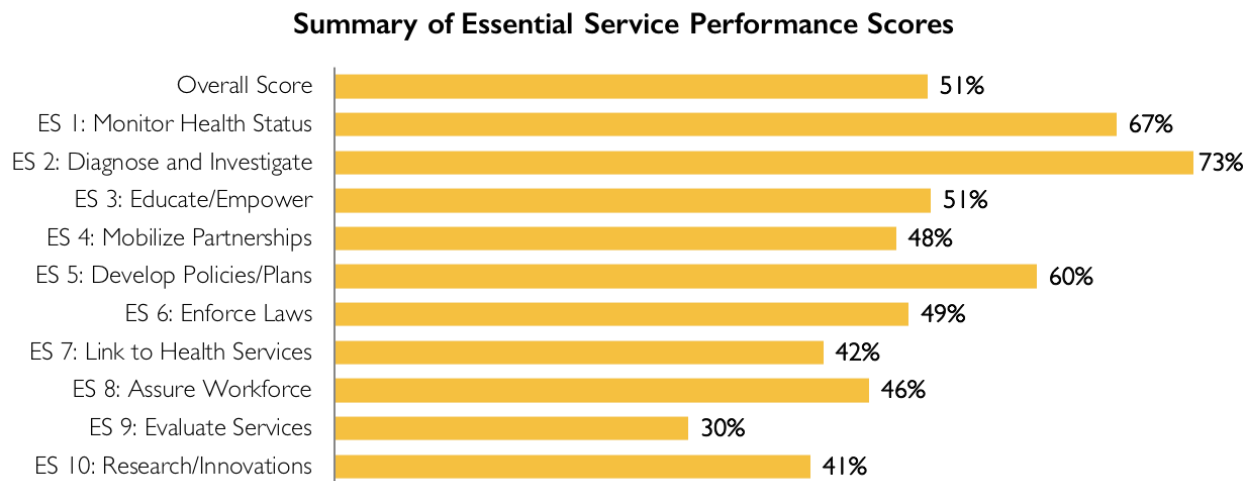
Recurrent themes that arose during the assessment include the following:

- **Collaboration:** There is a need to build on strong collaborations among public health system partners by broadening participation to include more nontraditional partners to help address the social determinants of health.
- **Communication:** Alaska needs creative solutions to improve data sharing, share training and expertise, and develop a centralized location where information regarding existing coalitions are listed to help reduce duplicative efforts and to develop a more unified approach among groups for greater collective impact.
- **Quality improvement:** Performance Management and Quality Improvement was the lowest rated Model Standard across all of the Essential Services. We need to continue to increase our capacity in this area.
- **Data:** Alaska has many good data systems and a high level of expertise to carryout health status monitoring activities. However, accessibility, sharing and utilization of data needs improvement.
- **Workforce recruitment and retention:** Alaska's public health workforce is challenged by the lack of capacity of the current workforce to adequately perform the existing workload, the challenges of recruiting and retaining of professional expertise in smaller communities, and an overall aging workforce.
- **Financial needs:** Resources for public health are decreasing, and much of the existing funding is for specific purposes, impacting the ability to work across the spectrum of system support.

Based upon the workgroup responses provided via voting during the assessment, an average score is calculated for each of the Essential Services. The scores can be interpreted as the overall degree to which Alaska's public health system meets the optimal performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

The graph on the next page summarizes all of the Essential Service performance scores. Alaska's performance scores for each Essential Service fall in the middle to high ranges, with the exception of one. There were four Essential Services that were scored as Significant (51% to 75%); ES 2: Diagnose and Investigate scored the highest at 73%, followed by ES 1: Monitor Health Status at 67%. The remaining Essential Services of Alaska's public health system fell in the Moderate range (26% to 50%). None of the Essential Services were rated as No Activity, Minimal or Optimal.

Summary of Essential Service Performance Scores



In addition to the overall rating, voting scores are averaged across the four Model Standards for all of the Essential Services, as shown in the graph on the next page. The overall scores for the four Model Standards fell mostly within the range of Significant across the 10 Essential Services. Alaska scored high for Planning and Implementation (54%), Capacity and Resources (54%), and State-Local Relationships (53%), all Significant ratings. The lowest score (40%) was for Performance Management and Quality Improvement, within the Moderate range.



While none of the overall scores by Essential Service or Model Standard fell below Moderate, several Essential Services had performance scores for some Model Standards in the Minimal range of 25% or less. Four of these scores were for Performance Management and Quality Improvement; one was for Planning and Implementation, and one was for Capacity and Resources.

Essential Service	Model Standards			
	Planning and Implementation	State-Local Relationships	Performance Management and Quality Improvement	Resources and Capacity
1. Monitor	Significant	Moderate	Significant	Significant
2. Diagnose and investigate	Significant	Significant	Significant	Significant
3. Inform, educate, and empower	Moderate	Moderate	Moderate	Moderate
4. Mobilize partnerships	Significant	Moderate	Moderate	Moderate
5. Develop policies & plans	Significant	Moderate	Moderate	Moderate
6. Enforce laws	Moderate	Significant	Significant	Moderate
7. Link to health care services	Minimal	Significant	Minimal	Moderate
8. Assure a competent workforce	Moderate	Moderate	Minimal	Moderate
9. Evaluate	Moderate	Moderate	Minimal	Moderate
10. Research	Moderate	Moderate	Minimal	Minimal

The results of this assessment will be used to:

- Enhance our understanding of Alaska’s unique public health system.
- Provide opportunities to work collaboratively to develop improvement strategies for the state health improvement plan, Healthy Alaskans 2030.
- Provide guidance to key stakeholders and policy makers to strengthen state, regional and local public health systems for a more integrated, effective system.
- Identify gaps in the public health system that can be advanced through quality improvement with key partners.
- Establish a common baseline for all partners within Alaska’s public health system to measure improvement.

Looking Back: Learning from Healthy Alaskans 2020

Healthy Alaskans 2020 is a framework of 25 health priorities created using the collective impact model and directs the structure and process of Alaska’s state health improvement plan. The collective impact model can be used to solve complex health or social problems, where scaling up smaller efforts have not been effective. It involves partners from various sectors establishing a shared understanding of an issue and developing agreed-upon strategies to address it. It requires a shift from individual, independent efforts to structured collaborative efforts to reach system outcomes. The alignment of partners around a common health goal capitalizes on the sharing of resources, ideas, and data.

The collective impact model was adopted early in HA2020s planning stages and has played a role in the development of the HA2020 framework. The collective impact model for social change brings organizations with shared goals together, in a structured way, to achieve social change. The founders of this model assert that five conditions must exist for a partnership to obtain collective success. Those conditions are:

- A common agenda with strong leadership support—steering committee/legislature, community stakeholders, together with the planning team;
- A shared measurement system that embraces a framework and focuses on data, defines and tracks success and provides ongoing learning;
- Implementation of mutually reinforcing activities such as assessing community readiness to determine if partners are willing to support one other as they undertake the activities and if they have the resources to implement successfully;
- Continuous communication for the purpose of developing trust; and
- A backbone support organization that plans, coordinates, and manages the partnership by guiding the vision and strategy of the partnership. Additionally, the backbone support organization manages communication, the collecting, and reporting of data, provides administrative support, advances policy and mobilizes resources.

In the transitional year from HA2020 to HA2030, it was necessary to conduct an evaluation of this process and structure of HA2020 to gather lessons learned that may be applied when developing HA2030. A retrospective formative evaluation was conducted between December 2018 and May 2019 to identify the strengths and areas for improvement in the structure and process, or the infrastructure of HA2020, using data collected through key informant interviews and participant surveys.

Evaluation results

In relation to the five necessary conditions of a successful collective impact model partnership previously cited, the HA2020 evaluation found the following:

Collective Impact Required Condition: Common Agenda

Strengths

- The State DHSS and ANTHC strong partnership - The partnership between DHSS and ANTHC was identified as HA2020s greatest strength by all participants and is one of the characteristics of Alaska's state health improvement plan that is unique from all others across the nation. The evaluation recommended that this partnership continue;
- HA2020 has clear goals and the focus on the 25 health priorities is clear;
- Flow of information from the Core to the Advisory Team works well;
- The Advisory Team and key HA2020 partners are confident in their roles within the HA2020 effort.

Areas for improvement

- Maintaining staff in key positions from both backbone entities; DHSS and ANTHC;
- There are limited actionable items for implementation across Alaska;
- Lack of funding for HA2020 implementation efforts and programmatic action items, aside from funds for coordinating staff.

Collective Impact Required Condition: Shared measurement

Strengths

- Annually updated scorecards of all 25 leading health indicators makes it easy for agencies to use the HA2020 data and align with HA2020 goals;
- Evidence based strategies and actions plan exist for each LHI.

Areas for improvement

- There is a need for a more interactive scorecard online;
- Need more culturally appropriate strategies and actions.

Collective Impact Required Condition: Mutually Reinforcing Activities

Strengths

- Evidence based strategies and actions plan exist for each LHI;
- The structure of HA2020 allows for a strong team.

Areas for improvement

- The HA2020 website needs revisions to include a HA2020 event calendar and a method for sharing stories from across the state to feature the work of Alaskans organizations, communities and partners and bring life to the HA2020 effort.

Collective Impact Required Condition: Continuous Communication

Strengths

- Strong internal communication.

Areas for improvement

- Weak external communication;
- Communication with key decision makers needs to be strengthened.

Collective Impact Required Condition: Backbone Support

Strengths

- Annually updated scorecards are useful to use and to show the progress of HA2020.

Areas for improvement

- Funding is needed for implementation projects around the leading health indicators;
- Evaluation needs to be integrated into the HA2020 effort.

Overall, the key informants and survey respondents agreed and remarked that the guiding principles of HA2020 are still relevant and the framework is strong. More effort is needed in the areas of communication and outreach, as well as presenting leading health indicator data online in an interactive manner by which viewers can tease out certain pieces of specific data relevant to a region or community, or be able to see data trends more easily. Many respondents commented that since HA2020 has a sound structure, process and key stakeholders actively involved, it is time to move into more of an implementation phase, whereby the backbone entities; DHSS and ANTHC, facilitate funded and structured pilot projects to implement evidence-based strategies and actions focused on a particular leading health indicator in order to contribute to positive movement toward the established target for that health priority. These key results and recommendations of the HA2020 evaluation conducted in 2018-2019 may be utilized and applied to the development of HA2030, the next iteration of the state health improvement plan.

Moving Forward: Healthy Alaskans 2030

A guiding principle of Healthy Alaskans has been to use the highest quality data available in every step of planning and implementation. This has been evidenced in a number of ways throughout the process, from organizational structures and processes to the selection of potential LHIs.

In the spirit of evidenced based public health, the process of selecting the Healthy Alaskans 2030 leading health indicators will be based on data driven recommendations by several Leading Health Indicator Development Teams. These teams will be composed of a diverse range of data and content subject matter experts, as well as recommendations offered by the Advisory Team after careful and thorough review of the aforementioned recommendations and the full set of data sources summarized in this report. Once LHIs are selected, targets for each LHI will be established with the goal to reach them by 2030. Recommendations for each target will be given by topic-specific teams comprised of content experts from DHSS, ANTHC and partner agencies. Each team will review the following for each LHI:

- Progress toward the HA2020 target (if the LHI was part of HA2020);
- Targets set for the same or similar indicators in other initiatives, grants, or statewide plans; and,
- Baseline data and trends over the last decade.

The teams of content experts will use the materials provided, combined with their own knowledge and experience in the topical areas, to develop recommendations for targets that strike a balance between being achievable and aspirational. The targets will be presented to the Advisory Team and will be approved and adopted by the HA2030 Steering Team.

Once LHI targets are established, another set of workgroups composed of program and intervention experts will convene to develop evidence-based strategies and actions that will be summarized in a document as guidance to organizations and communities on how they can contribute to achieving the Healthy Alaskans 2030 targets and goals.

Plans for Healthy Alaskans 2030 Implementation

Tracking Leading Health Indicators

The Healthy Alaskans Core Team made an early strategic decision to limit the number of health priorities to a manageable number for HA2020. This decision was based on lessons learned through Healthy Alaskans 2010, which, though incredibly valuable, selected such a large number of indicators (400+) that efforts to monitor indicators and focus efforts on strategies to meet objectives were limited. By focusing on a smaller set of leading health indicators in HA2020, those barriers were removed. The LHIs for HA2030 will also be limited with the intention to increase the likelihood that established targets are achieved by 2030.

The LHIs will be tracked on Alaska's Indicator-Based Information Systems for Public Health, or IBIS-PH. This web-based data tool will be refreshed regularly (annually, for most indicators) with updated data and information, including a short description of the public health importance of the LHI, definitions and notes, and a graph showing 10-year trends for Alaska and U.S., and the HA2030 target. The web-based system will allow public access (77% of Alaskans live in a household with internet use) to updated information for each LHI at any time. These data will also be summarized and posted in a scorecard format annually, with baseline, target, current values, and a colored icon indicating the extent to which progress is on track to meet the target for the LHIs.

Summary

The success of HA2030 is dependent upon many strategic decisions, including those related to the design of the organizational structure, creation and support of partnerships, and compilation and presentation of the best available data on health status, health factors, and health priorities. This document is intended to provide a clear snapshot of the health status of Alaskans and perceptions about health that are important to addressing health issues for all Alaskans.

The State of Alaska, Department of Health and Social Services, and the Alaska Native Tribal Health Consortium plan to continue in equal partnership to lead the new iteration of the state health improvement plan, Healthy Alaskans 2030 (HA2030). Through a comprehensive and inclusive process, we will encourage individuals, communities and organizations to implement strategies and actions to help move the needle on the HA2030 indicators and targets for the next decade to improve the health of all Alaskans, working toward the vision of Healthy Alaskans in Healthy Communities. HA2030 framework will continue to support the work of partners and stakeholders statewide who actively engaged in improving the health of Alaskans.

Appendix A: Healthy Alaskans 2030 Advisory Team (CY2019)

Name	Organization
Adam Rutherford	Dept. Corrections
Brenda Moore-Byers	Christian Health Associates
Darcy Harris	Anchorage Health Department, Environmental Services
Gloria Burnett	UAA Alaska Center for Rural Health - AHEC
Melinda Freemon	Anchorage Project Access- Medical & Dental Partnership
Deb Lowenthal	Alaska State Hospital and Nursing Home Association
Jeannie Monk	Alaska State Hospital and Nursing Home Association
Jennifer Baker	Youth Alliance for a Healthier Alaska (YAHA)
Kirsten Kolb	Alaska Native Tribal Health Consortium
Natasha Pineda	Anchorage Health Department
Michael Baldwin	Alaska Mental Health Trust Authority
Eliza Muse	DHSS, Office of Substance Misuse and Addiction Prevention
Mischa Chernick	PeaceHealth Ketchikan Medical Center
Panu Lucier	Thread: SEED
Sue Brogan	United Way
Tara Ferguson-Gould	Alaska Primary Care Association
Thomas Hennessey	Community member at large
Trevor Storrs	Alaska Children's Trust
Emily Nenon	American Cancer Society
Abby Struffert	American Cancer Society
Marcia Howell	Safe Alaskans
Kaerin Stephens	State of Alaska, Division of Public Health, Section of WCFH, Epidemiology
Malyn Smith	Job Corps
Carolyn Craig	Director of Community Health Aide Programs (CHAP)
Christine Golnick, MD	Medical Director (CHAP Alternate)
Michelle Hensel, MD	Medical Director (CHAP Alternate)
Megan Wilts	Care Coordinator Network
Crystal Meade	ANTHC Tobacco Program
Tiffany Hall	Recover Alaska/AK Wellness Coalition
Jess Limbird	Recover Alaska/AK Wellness Coalition
Karol Fink	DPH, Section of Chronic Disease Prevention
Sandra Heffern	Blueprint/AK Healthcare Transformation Project - coalition
Art Nash	UAF, School of Natural Resources, Cooperative Extension
DeShana York	UAF, School of Natural Resources, Cooperative Extension
Tim Struna	DPH, Section of Public Health Nursing
Ann Raucsh	Council on Domestic Violence and Sexual Assault, AK Dept of Public Safety
Lisa Aquino	Catholic Social Services
Joe Sarcone	Agency for Toxic Substances and Disease Registry
Sarana Schell	AARP Alaska
Allison Natcher	DHSS, SRCHS, Health Emergency Response Operations
Patrick Anderson	RurAL CAP
Dr. Joseph Klejka	Yukon-Kuskokwim Health Corporation
Eric Reimers	Alaska Native Health Board, Policy Coordinator
Marie Stewman	Southcentral Foundation
Mack Wood	DPH, Women's, Children's and Family Health
Farrah Greene	Community member at large
Sen.David Wilson	State of Alaska Legislature
Kendalin Farthing	Veterans Affairs/AK Air National Guard