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Making a Community Health Needs Assessment Participatory: A Case Study from an Alaska Native Health Care Organization

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Abstract

Community health needs assessments (CHNAs) often lack sufficient community member participation. This lack of participation contributes to a continuation of unmet needs and systematic inequities. Southcentral Foundation (SCF) is an Alaska Native-owned, nonprofit healthcare organization serving 70,000 Alaska Native and American Indian (AN/AI) people living in and around Anchorage and 55 rural villages. Results of a 1993 CHNA shaped the organizational mission, vision, organizational principles, objectives, and initiatives as SCF assumed care from the Indian Health Service. We describe methods used by SCF to maximize participation of diverse community members in a second large-scale CHNA in 2018, how results align with existing organizational values and priorities, and how results were disseminated. We discuss the benefits of periodic CHNAs and ongoing community engagement.

INTRODUCTION

Community Health Needs Assessments

As part of the Patient Protection and Affordable Care Act of 2010, non-profit hospitals are required to conduct a community health needs assessment (CHNA) every three years and to address the health needs that emerge. As hospitals across the country implement this requirement, certain challenges have emerged. A common one is substantive community member engagement. While Internal Revenue Service regulations require engagement of medically underserved, low-income, and minority populations in the service area (Internal Revenue Service, 2020, Powell et al., 2018), many hospitals engage a limited subset of stakeholders, such as community leaders or professionals in other agencies (Skinner et al., 2018); some hospitals do not solicit any feedback from community members who are patients (Franz et al., 2018). Per a recent mixed-methods study, broader community participation beyond leaders of local organizations occurred in only 28% of CHNAs (Pennel et al., 2017). CHNAs often draw on existing data, mostly about deficits, in lieu of directly engaging community members to identify what they perceive as needs (Kirk et al., 2017). Maximizing participation of diverse community members may be particularly important in the face of concerns raised about unequal treatment and persistent health disparities (Institute of Medicine, 2003).

In contrast to typical methods of health care system needs assessments, we provide an example of a 2018 CHNA conducted by Southcentral Foundation (SCF). Informed by its Indigenous evaluation values, the SCF CHNA was designed to substantively engage community members and to reflect their goals and expertise. Here, we describe the process by which this effort reached out to, engaged, and included the key stakeholders deemed critical to the Nuka System of Care, an award-winning, relationship-based, customer-owned approach to transforming health care, improving outcomes, and reducing costs (Gottlieb et al., 2008; Gottlieb, 2013). SCF uses the term “customer-owner” when referring to individuals who receive SCF services.

Southcentral Foundation History and Evaluation Values

SCF is an Alaska Native-owned, nonprofit healthcare organization serving 70,000 Alaska Native and American Indian (AN/AI) people living in Anchorage, Matanuska-Susitna Valley, and 55 rural villages in Alaska. SCF was established in 1982 under the tribal authority of Cook Inlet Region Inc. to improve the health and social conditions of Alaska Native people in southcentral

Alaska, to enhance culture, and to empower individuals and families to take charge of their lives (Cornell et al., 1998; Gottlieb et al., 2008; Gottlieb, 2013). SCF has long recognized people's expertise regarding their own experiences and the importance of aligning services with local goals and values (Baum et al., 2006; Cornwall & Jewkes, 1995). Needs identified by community member respondents in a major needs assessment conducted in 1993 resulted in changes to improve access and quality and to incorporate Alaska Native values into the mission, vision, operational principles, goals, and objectives (Table 1). These values include the importance of respect, relationships, family life, Alaska Native culture, and holistic health (Gottlieb, 2013; Chatwood et al., 2017). SCF's 2018 CHNA was shaped by evaluation principles that have evolved locally, through ongoing work in SCF's Research, Evaluation, and Improvement Departments, but that have considerable overlap with Indigenous evaluation principles developed in other areas. Briefly, the underlying values are described below.

Self-determination

Indigenous communities suffered when traditional ways of life were disrupted and people were subjected to the rules of outside institutions (e.g., Duran & Duran, 1995; Brave Heart et al., 2011; Warne & Frizzel, 2014). In contrast, self-determination is associated with greater empowerment and self-efficacy and is an important tribal value (LaFrance & Nichols, 2008; Brave Heart et al., 2011; Noe et al., 2007). In SCF's 2018 CHNA, self-determination meant community health needs were determined by survey and focus group respondents, health empowerment was a focus, and local values took priority in assessing the health care system. The 2018 CHNA was organized according to 7 domains driven by community values. The importance of evaluation reflecting local values has emerged in other Indigenous frameworks (e.g., Smith, 1999; LaFrance & Nichols, 2008; LaFrance et al., 2012).

Strengths-based

Many Indigenous communities have experienced deficit-based evaluation, such as establishing needs by highlighting disease rates higher than national averages. Communities have explained these approaches can be stigmatizing and disempowering (e.g., Kawakami et al., 2008). In contrast, strengths-based approaches may focus on resilience, family, community, social connectedness, identity, and values (e.g., Bryant et al., 2021). Additionally, strengths-based approaches often address the structural causes of health disparities (Fogarty et al., 2018). SCF's 2018 CHNA positioned respondents as experts on their own experiences and encouraged broad

discussion that encompassed community values and structural barriers to heath and let them describe their needs without comparisons to benchmarks.

Table 1
Examples of SCF approach to addressing results of 1993 CHNA

Domain	Result	Organizational Values	Actions	Ongoing Monitoring
Acceptability of Services	Disrespect of Alaska Native people and culture, care not culturally competent	Operational Principle: Services and systems build on the strengths of Alaska Native cultures	Mandatory 4-day employee orientation with cultural orientation	Satisfaction survey assesses respect of Alaska Native culture and traditions
Access	Difficulties getting appointments, waiting hours to be seen	Operational Principle: Access is optimized and waiting times are limited	Same-day access to primary care including to integrated behavioral health consultants	Satisfaction survey assesses appointment availability and wait for provider
Perceived Quality	Misdiagnoses and lack of appropriate treatment Unclean, outdated, understaffed, and "primitive" hospital	Corporate Goal: We strive to provide the best services for the Native Community Operational Principle: Outcome and process measures to continuously evaluate and improve	Created Data Services department to produce quality assurance metrics All employees trained in quality improvement techniques	Satisfaction survey assesses cleanliness and provider competence
Respect and Relationships	Disrespectful treatment by staff and providers Retold story every time to a new provider	Mission: To work together with the Native community to achieve wellness through health and related services Operational Principle: Together with the customer-owner as an active partner	Individuals and family empaneled to a primary care team Employees receive customer-service and other training to support positive relationships	Satisfaction survey asks about employee courtesy, provider attention and interest, and provider listening

Actionable

Indigenous communities often feel "overstudied," and for this reason, many Tribes require evaluations be actionable for the community (e.g., Smith, 1999, LaFrance & Nichols, 2008, LaFrance et al., 2012). The goal of SCF evaluation is to improve services and inform health system decisions, and not to study the population receiving the care. The 2018 SCF CHNA measures were therefore designed to be actionable, improvement-focused, and providing options relevant to decision-making.

Holistic

Indigenous communities often approach services holistically (e.g., Kawakami et al., 2008, LaFrance & Nichols, 2008). In the 1993 SCF CHNA, family well-being, as well as relationships with providers, came up as important topics related to individual health. The 2018 SCF CHNA included topics important to community members that fell outside the typical scope of a health system. For example, SCF research and evaluation revealed concerns about transportation and housing, so the 2018 CHNA provided lists of social concerns for prioritization (e.g., Ray et al., 2019).

METHODS

The 2018 SCF CHNA used a sequential mixed methods study design using a community survey, focus groups, and customer-owner satisfaction surveys.

CHNA Team and Community Engagement

The 2018 SCF CHNA was conducted by an 80+ person internal team that included AN/AI employees eligible to receive health care services. This team was comprised of program evaluators, researchers, data analysts, and improvement staff who designed the sampling scheme and instruments and collected and analyzed data. Administrative staff invited community members to participate in surveys and focus groups (Cornwall & Jewkes, 1995). SCF executive leadership reviewed, contributed to, and approved the study design and instruments. External oversight was provided by a highly experienced American Indian researcher and evaluator. As the 2018 CHNA was intended to improve existing services and develop new programs at SCF, it did not require review by an Institutional Review Board.

Planning for the 2018 CHNA began in December 2017; data was collected in January and February 2018. Analysis began in February 2018 and was completed in July 2018 with production of a final report. Results were disseminated to the organization and community throughout the remainder of 2018 and until March 2019.

Design Overview

Quantitative and qualitative methods were used to gather cross-sectional information about the health needs of AN/AI people served by SCF. Surveys obtained standardized information from

a larger sample of community members; focus groups contextualized survey data, allowed for more detailed inquiry, and elicited information about domains not assessed in the survey. Pre-existing satisfaction survey results from 2017 provided further insight into customer-owner perceptions of the process, relevance, and quality of care.

The CHNA was designed to assess current performance and identify gaps across seven domains. Domains were generated in terms of community priorities that emerged in the 1993 CHNA and had remained priorities according to ongoing research and evaluation. In this way, the overall structure of the 2018 CHNA was designed to closely reflect local values, which informed major areas of concern.

Domains

Acceptability of Services

In the 1993 CHNA, respondents reported that care was not culturally competent, with few Alaska Native providers, and a history of well-documented racism and disrespect. In response, SCF adopted cultural competence and respect as the foundation for its services. The 2018 CHNA assessed acceptability and cultural competence by 1) asking respondents to rank their level of agreement with a statement on SCF providing culturally relevant health needs (including more Alaska Native providers in both medical and behavioral health care, expanded access to Traditional Healing, and more Alaska Native approaches to health); 2) asking respondents to rank their level of agreement with SCF's success in offering services that build upon the strength of Alaska Native cultures (Table 2); and 3) asking focus group participants to describe good health care as well as SCF's strengths and weaknesses (Table 3).

Access to Services

Participants in the 1993 CHNA focus groups described difficulties obtaining appointments, waiting long hours to be seen, and a stressful queuing system in which people compete with others to be seen. For this reason, SCF has always prioritized access to services. The 2018 CHNA survey asked about barriers to accessing services and included items drawn from recent community focus groups (Table 2). Additionally, satisfaction survey questions related to access were included in the 2018 CHNA analysis (Table 4).

Table 2
Example survey items and response options from SCF's 2018 CHNA

Domain	Example Item	Response Options
Acceptability of services	SCF offers services that build upon the strengths of Alaska Native cultures.	Strongly Disagree Disagree Neutral Agree Strongly agree
Access to services	Have you experienced any of the following barriers to accessing SCF services in your community?	Lack of transportation Clinic hours conflict with schedule Life challenges Not sure where to call to get started Lack of phone SCF services are not available in my community Turned away for being late to an appointment Other
Alignment with SCF goals and values	SCF addresses the major health needs of Alaska Native people.	Strongly disagree Disagree Neutral Agree Strongly agree
Greatest health needs of Alaska Native people	What are the top 3 chronic conditions SCF should address?	Chronic pain Cancer (prevention and management) Lower respiratory diseases (e.g., COPD, emphysema) Diabetes Cardiovascular disease (high blood pressure, coronary artery disease, congestive heart failure) Chronic liver disease and cirrhosis Kidney disease Alzheimer's disease and related dementia Obesity Persistent mental illness Addictions Depression/Anxiety Other (please specify)
Greatest health needs of Alaska Native people	"Please list the top five health needs of Alaska Native people."	Open ended
Quality of services	SCF provides quality health and wellness services.	Strongly disagree Disagree Neutral Agree Strongly agree

Table 3
Example focus group items from SCF's 2018 CHNA

Domain	Example Item
Alignment with SCF goals and values	SCF wants to empower community members to own their health and healthcare. What are the best ways to do this?
General perspectives on SCF	• When you think of SCF, what are the first things that come to mind? • What changes, if any, have you seen over the past two years? • What, if any, are the strengths of the SCF Nuka System of Care? • What, if any, are the weaknesses of the SCF Nuka System of Care?
Greatest health needs of Alaska Native people	• Take a minute to think about the most important health needs of the Alaska Native community. What do you think these are? • What services should SCF provide to best address these health needs?
Quality	To you, what is good health care?
Respect and relationships in the care process	Tell me about your relationship with your primary care provider at SCF.

Table 4
Example items from SCF's satisfaction surveys

Domain	Example Item*
Acceptability of services	My culture and traditions were respected.
Access to services	An appointment was available when I needed it. I did not have to wait too long to be seen by my provider.
Alignment with SCF goals and values	I was involved in the decisions about my care.
General perspective on SCF	Overall, I am satisfied with my visit.
Perceived quality of services	I have trust in program/clinic employees. I would recommend my provider to family and friends.
Respect and relationships in the care process	The provider listened carefully to me. I received the right amount of attention from my provider.

***** Likert-scaled responses include Strongly disagree, Disagree, Neutral, Agree, Strongly Agree

Greatest Health Needs of Alaska Native People

This domain is tied to self-determination, wherein community health needs are determined by respondent feedback. In both surveys and focus groups, respondents were asked open-ended questions about health needs (Tables 2 and 3). Surveys additionally provided lists of needs for ranking, organized under general wellness, chronic conditions, acute health conditions, behavioral

health conditions, family and child health, oral health, substance use concerns, and social concerns (Table 2). Additionally, priorities for changes to services (i.e., medical, behavioral, wellness, and across services) were presented as lists to rank. All lists were generated after reviewing recent research and evaluation community focus group results and consulting leadership on other items that were under consideration for decision-making.

Alignment with SCF Goals and Values

SCF goals and values emerged from feedback in the 1993 CHNA and evolved through ongoing research, evaluation, and improvement projects that gathered customer-owner feedback. The 2018 CHNA survey asked respondents to rank statements about SCF's performance on these goals. Respondents ranked statements related to health empowerment, family wellness, holistic wellness, strengths-based care, and prioritizing customer-owner voice. Additionally, SCF values were incorporated into options for ranking, such as general wellness goals that included supporting healthy lifestyles, fostering healthy relationships, promoting connection to culture, celebrating strengths, building emotional health, and increasing spiritual well-being. Other value-related options made available for ranking included youth and elder activities, support for parents, healthy activities for families, and providing volunteer opportunities. These rankings allowed customer-owners to prioritize the expression of SCF values through services.

Perceived Quality of Services

SCF's focus on quality began in earnest when the 1993 CHNA documented respondent experiences with misdiagnoses, lack of appropriate treatment, and an unclean, outdated, and understaffed hospital. SCF measures quality using nationally recognized metrics such as the Healthcare Effectiveness Data and Information Set (HEDIS) and also strives to understand community perceptions of quality. In the 2018 CHNA, focus groups discussed respondent perceptions of good quality health care in an open-ended manner (Table 3). Potential service changes provided for ranking reflected options for improving the quality of medical and behavioral health care, including provider competence, diagnosis and treatment, and coordination of care. Quality-related SCF satisfaction survey questions were also analyzed (Table 4).

Respect/Relationships in the Care Process

The 1993 CHNA documented many reports of disrespectful treatment by providers and staff; in response, SCF made respect and relationships central to its care model (Table 1). In the 2018 CHNA focus groups, participants discussed their relationship with their primary care

provider in an open-ended manner (Table 3). The CHNA survey also included satisfaction questions related to respect and relationships in the care process (Table 4).

General Perspective on SCF

This domain offered respondents opportunities to highlight new themes about SCF services which were subsequently addressed through open-ended focus group questions (Table 3).

Self-Report Survey

Sampling

To ensure inclusivity, the sampling strategy was designed to represent the perspectives of diverse individuals, including adolescents, young adults, older adults, those served by residential programs, those experiencing homelessness, and rural as well as urban community members. To this end, surveys were administered to patients drawn from primary care clinics in the urban centers of Anchorage and Wasilla as well as three Community Health Centers in rural Alaska. Additionally, surveys were administered in pediatrics, behavioral health care, obstetrics/gynecology, complementary medicine, physical therapy, as well as programs serving elders, homeless youth, people seeking treatment for substance misuse, and people experiencing serious mental illness. Each location was assigned a set number of days to be surveyed proportional to visit counts; days were randomly assigned using *R* statistical software (R Core Team, 2013). The survey was offered to all individuals ages 14 and older present at selected clinics or programs.

Design

Survey items included close-ended questions with pre-defined answers, Likert-scaled responses, and open-ended questions. Items were informed by community feedback from prior SCF evaluation efforts, comments posted to social media (primarily the SCF Facebook page), and SCF leadership suggestions. The survey contained 53 items organized across five of the seven domains. The respect and relationships domain were addressed by satisfaction surveys and focus groups; general perspectives on SCF were covered by focus groups. Table 2 includes example survey items by domains.

Administration

The survey was administered by SCF improvement staff, who obtained verbal informed consent using a script that explained the CHNA and that emphasized the survey was voluntary and that responses were anonymous and would be used to inform care. Senior program evaluation,

research, and improvement staff reviewed the purpose, the stratified random sampling frame, ethical considerations emphasizing voluntariness and privacy, and efforts to reduce potential bias through scripting. Surveys were administered through the SurveyMonkey application on iPads, which randomized response order for the questions. A $10 gift card was offered to respondents as compensation.

Data Analysis

Data from the surveys was analyzed in Microsoft Excel using descriptive statistics, such as the percent of respondents who endorsed a given response choice. The sample size allowed for a 3% margin of error on proportions. Open-ended responses were imported into Excel, grouped by topic (with groupings reviewed and edited by multiple team members to reach consensus), and then counts were provided for each topic.

Focus Groups

Sampling

Staff recruited focus groups participants at the SCF 21st Annual Gathering, a large community event that promotes health and wellness and services provided by non-profit partners. Participants were also recruited at the same clinics and programs as the survey recruitment. To ensure diverse perspectives, staff from various clinics referred specific community members for the focus groups, considering sex, age, healthcare utilization, and health and social needs. A verbal informed consent process explained the CHNA and how results would be used and emphasized that participation was voluntary and responses were confidential.

Design

A semi-structured moderator guide was developed in conversation with SCF tribal and clinical leadership. The moderator used the guide to direct the discussion to consider whether services are aligned with SCF goals and values, general perspectives on SCF, greatest health needs of the Alaska Native community, and respect/relationships in the care process (see Table 3).

Administration

Focus groups were conducted by an experienced researcher or evaluator using a semi-structured guide. A second staff member took detailed notes; focus groups were also audio recorded. Three focus groups were conducted using video conferencing with rural health centers; participants gathered at the rural health center and used a webcam and teleconference line to

interact with the focus group moderator at SCF. The focus groups lasted from 45 minutes to 90 minutes. A $50 gift card was offered to participants as compensation.

Data Analysis

Experienced researchers and program evaluators conducted the qualitative analysis using the focus group notes, recordings, and transcripts. All responses to each question (across focus groups) were compiled and were coded inductively for emergent themes. A summary was written for each theme based on coded quotes.

Customer-owner Satisfaction Surveys

SCF requests feedback through satisfaction surveys at each point of care using iPads. Questions address access to services, alignment with SCF goals and values, general perspective on SCF, perceived quality of services, and respect/relationships in the care process (Table 4). Surveys are anonymous to encourage honesty and protect privacy. Results of SCF satisfaction surveys (N = 22,412) for the period January 1 – December 31, 2017 were also included in the analyses.

Data Analysis

Customer-owner satisfaction survey results were analyzed in SAS 9.3, and Excel was used to produce descriptive statistics.

RESULTS

Community Member Characteristics

A total of 1,418 respondents completed the self-report survey administered in SCF clinics. Of these, 76% were from the greater Anchorage area; 12% from Matanuska-Susitna Valley; 12% in rural communities (including 3% from rural communities on a road system, 3% in hub communities off the road system, and 6% in a village off the road system). About 61% of survey respondents were female, 93% were Alaska Native and/or American Indian (rural community health centers also serve non-Native people), 43% were employed full or part-time, 52% made less than $25,000 per year, and 23% were SCF employees. Respondents ranged in age from 14–85, with an average age of 40 years. The 18 focus groups had a total of 125 participants (including 3 virtual); six people who could not attend focus groups were interviewed separately. Of focus group

participants, 61% were female, 34% were employed full or part-time, and 55% made less than $25,000 per year. Of respondents completing satisfaction surveys (*N* = 22,278), 67% were female, and 86% provided feedback about Anchorage services, 11% about Matanuska-Susitna Valley services, and the remainder (3%) about rural services.

Findings from the self-report survey, focus groups, and satisfaction surveys are presented below according to seven CHNA domains.

Acceptability of Services

Focus group participants noted that respect for Alaska Native culture was prominent in SCF service delivery. Of survey respondents, 64% agreed that "SCF offers services that build on the strengths of Alaska Native cultures" (Table 5). Survey results indicated that hiring more Alaska Native providers is a priority across respondent groups. Many Elders, adolescents, people in treatment programs, and people experiencing homelessness advocated for increased access to Traditional Healing. Additionally, many men, Elders, and persons experiencing homelessness advocated for the provision of more Alaska Native approaches to health. Focus group participants in Anchorage expressed a desire for more cultural approaches across SCF services. This included better access to Traditional Healing, more cultural activities for youth, more cultural approaches to recovery, and better integration of Indigenous approaches to health into primary care.

Table 5
Alignment with SCF goals, objectives, and operational principles, 2018

Item	% Strongly Agree or Agree
SCF encourages me to take responsibility for my health	74%
SCF provides quality health and wellness services	71%
SCF is promoting family wellness	70%
SCF is achieving physical wellness among Alaska Native people	69%
SCF is promoting the wellness of the whole person	68%
Gives me what I need to manage my own health	68%
Ensure the available care is easy to use	65%
SCF addresses the major health needs of Alaska Native people	65%
SCF listens to the voice of the customer-owner when deciding what to do and how	65%
Offers services that build upon the strengths of Alaska Native cultures	64%
SCF encourages me to own our healthcare system	64%
SCF is achieving mental/emotional wellness among Alaska Native people	62%
SCF is achieving spiritual wellness among Alaska Native people	61%

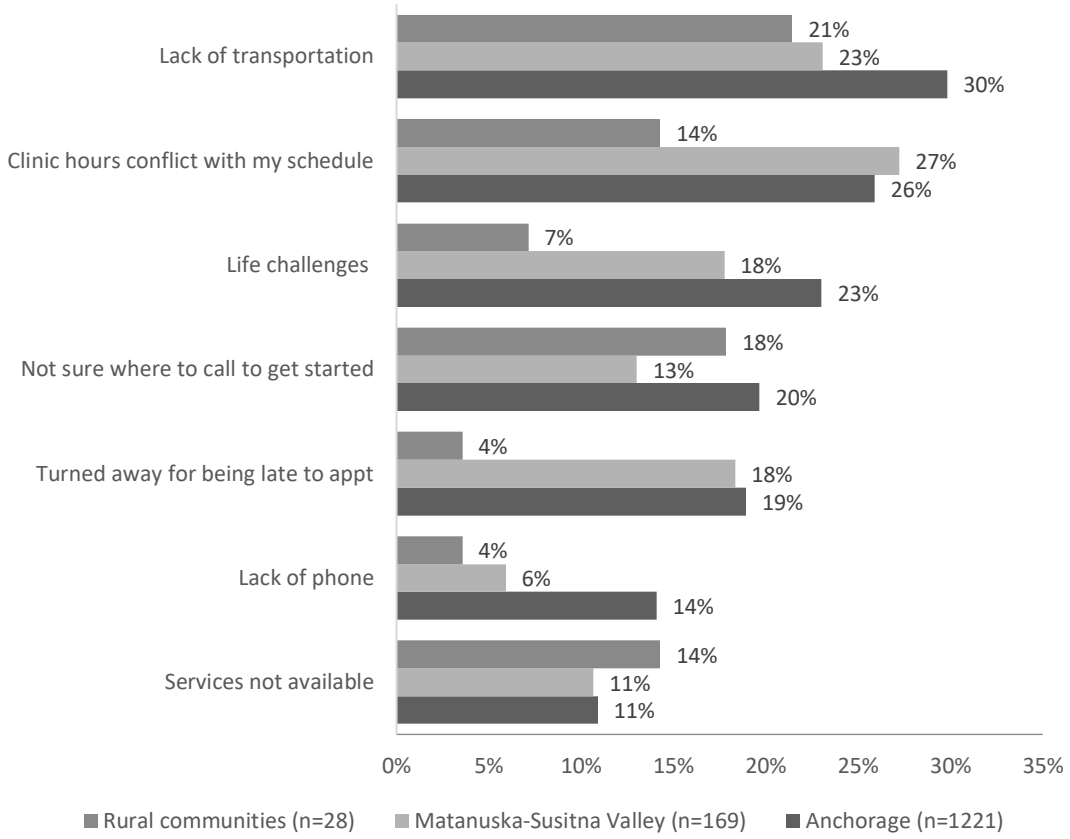

Figure 1. Barriers to access to care

Access to Services

Many focus group participants noted having good access to their primary care provider but raised concerns about service gaps (especially in rural areas), difficulties obtaining appointments when referred to specialists, and limited clinic hours.

The most common barriers to access (Figure 1) in Anchorage and the Matanuska-Susitna Valley were lack of transportation, clinic hours conflicting with schedules, and life challenges, such as family problems, homelessness, and unhealthy substance use. The most common barriers listed by rural participants were lack of services, transportation, or uncertainty about how to access the system.

Greatest Health Needs of Alaska Native People

The most frequent responses to survey items assessing the most important health needs were 1) alcohol, drug, and tobacco misuse; 2) oral health; 3) behavioral health; 4) food, nutrition, and obesity; and 5) cardiovascular health and heart disease. Respondents cited needs for more prevention,

addiction awareness, and short-term as well as long-term treatment for unhealthy substance use. Oral health needs included oral health awareness, increased access to dental services (e.g., increased appointments, increased locations), and support for ongoing oral health needs (e.g., denture fitting). Behavioral health needs spanned access to services, treatment for behavioral health issues (e.g., anxiety, depression), and suicide prevention, awareness, and support. Many respondents cited needs for greater awareness and education about healthy eating, nutrition counseling, increased access to food including traditional Alaska Native foods, and weight loss and weight management. Cardiovascular health and heart disease needs included more prevention and awareness, health education, and intervention related to blood pressure, cholesterol, and stroke.

Focus group participants most frequently requested wellness and preventative health including health education on diet, healthy food options, traditional foods, nutrition, exercise, and physical wellness. Respondents emphasized holistic health, including mental and behavioral health. Specific topics mentioned included children's and Elders' behavioral/mental health, emotional eating, depression, and suicide. Most respondents indicated cultural health and Elder health services were top health needs. Alcohol and drug misuse (including prescription opioids) were also top health needs across focus groups.

Survey respondents selected issues that SCF should prioritize in family and child health, acute health, chronic conditions, behavioral health, general wellness goals, social concerns, substance abuse, and oral health. Table 6 depicts the top three responses for each area. Suicide, addictions, and depression were repeatedly noted.

Finally, survey respondents were asked what changes SCF should make across four areas (Table 7). Major themes include more medical and behavioral health services in rural areas, more treatments for addictions, more opportunities for families and other groups of people to gather, better connection to social services, hiring more Alaska Native providers, and logistical issues related to navigating a growing medical campus.

Alignment with SCF Goals and Values

Most respondents agreed or strongly agreed with survey items that emphasized aligning SCF's vision, mission, and goals (Table 5). The highest agreement was for encouraging personal responsibility (74%) and providing quality services (71%) with the lowest agreement for spiritual (61%) and mental/emotional wellness (62%). Many of the health needs and services prioritized (Table 6 and 7) aligned closely with existing SCF goals and values.

Table 6
Priorities Identified by Community Members Completing Surveys

Health Area	Priorities Identified by SCF Community Members
Family and child health	Child abuse and neglect Relationship distress, including domestic violence Healthy parenting
Acute health conditions	Suicide Prevention of sexually transmitted disease Overdoses
Chronic conditions	Addictions Depression and anxiety Cancer
Behavioral health conditions	Suicide Addictions Depression
General wellness goals	Supporting healthy lifestyles, such as good nutrition and staying active Building behavioral and emotional health Fostering healthy relationships within families and community
Social concerns	Homelessness/housing instability Unemployment Food insecurity/access to healthy foods
Substance use	Alcohol Opioid pain medicines Tobacco
Oral health	Prevention of cavities and tooth decay Restorative care Emergency dental care

Table 7
Priorities for changes identified by community members completing surveys

Area	Priorities
Medical Services	Provide more medical services in rural areas Hire more Alaska Native providers Provide more opportunities for people to learn and practice healthy lifestyles
Behavioral Health Services	Improve access to treatment for addictions More behavioral health services in rural areas Hire more Alaska Native providers
Wellness Programs	More activities for youth More services for Elders More support for parents
General Changes	Help connect people to social services for help with life challenges Make it easier to get around the Alaska Native Medical Center campus, including parking Provide more healthy activities for families

Perceived Quality of Services

CHNA results documented mostly positive experiences, citing quality services, well-trained providers and staff, an organization committed to learning and improvement, a focus on community members' voices and rights, and appreciation for same-day access and providers who work to meet their needs. Numerous focus group participants felt that high quality health care is about strong relationships with providers, owning one's health, easy access to care, ability to receive various services and care in one location, holistic and cultural approaches to health, and continuity of care. In many cases, participants appreciated SCF's focus on these values. Opportunities for improvement included more holistic and cultural approaches to care and better follow-up after appointments, including on test results and referrals.

Respect and Relationships in the Care Process

Focus group participants praised providers for their availability, their problem-solving approach to care, their willingness to work with customer-owners to develop personalized care plans, and for going "above and beyond" in order to ensure customer-owners received good care. Most participants reported positive relationships with their providers and appreciated their provider knowing them. Many focus group participants described the ideal provider as someone who truly cares, who respects customer-owner choice, who listens, who is informative, who is thorough, who respects customer-owner knowledge of their health and body, who has good availability, and who meets customer-owner needs. Being thorough involved learning health histories, reading notes from appointments with other providers, taking time with customer-owners, listening well, explaining everything, looking at screenings, and following up on results. All these qualities were deemed common among many SCF providers. Many focus group participants indicated that encouraging these approaches to health care will build positive relationships.

General Perspective on SCF

Results from the 2018 survey and focus groups were consistently positive with respect to SCF's efforts. Many respondents cited the wide variety of services offered, well-trained and respectful providers and staff, a strong focus on community and family, and clean, updated, and more welcoming facilities. Figure 2 summarizes the overall CHNA satisfaction in 1993 and 2018, showing higher satisfaction in all categories.

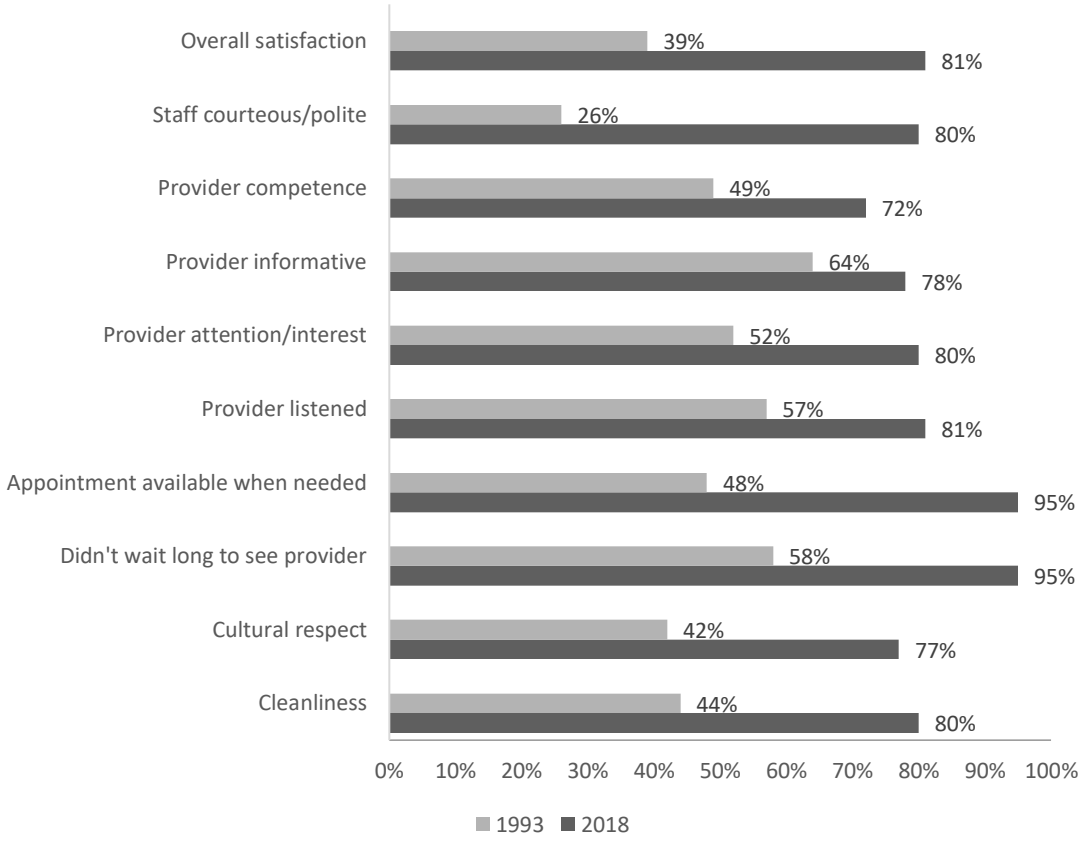

Figure 2. Comparison of satisfaction, 1993 and 2018

Focus group participants identified specific weaknesses and areas for improved service. The most common suggestions for improvement included increasing access to non-primary care services such as dental care, behavioral health care, substance use treatment, Traditional Healing, and Complementary Medicine; addressing rural services gaps especially in behavioral health care, substance use treatment, dental care, audiology, and Traditional Healing; improving processes and communication relating to referrals and follow-up care; increasing customer awareness of existing services; offering more youth activities; a need for cultural activities; increasing and improving services for Elders; increasing services for homeless customer-owners; and ensuring customer-owners feel that on each visit, their needs are understood and addressed.

Dissemination of Results

Results from the 2018 CHNA were disseminated through presentations to SCF executive leadership and its Board of Directors in July 2018; a full-day learning event with all SCF

employees in September 2018; articles in the community publication, *Anchorage Native News*, in Fall 2018; at SCF's 22nd Annual Gathering public event in February 2019; and posting of the report on the SCF intranet in March 2019.

Leadership and staff largely indicated that results were not surprising and that many issues were already addressed by corporate objectives or initiatives. For example, all top five service needs (i.e., alcohol, drugs, and tobacco misuse; oral health; behavioral health; food, nutrition, and obesity; and cardiovascular disease) aligned with existing Family Wellness Objectives (i.e., Reduce the rate of substance abuse; Improve oral health; Reduce the incidence of suicide; Reduce the rate of obesity; and Reduce the rate of and improve the management of cardiovascular disease). Some leaders expressed surprise that food, nutrition, and obesity were within the top five identified health needs versus other potential priorities, such as cancer.

As depicted in Table 8, many priorities for change were also in line with existing SCF objectives and initiatives. Several service expansions and program enhancements were already underway or planned. In recent years, more than $300 million has been spent to expand facilities, resulting in more than 500,000 square feet of clinical space for oral, family and child behavioral, and rural health services. Others, such as more services in rural Alaska, were not specifically identified in strategic plans but are an ongoing operational focus. Challenges due to transportation have been addressed by rendering service locations more convenient or accessible to populations, for example by co-locating psychiatrists who could provide medication-assisted therapy within primary care and offering services in shelters for individuals experiencing homelessness or within Elders programs.

Limitations

Due to a tight timeline for the 2018 SCF CHNA, survey and focus group questions could not be pre-tested by community members. Additionally, the disseminated results, while developed by staff with community communication experience, were not pre-tested with community members. The CHNA team recommended that for future CNHAs, longer timelines allow for greater community review at different points in the process.

Table 8
Examples of SCF approach to addressing priorities for change identified in 2018 CHNA

Priority for Change	Goal, Objective, or Initiative	Approach
More medical and behavioral services in rural areas	Objective: Improve access to SCF services	Expansion of services such as audiology, optometry, chiropractic, massage, acupuncture in rural clinics
Hire more Alaska Native providers	Initiative: Increase the percentage of Alaska Native and American Indian people in clinical positions	Percentage of Alaska Native and American Indian workforce tracked Numbers of individuals in certified medical assistant/licensed practical nurse assistant training program tracked
More opportunities for people to learn and practice healthy lifestyles	Objective: Increase the level of engagement of customer-owners in their own health care decisions FMW Objective: Improve customer-owner overall health	Health education expanding cooking and other classes as well as additional physical activity options Online health portal tracks food and exercise, syncs with activity trackers, provides access to health coaching, and wellness information
Improve access to treatment for addictions	Initiative: Improve our system for evaluating risk and early intervention for substance use disorder Initiative: Improve our system for treatment of substance use disorder	Medication assisted therapy transitioned to primary care from specialty behavioral health care Outpatient treatment and detox facilities expanded
More activities for youth	Objective: Improve customer-owners overall health	
More services for elders	Objective: Improve access to SCF services	Nurse co-located in Elder Program Expanded transportation capacity;
More support for parents	Initiative: Improve coordination and effectiveness of care from pre-conception to five years of age to support healthy families	System-wide deployment of parenting framework emphasizing protective factors and other parenting curricula Expansion of home visitation services Expand staff expertise in infant and early childhood mental health
Help connect people to social services for help with life challenges	Initiative: Improve overall health and quality of life of targeted customer-owners with an ongoing condition, issue, or problem	Provides intensive case management to homeless residents as part of a multi-agency initiative to connect homeless residents with housing and support services in Anchorage
Make it easier to get around the ANMC campus	Goal: We will develop and improve our operations that support delivery of services to our customer-owners Initiative: Improve the effectiveness of space allocation across SCF	Improved signage Shuttle providing transportation between clinics and programs

DISCUSSION

Health Empowerment

Health empowerment emerged as a theme across domains. Quality health care was described as encouraging customers to own their health. Ideal providers were described as respecting customer-owner knowledge of their health and empowering them to make decisions. Food and nutrition knowledge was listed as a top health need; more health education on prevention and wellness was requested. Additionally, there was considerable interest in Alaska Native approaches to wellness as well as recruitment and retention of Alaska Native providers. Many Indigenous communities desire health empowerment and self-determination. SCF's support of this needs assessment, efforts to ensure the voices of its customer-owners are heard, and commitment to addressing their needs is a remarkable example of contemporary paths to improving health through health empowerment and self-determination (e.g., Wallerstein, 1992; Maar, 2004; Chino & DeBruyn, 2006).

Beyond Medical Health

Community members regularly selected behavioral health conditions as top health needs. For example, suicide and overdoses were highlighted as urgent health needs; not surprisingly, addiction, depression, and anxiety emerged as similarly important chronic health needs. Open-ended survey and focus group responses emphasized the need for more behavioral health and substance misuse services. Many tribes recognize the emotional toll of colonization as well as the effects of trauma on overall health and prioritize addressing emotional trauma as a path to overall wellness (e.g., Smith, 1999; Ray et al., 2019).

Beyond the Individual

Across services and domains, respondents prioritized activities for families, parents, Elders, and youth, as well as places for people to gather. This interest in family, community, and interconnectedness is noted in other Indigenous approaches to health (e.g., Chino & DeBruyn, 2006). There is increasing evidence that, in the broader world, social connectedness and relationships have a major effect on disease and death risk and should be considered part of public health (e.g., Holt-Lunstad et al., 2017).

Beyond the Clinic

Respondents recognized that life challenges, such as homelessness, lack of transportation, or family struggles, affect health and access to care. They prioritized better connection to social services, more help for people experiencing homelessness or unemployment, initiatives to address food security, and help with transportation issues, especially for Elders. There is increasing recognition that social determinants of health, such as homelessness, disproportionately affect individual health, as well as health care cost, and that addressing these concerns can be an effective, and even cost-effective, approach.

CONCLUSION

Designing this effort in terms of domains and items of community concern yielded findings that otherwise differ greatly from deficit-based or disease-focused approaches to health needs assessments. The focus on empowerment, integration, culture, and community reflects values held in many Indigenous communities. More recent public health studies document increasing evidence for the effectiveness of these approaches (e.g., Bourke et al., 2018, Pomerville & Gone, 2019).

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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Inviting and Honoring the Voice of the Community

Commentary on Ray et al., *Making a Community Health Needs Assessment Participatory: A Case Study from an Alaska Native Health Care Organization*

Southcentral Foundation Leadership

The heart of Southcentral Foundation's (SCF) customer-owned, relationship-based Nuka System of Care is the voice of Alaska Native and American Indian (AN/AI) peoples, which drives how the system operates and continues to evolve. SCF does not use the passive term "patients" but instead uses the term "customer-owner: to acknowledge that the community is both a customer of services provided and the owner of the system and their individual wellness. SCF is owned and operated by Alaska Native people, and the organization's direction and activities come from listening to the customer-owner. We draw upon the knowledge, strength, and history of Alaska Native peoples and relationships with one another, the land, and ancestors and those to come as a health care system. We have used multiple modes of listening and data collection in community needs assessments since time immemorial.

SCF began contracting with the federal government to provide services, and this role expanded in the 1980s and 1990s. In 1998, after more than 50 years of management by the Indian Health Service, SCF assumed complete responsibility for primary care services. In preparation for a historic change in healthcare management, we conducted the first needs assessment, holding various types of listening sessions with stakeholders from our region. We wanted to hear from everyone who had something to share. We wanted to hear people's concerns as well as their hopes. We wanted to learn what was going well, what needed to stop immediately, and what small and large changes needed to be made. The tribal, operational, and clinical leadership took time to review the feedback and took additional time to deeply consider and strategize how to use the feedback to create the organizational mission, vision, key points, and operational principles. The results of this needs assessment were utilized to develop, implement, and deliver programs of the Nuka System of Care.

With customer-ownership as the foundation for which the health care system is built, shaped, and improved, SCF has developed and manages a variety of listening posts. These listening posts are designed to ensure the wants and needs of customer-owners are elicited, heard, and integrated into every decision, structure, and process of the system. In the decades that have passed, we have strategically developed internal systems, processes, and most importantly, have nurtured the growth and development of people who have improvement, evaluation, research, and development experience and the lived experience of being a customer-owner. We were able to draw upon internal experts who utilize both Indigenous evaluation methods and Western improvement models to conduct our most recent community needs assessment and work with organizational leadership to translate evaluation findings into meaningful community health practices.

In 2018, we used these internal experts to conduct the second comprehensive needs assessment. The following are some recent improvements and expansions made by SCF in response to feedback provided by customer-owners:

- Investment and redesign of Dental Services to ensure that customer-owners have access to an integrated dental team of their choosing.
- Investment and improvement in the behavioral health continuum of care, including but not limited to: opening a Crisis Stabilization Center, planning for a 2-7 day residential treatment facility, expanding the role of Intensive Case Management and family-based community treatment, and the addition of two outpatient specialty behavioral health clinics.
- Expanded services for substance misuse.
- Launched a trauma-informed, culturally rooted program at Hiland Mountain Correctional Center, part of SCF's Nui'ju Healing Place therapeutic community.
- Opened the Centennial Center Clinic, in partnership with Cook Inlet Housing Authority, to provide easier access to medical services for its nearly 600 residents, half of whom are customer-owners.
- Continued work on improving the services already established within the Nuka System of Care.

As SCF continues to improve and expand services specific to the health care needs of Alaska Native and American Indian peoples, the voice of the customer-owner remains central.

The Disparate Roots and Potential Development of Alaska's Public Behavioral Health System

Joseph D. Bloom, MD, and Aron S. Wolf, MMM, MD

Abstract

The community mental health center era in the United States was based on delivering services cataloged in three areas of behavioral health needs; (1) primary prevention of mental illness: the prevention of illness before it develops; (2) secondary prevention services: the early treatment of mental illness to reduce the severity of illness, and (3) tertiary prevention: treatment aimed at the reduction of the burdens of chronic mental illness. To attain these goals in a particular state in the United States has been very difficult, and Alaska, which has only been a state since 1959, is not close to attaining these goals. As a matter of fact, this paper will demonstrate that Alaska has had more trouble than most states in providing even rudimentary services in several of these areas. Yet, because of a curious constellation of factors, this paper presents the reader with a hopeful possible alignment of programs which, if more fully developed and linked in Alaska, can become an integrated public behavioral health system open to all the residents in the state.

INTRODUCTION

Alaska was purchased from imperial Russia in 1867, most likely to prevent the territory from being sold to the British or Canadian governments, and it wasn't until 1884 that the U.S. federal government made its first attempts to set up a rudimentary government consisting of several civil, judicial, and land districts in the Territory (Gruening, 1954). Significant development began in the late 1890s following the 1896 gold strikes in the Klondike region of Canada's Yukon Territory, and later the beaches of Nome.

In 1899, Congress established the first territorial criminal code for Alaska, a section of which authorized the commitment of mentally ill prisoners to an unspecified mental institution outside of the Territory. A year later, Congress established a code of civil procedure recognizing the "civilian insane" and authorizing the territorial governor to develop a contract with an asylum west of the Rocky Mountains, submitting the lowest bid, for persons legally adjudged "insane." In 1905, the Territory developed a contract with a privately owned hospital in Portland, Oregon, later named Morningside Hospital (Morningside Hospital, n.d.). This contract lasted until 1962.

In 1956 Congress designated the Alaska Territory as having fiscal and functional autonomy for the territory in the field of behavioral health which included the hospitalization of involuntary mental patients (Naske, 1960). This law also set aside one million acres of land, with the income derived from this land to be used in support of the building and operation of the new psychiatric hospital in the Territory, along with an associated community behavioral health program. Alaska became the 49th state of the United States in 1959.

Controversy surrounding the set-aside land surfaced in the late 1970s, when it became clear that the state government had never properly accounted for the revenue produced by these lands. A class action lawsuit against the state was filed, culminating in the Alaska Supreme Court decision in *Weiss v. State of Alaska* (1985). This decision ordered the state to reconstitute the land trust with the 500,000 acres of original land with an additional 500,000 acres and a cash allotment of $200 million. It took another decade to create The Alaska Mental Health Land Trust (the Trust) to administer these lands with the income to be used for the benefit of all Alaskans with a "mental disability" (Shrader, 1987). The Trust today figures prominently in contemporary Alaska, both at the state hospital, the Alaska Psychiatric Institute (API), and in support of many statewide behavioral health programs (see below).

Building a Health and Behavioral Health Care System for Alaska Natives

In the1954 Public Law 83-568, the U.S. Congress made major changes in the provision of health services for all Alaska Native and American Indian (AN/AI) people when it transferred the responsibility for health care from the Bureau of Indian Affairs to a new program in the United States Public Health Service, later named the Indian Health Service (IHS). This was a transfer of necessity, and nowhere in the United States were the health problems of Native peoples more dire than in Alaska (The Alaska Health Survey Team, 1954). The groundbreaking 1954 report "Alaska's health: A survey report" (also known as the "Parran Report") included a chapter on the behavioral health care provided at Morningside Hospital with very strong criticism of the Alaska commitment procedures leading patients to that hospital (The Alaska Health Survey Team, 1954).

When IHS began its work, the AN population had very severe health problems resulting from infectious diseases, particularly tuberculosis, along with childhood infectious diseases (The Alaska Health Survey Team, 1954). Over the next decade, IHS made steady progress in reducing the toll of these diseases, and by 1966 IHS developed its first small behavioral health program located in the Anchorage Area Office. This program provided psychiatric consultation to IHS hospitals in the north and west of the state and provided a liaison between IHS hospitals and API. At that time the IHS rural programs were organized around rural village health aides working with five regional hospitals located in the cities of Barrow, Kotzebue, Bethel, Dillingham, and Tanana, with a central referral hospital, the Alaska Native Medical Center (ANMC) located in Anchorage. ANMC provided specialty care to AN patients referred from the rural hospitals and as the general hospital for all AN/AI living in Anchorage. There was also a large IHS hospital located at Sitka in southeast Alaska, which provided care to AN people living in the Alaska panhandle, with some specialty care and access to AMMC as needed. Today, 99% of IHS's Alaska health services budget is allocated to tribal organizations (Indian Health Service, n.d.) to operate the prior IHS system.

The seminal event in the contemporary history of the AN population occurred with the passage of the Alaska Native Claims Settlement Act of 1971 (Jones, 1981). This law recognized 13 regional for-profit corporations and some 200 individual village corporations and provided the newly created corporations with ownership of land within the governmental structure of state and federal law. Around the same time, regional health programs, organized mainly as not-for-profit corporations, developed in each area corresponding to the large regional for-profit corporations. In 1997, the health corporations developed a central coordinating consortium, the Alaska Native

Tribal Health Consortium (ANTHC) to provide services for rural villages and hospitals at ANMC. In 2021, the Consortium had 17 members covering the entire state (ANTHC, 2021).

Today, these health entities and ANTHC provide sophisticated medical and behavioral health services to people in all areas of the state. In rural areas, they provide health services to AN/AI people living in the region and to all others wishing to use their services on an emergency or fee-for-service basis. The attached map, sourced from an ANTHC publication (ANTHC, 2021, pg. 12), delineates the approximate boundaries of all the AN health corporations.

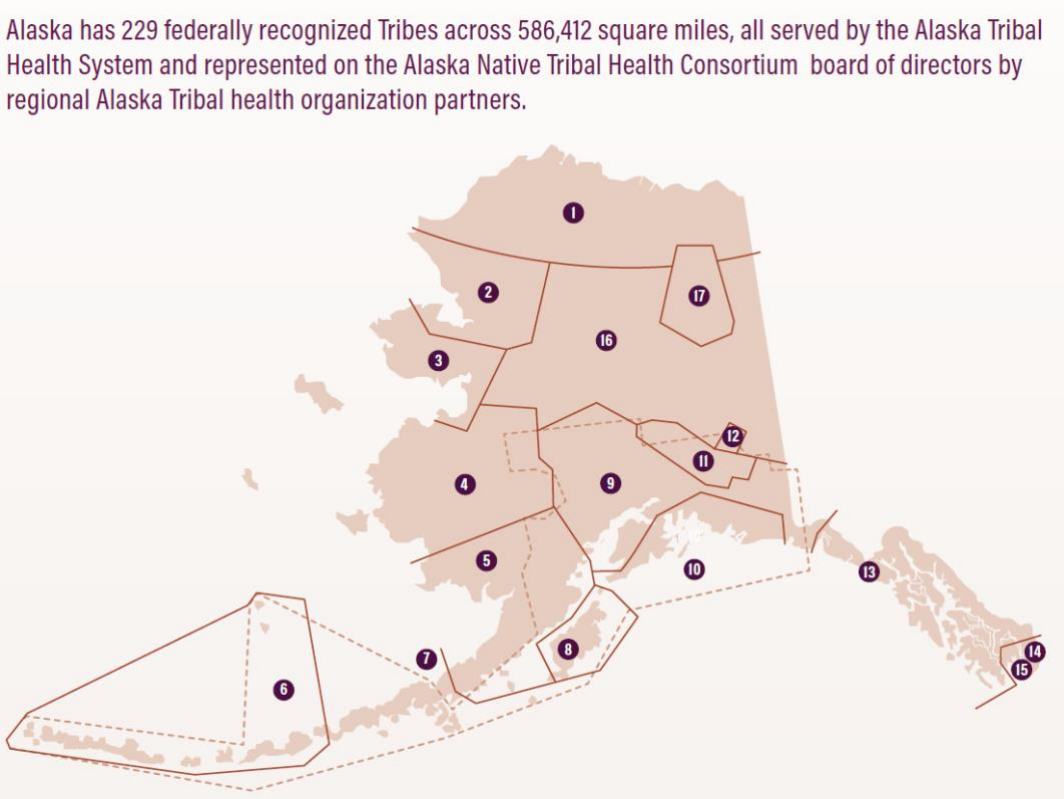

Figure 1. Alaska Tribal Health System (Source: ANTHC, 2021: Our health in our hands, pg. 12)

1. Arctic Slope Native Association
2. Maniilaq Association
3. Norton Sound Health Corporation
4. Yukon-Kuskokwim Health Corporation
5. Bristol Bay Area Health Corporation
6. Aleutian Pribilof Islands Association
7. Eastern Aleutian Tribes
8. Kodiak Area Native Association
9. Southcentral Foundation (dotted line)
10. Chugachmiut
11. Copper River Native Association
12. Mt. Sanford Tribal Consortium
13. SouthEast Alaska Regional Health Consortium
14. Ketchikan Indian Corporation
15. Metlakatla Indian Community
16. Tanana Chiefs Conference
17. Council of Athabascan Tribal Governments

Alaska is often divided into 3 large geographic areas, the northern and western parts of the state bordering on the Arctic Ocean and the Bering Sea, South Central Alaska, and the Southeastern Alaska Panhandle. Table 1 provides further information about the major regional health corporations starting in the western part of the state and moving eastward, briefly providing general information about eight of the nine health corporations and the percentage of each area's population represented by AN/AI people. The table also includes the main cities for each corporation, the numbers of villages served, whether there is a rural hospital in the city, and the website for each corporation. Each one of these health programs is large and complex, and the reader is encouraged to review them to understand how important they are in organization and delivery of health services in all rural Alaska. We do highlight two of these corporations, the Southcentral Foundation and the SouthEast Alaska Regional Health Consortium, which have additional roles in their regions and in relation to the whole state.

Table 1
Alaska Native health corporations by regional population, West and Central Alaska

Name	Regional Population (% AN/AI)	Main Town or City	Hospital (Y/N)	Village	Websites
Arctic Slope Native Association	11,031 (52%)	Barrow	Y	5	https://arcticslope.org/
Maniilaq Association	7,793 (83%)	Kotzebue	Y	11	https://www.maniilaq.org/
Norton Sound Health Corporation	10,046 (75%)	Nome	Y	5	https://www.nortonsoundhealth.org/
Yukon-Kuskowim Health Corporation	27,000[a] (84%)	Bethel	Y	44	https://www.ykhc.org/
Bristol Bay Area Health Corporation	± 8,000 (72%)	Dillingham	Y	28	https://www.bbahc.org/
Tanana Chiefs Conference	100,000 (8%)[b]	Fairbanks	N	39	https://www.tananachiefs.org/
Southcentral Foundation	400,000 (8%)	Anchorage	Y[c]	55	https://www.southcentralfoundation.com/
Kodiak Area Native Association	13,101 (14%)	Kodiak	Y[d]	5	https://kodiakhealthcare.org/

[a] Combination of two boroughs
[b] Includes Fairbanks and Anchorage region
[c] Anchorage Native Medical Center (referral & specialty hospital)
[d] Community hospital

The Southcentral Foundation, located in Anchorage and its populated adjacent areas, encompasses a total population of 400,000 people and provides health and behavioral health services to 55 rural villages and to all AN/AI people living in the southcentral area. Along with ANTHC, the Southcentral Foundation co-manages ANMC, the hospital responsible for delivering both general and specialty care to all AN/AI individuals in the Anchorage area and all AN/AI individuals referred from rural villages and hospitals for specialty medical services. Non-AN/AI persons are referred to physicians and the general hospitals in the private health care community. The Southcentral Foundation also provides significant psychiatric and other behavioral health services to ANMC and to the Foundation's outlying villages. The Southcentral Foundation is also one of the cooperating programs that are part of the Trust's "Crisis Now" initiative aimed at developing a new system of behavioral health crisis care in the Anchorage, Matanuska-Susitna (Mat-Su), and Fairbanks areas of the state.

Southeast Alaska is a unique part of the state, in many ways isolated from the western parts of the state. The area contains some 73,000 people, of which approximately 20% are AN/AI (Alaska Department of Labor, 2022). The area has several smaller cities, including Juneau (the state capital) and Ketchikan, each with hospitals and the area AN health corporation, the SouthEast Alaska Regional Health Consortium (SEARHC). SEARHC is large and is represented throughout all of southeastern Alaska. SEARHC is headquartered in Juneau, operates a general hospital in Wrangell and a multi-specialty hospital in Sitka, which includes a psychiatry service and a general hospital that used to be named Sitka General Hospital. SEARHC has 27 locations in its catchment area. This corporation has cooperative relationships with non-Native health facilities and treats both Native and non-Native patients in its various programs. It is part of ANTHC and has further specialty back-up with ANMC in Anchorage.

In summary, ANTHC, together with the regional health corporations, have developed significant statewide health and behavioral health programs, including recent additions of a village behavioral health aide training program and a behavioral health wellness program located in Anchorage that provides behavioral health evaluation and treatment services across the state via a telehealth network.

The State Hospital: The Alaska Psychiatric Institute (API) – 1962-present

The Alaska Psychiatric Institute (API) opened in 1962 with a capacity of 225 beds and the ability to expand to 450 beds as future need required. It was built for the treatment of all mentally

ill Alaskans, voluntary or committed, Native or non-Native, adult or child. In its first year of operation, API admitted 217 patients, 27% with developmental disabilities who were later transferred to a new facility in Valdez following the 1964 Good Friday earthquake. Seventy-eight percent of the patients in its first year were voluntary, with AN patients comprising 28% of the total admissions (Rogers, 1964). By 1966 all remaining patients at Morningside Hospital were transferred to API.

The original API functioned for over 40 years providing a broad range of services to all Alaskans. However, in the early years of this century, API was judged to have too many beds and an aging building. A new API with only 80 beds was planned and opened in 2005. Its bed limitation reflected both state fiscal constraints and national trends in state hospital bed-reduction. (Torrey et al., 2012; SitNews, 2005). The 80 beds were divided into two 25-bed units for acute voluntary and involuntary civil patients, and 3 separate 10-bed units, one each for adolescents, longer term adult patients, and for forensic patients requiring competency to stand trial evaluation or restoration services.

This second phase of API has not gone well, especially over at least the last decade. Problems were summarized in a 2018 report to the state legislature noting that the hospital was not able to keep all its 80 beds open on a consistent basis due to staff shortages, assaults against patients and staff, and structural disrepair (Burns & Hale, 2018). In 2019, the state contracted briefly with a private hospital management company to run the hospital, and in the same year, API was threatened with the loss of its CMS certification. The API Archives (API, n.d.) present detailed consultation reports that the state pursued to help resolve many of these administrative problems.

As of the writing of this paper in 2024, API continues to experience staffing, programmatic, and facility problems (Alaska Ombudsman, 2022) but remains the only facility in the state offering longer-term treatment services especially for involuntary court-committed patients. As of October 2024, the adult civil units had 60 beds in operation, with 59 in use and a waiting list of 15 individuals; the forensic unit maintained its maximum capacity of 10 beds, all occupied, and a waiting list of 56 individuals; and the adolescent unit had 7 of its 10 beds occupied with a waiting list of 2 (API, 2024). We were unable to attain any detailed longitudinal or current demographic, legal status, or length-of-stay data about these patients either in the hospital or on waiting lists. We presume that most or all of the 76 patients in the hospital were involuntary patients and that the hospital now serves very few, if any, voluntary adult patients.

It is important to note that insanity acquittees are no longer part of API's patient population following multiple homicides committed by an insanity acquittee on work release from API in 1982 (Brennan, 2001) and due to effects of the 1983 Hinckley verdict which led many states to change their insanity defenses (Steadman et al., 1993). These events quickly led to the de facto end of successful insanity defenses in Alaska (Gordon et al., 2016). This change in the state's insanity laws has now created a population of prison inmates, Native and non-Native, with severe mental illnesses in Alaska's prisons (Bloom & Kirkorsky, 2021).

The adolescent unit also needs some further explanation. Although this paper focuses on involuntary civil and criminal court adults, Alaska has significant problems with providing necessary care and treatment to its child and adolescent population, especially in providing a legally necessary range of community treatment programs particularly in the rural areas of the state. On December 15, 2022 the Civil Rights Division of the U.S. Department of Justice found that there was "reasonable cause to believe that the State of Alaska violates Title II of the Americans with Disabilities Act (ADA) 42 U.S. 12132, by failing to provide services to children with behavioral health disabilities in the most integrated setting appropriate to their needs" (United States Department of Justice, 2022). The findings were based on the United States Supreme Court decision in *Olmstead v. L.C.* (527 U.S. 581, 607 (1999)) in which the state of Georgia was found deficient in not providing hospitalized behavioral health patients with a variety of community behavioral health services which they needed in order to live successfully in the community. Although a focus on children and adolescents is not a major focus of this paper, as will be seen in the discussion, it merges very closely to the problems experienced by API's adult patients.

As mentioned, API's adult population is now almost entirely composed of involuntary patients, including those hospitalized for evaluation and treatment under Alaska's civil commitment law and those patients involuntarily hospitalized for evaluation for competency to stand trial and, where necessary, for competency for restoration services. Each area will be discussed briefly.

Civil Commitment

Alaska's civil commitment laws apply equally to all Alaskans. The very complicated civil commitment issues, legal and jurisdictional, found in civil commitment law that exist between state, federal, and tribal governments on many American Indian reservations do not apply in Alaska (Manson et al., 1987; Shore et al., 2008).

Alaska's civil commitment statutes (AS. 47.30.700 - 47.30.915, 2020) are like those in other states, except in relation to medication refusal (see below). The process begins with the initiation of an involuntary commitment petition, which in turn can lead to an Emergency Detention in an Evaluation Facility for up to 72 hours at API or in general hospitals in Fairbanks, Juneau, and in the Matanuska-Susitna Borough (Mat-Su). It is now possible to have a further 7-day extended evaluation and treatment period in these hospitals. After evaluation, the person is either discharged or scheduled for a hearing for a possible 30-day commitment. Case law and statutes make it clear that persons can only be held in jails for transport purposes while waiting for a bed in an evaluation center. Patients who are committed for 30 days usually go to API, though new provisions allow some general hospitals to retain some patients following a 30-day commitment hearing. Ninety and 180-day commitments are possible following the initial commitment period.

The authors were unable to access any system-wide longitudinal or current data, rural or urban, Native or non-Native, that report the actual numbers of and where the patients are detained and then those who are released or move on to the various levels of commitment.

Competency to Stand Trial Evaluation and Restoration Services (CST)

Alaska has a familiar statutory process for determining competency to stand trial (AS. 47.100, 2020) and possible commitment for restoration services following a finding of incompetency (AS. 12.110, 2020). If competency restoration is deemed necessary, the individual is committed to the custody of the commissioner of DHHS for up to 90 days for treatment with renewable period as necessary.

In practice the 10-bed forensic unit at API was never adequate to handle the volume of patients needing CST services. In 2018, the state and the Trust entered a contract to conduct a study focused on the adequacy of API's forensic services (Alaska Department of Health and Social Service, 2019). The report made recommendations to immediately increase the number of forensic beds at API to 20, and ultimately to 25, and to explore options for an additional jail and/or a community-based restoration program (Felthous & Bloom, 2018; Ash et al., 2020). Data presented to the Alaska Legislature, prior to these changes, noted that between FY2020-2022 there was an average of 30 individuals on the waitlist for CST restoration, most waiting in jails an average of 158 days for admission to API's 10-bed forensic unit (State of Alaska House Health and Social Services Finance Subcommittee, 2022).

As of the writing of this paper, the state has begun to initiate a 20 slot increase in the competency to stand trial cases which will include 10 outpatient slots for individuals who are on bail and 10 additional slots within the correctional system. Each of these 20 new slots may be used either for competency evaluations or restoration services. They will be staffed with appropriate professional personnel, and the new service became operational in the spring of 2024.

The Alaska Mental Health Trust and the "Crisis Now" Initiative

In 2019, as these problems continued to exist at API, the Trust, with the support of state government, focused attention on the development of new community behavioral health crisis services. The Trust contracted with Recovery Innovations, Inc., a Phoenix-based company knowledgeable in the development of these services. Their report, "Crisis Now," focused on Alaska's most populous areas, Anchorage, its neighboring Mat-Su Borough, and the Fairbanks North Star Borough (Recovery Innovations, Inc., 2019; see also Alaska Mental Health Trust Authority, 2020).

The major elements of the new program have significant national support, reflected in a recent conference entitled REIMAGINE (2022), which was co-sponsored by over 30 prestigious behavioral health organizations. The model endorsed the development of a model crisis program with three interlocking components. First, the regional or statewide crisis-call centers associated with the new 988 national behavioral crisis phone number would segregate behavioral health crises phone calls from the traditional 911 phone service. The crisis phone service would lead, as necessary, to a referral to a centralized 24/7 mobile crisis team, which in turn is backed by newly developed crisis stabilization and short-term treatment facilities (National Action Alliance for Suicide Prevention, 2016), which are centers that are designed, in part, to relieve the pressure on general hospital emergency departments and in-patient units. As a result, the role of general hospitals would be significantly reduced, as they would serve more as referral and/or back-up facilities for the new crisis program. State hospitals continue in their role as longer-term facilities for both voluntary and involuntary patients. A detailed "toolkit" for the development of these services was published by the federal government in 2020 (Substance Abuse and Mental Health Services Administration, 2020).

The Alaska Legislature

Important components of the "Crisis Now" model were adopted from a review of functioning behavioral crisis programs in Arizona's Maricopa and Pima Counties. In Arizona statutes, these programs also function as civil commitment screening agencies (AZ. Rev. St. 36.520, 2022), components of Arizona's civil commitment process (AZ. Rev. St. 36 Articles 4, 5, 2022; Balfour et al., 2016). This association between the new behavioral health crisis services and civil commitment was adopted in Alaska, and together with other elements of the program, required that the Alaska legislature pass necessary significant enabling legislation. It took two legislative sessions to finalize the new statutory provisions with the final bill passing in 2022 (AK HB 272).

The new legislation is complicated and was reviewed in detail in a Trust publication (Alaska Department of Health, Office of the Commissioner, 2022). In summary, the new statute:

1. Recognized two types of new residential facilities, a Crisis Stabilization Center, a facility where a person can be held for 24 hours, and a Crisis Residential Center with the ability to house crisis patients for treatment either voluntarily or involuntarily as a Designated Evaluation and Treatment Center (DETs) within Alaska's civil commitment statutes (AS. 47.30.700 - 47.30.915, 2020).
2. Made changes in the definition of a "mental health worker," specifying who can initiate an involuntary commitment petition hold in a Crisis Stabilization Center and broadened the definition of "mental health worker" to who can provide designated services in these centers.
3. Made it clear that the new centers were open to walk-in clients and to police officers who, instead of filing criminal charges, could bring an individual in a behavioral health crisis to these centers, while preserving the possibility of filing charges later if the person did not cooperate with the program.
4. Sets out criteria for the use of involuntary psychotropic medication for patients held in the new crisis facilities to be used in dangerous crisis situations, without court approval, or in continuous use with court approval. These provisions preserve Alaska's strong position on the civil rights of involuntary institutionalized persons who refuse psychiatric medications in non-dangerous situations. This is outlined in the Alaska Supreme Court's decision, *Myers v. Alaska Psychiatric Institute* (2006), which made it clear that in a hearing regarding treatment refusal a court would have to go beyond the typical state standard of incompetency to make treatment decisions to override a refusal

(Hinton & Forrest, 2007). *Myers*, now codified in Alaska law (AS.30.839, 2021), gives these legal rights to persons held involuntarily in the new crisis centers.

Initial Crisis Now Programs

As mentioned, initial Crisis Now funding is focused on the Anchorage, Mat-Su, and Fairbanks North Star areas. Initial seed funding came from the Trust with the expectation that long-term financing would come from Alaska's 1115 CMS Waiver provisions (Recovery Innovation, Inc., 2019). Initially, the City of Fairbanks received a $937,000 Trust grant to develop a mobile crisis team and for associated planning for further development (Alaska Behavioral Health, n.d.). In Anchorage, the local fire department contracted with the Borough to provide mobile crisis services and planning for the development of a mobile crisis team in the Mat-Su Borough, which already has a functioning general hospital psychiatric program that participates in the civil commitment process. Also in Anchorage, the Trust funded a $400,000 grant to the Providence Health system and a $485,000 grant to Southcentral Foundation and ANTHC to study the development of the 24-hour crisis facilities and associated case management services (Alaska Mental Health Trust Authority, 2021). These facilities at ANMC and at Providence are now in the initial construction phase with some programming already operational.

DISCUSSION

This paper highlights four programs, AN health corporations with ANTHC, State of Alaska programs, Crisis Now, and programs for children and youth. These programs are key components of a possible future coordinated statewide behavioral health program in Alaska. Of the four, only the AN health corporations with ANTHC have developed significant current service delivery programs available to all Alaskans in rural and semi-rural areas of the state and to AN/AI individuals in Anchorage and in other cities. The responsibility for long-term hospital level treatment of severely mentally ill children and adults, especially those hospitalized involuntarily, has belonged to the state of Alaska since before API opened in 1962, with at that time a proposed maximum capacity of 450 beds. This number of beds was never achieved, and API has demonstrated significant problems since the opening of the new 80-bed API in 2005. These problems are not resolved. The third program, Crisis Now, brought forward by the Alaska Mental Health Trust, proposes a new approach to the development of behavioral crisis services designed

partly to reduce overcrowding in general hospitals, jails, and perhaps at tertiary care facilities like API. This program is in its infancy. The fourth area corresponds with the inadequacy of Alaska's child and adolescent inpatient and outpatient care in the state (United States Department of Justice, 2022). These problems are consistent with the state's clear responsibility to provide an appropriate mix of inpatient and outpatient programs for all of the serious mentally ill. Each of these four areas will be discussed.

The AN health corporations and ANTHC trace their formation to the Alaska Native Lands Claims Act of 1971. This settlement agreement was unique and broke with the past relationship between the federal government and America's Native peoples, which may be traced in part to the United States Supreme Court decision in *Cherokee Nation v. Georgia (1831)*. This decision started basically as a land dispute settled in favor of tribal sovereignty, which defined the lands in question as "domestic dependent nations" related primarily to the federal government. This decision resulted later in the formation of AI reservations across the continental United States. In contrast to the reservation system, the 1971 Alaska Settlement Act was based primarily on providing the AN people and their distinct regional and village corporations with land and fiscal resources to define their own future within the structure of settlement itself and within state and federal law.

The regional health programs together with ANTHC and ANMC represent a uniquely integrated system encompassing all areas of the state. Alaska's rural villages have health programs based on the work of designated health aides and, now in many villages, other primary care health personnel including behavioral health aides trained under the auspices of ANTHC. All have telehealth connections with regional clinics or rural hospitals. Each regional health corporation has a behavioral health program that emphasizes suicide prevention and substance abuse prevention and behavioral health treatment for a wide range of individuals and family services. Taken together, these corporations exemplify a traditional public health model of organized service delivery in catchment areas made up of people having strong cultural ties.

In Alaska, the state bears the statutory responsibility for hospital-level care for severely mentally ill patients requiring voluntary or involuntary hospitalization (Caplan, 1964). As time has progressed, there are now general hospital psychiatric beds in Fairbanks, Anchorage, Mat-Su, and in some of the cities of southeast Alaska, which mostly serve voluntary patients and (as previously described) some at the early phase of civil commitment involuntary hospitalization. But it is API, with only an 80-bed total capacity and a significant history of internal problems, which has demonstrated over many years that it has problems carrying out its statutorily directed

responsibilities, for all patient groups, but especially for involuntary children, adolescents, and adults. The problems related to involuntary adults were clearly illustrated recently in the case of *Disability Law Center v. State of Alaska* (2020). The case was filed on behalf of patients either boarded in general hospital emergency rooms, termed psychiatric boarding (Bloom, 2015), or detained in Alaskan jails while waiting for a bed at API. Judge William F. Morse issued his final order in the case in 2021 by reaffirming state law which prohibits detaining in jails patients on civil commitment petitions for any reason other than arranging for immediate transfer to the proper facilities. Instead of immediately sanctioning the state of Alaska, the Judge granted the state and the Trust time to begin implementing the new "crisis now program (*Does v. State of Alaska, 2021).*

Although the case focused primarily on civil commitment, the decision also recognized the significant problems at API in the delivery of CST services, as evidenced by the long waiting lists of jail detainees waiting for a bed at API. Similar situations have been reviewed by the Ninth Circuit District and Appeals courts, first in Oregon, (*Oregon Advocacy Ctr. v. Mink,* 2003), and later in the state of Washington (*Trueblood v. Washington State Department of Social and Health Services, 2016).* In these decisions the Ninth Circuit ordered strict limits on the number of days that detainees could be kept in jail after a court has ordered them transferred to a psychiatric hospital for competency to stand trial evaluation or restoration services. Alaska is within the jurisdiction of the Ninth Circuit Courts, and the state might have a difficult time justifying its current practice of detaining individuals in jail for long periods of time while they wait for a hospital bed at API (Bloom & Kirkorsky, 2021, Felthous & Bloom, 2018). Opening the new 10 slots within the Department of Corrections should be helpful but they will likely not pass court review if they are just custodial in nature. Active evaluation and treatment will need to take place within a therapeutic environment.

The Crisis Now programs are in their earliest phases of development in the Anchorage-Mat-Su region and in Fairbanks Boroughs. These will not be easy programs to develop and operate, and continuous advocacy will be needed. Important at the beginning is a clear realization that crisis treatment programs will only succeed if options for discharge of patients from these new facilities are readily available. API has a very important role in this calculation as the new crisis centers will also be part of the state's civil commitment program, which has been designed to evaluate and provide short-term treatment to some involuntary patients. However, regardless of how the client entered a crisis center, if there is limited availability for discharge, the new centers will have the same boarding problems as now exist in community hospital emergency rooms and jails.

The fourth program focuses on children's programs secondary to the 2022 federal Justice Department's finding that the state of Alaska has failed in the provision of required services for children in the most integrated community-based services appropriate to their needs, (U.S. Department of Justice, 2022). In reality, the needs of adults and children are very similar; they require adequate institutional and community programs that include the provisions of the new crisis programs, as described in this paper. Currently, there are not enough hospital psychiatric beds, voluntary or involuntary, at API or other in-state facilities to provide inpatient services for either children or adults. For adults, the result is the spill over of adults from civil commitment into the criminal justice system (Hansen et al., 2023). The same is true for children and adolescents. The use of behavioral psychiatric beds increased in the private community, and when the in-state supply of beds and community programs were exhausted, the state resorted to contracting with out-of-state psychiatric residential treatment facilities (in-patient mental health treatment facilities for Medicaid-enrolled patients under 21), where there are now children and adolescents receiving services country-wide (U.S. Department of Justice, part A, 5-9, 2022).

One answer to the overuse of institutions was for the state to improve the front-end of the continuum of behavioral services outlined in the Crisis Now initiative in the Anchorage, Mat-Su, and Fairbanks areas. With the passage of necessary enabling legislation, this initiative is in a developmental state; however, there remains a question as to whether this approach for children and adults can be implemented in other parts of the state, particularly in rural Alaska.

Following the 2022 Department of Justice's investigation report, the State of Alaska's Departments of Health and Community Services formed the Behavioral Health Roadmap Project for Alaska Youth (Alaska Behavioral Health Roadmap Project, n.d.). In the fall of 2023, this Project issued a draft report that summarizes statewide meetings held in five distinctive areas of the state (Alaska Behavioral Health Roadmap Project for Alaska Youth, 2023). The report focused on the review of current regional programs and future needs necessary to bring each area of the state into compliance with the findings of the Department of Justice's earlier investigation (United States Department of Justice, 2022). The Project's draft report catalogues possible components of a suitable program for children, which already exists in some of the five areas of the state.

Earlier in the paper, the authors summarized some of the characteristics of each of the larger AN health corporations that already have the equivalent of central call centers, the ability to transport patients from villages to towns with hospitals, and tele-health links to villages and cities for psychiatric consultation as may be needed. In some of the rural towns, there are also residential

treatment programs that provide residential services for substance abuse and some chronic behavioral health patients. Currently, the rural hospitals and their physicians and advanced practice nurses provide the best approach to short-term crisis intervention and management of severe behavioral crises with eventual transfer to a longer-term crisis stabilization center in the same city or in larger cities in Alaska. With this approach, starting a crisis stabilization center in a selected rural city with a hospital and sufficient population base to support the additional requirements of these programs does seem feasible. The best fit for starting such a program might be the Arctic Slope Native Association (population 11,031) in northwest Alaska, the Yukon-Kuskokwim Health Corporation and its main town, Bethel, (regional population 18,666) in western Alaska, or the Norton Sound Health Corporation headquartered in Nome (regional population 10,489).

In conclusion, Alaska is unique in the strength and organization of its rural programs under the leadership of the AN regional health corporations and ANTHC. These programs have had many successes and can accomplish much more in the future. The Trust, a significant positive force in Alaska's behavioral health programing, has now invested in a nationally recognized approach to behavioral crisis care. It is up to the State of Alaska to further invest in building the crisis program, to fully rehabilitate API as the anchor for one end of the behavioral health program spectrum of care for the state for adults, and adequate funding for the community hospitals and other community services for local inpatient care for children and adults.

Finally, all the programs discussed in this article need to develop functional information systems both within and between these programs. This is critical for any future development of a true integrated statewide public behavioral health program for the state of Alaska.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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