

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 health 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).

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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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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%

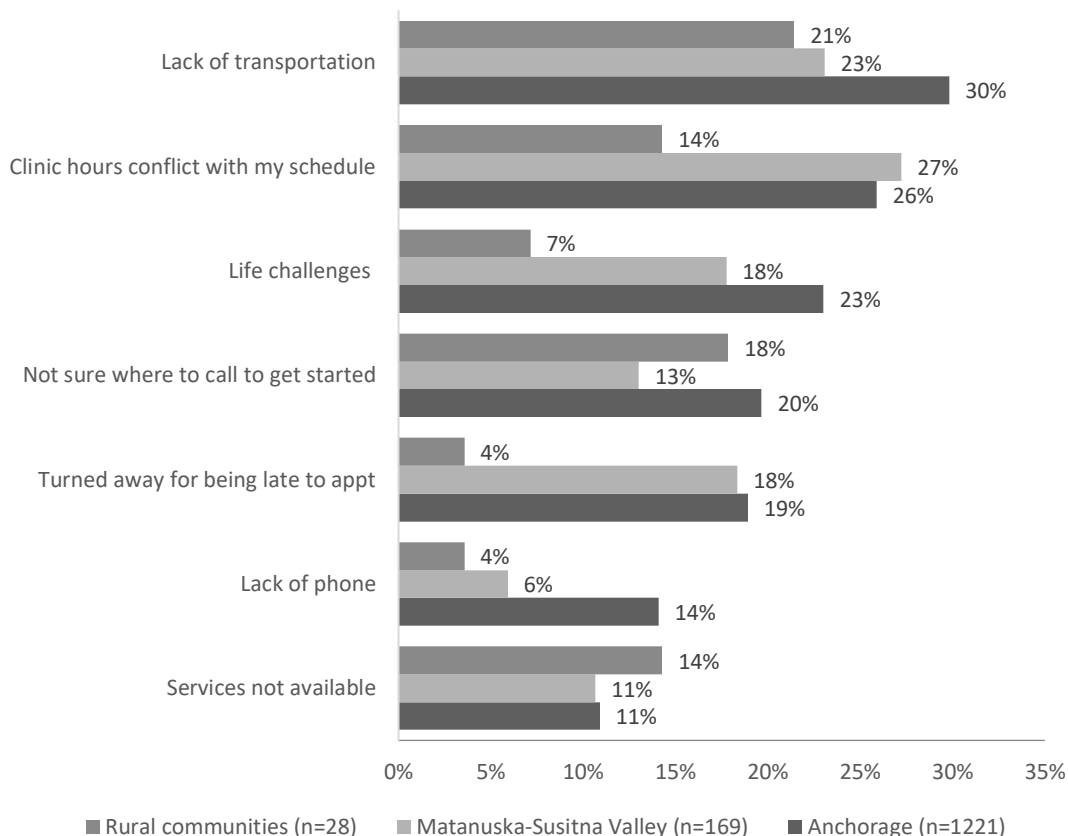


Figure 1. Barriers to access to care

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.

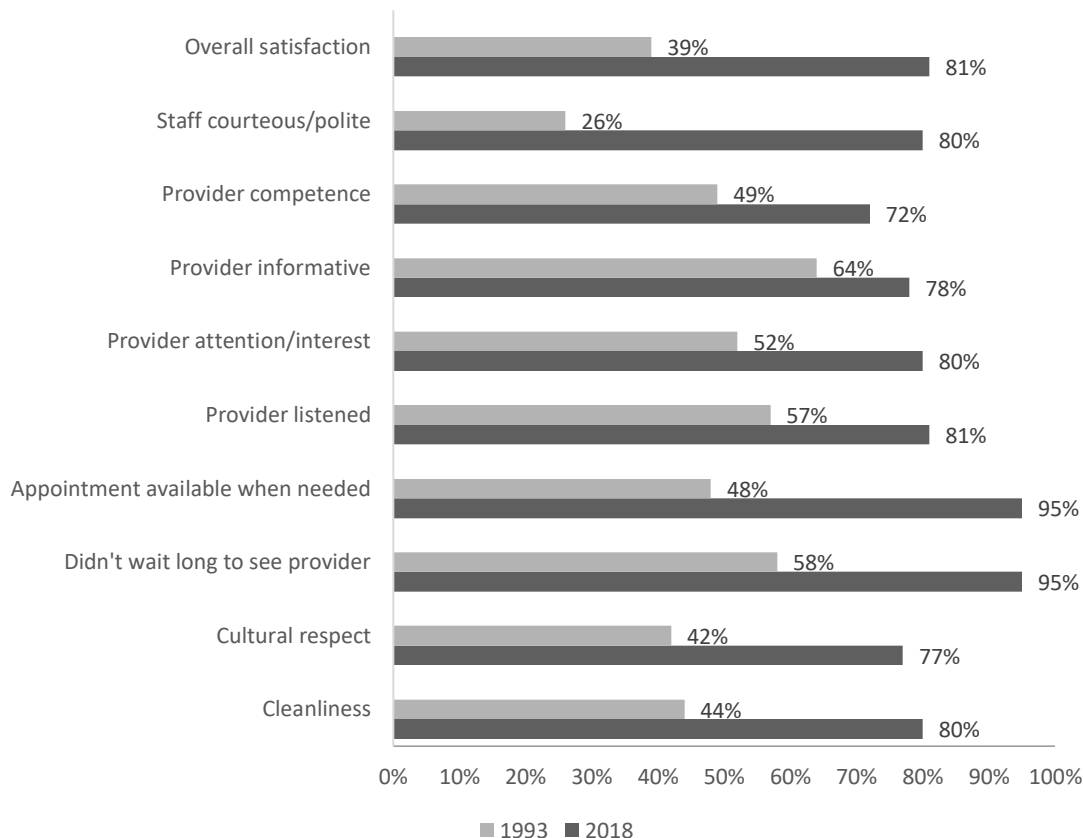


Figure 2. Comparison of satisfaction, 1993 and 2018

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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