HEALTHY ALASKANS 2020 IMPLEMENTATION PILOT

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A

PROJECT REPORT

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Abstract

Healthy Alaskans (HA), now in its third iteration (HA2020), is Alaska's Statewide Health Improvement Plan (SHIP). HA2020 consists of an overarching framework of 25 health goals or Leading Health Indicators (LHIs), for the state to track and achieve by the year 2020. These goals have a broad span and were informed by input from over 3,000 Alaska residents. Building upon the 25 LHIs as well as identifying evidence-based strategies to help achieve these goals brought the initiative to its implementation phase. In order to advance the initiative, four individuals (known as Coordinating Partners or CPs) were chosen to coordinate and pilot action strategies for four of the LHIs: socioeconomic status, suicide, tobacco, and domestic violence. Assessing the CP experience will provide the HA2020 Core Team with feedback from its core partners as it moves forward with implementing strategies to improve all 25 Leading Health Indicators. This practicum consisted of interviews with the CPs about their initial experience, from which themes and recommendations were extracted to assist future outreach and implementation efforts. Consistently occurring themes include the need to explicitly explain the role of the Coordinating Partners and the expectations and timeline for success. CPs expressed lack of clarity and divergent understandings about their role and expectations. Another key component of this practicum project was an extensive environmental scan and an online survey to help identify and document community agencies and individuals actively working to achieve the 25 LHIs. The results were compiled in a searchable spreadsheet with individual tabs for each pilot indicator, and shared with the CPs to facilitate outreach.

Keywords: state health improvement plan, environmental scan, survey, interviews, leading health indicators, Alaska

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Introduction

Beginning in the 1990s, the State of Alaska's Department of Health and Social Services (DHSS) began work on a Statewide Health Improvement Plan (SHIP) called Healthy Alaskans. Healthy Alaskans 2000, published in 1994, was followed by Healthy Alaskans 2010, and is now in its third iteration, Healthy Alaskans 2020 (HA2020). During this time, it has evolved into a partnership between DHSS and the Alaska Native Tribal Health Consortium (ANTHC) (Alaska Dept. of Health and Social Services, 2001). HA2020 identified a framework of 25 health-related goals known as the Leading Health Indicators (LHIs) through a comprehensive state health assessment and input from multiple supporting partners and over 3,000 Alaskans. Progress on these LHIs is tracked using a variety of sources and updated annually on the HA2020 Scorecard (see Appendix A).

Supporting the LHIs are 75 evidence-based strategies finalized in July 2015. Creating alliances and networks among the many organizations dedicated to improving health and wellbeing throughout the state is critical in order to implement and promote these strategies. The first statewide implementation phase of HA2020 will utilize Coordinating Partners (CPs), key individuals selected to lead projects in fours LHIs.

Prior to selecting the Coordinating Partners, the HA2020 Core Team (see Appendix B) chose nine Leading Health Indicators and ranked these nine in terms of their importance and support. Input solicited from the Advisory Team (see Appendix C) aided in the process of further narrowing down these nine LHIs into the four chosen for the pilot. The implementation plan was introduced and ideas and invitations for the CPs were also shared during two webinars that were hosted for the Advisory Team members.

The four Leading Health Indicators selected to pilot the implementation were socioeconomic status, suicide, tobacco, and domestic violence. The second step was to identify health champions, called Coordinating Partners, working towards these specific health goals. In February 2016, through participation and input from the Advisory Team, those Coordinating Partners were selected. The CPs represent professionals from both tribal and state entities as well as a social service agency.

Involvement of many community members throughout the state is integral to the success of HA2020. Additionally, HA2020 relies upon input from professionals working within the many sectors that affect health. This collective effort can be seen through the participatory manner in which the Advisory Team, comprised of 25 health professionals working in a broad range of enterprises, including corrections, sanitation and education, assisted with selecting both the pilot project indicators and the Coordinating Partners.

While many states have SHIPs, as can be seen on the Healthy People 2020 website (www.healthypeople.gov), conversations between Core Team members with contacts at the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation (RWJF), have revealed that neither organization knows of any other state with such a comprehensive implementation plan. In addition, the Association of State and Territorial Health Officials (ASTHO) and the National Network of Public Health Institutes (NNPHI) have both reached out to Alaska to present on the unique HA2020 implementation strategy. It is evident through the interest and engagement of health agencies and institutions outside of the state that Alaska is at the forefront of implementing a comprehensive State Health Improvement Plan.

There are both benefits and downfalls to being at the forefront of any movement, including the implementation phase of a SHIP. While other states can learn from Alaska's experience,

Alaska does not have an evidence-based strategy to inform its efforts and thus has to rely largely upon individual ideas about how to implement the initiative. Had other states already gone through the process and candidly shared their experience, Alaska might have been able to avoid or mitigate potential pitfalls or errors. SHIP implementation is truly uncharted territory.

As Alaska's SHIP, HA2020 does, however, have the benefit of being premised on two effective models of population health improvement: the ecological model and the collective impact approach to building collaboration between many sectors working to improve health.

Ecological Model and Social Determinants of Health

The ecological model has its origin in the 1950s and there are many models, which Sallis, Owen and Fisher (2008) divide into those that either primarily serve to explain behavior or are useful in guiding behavioral interventions. All models share the general underlying theme that forces outside individual control greatly affect health.

Bronfenbrenner's Ecological Model Systems theory, shown below, consists of a series of concentric rings called "spheres of influence" (Wortham, 2008). The innermost circle represents the individual and moving outwards are the microsystem, meso-system, exosystem, with the last external ring being the macrosystem. To enact lasting change, one must address as many of these spheres of influence as possible, as HA2020 aims to do.

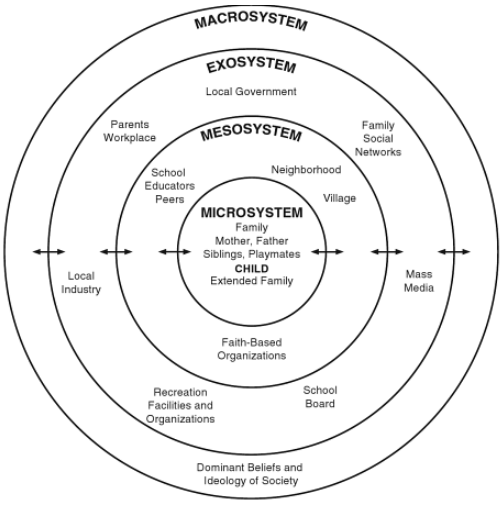


Figure 1. Bronfenbrenner's Ecological Model System

This holistic, multilevel view is supported by Healthy People 2010, a precursor to Healthy People 2020 and an initial framework utilized by Healthy Alaskans that states "Healthy People 2010 recognizes that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity—an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment, as well as data collection itself" (U.S. Department of Health and Human Services, 2000, p. 16). In addition, the importance of engaging multiple partners is acknowledged by the statement that "[c]ommunity partnerships, particularly when they reach out to nontraditional partners, can be among the most effective tools for improving health in communities" (U.S. Department of Health and Human Services, 2000, p. 4). The ecological model and statements above enforce the idea of a multidisciplinary and multilevel approach that characterizes many public health improvement efforts, and is aligned with the implementation strategy of HA2020 to create networks and partnerships.

Frances Butterfoss, the president of Coalitions Work and an author well known for her work on coalitions, defines a coalition as a "type of partnership" and "a formal, multipurpose, and long-term alliance" (Butterfoss, 2002, p. 163). Coalitions are integral to effecting change and

building support around innumerable issues and their effectiveness is apparent in many endeavors, including many relevant to public health. Given the multifaceted nature of public health, coalitions that bring together many stakeholders are commonplace.

Ecological models are heavily influenced by social determinants of health (SDH), as each ring surrounding an individual and thereby affecting their health and wellbeing, encompasses factors such as education, poverty, transportation, and justice. These factors are often known as social determinants of health (SDH), defined very basically as "causes (of diseases) that originate from society and its configuration" (Friis & Sellers, 2014, p. 755). A further definition mentions "major social forces and concepts that influence the occurrence of disease" (Syme, 2000, p. xii). Social determinants of health fall into all spheres of influence and encompass ethnicity, gender, housing conditions, food availability, socioeconomic status, education, recreational opportunities, family dynamics, working conditions and environmental stressors. The World Health Organization states that "[t]he...conditions in which people are born, grow, live, work and age...are shaped by the distribution of money, power and resources," and that "[t]he social determinants of health are mostly responsible for health inequities" (World Health Organization, 2015). Ensuring health equity for all Alaskan residents by tackling health inequities or disparities is one of the key missions of HA2020 (AK DHSS & ANTHC, 2015, p. 1). Many of these "forces and concepts" are impossible to change without the concerted and combined efforts of many individuals and organizations, but with such efforts, change is possible and success stories do exist. Some of the most dramatic successes include decreased tobacco usage, increased immunization rates, and improvements in food, motor-vehicle, and workplace safety (Centers for Disease Control and Prevention, 2013). None of these examples of public health successes were achieved alone or in silos.

Healthy Alaskans 2020 acknowledges the importance of the social determinants of health in determining individual and population health. Leading Health Indicators 24 and 25 are particularly important to address factors that can result from conditions beyond individual control such as poverty (24) and educational attainment (25). Additional Leading Health Indicators related to SDH address environmental health concerns such as access to fluoridated water and wastewater services. Access to care is another factor that can greatly impact health especially in Alaska – the nation's largest state and one in which many residents rely on boat or plane to reach care. As a 2011 report issued by the Alaska Health Care Commission states, "[a]pproximately 75% of Alaska's communities are not connected by road to a community with a hospital, and nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft" (p. 9). These are unique challenges.

Given the power of effective partnerships and unions to engender change, Healthy Alaskans' strategy to build and create alliances around the state's foremost health issues makes sense.

Collective Impact Approach

Collective Impact was first introduced by John Kania and Mark Kramer in a 2011 article in *Stanford Social Innovation Review*. In this article, collective impact is defined as "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem" (p. 36). A further definition provided by Preskill, Parkhurst and Splansky Juster (2014), adds that "[m]ore than simply a new way of collaborating, collective impact is a structured approach to problem solving" (p. 4).

Kania and Kramer provide three examples of successful projects premised on the collective impact approach, and one of these projects, Strive, is now active in Alaska under the banner of

United Way with the name 90% by 2020. It focuses on increasing high school graduation rates in the state, and has already made some progress on this Leading Health Indicator with the website noting that "[i]n the past decade we've seen a steady increase in graduation rates in Anchorage, from 59% to 80%" (United Way, 90% by 2020 website).

There are five conditions necessary for the collective impact approach to be successful. Healthy Alaskans 2020 aims to meet all five. These conditions are "a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations" (Kania & Kramer, 2011, p. 39). The 25 LHIs on the HA2020 Scorecard constitute the common agenda, the first collective impact condition. These goals were vetted by many individuals and organizations as the most critical to address to improve the health of all Alaskans. The second and third conditions are to be undertaken by the Coordinating Partners as they reach out to organizations and begin cultivating trusting relationships. Open communication, or "continuous communication," is already in use, and is exemplified in the selection process of the LHIs to pilot and the first cohort of CPs. HA2020 is overseen by a Core Team that fulfills the backbone organization component, and the members of this team are dedicated to transparency and reliance upon feedback from the larger community, as represented by the Advisory Team.

Collective impact has been successful in tackling a range of issues, but the examples presented in Kania and Kramer (2011), while highly successful, are small, community-level interventions. It is, however, important to remember that community-level changes are the first ripple and as the ripple effect posits, these small changes can spread to make larger changes, or ripples. Nonetheless, enacting large-scale examples of success is a challenge.

Cultivating trusting relationships among organizations that have hitherto been forced to compete for limited funding takes time and effort. It is perhaps the largest barrier that must be

overcome and will undoubtedly be a challenge for the Coordinating Partners. Kania and Kramer state that "participants need several years of regular meetings to build up enough experience with each other to recognize and appreciate the common motivation behind their different efforts" (2011, p. 40). This is a daunting proposal given the dedication it would require, but this practicum project confirmed that coalitions focused around particular LHIs already exist, thus these meetings are currently under way for at least some LHIs.

Around the World – Plans and Theories

Many nations around the world have developed health improvement plans. A literature search revealed articles on Australia, Canada, Germany, Israel, Spain, Sweden and the United Kingdom. Canada may have been one of the first to develop such a plan. David Brown, at the Centers for Disease Control and Prevention, states that the proclamation of Healthy People back in 1979 as "a landmark in the history of public health" was "too favorable a statement as it was by no means the only such national effort of its kind," and goes on to mention a Canadian government publication espousing a national health plan in 1974 (2009, p. 95). He also mentions that prior to the leadership of Dr. William Foege, there had not been a focus on prevention, instead "national attention was turned toward disease management and treatment" (2009, 94). Dr. Foege's foresight led to a reorientation that elevated prevention and in turn the Center for Disease Control was renamed the Centers for Disease Control and Prevention (Brown, 2009). This reorientation was fundamental to public health history and to all health planning endeavors.

Launched in 2005, Healthy Israel 2020 (HI2020) has interesting parallels to Healthy Alaskans 2020. Israel has an "uneven distribution of health," much like Alaska, and therefore both plans share a focus on health equity (Rosenberg, Lev, Bin-Nun, McKee, & Rosen, 2008, p.

1218). Given the 'uneven distribution of health' between Alaska Natives and non-Alaska Natives, HA2020 has a separate scorecard for each population. A further commonality between Alaska and Israel is their diverse populations, and Rosenberg et al. cite "unique health cultures…among rural Israeli Arabs, the Bedouin, recent Ethiopian immigrants and ultra-orthodox Jews" (2008, p. 1222). Given the fact that Anchorage has the "country's three most diverse census tracts," this commonality is evident (Basu, 2016).

The authors note how HI2020 has learned much from the United States' National Health Improvement Plan, the World Health Organization's Health21 program, previously known as Health for All, and Healthy People, and finishes by citing a further similarity: the threat of being "derailed by political change," including a lack of funding (2009, p. 1223). Unfortunately, looking to other countries for guidance on the implementation of a health improvement plan yields a dearth of evidence and literature about implementation activities abroad.

As the ecologic model demonstrates, public health encompasses many fields of study, and consequently there are a multitude of programs targeting specific and wide-ranging issues. What differentiates Healthy Alaskans and other large-scale health improvement plans is that they are ambitious, holistic and bold. As mentioned, there are a variety of programs dedicated to improving health, as can be seen in a report funded by the Robert Wood Johnson Foundation, *Investing In America's Health* (2015). None of the programs reviewed take such a comprehensive view of health as HA2020, and yet sufficient and sustained funding has been challenging for Healthy Alaskans 2020. The State of Alaska is in a difficult fiscal climate; however it is foolhardy to think that funding for health can be cut without repercussions that may well eventually end up costing the state more than supporting bold, comprehensive, preventative plans like Healthy Alaskans 2020. Although found in an article about Australia, the term

"unsustainable financial costs of inaction" is applicable (Moodie, 2008, p. 588). It is however a rare politician or policy-maker who is able to take a long-range and expansive mindset; unfortunately election cycles do influence decision-makers.

Healthy People 2020, and the recently announced Healthy People 2030, are certainly not the only national health improvement plans. Other notable, large-scale plans within the United States are the Robert Wood Johnson Foundation's "Culture of Health," and the American Public Health Association's "Generation Public Health" whose vision is to "create the healthiest nation in one generation" by focusing on the social determinants of health (APHA Generation Public Health website). This echoes Australia's National Preventative Health Strategy goal to "become the healthiest country by 2020" (Moodie, 2008, p. 588). The Matanuska-Susitna Borough Foundation has also adopted similar language; their mid-term goal for 2017 is that "[t]he Mat-Su Borough is the healthiest borough in Alaska," and their long-term goal for 2020 is that the "Mat-Su Borough is the healthiest borough in the United States" (Mat-Su Health Foundation website).

In addition to multiple health improvement plans, there are multiple theories about how to engender change. Besides collective impact, another approach commonly found in the literature is Health in All Policies. The Association of State and Territorial Health Officials (ASTHO) defines this as "a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and at all levels, to improve the health of all communities and people" (2013, p.2). This approach aligns well with the ecological model in recognizing that many levels, or spheres of influence in Bronfenbrenner's model, affect health. It also incorporates the importance of collaboration and social determinants of health by referencing the health of communities. Living in a community that provides residents with ample and safe recreational spaces, economic opportunities, and healthy food options greatly affects the health of the

residents. As the ASTHO document states, "[c]ommunity design, transportation systems, agricultural activities, access to goods and services, and safe and affordable housing are all examples of environmental conditions that have significant impacts on health" (2013, p. 4). Other health improvement plans that acknowledge the role that community health plays in population health are RWJF's "Healthy Kids, Healthy Communities" program and CDC's "Healthy Communities Program." The latter program emphasizes the importance and effect of the physical environment upon health, as seen pictorially in the CDC infographic (Appendix D). Additionally the University of Alaska Anchorage College of Health's mission is "[a]dvancing the health and well being of people and communities" (UAA College of Health webpage). These initiatives and mission statements make it apparent that healthy communities are recognized as an important component of overall health.

The Health in All Policies approach (used in Healthy Minnesota 2020) is compatible with the collective impact approach, as mentioned previously, and such a multimodal approach may strengthen subsequent work. Indeed Glanz and Rimer (2008) postulate that "it is likely that the strongest interventions will be built from multiple theories" (p. 510). It is however necessary to distinguish between theories in actual use, otherwise there is no definitive way to know what theory, or part of a theory, is contributing to understanding and effective action, and what parts may be ineffective.

Goals and Objectives

The overarching goal of the practicum was to assist the HA2020 Initiative with their primary mission to "improve health and ensure health equity for all Alaskans" (AK DHSS & ANTHC, 2015, p. 1). In order to accomplish this goal, the project identified three main activities. The first was an environmental scan resulting in a comprehensive list of organizations dedicated to health

improvement in Alaska. The results were to be uploaded and expand the utility of the Alaska Health Education Library Project (AHELP) website. AHELP was started in the late 1990s for health professionals as "an electronic clearinghouse of current health promotion and health education resources that are specific to and available in Alaska" (AHELP website). It's separated into the following subsections: projects, materials, people, links, evidence-based public health tools, and a calendar of events.

Well-connected networks of organizations that share a similar focus and dedication to improving each of the 25 LHIs are the eventual goal of HA2020. An essential first step was to identify such organizations, and this was the goal, along with furthering the utility of AHELP, of the environmental scan.

An environmental scan is gathers and analyzes data and can serve a variety of purposes across multiple fields. In public health, an environmental scan is often used as part of a needs assessment and the results can be used to make changes to existing programs or to implement strategies that address the particular needs of a community. For this project, an environmental scan was used to gather information on existing services and organizations. While "there is no one correct way to conduct an environmental scan," one common shared characteristic of an environmental scan is that "information is gathered from a variety of sources, including literature reviews, surveys, interviews, focus groups and site visits" (Randolph, Dewberry Moore, Nowrojee, Memiah, & Bronner, 2005, p. 529). Data from the environmental scan were entered into a spreadsheet.

The second practicum activity was to create and disseminate an online survey to identify organizations, partnerships, groups and coalitions to supplement the environmental study.

Respondents linked the organizations they identified with particular LHIs. This additional information led to a spreadsheet searchable by LHIs and keywords.

The online survey was emailed in waves beginning on November 24 from the Healthy Alaskans 2020 email address to the 130 HA2020 Key Partner organizations, multiple listservs, and individuals identified in the environmental scan. While it is apparent that many sectors are involved in health improvement, it was necessary to do some prior research to identify where and to whom specifically the survey should be emailed and the environmental scan fulfilled this step.

The HA2020 Core Team assisted in the survey's dissemination and aimed for the broadest reach possible. The goal was to identify and gather complete data on at least 100 existing groups within the state working on the LHIs, and to compile the data into an online resource with contact information for each identified entity. The goal of 100 groups, subsequently obtained, was chosen during the proposal development and was rather arbitrary. In retrospect, using a percentage of invited participants would have been a more well-informed decision.

The HA2020 Core Team has cultivated multiple connections through their work in the state and their assistance in encouraging individuals to participate in the survey, through reminder emails and individual outreach, boosted the response rate (n=100). An environmental scan to identify those to whom the survey should be distributed, confirm the information provided, and supplement the survey results helped achieve this goal.

The searchable database resulting from the environmental scan and survey assisted HA2020 to identify potential partner organizations that in turn can serve as dissemination and communication entities for HA2020 now and in the future. The survey attempted to reach all potential stakeholders, and given the broad range of HA2020 goals, the resulting database of

potential partners was not limited to health-specific groups, but instead aimed to capture all groups that promote health whether directly or indirectly.

The second goal of the project was to learn from the experiences of the first Coordinating Partners and, in doing so, assess the effectiveness of the implementation strategy devised by the HA2020 Core Team. The third activity addressed this goal: the creation of an interview guide and subsequent key informant interviews with the Coordinating Partners. These interviews occurred in March and were transcribed to facilitate a thematic analysis. The interviews ultimately resulted in a list of recommendations to ensure that future Coordinating Partners are given sufficient guidance and assistance to succeed in strengthening alliances and make progress in meeting the target rates around their specific LHI.

Background

Selection of LHIs and Coordinating Partners

The selection of the first four Coordinating Partners was the result of multiple steps, with the Core Team making the final decision, informed by input from the Advisory Team. Both the LHIs and CPs selected for the pilot implementation were selected using the data-informed process described below.

Two webinars, conducted on separate days and weeks in November, introduced the Advisory Team to the implementation plan and the use of Coordinating Partners. Polls administered throughout the webinars asked Advisory Team members to indicate their level of confidence in the implementation process, specific topics or LHIs for the pilot, and advice on possible Coordinating Partners, including their personal interest in serving as a Coordinating Partner.

Prior to the webinars, the Core Team discussed the LHIs and made a short list of nine LHIs

to present to the Advisory Team. Members were asked to rate the LHIs on the following three criteria: existing broad and active networks or coalitions; those with the highest profile and urgency, and those LHIs which were well-established, funded and gaining in momentum. The results can be seen in Table 1.

Table 1

Advisory Team Rankings of the Pilot LHIs

	Webinar Day	Broad/active network/coalition	Highest profile/ urgency	Well established, funded, gaining momentum	Straight total	Average percentage
Tobacco	1	5	1	6	12	
	2	3	2	0	5	
Percentage of responders		57%	21%	50%	17	43%
Obesity	1	0	0	0	0	
	2	0	0	3	3	
Percentage of responders		0%	0%	25%	3	8%
Suicide	1	7	9	5	21	
	2	3	4	3	10	
Percentage of responders		71%	93%	67%	31	77%
Social Support	1	2	1	1	4	
	2	0	0	0	0	
Percentage of responders		14%	7%	8%	4	10%
Domestic Violence	1	5	5	3	13	
	2	4	3	4	11	
Percentage of responders		64%	57%	58%	24	60%
Alcohol use	1	3	8	6	17	
	2	1	2	1	4	
Percentage of responders		29%	71%	58%	21	53%
Vaccines	1	3	0	3	6	
	2	1	0	1	2	
Percentage of responders		29%	0%	33%	8	21%
Water	1	1	3	0	4	
	2	0	0	0	0	
Percentage of responders		7%	21%	0%	4	10%
SES	1	2	1	0	3	
	2	0	0	0	0	
Percentage of responders		14%	7%	0%	3	7%
Day 1 (Nov.10) total # of people voting		10	10	8		
Day 2 (Nov.19) total # of people voting		4	4	4		

The above criteria, along with the desire to have a mix of well-funded and broadly supported issues with those that are not currently making progress or on track to reach the HA2020 target rate, informed the selection of the four LHIs. Although three LHIs were originally proposed, the decision to add an additional LHI was made after assessing the level of support among the advisory team and the number of volunteers for Coordinating Partners during the webinars.

Socioeconomic status, represented most prominently by LHIs 24 (poverty) and 25 (educational attainment), reflect HA2020's commitment to tackling underlying factors that affect health. The impact of these factors on health and health equity cannot be overestimated. A February 2016 Brookings Institution report noted "recent studies show that the differential in mortality rates across social and economic status groups has widened in the United States" (Bosworth, Burtless & Zhang, p. 61). These studies support increased media coverage and political campaigns addressing both income growth and wealth inequality. A previously mentioned CDC infographic (Appendix D), makes it clear that socioeconomic indicators, such as poverty and high school graduation rates, play an outsize role in health, affecting health more than clinical care, the physical environment or health behaviors. This physical depiction supports the ecological model as well as the choice of socioeconomic status as one of the four pilot LHIs.

Information from the polls administered to the Advisory Team was gathered into a spreadsheet (see Table 1). The four LHIs that rated highest in the selected criteria were (in aggregate) suicide, domestic violence, alcohol use, and tobacco (respectively). Suicide was identified as having the most urgency by all but one respondent, and had the highest rating (93 percent) of any LHI in any criteria. Consensus on the top three issues was broad, and socioeconomic status, which was rated last by the average percentage on the above criteria, was chosen to fill the role of the struggling LHI.

Five Advisory Team members were interested in serving as Coordinating Partners, and the Core Team followed up in personal communication with the potential volunteers. The Core Team also conducted due diligence in ensuring that the individuals chosen had the necessary tools to succeed, which ultimately led to the selection of other Coordinating Partners. In other words, the predicted success of certain individuals as the pilot Coordinating Partners took precedence over the enthusiasm of the volunteers.

Various additional names were floated during the weekly Core Team meetings, and one potential CP who was enthusiastically reviewed was dropped from consideration when she was appointed to be the board chair at a large hospital, since she would be fully engaged with her new role. At one point concern was also expressed over selecting a particular Advisory Team member who had indicated that she would be willing to serve as a Coordinating Partner for two of the LHIs. This was originally seen as indicative of conflicted priorities or of not being fully committed to one specific LHI. This concern may be symptomatic of a larger problem - but one that can easily be remedied. Since the LHIs are necessarily related, the idea of selecting a separate Coordinating Partner for each of the 25 LHIs may need to be reassessed. One possible remedy that was discussed is to group the LHIs. At the same time, when the LHIs are grouped, it is harder to separately assess the unique impact of the strategies. For instance, it is hard to know if a reduction in suicide would be attributable to specific efforts in suicide prevention or to an uptick in social support or a reduction in domestic violence.

In time, the Coordinating Partners may well come together to tackle groups of issues or, perhaps less likely due to the workload, a single Coordinating Partner may take on multiple LHIs, but these arrangements will complicate assessment. This demarcation between strategies and results, or more broadly causation, is complex and an endemic issue among public health

improvement efforts. Differing opinions about how to solve intransigent health issues also contributes to the multitude of groups dedicated to health improvement.

As the selection of the Coordinating Partners neared, the idea of having an organization affiliated with the Leading Health Indicators selected (SES, suicide, tobacco and domestic violence) was raised by Jayne Andreen, who worked in Community Health Promotion and Improvement at the Alaska Division of Public Health. One of the main reasons behind this suggestion was sustainability. In her words,

> [i]t is important that the CP be an organization, which can, maybe should, assign a lead staff person. When looking at sustainability of public health initiatives, we know that a systems approach has a much better chance of being implemented over a period of time. When, not if, the person leaves, the organization would have the responsibility of ensuring the functions are maintained by the replacement or another employee. That way the records and information are also maintained across the many changes that occur in individuals' lives.

For instance, the CP chosen to lead efforts in suicide prevention (Kate Burkhart) is part of the Suicide Prevention Council. If a Coordinating Partner had to relinquish the role or move on, another individual within the organization would, it was assumed, be more well versed to replace them than an individual from another organization unfamiliar with HA2020 or who did not already have a relationship or knowledge of the initiative.

Similarly, it is also a natural fit for an employee of the Council on Domestic Violence and Sexual Assault to lead the effort against domestic violence. Their role as a champion or advocate of that LHI is essentially part of their responsibility already, and as Coordinating Partners are to serve as champions of an issue, that selection was a natural choice.

One more reason to choose a CP from an organization associated with the indicator in question is that Alaska has an especially dynamic population, with Alaska experiencing more in and out-migration than many other states. The Alaska Population Overview states that, "Alaska has among the highest rates of gross migration (in-migration plus out-migration) in the nation" (AK Dept. of Labor and Workforce Development, 2015, p. 11). This statewide population trend makes sustainability an especially pertinent issue in CP selection.

In conclusion, the four Coordinating Partners selected were Lisa Aquino (SES), Kate Burkhart (suicide), Dana Diehl (tobacco), and Ann Rausch (domestic violence).

Methods

Environmental Scan

Of the two main goals of this practicum, the first was to expand the AHELP website by conducting an environmental scan. This was supplemented by survey results with the end goal being a comprehensive list of organizations dedicated to health improvement within the state.

The tools utilized to build this database were an environmental scan and a Qualtrics online survey. During the environmental scan, it became clear that the Leading Health Indicators did not sufficiently cover the range of organizations and programs that worked both directly and indirectly toward promoting health. In fact, it would be virtually impossible to track the multitude of factors that affect health; one reason being that not all can be identified or at least tackled. Health is not static; there continue to be discoveries and new ideas generated as research and practice continues. To make the database more applicable to the range of health issues one might search by, additional keywords supplemented the LHIs as search categories.

Table 2

LHI Spreadsheet and Additional Keywords

LHI	Keywords	Additional Keywords
1	Cancer	Addiction
2	Tobacco, cigarettes - youth	Behavioral Health
3	Tobacco, cigarettes - adults	Camp
4	Overweight, obesity - adults	Caregiving
5	Overweight, obesity - youth	Childcare
6	Exercise, physical activity	Clothing
7	Suicide	Detention, Correctional system, incarceration, self-sufficiency, reentry
8	Mental health - youth	Disability, intellectual and developmental disabilities
9	Mental health - adults	Food, hunger, food pantry, subsistence
10	Social support	Environmental health
11	Child abuse, neglect	Healthy Relationships
12	Rape, sexual assault	HIV, STDs
13	Dating violence, domestic violence	Homeless
		Housing
14	Alcohol-induced death, substance use	Immigration
		Job training, employment
15	Binge drinking, substance use	Legal assistance, Law, justice
16	Unintentional injury	LGBTQ
17	Childhood vaccinations	Mediation
18	Chlamydia	Mentoring
19	Home water & wastewater services	Microfinance, entrepreneurship
		Nutrition
20	Fluoridated community drinking water	Parenting
		Resiliency
21	Early prenatal care	Runaway
22	Preventable hospitalizations	Scholarship
23	Cost as a barrier to healthcare, access	Seniors, elders, elderly, older, aged
		Shelter
24	Poverty	Social Services
25	High school graduation, equivalency	Transportation
		Veterans
		Youth

The environmental scan aimed to include all the possible agencies and organizations working toward health improvement, which quickly became overwhelming. A very broad, public health approach was taken to defining 'health improvement.' For instance, afterschool music groups and summer camp programs for youth were included given that they might promote interpersonal skills, help build social support, and foster healthy behaviors and habits. Another consideration was that the list should be responsive to Alaska's particular needs. For example, "three-quarters of Alaskans will not obtain a college degree," and therefore the list should reflect the need for other income-generating career pathways such as job training and apprenticeship programs (Drygas, 2016, p. 3). Transportation is another Alaska-specific need; as was mentioned in the introduction, many residents rely on boat or plane to reach care and therefore need assistance with transportation costs.

It was easy to find some helpful lists for the environmental scan, and indeed many of these lists were ultimately used, but they did not encompass all the agencies that could be thought of to improve health or have the entire state as their geographic reach. Furthermore, some lists had not been maintained and listed agencies or programs that no longer existed.

Resources mined for information included the list of charities in the Pick.Click.Give campaign, the Department of Public Health behavioral health grantees, recipients of grants from the nine community foundations, the United Way Be the Change 907 list, Rotary donor recipients, the Alaska Public Health Association conference, the UAA Center for Community Engagement & Learning Urban in Alaska conference, local newspapers, the Alaska Economic Trends Magazine, the HA2020 strategy work group members, the AHELP database, the 211 directory, Rasmuson donor recipients, the State of Alaska SHARE campaign, the UAA Community Campaign, and the Anchorage Youth Central's organization list. Conversations at

the conferences mentioned above also yielded additional organizations and connected the student with individuals working at certain large agencies or organizations, such as the Municipality of Anchorage, the Aleutian Pribolof Island Association, and the SouthEast Alaska Regional Health Consortium. After introducing herself and the project, the student enlisted individuals at these agencies to verify the information and fill in the blanks by entering the information in the emailed spreadsheet. The spreadsheet was also sent to Alaska's Collective Impact group, as recommended by a Community Partner. Finally listening to certain radio programs, especially Line One: Your Health Connection on Alaska Public Radio, helped build the list.

Survey Creation

The second tool used to create a list of all health-promoting organizations in the state was a Qualtrics online survey. Qualtrics was chosen as it had been used successfully in previous coursework, and is used by many notable organizations, including the Northwest Center for Public Health Practice at the University of Washington. The survey was created so that each identified organization would be linked directly to a Leading Health Indicator, as well as to supplement the environmental scan. One purpose of creating this linkage was to enable the HA2020 Core Team to supply the Coordinating Partners with a list of possible contacts for their particular LHI. To facilitate usage, the spreadsheet has separate tabs for each of the four LHIs.

The online Qualtrics survey developed to inform HA2020 of statewide organizations went through numerous editions and confirmed the difficulty of designing a survey that could both collect valuable information while being concise enough to encourage participation and completion. Hours on the phone with Qualtrics enabled use of loop-and-merge and skip and

display logic techniques, thereby ensuring that participants viewed only those questions pertaining to their selected LHI(s).

The survey was reviewed by members of the Core Team and their feedback and suggestions led to the final version. A separate conversation with Jayne Andreen of AHELP (since retired) assisted with final revisions and led to the abbreviated survey distributed by email beginning November 24, 2015. A copy of the survey can be seen as Appendix E.

The first question of the survey allowed participants to choose the Leading Health Indicators (LHIs) for which they could identify specific organizations. From that point forward, the survey displayed only questions about those LHIs. Each participant could identify a maximum of three organizations for each selected LHI. The survey displayed the entire text of the LHI as they moved through the relevant questions. For each organization, there were five questions: name, type of organization (public, private non-profit, professional, tribal, coalition and voluntary), the groups in the coalition (displayed only if coalition was selected), the geographic area served by the organization, and contact information. The 'type of organization' and 'geographic region served' questions align with AHELP categories, and were deemed the most important of the more comprehensive information AHELP collects. The survey's final revisions were made to help facilitate the survey's usefulness in expanding AHELP.

Initial drafts included questions regarding publications and the frequency of meetings but these were deleted since the primary purpose of the survey was to supplement the environmental scan. Collecting full and detailed information about the hundreds of organizations within the state was beyond the scope of a single practicum project.

Certain questions, including the two excluded items regarding publications and meeting times, were meant to capture was activity level of the group, but in reality, they did not

necessarily capture this information. The publication question also lacked the detail that AHELP required of publication submissions. The question about meeting times was removed when a Community Partner testing the survey indicated it was confusing, with respondents unsure if they were to record the meeting frequency of their entire organization or if they were being asked about smaller group meetings within the organization. For example, the Core Team of HA2020 holds weekly meetings, but other groups involved in HA2020 meet much less frequently. Another initial question asked how the meeting was conducted, whether in person or remotely. As these questions did not serve a clear purpose and only added to the likelihood that the survey would be overwhelming, they were deleted. As a guide to clinical research states, "[w]hen in doubt, leave it out" (Cummings, Kohn, & Hulley, 2013, p. 223).

Despite being abbreviated, the survey had 404 possible entry fields, had a participant selected all 25 LHIs and entered the maximum of three organizations for each LHI, with each one being a coalition. The likelihood anyone would have seen all the questions was remote.

Survey Distribution – Participant Selection

The survey distribution was dictated by the environmental scan, and was a purposeful convenience sample. The list of organizations and their programs quickly grew to be almost unmanageable however, and it was decided to approach the dissemination of the survey link in 'waves' as there were so many potential recipients. Beginning with the initial input, it was almost impossible to avoid learning of new organizations or individuals who could contribute. Using waves of distribution lessened the need to try and capture every possible respondent in one email or day. It was also important to respect the time of the community partner. As the survey was disseminated from the HA2020 email address, Mr. Dickey, the State of Alaska HA2020 co-

lead, had to enter all the addresses and forward all the responses to the student. Many of the responses were auto responses, but some required further action, such as those providing alternate contacts. Including the student's email address in the email was an attempt to mitigate the community partner's time, but unfortunately did not prevent any such responses.

While sending the survey link from the Healthy Alaskans 2020 email was beneficial in that it elevated the gravity and ensured the sender identity of the email and decreased the risk of it getting ignored or sent to spam, it posed difficulties insofar as the student investigator could not continually monitor this email. As a consequence, it is unknown exactly how many of the recipients did not receive the email.

Given that the recipient list grew so large, avoiding duplicates was also harder than imagined. The recipients of certain listservs, such as the Alaska Public Health Association (ALPHA) listserv, were not shared with the student making it impossible to delete duplicates, and many emails were sent on the student's behalf without directly involving the student.

Other listservs that received the survey link include: ANTHC, the Alaska Mobilizing for Action through Planning and Partnerships (MAPP), AHELP, the Tribal Health Directors, the Alaska Tribal Health Quality Collaborative, the Anchorage Service Unit Tribal Health Council, the Medical Services Networking Committee, the Clinical Directors, and the 28 Division of Public Health Section Chiefs and Assistants. The survey link was additionally shared on the Facebook page of the University of Alaska Anchorage MPH program and ANTHC, and recipients were invited to share the survey link with others. For this reason, the denominator is unknown and it is not feasible to calculate a response rate. Similarly one cannot compute an exact completion rate as the skip and branch logic prevented participants from seeing every question, making a 100 percent completion rate unachievable.

The initial wave of survey distribution occurred on November 24 with emails sent to 670 individuals. For organizations without an individual contact, a general inbox email address was used. Further waves, including reminders, went out over the next month and 2,145 is the best estimate of how many individuals received the email (see Appendix F). Fifty four of the emails were returned as undeliverable, and, as mentioned above, it is impossible to know how many duplicates exist. Any estimate of response rate is also impacted by the fact that recipients were invited to send the survey on to anyone they believed could assist; this snowball method of distribution further clouds accurate estimates of response rate. The survey was initially closed in December, but a community member requested that it be reopened, and it was permanently closed February 1, 2016.

Shortly before the survey was distributed, Ms. Andreen, Mr. Dickey and the student conversed regarding recipients of the survey link. Ms. Andreen has many years of experience in public health and advocated for a limited approach by emailing public health organization leaders, rather than the broad list. The selection criteria were very inclusive, and for instance included the 160 members of Federation of Community Councils. The reasoning behind including such community members was that they might be knowledgeable of smaller, community-based organizations.

In order to follow Ms. Andreen's advice, it would have been necessary to know the leaders of organizations - knowledge the student did not possess. She further reasoned that the survey results would require a lot of data cleaning and this did occur, but was not deemed an important enough reason to limit the recipients, and ultimately it was decided that the widest distribution possible would yield a higher response rate and more varied responses. It was hoped that the survey would capture the small programs or organizations that recipients might know of through

personal exposure or experience. It was easy enough to find the large organizations through an environmental scan; however knowledge and recognition of the smaller, more rural organizations that do not have the capacity to have a website was the aim.

The email text accompanying the survey link went through two rounds of editing, as did the text introducing the survey once the link was opened. This approach helped convey the message that this information could be helpful for others involved in public health as well as convey gratitude to those who participated in the survey.

Interviews

The second goal of this practicum was to learn from the initial experiences of the first Coordinating Partners through key informant interviews. A doodle poll facilitated scheduling the interviews. All of the Coordinating Partners were invited to select a date and time the week of March 21 that would work for them. One of the Coordinating Partners was out the week of March 21; her interview occurred on March 18. The interviews were recorded using an Echo Smartpen that allowed the audio files to be electronically sent to the transcription firm, Hired Hands. Considering how valuable the information may be for future recruitment of Coordinating Partners and implementation activities, funding for the transcription of the interviews was jointly provided by ANTHC and the State of Alaska.

In the project proposal these interviews were to occur in January, as it was expected that by then the CPs would have been in their position for approximately three months. This did not occur for a variety of reasons beyond the student's control, and the interviews were pushed back to give the CPs enough time to provide the Core Team with a good understanding of their initial experiences as the first cohort of Coordinating Partners engaged in the HA2020 implementation.

Given the time difference between the original plan and actual interview date, the interview questions included in the proposal were reviewed in February. The Core Team confirmed that the questions were all still relevant, and several questions were added to assess the value of the spreadsheet. Certain questions were reworded to ask what the Coordinating Partner "anticipated" rather than "experienced" due to the time difference between the original and actual interview dates. The interview guide and consent form are attached as Appendices H and I respectively.

The interview guide was loosely based on a template used by the ANTHC Colorectal Cancer (CRC) Family History Outreach Program, and changes were made using sources of advice such as Bernard's *Social Research Methods* (2013) and *Designing Clinical Research* (Hulley et al., 2013). These sources provide appropriate interview technique and probing strategies, and further guidance was gained by documents supplied by Hired Hands, the transcription firm, on how to obtain the most clear and precise recordings.

Validity and Reliability

Ensuring that surveys and interviews are designed to collect the data they intend to and are not unduly affected by the interviewer, the timing, or the wording used is critical to gathering valid and accurate data. Reliability addresses whether the data collection tool will consistently collect the same data or if it is poorly designed and thus subject to bias and variability (Bernard, 2013). In order to increase both the validity and reliability, the online survey and the interview guide were evaluated in October 2015 by the HA2020 Core Team members as part of the proposal development. The Core Team and additional individuals, including the student investigator, also conducted a pilot test of the online survey during the proposal development.

External validity refers to the extent to which results can be generalized; in other words, can the data gathered from a small sample size be reasonably ascribed to a larger population that was not involved in the study? Making sure the sample is representative of the general population and increasing the sample size are methods to increase external validity. The online survey was widely distributed throughout the state (see Appendix F) and aimed to capture the views of many diverse parties, although it is possible that non-respondents may vary in some particular way from respondents. One known consideration is that not all individuals have access to the internet, and therefore it is possible that certain individuals were missed. While responding to the survey was of course voluntary, attempts to capture all possible responses were made by sending email reminders, as well as reopening the survey when requested to do so in 2016. Additionally the Core Team was instrumental in forwarding the survey link to groups that the student was unaware of and that were not included in the environmental scan.

The wording in the introduction to the survey was left sufficiently loose to invite multiple types of organizations to be identified; respondents were asked to include "organizations, partnerships, coalitions and groups." The online survey did require a certain level of knowledge about organizations respondents chose to identify, and therefore an ongoing environmental scan to fill in numerous blanks was necessary. Additionally, the survey wording could have been clearer yet this revision was not conducted before the survey was distributed.

It is hard to know if the findings from the key informant interviews will be generalizable, but the data is valid and valuable due to the uniqueness of the respondents' positions. In addition, they are the only individuals who can reasonably comment on how the implementation is going for they are the initial and sole testers, at this point, of the implementation. It is their personal experience that was of interest.

The interview guide was adapted from one previously used by ANTHC to conduct key informant interviews regarding the Colorectal Cancer (CRC) Family History Outreach Program, and thus benefits from having been previously checked for validity and reliability. Using an interview guide that specifies the questions and order that they are to be asked helped contribute to the reliability of the interviews, and inter-rater reliability was not a concern for the same individual conducted all of the interviews and the thematic analysis.

Results

While the environmental scan generated approximately 95 percent of the results, the survey did fill in certain contact information gaps by adding 127 entries to the name, email, telephone and web address columns. It also contributed 44 organizations and programs to the existing 2,000 plus. While most responses provided duplicate information, which was in itself confirmatory, the survey further aided in identifying the Leading Health Indicator/s that organizations and programs served. The first question of the survey was “For which of the following Leading Health Indicators, can you identify specific organizations? (Please select all that apply).” The distribution of answers can be seen in Table 3.

Table 3

Survey Results to LHI Selection Question

#	Answer	Bar	Response	%
1	Cancer Deaths		16	24.62%
2	Tobacco Use - Youth		17	26.15%
3	Tobacco Use - Adults		23	35.38%
4	Overweight or Obesity - Adults		16	24.62%
5	Overweight or Obesity - Youth & Children		15	23.08%
6	Physical Activity - Adults & Youth		24	36.92%
7	Suicide Deaths		23	35.38%
8	Mental Health - Youth		25	38.46%
9	Mental Health - Adults		27	41.54%
10	Social Support - Youth		20	30.77%
11	Child Abuse & Neglect		31	47.69%
12	Rape		20	30.77%
13	Dating Violence - Youth		17	26.15%
14	Alcohol Induced Deaths		7	10.77%
15	Binge Drinking - Adults & Youth		14	21.54%
16	Unintentional Injury Deaths		11	16.92%
17	Childhood Vaccinations		24	36.92%
18	Chlamydia		16	24.62%
19	Home Water & Wastewater Sevices		15	23.08%
20	Fluoridated Community Drinking Water		9	13.85%
21	Early Prenatal Care		20	30.77%
22	Preventable Hospitalizations		10	15.38%
23	Cost as a Barrier to Healthcare		10	15.38%
24	Poverty		10	15.38%
25	High School Graduation		21	32.31%
	Total		441	100.00%

From the results above, it is apparent that the majority of survey respondents knew the most about child abuse and neglect, mental health and physical activity in that order. None of these topics were in the short list of LHIs given to the Advisory Team so one cannot compare those. If we turn to the short list of LHIs and compare the results above with the ranking of which LHIs had "broad or active networks or coalitions," it would seem that the survey results came from a far different group than the Advisory Team. While the category of "broad or active networks or coalitions" is not exactly the same as knowing about certain LHIs, this loose comparison is interesting. The AT ranked the LHIs with the "most broad or active networks or coalition" as suicide (10), domestic violence (9), tobacco (8), alcohol and vaccines (4), social support for youth and socioeconomic status (2), water (1), and obesity received zero votes in this category. The survey provided the following LHIs with the according number of votes: suicide (23), domestic violence (17), tobacco (40), alcohol (21), vaccines (24), social support for youth (20), socioeconomic status (31), water (24), and obesity received 31 clicks. Accounting for the different comparison group sizes and making proportional comparisons, there is the most marked difference in obesity, socioeconomic status, social support for youth, and water.

Table 4

Different Rankings of Survey Respondent Selections versus Advisory Team Selections

	#1	#2	#3	#4	#5	#6
Survey Respondents	Tobacco	Obesity SES	Water Vaccines	Suicide	Alcohol	Social support – youth (Last: DV)
Advisory Team	Suicide	Domestic Violence (DV)	Tobacco	Alcohol Vaccines	Social support – youth & SES	Water

This quick comparison is primarily of interest in regard to the ease or difficulty future Coordinating Partners may encounter in fostering alliances. It is hard to come to any conclusion about their success however as it may be easier to foster alliances when an LHI has only a few groups, rather than those that enjoy broad or active networks or coalitions. They are also many other variables in play dictating the success of future CPs.

Of the 2,145 emails inviting participants to complete the survey, 243 individuals opened the survey. Of the 243 who opened the survey, 143 entries were blank and consequently deleted. Twelve of those deleted had only entered their names at the very end of the survey. This left exactly 100 responses with any usable data.

Figure 2. Succession of survey invitation to results

The proposal had 100 organizations as the goal and it is truly fortuitous that exactly 100 results were attained. Cleaning the survey results was very time-consuming as the survey had approximately 1,180 columns (one for each multiple choice answer option) and many of the columns were blank. A further issue arose from a lack of accuracy, and necessitated that the student verify the provided information. For instance, some councils were identified as commissions, and vice versa. This was predicted by Ms. Andreen, but was unavoidable.

The four interviews with the Coordinating Partners were conducted on March 18, 21, 22 and 23. They lasted an average of 38.79 minutes, and ranged in length from 30.15 minutes to 53.58 minutes, and generated almost 90 transcribed pages. The 19 questions (see Appendix I) were asked of all respondents in the same order, were digitally recorded using an Echo Smartpen, and

sent electronically to Hired Hands by uploading the files to the Hightail Uplink website. The files were not proofread by Hired Hands and were priced accordingly at the "graduate student" rate.

The consent form (see Appendix J) drafted to meet Institutional Review Board requirements was returned to the student investigator by all respondents, and informed the respondents that their answers would be reported in aggregate and, although direct quotes might be used, they would not be individually ascribed unless they pertained to non-controversial topics such as their length of involvement. This was reiterated before the conversation began, and the respondents were asked if they had any questions. The Coordinating Partners received the list of questions prior to the interview, and the resulting transcripts were sent to the Coordinating Partners prior to being shared with the Core Team so that they could remove any comments or words they did not wish to share, or deny permission to share the transcript. This step was not previously described in the proposal, but was requested by one of the Coordinating Partners during our conversation, and therefore was offered to the other Coordinating Partners as a courtesy.

Discussion

As time went on and new additions were still continually added to the environmental scan led to the conclusion that it may indeed be impossible to truly encompass all health-promoting programs and organizations within the state. In addition, grants come and go and therefore it is almost inevitable that certain programs will lose funding and cease to exist. These factors make the spreadsheet out of date the minute it is thought to be complete.

A good analogy is the painting of the Golden Gate Bridge that is purportedly never completed. It is so long that by the time one end is finished; the painters must simply begin again at the other end. The list of organizations and their respective programs, along with the contact

information, became so lengthy that even if one was able to fully complete the list, they would need to start at the top again and verify that the information was still current and accurate, as well as add any new programs that had since emerged, making it a Sisyphean task.

The changes that occur chiefly through loss of funding and shifting personnel and leadership, and multiple other factors, necessitate that the organizational list be uploaded to the web so that it may be updated as necessary. If it does not exist online, it will quickly become stale and of limited use. Of course even if it is uploaded to the web, it must be of enough worth that it is maintained, and this maintenance takes resources, time and dedication.

Alaska Health Education Library Project Expansion

The student became aware of the Alaska Health Education Library Project only after writing the first draft of the proposal and midway through the survey development that took an investment of many hours. The amount of information required by AHELP was much too detailed to try and collect through a survey, especially one that provided no compensation, but it was hoped that the list generated would help expand AHELP beyond the data it currently contained, primarily state programs. In addition the information AHELP collects, specifically the questions about whether the program is modeled on another program and whether it is evidence-informed were deemed too difficult for many to answer. Questions such as these would require detailed knowledge of the project and therefore were not appropriate for a broadly circulated survey using a snowball sample distribution method. Furthermore, such questions may frustrate respondents and lead to a lower completion rate.

It became clear as time went on and as the project was discussed with many friends and colleagues that AHELP, while a valuable creation, is not a widely known or used resource. It

was initially chosen and identified in the proposal as the location for the environmental scan and survey results due to the support it had among one member of the Core Team who has since retired and is therefore no longer able to dedicate any time or resources to AHELP. When it was initially discussed in the fall of 2015, the option of making alterations to have it align with HA2020 was a possibility, however this option was not realized.

As AHELP is not currently a well-utilized resource, it would require marketing and currently no such funds to conduct marketing or promotion exist. The funding for AHELP's creation and development has expired and the information technology specialist who was able to make changes and help with its expansion and functionability is no longer available. Furthermore AHELP was not created to be compatible with Excel and therefore it would have taken an exorbitant amount of time to supplement its contents. Lastly, with no dedicated staff or funding and with changes at the state level occurring rapidly, many of AHELP's 81 entries are outdated. With no funding, no IT assistance, no champion, and doubt about its utility and appeal, AHELP as the destination for all the data collected began to be questioned beyond the initial concerns of how much congruent information could be collected. The community partner and other members of the Core Team understood these drawbacks and encouraged the student to look for an alternate host for the data.

Conversations thus ensued with individuals knowledgeable about data sources. In February, the student investigator reached out to Charles Utermohle, a public health data analyst at the State of Alaska, whom the student had heard speak about Alaska's Indicator-Based Information System for Public Health Data Resource (IBIS) and other data sources at an Alaska Public Health Association pre-summit presentation. He and the student spoke briefly with Jayne Andreen at the conference and met again in mid-February to discuss alternate locations. Mr.

Utermohle helped further the student's understanding of how data can be presented and the options for doing so, although we were unable to determine a source for the information. The student also spoke with Sigrid Brudie, the medical reference librarian at the University of Alaska Anchorage (UAA) Consortium Library, who recommended that the student contact Freya Anderson, the Head of Information Services at the Alaska State Library, and look into the resource of libguides. Libguides were not pursued however as the student was ideally looking to contribute to a source that could vet the data in addition to store it in an online database, rather than as a document. The student further solicited advice from Kathy Murray, the head of Alaska's Medical Library at UAA's Consortium Library, who is familiar with AHELP. She discussed the possibility of uploading the spreadsheet to an Institutional Repository that is in early stages of development, and this option may be explored in the future.

A new website called Alaskans Changing Together came to the Core Team's attention in 2016. It is described, on its website, as "a BOLD call to action for all communities throughout Alaska to form Wellness Coalitions in their community" and goes on to state that it "will serve as a bridge between existing State Prevention Programs and Alaskan communities to help ensure that everyone has access to the materials needed" (Alaskan's Changing Together website). It is building a directory of wellness resources and Dr. Diana Redwood reached out to Matt Bailey, who runs the website, to see if they would be interested in hosting the information. She was informed that they would need to individually enter each item and while they would welcome having the data entered on their website, they were unable to assist with this task. As Alaskans Changing Together is a recent creation it is hard to say how well known it is and this casts doubt upon its utility. This source is however worth monitoring for it may grow and therefore become a viable resource and be a good host for the information compiled.

A further database that was explored was the 2-1-1 phone number and website. It held a lot of promise as a source as it continues to be funded, all entries are vetted and current (the database is updated in its entirety once a year), and it has attracted a significant number of users. As of 2013,100,000 Alaska residents had utilized the service to find assistance (United Way, 2013). Michele Brown, who is the President of United Way of Anchorage which operates the 2-1-1 service, stated that,

> [b]efore Alaska 2-1-1, people had a much harder time figuring out who and where to call. If we can give people one place to go for their questions, to cope with problems, to get help, hopefully to get the one referral they need, then we cut through a lot of the rigmarole and hassles people face when they don't know where to turn (United Way, 2013).

This sentiment mirrored perfectly the student's main reason for creating this database. While assisting Healthy Alaskans 2020 was the primary goal, the student was eager to assist all Alaskans find the services they needed, as opposed to only assisting the networking efforts of the Coordinating Partners. It was the student's desire to create something useful and helpful, and it made sense to utilize and help strengthen a successful program, rather than dedicate resources to a new website or another source of information.

A further reason 2-1-1 holds appeal is that it is a national source and with Alaska's highly dynamic population, having a number that was utilized in the rest of the nation would be a positive connection. Furthermore, Alaska 2-1-1 is available in over 170 languages making it highly accessible, and represents the holistic view of public health by offering (2,965) services including housing/shelter, food, utilities, material goods, transportation, employment and "income boosts," and mental and physical health (United Way of Anchorage, 2015). These

categories represent socioeconomic barriers to health and thus tie in well with Healthy Alaskans. Lastly, United Way is a key partner of Healthy Alaskans 2020 and it was therefore a natural fit.

The student met with United Way twice to discuss the possibility of storing the information on their website. They were able to go through the environmental scan and assess if they could use the data and while enthusiastic about the information collected, they currently do not have the resources necessary to utilize it. As 2-1-1 reaches out to each source it adds to its database to request a submission form, in order to utilize the student's data they would first need to see if the agencies they do not already include truly meet any of their clients' needs and if so, then contact the organization to solicit the form they require. Their list of categories is set by the Alliance of Information and Referral Systems, an accrediting agency, and is focused on helping individuals throughout the state connect to resources. This differs from AHELP which is more appropriate for health professionals. For this reason, many of the entities in the database are not well-suited to their mission. United Way decided to explore the option of their partner agencies using the data, and future discussions about possible collaboration may occur.

A final possibility explored was the Department of Commerce, Community, and Economic Development's Community Databases. The student met with Manjula Boyina, a research analyst at the Community and Regional Affairs division, in February to explore whether they were able to utilize the data. Unfortunately the databases are not designed to hold this type of data, and they do not have the capacity and resources to explore expansion at this time.

While it was originally thought that the data would be stored on AHELP, numerous individuals have expressed interest in the information, and therefore it may instead be distributed individually. This of course limits the sustainability, however it is possible that it may in the

future be uploaded if enough individuals find it helpful and are able to commit to maintaining it. The HA2020 Core Team also plans to continue looking for a suitable online host.

Interviews

It was apparent from the interviews that all of the Coordinating Partners are excited about their role in furthering the Leading Health Indicators of HA2020; some of the most positive comments were that they were "passionate about the project [and] really believe in Healthy Alaskans 2020 and the idea of it," and that they were "proud to be asked" to be a Coordinating Partner. It is also apparent that the due diligence conducted by the Core Team in the selection of these individuals was ultimately worth the extra time in that all of the CPs selected play important roles in health promotion in Alaska.

Coordinating Partner positions and respective LHIs are as follows: Lisa Aquino (SES) is the Executive Director of Catholic Social Services; Kate Burkhart (Suicide) is the Executive Director of the Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Board and Statewide Suicide Prevention Council; Dana Diehl (Tobacco) is the Program Manager of the Tobacco Prevention Program at the Alaska Native Tribal Health Consortium; and Ann Rausch (Domestic Violence) is the Prevention Program Coordinator at the Department of Public Safety, and the Program Coordinator of the Council on Domestic Violence and Sexual Assault. It is apparent from the Coordinating Partners' titles that they are ideally suited to take a leading role in furthering health promotion under the banner of HA2020, and indeed, their work already closely aligns with HA2020 in that they are working to "improve health and ensure health equity for all Alaskans" (AK DHSS & ANTHC, 2015, p. 1).

Furthermore the Coordinating Partners occupy positions that do not require that they seek

permission to serve in such a role, and this is especially true for the three CPs who are employed by the co-creators of HA2020, ANTHC and the State of Alaska. For the three CPs who work for either the State of Alaska or ANTHC, their involvement is natural. All, however, have supervisors and boards that oversee their work, and one of the expressed desires was an "elevator pitch" so that they could concisely explain their role and how it would benefit their organization to the board and others. The desire for such a tool is summed up by the statement that an "easily digestible overview of Healthy Alaskans 2020, and then my specific indicator that I'm a coordinating partner of that I could give in less than 10 minutes, then that's something I could give to my board, and I could give to my staff, and that would be helpful." When this type of document or tool was proposed to other respondents, it was enthusiastically received. A further request regarding the board's involvement, was that "once we've got a nice data set to share, having them [HA2020] come to a board meeting and share that, I think it would be informative to board members but it would also show kind of the value of having staff participating in projects." Outreach and communication is a consistent condition of keeping HA2020 relevant and furthering its utility in aligning health improvement efforts.

It is fortunate that all but one of the CPs reported being engaged with the development of HA2020. Ms. Burkhart began her involvement with Healthy Alaskans 2010, and Ms. Aquino, in her previous position at the State of Alaska Division of Public Health, "was the original staff member there which started Healthy Alaskans 2020," and her involvement goes back to 2012. She also serves on the Advisory Team and therefore may have a greater understanding of the role of CPs in the implementation plan (than the other CPs), as their role was shared in the webinars held for the Advisory Team in November. Ms. Diehl has the least history with HA2020 as she "wasn't involved with it until early this year," but was familiar with the program due to her

position at ANTHC, and was invited to conduct a "courtesy review" of the strategies outlined for reducing tobacco usage as they were finalized.

All of the Coordinating Partners reporting being asked to participate instead of volunteering, although one stated that it was "a bit of both," and that she "volunteered because they asked." Another reason contributing to a particular CP's willingness to become involved and be a champion of a particular LHI was that, in her words, it is challenging and, due to her position, she was uniquely suited to address the issue.

The overwhelming factor that was considered prior to them taking on the role was "time." Busy professionals were chosen to fill this role, and therefore the initial concern of them taking on an additional responsibility was understandably whether or not they could dedicate much time to HA2020 activities. One of the comments that addresses the issue of time and goes beyond to speak to a fundamental issue was about how HA2020 activities fit into their existing role and "how relevant does this become to our work?" This respondent was interested to know "does this become some sort of [a] regular part of people's work to where it's informing their work, or is it just something on the to do list to do for public health because we love public health? And then we don't ever think about it again." This comment really addresses a main challenge of implementation. If Healthy Alaskans 2020 is to be relevant, it must tie into existing efforts in a way that helps organizations and individuals, and must meet organizations where they are and fully integrate itself into health improvement efforts, rather than be a separate "to do list" item. This idea of meeting potential partners where they are was echoed by the recommendation that future CPs "see how the high level goals is [sic] important to all the partners you'll be communicating with. I think if it's not--like if that goal doesn't speak to you, then it's going to be--this is going to be really hard."

The lack of funding was another concern expressed by the Coordinating Partners. As one of them stated there is "a pretty constant and dramatic erosion in resources financially, but at the department, especially in public health, the staffing resources are not there." A few of them however spoke to the ability they have to delegate tasks; in other words, they have staff resources, while another said that "it's just me." Regardless of their ability to delegate, the Alaska budget is a constant concern these days, and one respondent thought "that's going to be all a long term hindrance to Healthy Alaskans 2020 as well as everything."

It was too soon to generate accurate answers to the question regarding how much time the CPs spent on activities related to HA2020, but using the word "anticipate" instead of "experienced" allowed one to estimate, and can also be used for comparison in follow-up interviews. The estimates ranged from a week every six months to an hour every week. A frequent sentiment echoed by CPs that they have not "even gotten started yet," and also being unclear about their role and the responsibilities it entails, made it difficult for them to answer some of the questions. Conversely as all of the CPs are well-versed in health promotion, they are knowledgeable about barriers and are able to adequately assess the strengths and weaknesses of the implementation plan. One of the main strengths was the inclusiveness of HA2020 – many individuals and organizations have been involved in its creation. Funding constraints and lack of time were raised as two of the main limitations, but they cannot truly be considered weaknesses for HA2020 has no control over either condition.

The following recommendations originate from the conversations the student investigator conducted with the Coordinating Partners and address their concerns and suggestions. Certain recommendations below were shared during a 'kick-off' call that the Core Team held with three of the Coordinating Partners, but the individual call allowed them to confidentially further

explore what specifically would assist them and share their concerns. In the initial conversations with the Coordinating Partners, they expressed the need for guidance and concrete steps, and this was further vocalized during the interviews. This was a reasonable expectation, but it was difficult to dictate exact steps and a timeline for a plan that is still in developmental stages and semi-experimental. Furthermore, while the general framework of reaching out to create alliances and promoting the shared utilization of evidence-based, measurable strategies is understandable, if this were easy to achieve it would have already been accomplished. The roles and responsibilities of the Coordinating Partners was of course a focus of the Core Team, however the document created, Responsibilities and Benefits of Being A Coordinating Partner (see Appendix K), did not fulfill the level of detail nor the timeline desired by the CPs, and providing them with more detailed information is necessary.

Recommendations:

1) Create a document/job description to fully explain the role and what it entails
2) Share the description prior to asking if they would be willing to participate as a CP
3) Develop a timeline and specific actions for the CPs to pursue
4) Share the Advisory Team webinar with CPs – especially graphic of how the CPs are to reach out and create linkages
5) Develop an "elevator pitch" for the CPs to concisely explain to their board and others their role and the benefit it can provide to their organization
6) Provide updates and stay in contact with Key Partners and Advisory Team
7) Share data with all stakeholders – could be in form of public presentations
8) Share HA2020 strategies and actions with all working on health promotion
9) Link community groups/organizations with strategies

10) Keep the list of organizations current and update as necessary

The first four recommendations come from the need of the CPs to fully understand their role and responsibilities prior to signing on. As mentioned above, there is a need for guidance and concrete steps, and while a document entitled Responsibilities and Benefits of Being a Coordinating Partner (Appendix K) was distributed, it is clearly not meeting the desired specificity. The most glaring example of miscommunication and misunderstanding was one of the CPs thinking she was responsible for four pilot LHIs. This misunderstanding was due to receiving an email with the spreadsheet for all of the four LHIs attached, and was quickly cleared up, however it does expose a gap in understanding. It is quite possible that the role of a Coordinating Partner will develop and possibly shift over time, but establishing some more specific guidelines to encourage participation and begin the discussion and work of aligning strategies and measures and creating alliances remains essential.

Recommendation number six, constant communication, is due to one of the CPs feeling that many Key Partners will "not…remember their involvement or there's going to be new stuff. So there's going to be a lot of reeducation that's going to have to happen, and that could be a barrier just in terms of the amount of time it's going to take." Had the Core Team remained in contact with many of the Key Partners, it may save the CPs from the need to revisit old information and reestablish relationships. Conversely many of the Key Partners listed on the spreadsheet are familiar to the Coordinating Partners, and many of them do work together in some capacity so this may be quicker than anticipated. This recommendation is also not new to HA2020, and mirrors their own recommendation as set forth in the Alaska Community Capacity Review 2014, to "Regularly Monitor and Report Progress." As stated in the Review this step of "[m]onitoring and communicating progress in a continuous cycle promotes accountability, helps sustain

momentum, and informs decision-making responsive to results" (State of Alaska Department of Health and Social Services and the Alaska Native Tribal Health Consortium, 2014, p.26).

Some of the above recommendations, specifically number seven and eight, resulted from certain CPs not feeling as if HA2020 is well-known enough to make their job of reaching out practical. If, for instance, the strategies and actions were broadly shared and known, then individuals would be more receptive to a conversation introducing the implementation plan and possible sharing of measures. In other words, familiarity with HA2020 and the strategies and actions would help facilitate the necessary conversations and outreach in which the CPs will engage. These two recommendations may also foster greater buy-in from members of the public and help them understand the benefit of being involved with HA2020. Ultimately greater buy-in and enthusiasm about the initiative can only enhance Healthy Alaskans 2020's potential. Healthy Alaskans 2020 has tried to address this recommendation by presenting the implementation plan and background data at the Alaska Public Health Association conference, and can perhaps increase their impact by holding biannual webinars for all interested parties to join in and find out about recent developments. Gaining buy-in and generating enthusiasm is however truly a challenge for all health improvement efforts, not just HA2020.

Recommendation number nine would take an enormous amount of time to accomplish. It would require an individual to find out the strategies, if any, utilized by all the entities on the spreadsheet generated by the student investigator. This would be an immense task. HA2020 does however list the organizations working on the evidence-based strategies it identified in a publication on the strategies and actions, so this is a starting point.

The spreadsheet was found helpful by the three Coordinating Partners who received it prior to the interview. There were several new contacts provided, but unfortunately from one of the

responses, it seems to already be out of date. It was heartening to hear that the spreadsheet was helpful and, especially if it could be kept up-to-date, it may well be a valuable resource to future Coordinating Partners, some of whom may not have the extensive networks of the current CPs.

Because the purpose of these conversations was to generate a list of recommendations, all the positive comments were not highlighted, but it was apparent throughout the conversations that the Coordinating Partners are familiar enough with Healthy Alaskans 2020 to be enthusiastic about its potential. Additionally none of the recommendations above will be too new to the Core Team. They realize many of the challenges and are working towards meeting them. This is an iterative process, and the lessons learned in this pilot will refine future outreach efforts.

Strengths and Limitations

One of the strengths of the study was the broad reach of the survey. It was helpful in itself to have such a list of potential respondents. Although it was searched for, there was no such list generated during the extensive health assessment conducted in the early days of Healthy Alaskans, and the creation of this list may well be beneficial to future outreach efforts.

Many of the names were on listservs and a debt of gratitude is owed to those who reached out to these listservs and to those who manage the listservs. They were gracious enough to deem the survey worthy of being distributed and did so on the student's behalf.

Another strength was the outreach conducted during the environmental scan. The student talked to many individuals about the project and benefitted tremendously from the feedback that was offered. It is fair to say that these connections strengthened the depth and reach of the study, as well as promoted individuals' knowledge of Healthy Alaskans 2020.

A further strength is that when agency websites were unclear about their focus or background or seemed dubious, the student attempted to gain more information though vetting organizations, such as Charity Navigator, before deciding whether to add them to the organizational list.

In addition, the sincere and honest feedback provided by the CPs during the phone interviews was a benefit. The opportunity to confidentially share their views boosted their ability to be candid and the list of recommendations accurately reflects their desire to improve the framework and their experience, as well as that of future Coordinating Partners.

The main limitation was the time it took to move forward. Although delays were anticipated, the practicum had an end date and had the Coordinating Partners been chosen earlier (the original plan was to have them selected by November 1, 2015), then the interviews may well have been more informative and helpful. While small delays and variations were anticipated and led to the timeline in the proposal being referred to as a framework, the delays that were encountered caused difficulties and limited the content and analysis of the interviews.

One of the reasons behind the belated selection was the extra time it takes to make decisions using consensus. When a member of the Core Team was absent during a weekly call, decisions would be delayed until all members were present. Another reason was the busy schedules of the Coordinating Partners; this led to delays in contacting them and in coordinating conference calls with all present. The latter was never possible and it was necessary to therefore have two ‘kick off’ telephone discussions. Another example of how schedules impeded progress was convening the Advisory Team. While originally planned to occur in October 2015, the webinars ended up occurring in November as not enough members could attend in October.

Another limitation that this practicum incurred was a lack of planning by the student investigator. In retrospect, the study might have solely consisted of an environmental scan and

conversations with individuals knowledgeable about health promotion efforts within the state, and still have been of value to the community partners. Conducting a survey took up valuable time and cleaning the results also took time away from completing the spreadsheet. As it is, the current version contains large areas with no information. Given that all of the information provided by the survey could have been gathered with more time spent on the environmental scan, the time dedicated to creating, vetting and testing the survey contributed to the student's appreciation of the complexity of survey design and implementation, but may not have added much new content for the project.

The primary problem with the survey was its length and the time it would take individuals knowledgeable of organizations in more than a few health categories or LHIs to complete. This idea is supported by the fact that one member of the Core Team in an individual email was simply told "too long," by a colleague when she solicited their response. While this problem was identified as a potential barrier prior to dissemination, a way to condense the survey was not realized. Had it been known before it was disseminated that AHELP expansion would not remain part of the project, at least two questions could have been removed.

The survey results did illuminate certain gaps in the survey design. For instance asking participants to identify organizations provided some responses that were so broad as to be unhelpful, such as "ykhc" and the "state." It is apparent from these answers that the question should have been about what programs organizations operate for that may have provided more useful information. The survey question phrasing could have benefitted from more scrutiny.

This type of broad response noted above also gives rise to the possibility that the survey may have been misunderstood. It may have been better to specify that the results were supplementing an environmental scan and therefore identification of smaller groups, especially those without a

web presence, would be appreciated. It was anticipated that the survey results would necessitate further research, and while the student did have to clarify the results with web research, the student was unable to take the time to return to the environmental scan.

Additionally the goal of the project to create a list of all health-promoting organizations in the entire state was unrealistic. There had to be a line drawn regarding the end of the environmental scan, otherwise it could have gone on indefinitely. It is hard to know how much information exists before one begins collecting it, but again had the student invested more time in the planning stage of the project, the realization that this goal was overly ambitious may have occurred sooner rather than later.

A very broad, public health approach was taken in defining the term 'health-promoting" and having a clearer understanding or tighter definition of what data to collect would have been helpful. The goal to make the data useful to multiple audiences encouraged the student to attempt to enter all possible agencies yet this was simply not feasible. Civic organizations such as Rotary, Lions and Kiwanas, hospital and medical organizations and programs, and churches and religious groups represent some of the main gaps in information that occurred due to time constraints. Furthermore, as the environmental scan was largely conducted electronically, organizations that did not have a web presence were most likely excluded, unless information of them was passed along manually, and since not all individuals have access to the internet, it is possible that certain individuals were missed due to the survey format.

Another limitation was the timing of the survey. The end of the year is a busy time for most, and the Thanksgiving and winter holidays meant that individuals were delayed in responding. This year's legislative season in particular has required many DHSS staff to spend time

defending their division or departmental budget, and certain individuals have even had to defend their specific position.

While inter-rater reliability is not an outright concern for, as stated in the methods, the student investigator conducted all of the interviews and the thematic analysis, this may also be a potential source of bias. Having had two sets of eyes look over the data may have provided an added benefit, but this was an individual project and therefore the student largely used her own judgment. It is important to acknowledge one's own bias in research and this bias may have also presented itself in the exclusion of certain groups from the organizational list.

In early March, Ms. Acquino, in a conversation with Dr. Redwood and Mr. Dickey, suggested that it made more sense for the Coordinating Partners to initially connect with the Key Partners before reaching out to other groups. This change in approach was one of the most evident examples of how this implementation is truly a work in progress, and how it is hard to come to firm conclusions when one has a limited amount of time upon which to base their research and study. While the spreadsheet is still a worthwhile effort, this suggestion led the student to add the Key Partners to the spreadsheet in March and to further reassess the applicability of the initial interview questions.

As with many aspects of this practicum, the lesson of how real life dictates, and one may say interferes, with what is possible was experienced in this process. The following quote captures this sentiment well; "the complexities of the real world mean that what seems to make sense at one step may make less sense when seen from the perspective of a later step" (Ardal, Butler, Edwards, & Lawrie, 2006, p. 3). It is inevitable that one will learn as one goes, and therefore it is the rare plan that will not progress or change. The use of AHELP was the most evident example of the above quote. At the time of the proposal, AHELP appeared to be a good option and the

survey questions were designed around AHELP categories. As the project progressed however the student began to realize its limitations, and for the reasons outlined in the discussion, AHELP was no longer considered the best option by the student and the community partners. This necessitated a search for other options. The inability to find a well-utilized, sustainable and securely funded host for the data collected was a major drawback, and continues to disappoint the student. It is hoped that many individuals will be able to benefit from the data collection, but its sustainability is currently unknown.

Some of the above limitations may be viewed as challenges to overcome, whereas others were beyond the student's control. The student investigator made valiant attempts to overcome the challenge of not pursuing AHELP expansion by reaching out to multiple individuals and agencies, but was ultimately unable to find a viable home for the expansive organizational list. The other main limitation was the prolonged amount of time it took to decide upon the Coordinating Partners and while the student could not mitigate this delay, having well-vetted and qualified Coordinating Partners that can engender improved health is at the very least on par with the importance of fulfilling a project goal of conducting informative interviews.

Public Health Implications

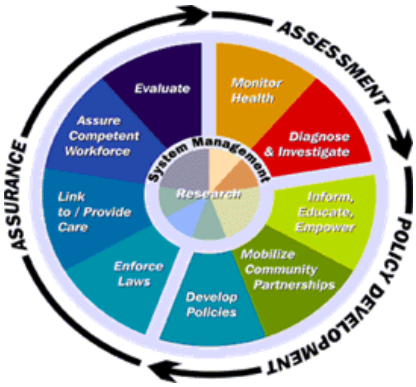
The basic tenets of ecological models while "widely recognized as useful and appropriate orientations for contemporary health promotion" have yet to overcome certain pitfalls such as the conflation of population health with individual health known as the "ecological fallacy" (Glanz & Rimer, 2008, p. 514). HA2020's implementation approach will contribute to the evidence that multi-level interventions and a focus on social determinants of health as the ecological model

supports, is one of the most effective ways to improve health. HA2020 rises to the "[c]hallenge to conduct better research on ecological interventions" (Glanz & Rimer, 2008, p. 515).

This project may also confirm the importance of using a collective impact approach, and thereby will supplement the literature on this fairly recent theory of change if one chooses to evaluate how this approach was implemented and its success in engendering change. If this implementation process created a series of strong, coherent and dedicated teams of individuals and organizations focused on reducing the health burden posed by the 25 Leading Health Indicators, it would contribute to removing any doubts surrounding the effectiveness of the collective impact approach.

This project is the first test of the strategies and actions that Healthy Alaskans put forth in 2015. These evidence-based strategies are in varying levels of implementation, including inactive, and this pilot has helped assess whether or not the use of Coordinating Partners can advance the state's efforts to align around these strategies and consequent measures. In order to improve quality and make progress, evaluation and assessment are critical. How does one know if something is working or not if it is not monitored? This study is the first in what will be many attempts to assess HA2020's implementation strategy.

In the proposal, four of the Ten Essential Public Health Services (Figure 3) were highlighted as being most applicable to the work of Healthy Alaskans 2020 and this project. The student's work was primarily focused on number four: "[m]obilize community partnerships and action to identify and solve health problems" (Centers for Disease Control and Prevention, 2014, p. 4). The creation of the spreadsheet and survey were designed with the goal of connecting people in the spirit of health improvement.



Fiaure 3. The ten essential public health services

One of the Ten Essential Public Health Services that was not highlighted was number nine: "[e]valuate effectiveness, accessibility, and quality of personal and population-based health services" (Centers for Disease Control and Prevention, 2014, p. 4). Although this project is far from an evaluation, it does contribute to the knowledge of how health improvement plans, especially at the state level, can be implemented and whether or not the approach Alaska is using is effective. This information is one of the main contributions that Healthy Alaskan's pilot implementation can make, besides the most important contribution of improving Alaska's health.

While the Coordinating Partners are primarily tasked with reaching out, it is clear that improving health needs a collective impact approach where group of diverse stakeholders come together with a common goal or vision. Number five regarding the development of "policies and plans that support individual and community health efforts" is the definition of Healthy Alaskans (Centers for Disease Control and Prevention, 2014, p. 4). Healthy Alaskans is the most comprehensive, ambitious and evidence-based plan the state has to support health efforts.

Number ten is an important service for it requires that no public health effort rest. As was stated earlier, health is not static and all professionals must be both searching for and receptive of "new insights and innovative solutions" (Centers for Disease Control and Prevention, 2014, p.

4). HA2020's Core Team is a group of engaged and curious health professionals whose very role at the forefront of a SHIP implementation exemplifies the last essential health service.

Conclusion and Recommendations

The budget cuts proposed to the State of Alaska's DHSS, along with limited future state funding, gives rise to the possibility of win-lose behaviors and competition rather than collaboration. The lack of funding, while problematic, has already threatened Healthy Alaskans 2020 and yet the commitment and dedication of the Core Team is admirably unwavering. The implementation plan does however depend upon collaboration and the possible conflict that may arise between agencies struggling for limited resources is a concern. This challenge was brought up in at least one of the interviews as a possible impediment to progress.

Evaluating the use of Coordinating Partners is highly recommended. Due to the limited time frame allocated for this project, it was not feasible to wait to interview the Coordinating Partners and, as they had been in their positions slightly less than a month and received the spreadsheet and outreach email template March 18, these interviews were limited in their scope and the ability to pull recommendations from them. Follow-up interviews will hopefully provide more solid evidence that their utilization is an effective implementation strategy and provide the HA2020 Core Team with further information on how to improve the experience of future CPs.

A further recommendation is to continue participating in national speaking engagements that share the HA2020 implementation strategy. The reasoning behind this recommendation is fourfold. First, it will inform others of the state's efforts and generating interest and conversations about it may yield helpful feedback. Second, raising the awareness and visibility of an issue contributes to the possibility of future funding opportunities – it must remain relevant

and visible to be considered worthy of funding. Third, it may assist other states in implementation of their SHIP. Being at the forefront of implementing a State Health Improvement Plan gives our state the opportunity to assist others as they progress. Finally, since the State of Alaska is publicly funded, it has a responsibility to educate residents on its activities.

Beginning in June, the student started attending weekly meetings with the Healthy Alaskans Core Team, and has made valuable contributions to the implementation. Student or unpaid assistance is both necessary and valued, and one final recommendation is that the team cultivate a strong connection with the University of Alaska Anchorage Department of Health Sciences to encourage future student engagement and assistance.

The current lack of coordination between states working on state health improvement plans is puzzling, but is symptomatic of larger divisions. The Department of Health and Social Services for instance is so large that employees in certain sections do not know what employees in other sections are doing. This lack of cohesion and simple knowledge sharing lends itself to the perception that the system is bloated, whereas the true need is to build cohesion and thereby align efforts rather than make reductions.

A large part of this work was generated from the student's frustration that there was not one centralized database in the state listing groups promoting health improvement. This project led the student to understand why such a resource does not exist, yet there is no doubt that it would be a helpful tool if the resources necessary could be dedicated to its creation and maintenance. AHELP could be grown if resources and time allowed, especially since people want to see action if polled (Huang, S., 2015). It was stated in the introduction to the survey that entries would be reviewed for possible inclusion into AHELP, but for reasons already stated, the student investigator, after consulting with the Core Team, moved away from contributing to AHELP.

Not every research endeavor ends in a ‘silver bullet’ or with ground-breaking revelations, but the spreadsheet created as a result of this project, as well as the list of recommendations generated from the CP interviews, were valuable contributions to Alaska’s SHIP. Continuous Monitoring is an essential public health service and must begin in the early steps of a project, and this project exemplifies HA2020’s commitment to continual improvement. It will be vital to the success of Healthy Alaskans 2020 to maintain engagement with the Coordinating Partners and assess their experience and this pilot project was the first look at this implementation strategy.

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Appendix A

Healthy Alaskans 2020 Scorecard

HEALTHY ALASKANS 2020

A JOINT PROJECT OF THE STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES & THE ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Healthy Alaskans 2020 Scorecard

	HA2020 Leading Health Indicator	2010* Baseline	HA2020 Target	Current Data	Progress to Date
	Reduce the cancer mortality rate per 100,000 population	176.0	162.0	167.9 (2013)	△
	Increase the percentage of adolescents (high school students in grades 9-12) who have not smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days	74.8%[a]	80%	82.9% (2013)	★
	Increase the percentage of adults (age 18 years and older) who currently do not smoke cigarettes	77.8%	83%	78.2% (2013)	△
a	Reduce the percentage of adults (age 18 years and older) who meet criteria for overweight (body mass index of ≥ 25 and < 30 kg/m^2)	38.3%	36%	36.0% (2013)	★
o	Reduce the percentage of adults (age 18 years and older) who meet criteria for obesity (body mass index of ≥ 30 kg/m^2)	29.2%	27%	29.5% (2013)	●
.i	Reduce the percentage of adolescents (high school students in grades 9-12) who meet criteria for overweight (age- and sex-specific body mass index of ≥ 85th and < 95th percentile)	14.4%[a]	12%	13.7% (2013)	△
.ii	Reduce the percentage of adolescents (high school students in grades 9-12) who meet criteria for obesity (age- and sex-specific body mass index of ≥ 95th percentile)	11.8%[a]	10%	12.4% (2013)	●
.i	Reduce the percentage of children (students in grades K-8) who meet criteria for overweight (age- and sex-specific body mass index of ≥ 85th and < 95th percentile)	16.7%[b,c]	15%	16.7% (2013-2014)	●
.ii	Reduce the percentage of children (students in grades K-8) who meet criteria for obesity (age- and sex-specific body mass index of ≥ 95th percentile)	16.6%[b,c]	15%[c]	16.8% (2013-2014)	●
a	Increase the percentage of adults (age 18 years and older) who report 150 or more total minutes per week of moderate or vigorous exercise where each minute of vigorous exercise contributes 2 minutes to the total	57.5%[d]	61%	55.0% (2013)	●
o	Increase the percentage of adolescents (high school students in grades 9-12) who do at least 60 minutes of physical activity a day, every day of the week	20.2%[a]	23%	20.9% (2013)	△
a	Reduce the suicide mortality rate per 100,000 population, among the population aged 15-24 years	46.0	43.2	41.4 (2013)	★
o	Reduce the suicide mortality rate per 100,000 population, among the population aged 25 years and older	25.0	23.5	26.9 (2013)	●
	Reduce the percentage of adolescents (high school students in grades 9-12) who felt so sad or hopeless every day for 2 weeks or more in a row that they stopped doing some usual activities during the past 12 months	25.2%[a]	23%	27.2% (2013)	●
	Reduce the mean number of days in the past 30 days adults (age 18 and older) report being mentally unhealthy	3.2	2.9	3.1 (2013)	△
o	Increase the percentage of adolescents (high school students in grades 9-12) with three or more adults (besides their parents) from whom they feel comfortable seeking help	44.6%[a]	47%	42.8% (2013)	●

*2010 unless otherwise noted; [a] 2009; [b] 2009-2010 school year, ASD and Mat-Su School Districts only; [c] Modified due to change in data collection methodology; [d] 2011; [e] 2013; [f] 2009-2011

★ Target Met △ On Track to Reach Target ● Not on Track to Reach Target

Updated 07/24/2015

HEALTHY ALASKANS 2020

A JOINT PROJECT OF THE STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES & THE ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Healthy Alaskans 2020 Scorecard

	HA2020 Leading Health Indicator	2010* Baseline	HA2020 Target	Current Data	Progress to Date
11	Reduce the rate of unique substantiated child maltreatment victims per 1,000 children (age 0-17 years)	15.3	14.4	13.0 (2013)	☆
12	Reduce the rate of rape per 100,000 population	125.4[c,e]	113.0[c]	no update	n/a
13	Reduce the percentage of adolescents (high school students in grades 9-12) who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months	9.1%[c,e]	8%[c]	no update	n/a
14	Reduce the alcohol-induced mortality rate per 100,000 population	16.3	15.3	16.4 (2013)	●
5.a	Reduce the percentage of adults (age 18 years and older) who report binge drinking in the past 30 days based on the following criteria: 5 or more alcoholic drinks for men; 4 or more alcoholic drinks for women on one occasion	21.8%	20%	18.5% (2013)	☆
5.b	Reduce the percentage of adolescents (high school students in grades 9-12) who report binge drinking in the past 30 days based on the following criteria: 5 or more alcoholic drinks in a row within a couple of hours, at least once in the past 30 days	21.7%[a]	17%	12.8% (2013)	☆
16	Reduce the unintentional injury mortality rate per 100,000 population	58.3	54.8	52.4 (2013)	☆
17	Increase the percentage of children age 19-35 months who do receive the ACIP (Advisory Committee on Immunization Practices) recommended vaccination series (2013 ACIP recommendation: 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella, 4 PCV)	65.0%	75%	67.1% (2013)	△
18	Reduce the incidence rate of Chlamydia trachomatis per 100,000 population	849.6	705.2	786.5 (2013)	△
19	Increase the percentage of rural community housing units with water and sewer services	78.0%	87%	85.0% (2014)	△
20	Increase the percentage of the population served by community water systems with optimally fluoridated water	54.8%	58%	45.7% (2013)	●
21	Reduce the percentage of women delivering live births who have not received prenatal care beginning in the first trimester of pregnancy	21.3%	19%	20.6% (2013)	△
22	Reduce the rate of preventable hospitalizations per 1,000 adults (hospitalizations that could have been prevented with high quality primary and preventive care) based on the Agency for Healthcare Research and Quality (AHRQ) definition	7.1	6.7	7.3 (2011)	●
23	Reduce the percentage of adults (age 18 years and older) reporting that they could not afford to see a doctor in the last 12 months	14.7%	14%	14.1% (2013)	△
24	Increase the percentage of the population living above the federal poverty level (as defined for AK)	84.5%[f]	90%	84.0% (2013)	●
25	Increase the percentage of 18-24 year olds with a high school diploma or equivalency	81.2%	86%	79.8% (2013)	●

*es: *2010 unless otherwise noted; [a] 2009; [b] 2009-2010 school year, ASD and Mat-Su School Districts only; odified due to change in data collection methodology; [d] 2011; [e] 2013; [f] 2009-2011*

☆ Target Met △ On Track to Reach Target ● Not on Track to Reach Target

Updated 07/31/2015

Appendix B

Glossary

AHELP = Alaska Health Education Library Project website

AK DHSS = Alaska Department of Health and Social Services

ANTHC = Alaska Native Tribal Health Consortium

CDC = Centers for Disease Control and Prevention

Coordinating Partners = Individuals chosen to pilot HA2020 implementation by coordinating networks working on similar LHIs, by promoting the evidence-based strategies, and by gathering data on strategy implementation

HA2020 = Healthy Alaskans 2020

HA2020 Advisory Team = Comprised of 25+ individuals committed to furthering the work of HA2020 through consultation, advocacy and providing advice and input on all matters related to HA2020

HA2020 Core Team = Comprised of Diana Redwood (ANTHC), Michael Dickey (Alaska Division of Public Health, Alaska Department of Health and Social Services), Andrea Fenaughty (Alaska Division of Public Health, Alaska Department of Health and Social Services), Jayne Andreen (Alaska Division of Public Health, Alaska Department of Health and Social Services), & Mary McEwen (Alaska Division of Public Health, Alaska Department of Health and Social Services). Jayne Andreen left the Core Team upon her retirement in December 2015. The Core Team meets weekly and has been instrumental in furthering the work of HA2020; their current focus is on the implementation strategy.

HA2020 Data Team = Comprised of Andrea Fenaughty (Alaska Division of Public Health, Alaska Department of Health and Social Services), Mary McEwen (Alaska Division of Public Health, Alaska Department of Health and Social Services), & Romy Mohelsky (ANTHC), who monitor HA2020 LHIs throughout the year and annually update the scorecard

Key Partners = 130 organizations who had ongoing representation (usually one or two staff) and provided input in shaping the development of the HA2020 Strategies and Actions Document

LHIs = Leading Health Indicators (25); also known as health improvement goals

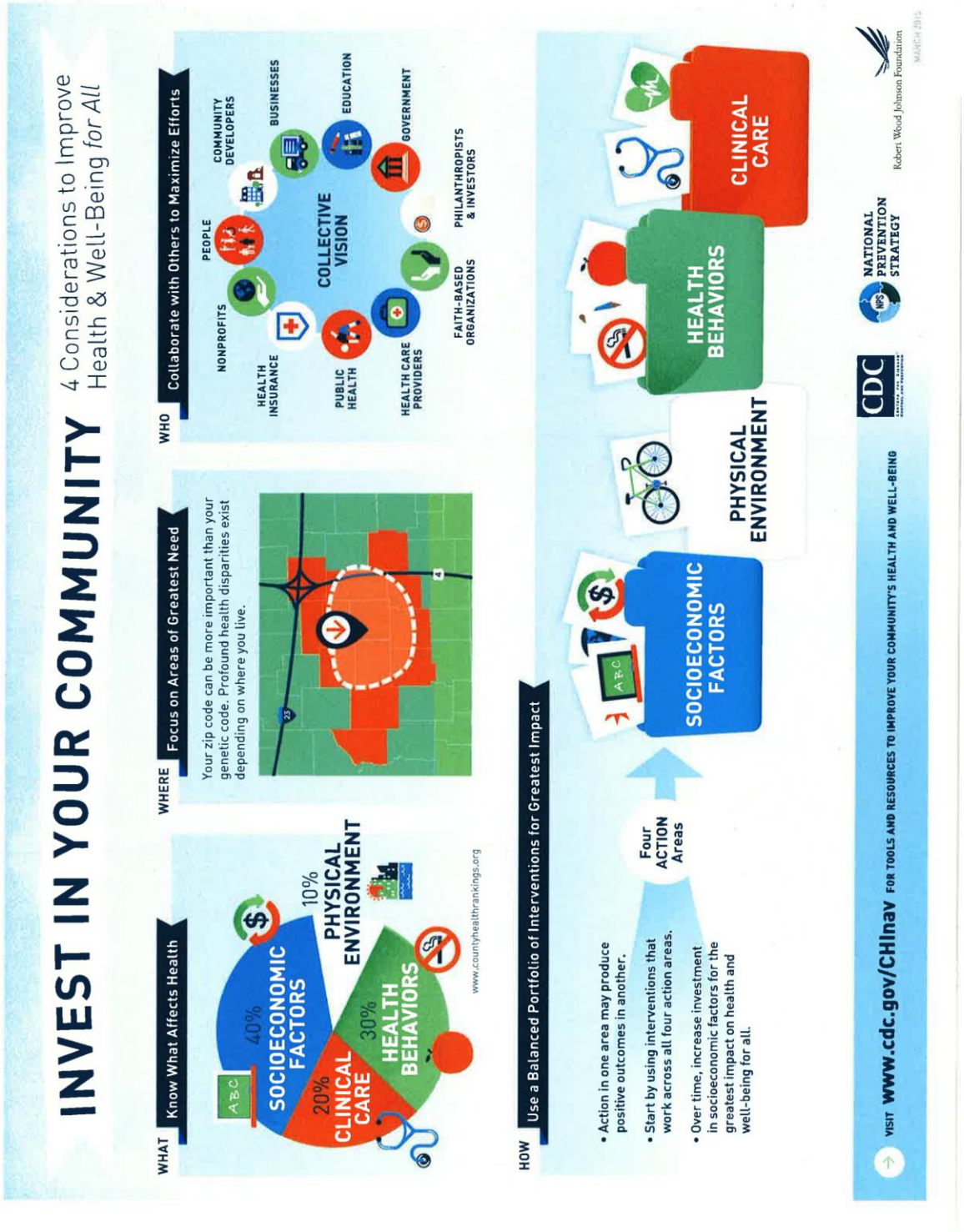
SHIP = Statewide Health Improvement Plan

Appendix C

Advisory Team Roster

Appendix D

Centers for Disease Control and Prevention Infographic



Appendix E

Survey Identifying Organizations

(Distribution: November 24, 2015 – February 1, 2016)
https://newqtrial2015az1.qualtrics.com/SE/?SID=SV_7VOmL7tUq3vnJT7

Through the work of Alaskans statewide, the Healthy Alaskans 2020 (HA2020) initiative has identified 25 Leading Health Indicators (LHI), as well as strategies and actions to reach health improvement targets by 2020. We are now moving into the implementation stage of HA2020, and we need your help!

To include all potential partners, we are asking you to identify organizations, partnerships, coalitions and groups within Alaska for those of the 25 Leading Health Indicators with which you are familiar. This information will be compiled and posted on the Alaska Health Education Library Project (AHELP) website. Your participation, while greatly appreciated, is voluntary and you may exit the survey at any time without penalty.

Finally many organizations and disciplines are involved with Healthy Alaskans 2020 and this survey is accordingly being widely distributed. We apologize in advance if you receive it more than once. Thank you again for your ongoing dedication and assistance!

Instructions: Up to three organizations may be identified for each LHI.

For each LHI chosen by the respondent, the following questions and answer responses are given after the name of the organization/group:

Q1: What option below best describes the type of organization?

A1: Public/Private non-profit/Professional/Tribal/Coaltion/Voluntary/Other – please specify

Q2: Please identify the groups involved in the coalition? (Only displayed if Coalition is selected)

Q3: What is the geographic area served by the organization?

A3: Statewide/Regional/Local

Q4: Please provide the contact information for the group.

A4: Contact Person/Address Line 1/Address Line 2/City/State/Phone/Website

Appendix H

Key Informant Interview Guide for Coordinating Partners

Name: _____ Day: _____

Position: _____ Time: _____

LHI: _____

The focus of this evaluation is to better understand the experiences of Healthy Alaskans 2020 (HA2020) Coordinating Partners. Input from this evaluation will be shared with the Healthy Alaskans 2020 initiative to make improvements in HA2020 implementation.

My purpose in talking with you today is to learn more about your thoughts, feelings and experiences with implementing the Healthy Alaskans 2020 LHI strategies and actions, specifically around your role as a Coordinating Partner.

Your participation in this interview is completely voluntary and while your participation is greatly appreciated, you may discontinue the survey at any time without penalty, and any public presentation will report the results in aggregate. Are you willing to be interviewed?

The interview will ask questions about your involvement with HA2020, HA2020 implementation, support and progress, and will also solicit your advice and input. We truly want to understand both successes and barriers that you faced. Do you have any questions before we begin?
(Note: All questions will be asked of all interviewees)

Interview Questions

1. How did you get involved with HA2020? When?

2. Did you volunteer to be a Coordinating Partner or were you asked to take on this role?

3. What made you interested in participating as a Coordinating Partner?

4. What were factors that you considered before taking on this role?

5. What were your initial concerns? If you shared them, were they adequately addressed?

6. What do you see as the benefits to you or your organization by your participation?

7. Did/does your organization assist you with funding, staff and/or time to act as a Coordinating Partner? If so, how much funding, staff and/or time were you provided with?

8. Approximately how much time per week do you spend on activities related to HA2020?

9. Is there something HA2020 could do to help justify your involvement as a Coordinating Partner to your organization/board?

If hesitant, acknowledge brief amount of time in position, and that questions may be hard to answer at this time.

10. Do you feel you received adequate information about the role of a Coordinating Partner? If no, probe for explanation. What would you have liked to have known prior to becoming a Coordinating Partner?

11. Have you received enough assistance and direction from HA2020 in implementing the LHI strategies and action steps?

12. What do you hope to achieve as a Coordinating Partner?

13. What were some barriers you experienced or anticipate you may experience?

14. What do you think are the strengths of how the HA2020 strategies and actions are being implemented? Weaknesses?

15. Have you had a chance to look at the spreadsheet? Is this a helpful resource? How could it be more helpful? Did you learn of other organizations you weren't aware of working on the LHI?

16. Are you currently working with any of the key partners? If so, in what capacity?

17. Do you feel comfortable explaining HA2020 and reaching out to other organizations you currently don't have a relationship with?

18. What would you recommend changing or keeping the same for new Coordinating Partners? What advice would you give to new Coordinating Partners?

19. Do you have any additional comments?

Thank you for your time!

Appendix I

Informed Consent Form for Interview Subjects

PRINCIPAL INVESTIGATOR

Laila Allen
in Public Health Student
University of Alaska-Anchorage
907.245.0033

RESEARCH SUPERVISOR

Dr. Rhonda Johnson, DrPH, MPH, FNP Master
Professor of Public Health
University of Alaska-Anchorage
907.786.6545

DESCRIPTION: I am currently pursuing a Masters in Public Health degree at the University of Alaska Anchorage. As part of my final project, I am assisting the Healthy Alaskans 2020 Initiative (HA2020) with assessing the implementation strategy of using Coordinating Partners. Coordinating Partners have the responsibility of furthering HA2020, a statewide health improvement plan, by linking networks of agencies working towards specific health improvement goals, and collecting common measurement metrics to assist the HA2020 Initiative monitor their progress. A critical component of understanding how this strategy is progressing is gathering information from the Coordinating Partners.

The goal of this interview is to understand your experience as a Coordinating Partner. The interview will begin with how you became involved with HA2020, proceed with questions about the infrastructure, support and progress, and end with your advice and input. We truly want to understand both successes and barriers that you faced. It is estimated that this interview, which will be taped and then transcribed, will take approximately an hour of your time.

The interview guide, listing the 19 questions in the order they will be asked, will be distributed to the Coordinating Partners prior to the interview.

VOLUNTARY PARTICIPATION: Your participation in this interview is completely voluntary and you may discontinue the survey at any time without penalty.

CONFIDENTIALITY: Your responses will be aggregated with the other Coordinating Partners' answers and your name and organization will not be individually attached to any statements, opinions or other information you share with me. The taped interview will be destroyed once it has been transcribed and the transcription will be stripped of identifying information and stored on a secure, private computer.

POTENTIAL BENEFITS & RISKS: A potential benefit of participation is an improved outcome for Healthy Alaskans 2020. By understanding your experience, the HA2020 Initiative will be able to more fully assist, prepare, and aid future Coordinating Partners. Playing an important role in improving the state's population health is the largest benefit, and your willingness to share your experience and knowledge may provide valuable insights into the implementation strategy

of using Coordinating Partners. While there are no foreseeable risks, the interview will necessitate approximately an hour of your time and there is a possibility of distress caused by relating a negative experience.

CONTACT/FURTHER INFORMATION: If you have any questions or would like further information about this project, please contact the Principal Investigator by phone. If you have any questions about your rights as a research subject, please contact Sharilyn Mumaw, Research Integrity and Compliance Officer, at 907-786-1099. Thank you!

By signing below, you acknowledge that you understood the information above, and consent to being contacted and interviewed by the Principal Investigator.

SIGNATURE: _____ DATE: _____

Appendix J

Responsibilities and Benefits of Being a Coordinating Partner

Coordinating Partner

Purpose of Coordinating Partner: Provide linkages between HA2020 and partners to achieve LHI objectives and assure continued momentum of the HA2020 effort. Promote implementation, monitoring, and reporting on the status of the priority strategies and actions implemented related to a specific HA2020 leading health indicator (LHI) or set of LHIs.

Roles and Responsibilities:

- Serve as a HA2020 advisory team member and as public ambassador for the initiative/LHI(s)
- Serve as liaison between HA2020 and communities
- Help identify others working on specific LHI to promote alignment of agencies
- Coordinate efforts and communication among identified key partners, coalitions, and other organizations working on priority strategies and actions to facilitate the success of achieving the LHI targets by 2020
- Identify measure(s) for LHI strategies and report progress to HA2020 Core Team
- Assist the Core Team in identifying technical assistance needs of HA2020 partners
- Participate in identifying and soliciting HA2020 success stories
- Where appropriate promote the HA2020 initiative by providing information at meetings, conference, etc.

Benefits to Participation

- Gain experience and skills as a leader contributing to an initiative receiving interest on a national level.
- Impact health at a state-wide level
- Expand your network of linkages
- Receive individual and organization recognition
- Get exposure to new concepts, people, and grow as a health professional
- Promote health equity
- Be part of the first implementation of Alaska's State Health Improvement Plan; and one of the first plan implementations in the country
- Receive technical assistance related to all HA2020 activities

Appendix K

State of Alaska Confidentiality of Information Agreement

Appendix L

State of Alaska Volunteer Service Agreement

Appendix M

Letter of Support

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services
DIVISION OF PUBLIC HEALTH
Director's Office
3601 C Street, Suite 756
Anchorage, Alaska 99503-5924
Main: 907.269-8126
Fax: 907.269-2048

Dr. Rhonda Johnson
BOC3, Suite 220
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508-4614

Dear Dr. Johnson,

I'm writing this letter in support of Laila Allen's proposed practicum project. I have reviewed Laila's proposed scope of work and discussed specifics regarding how her work will support the efforts of Healthy Alaskans 2020 and also provide quality experience to advance her knowledge and skills in the field of public health. Through the proposed work, Laila will assist us in executing HA2020's implementation plan. She will be corresponding with and collecting information from the HA2020 Advisory Team, identifying relevant coalitions, analyzing data, and evaluating stages of the implementation. During her work on this project, Laila will have access to and permission to use data that will support HA2020 efforts.

The work for this practicum will be taking place in the Director's Office of the Alaska Division of Public Health located at 3601 C Street, Suite 756, Anchorage, AK 99503. I do not have any concerns about the practicum activities based on communication with Laila. The agency supports her proposed plan and approves of this project.

Sincerely,

Michael G. Dickey, MPH
Quality and Performance Improvement Manager
Division of Public Health, DHSS

Appendix N

Institutional Review Board Exemption Status Notification

UAA Research & Graduate Studies

3211 Providence Drive
Anchorage, Alaska 99508-4614
T 907.786.1099, F 907.786.1791
www.uaa.alaska.edu/research/ric

DATE: November 2, 2015

TO: Laila Allen
FROM: University of Alaska Anchorage IRB

PROJECT TITLE: [817827-3] Healthy Alaskans 2020 Implementation Pilot
SUBMISSION TYPE: Amendment/Modification

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE: November 2, 2015
EXPIRATION DATE: November 1, 2016

Your Institutional Review Board (IRB) proposal meets the U.S. Department of Health and Human Services requirements for the protection of human research subjects (45 CFR 46 as amended/revised) as being exempt from full Board review. In keeping with the usual policies and procedures of the IRB, your research project is approved with suggested revisions. Thank you for a copy of these revisions.

Therefore, you have permission to begin data collection for your study. If this study goes beyond one year from the date of this letter, you will need to submit a Progress Report for approval to continue the research. Please submit a Final Report at the end of your project.

Please report promptly proposed changes in the research protocol for IRB review and approval.

On behalf of the Board, I wish to extend my best wishes for success in accomplishing the objectives of your study.

Sharilyn Mumaw, M.P.A.

Research Integrity & Compliance Officer