UAA Alaska Center for Rural Health and Health Workforce
UNIVERSITY of ALASKA ANCHORAGE
Alaska's Area Health Education Center (AHEC)

Health Equity Analysis
ALASKA

2023

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Introduction

The Alaska Center for Rural Health and Healthcare Workforce (ACRH-HW) designed and administered a survey to assess the needs of Alaskan communities in the areas of health equity and continuing education for healthcare professionals.

The study was designed to gather data from across the State of Alaska from an adequate representation of the population and healthcare workforce. During the pandemic, certain health inequities were brought to the forefront of the mainstream community's attention. Now, as many pandemic-specific issues have come to a close, this survey was conducted to reassess health equity concerns and continuing education needs for a healthcare workforce that has endured extreme levels of stress and demand.

The survey is part of initial planning phases to inform the launch of the CACHE (Clearinghouse for Alaska's Continuing Health Education), a one-stop shop for healthcare continuing education and training opportunities. The CACHE has been under development and is slated to launch before the close of the 2023 fiscal year. The CACHE will list training and continuing education opportunities from a variety of training providers both in-state and out of state. It has the capacity to create topic specific learning paths for users, track completed CE training for documentation and employer verification, register and collect payment for events and serve as a statewide marketing tool for education providers. For more information on the CACHE, visit Continuing Studies at UAA College of Health.

The Health Equity portion of the survey was designed to gain a better understanding of the health equity topics and challenges being faced across the State of Alaska. The themes identified by respondents across the state as areas of need include the following:

- Mental Health Treatment
- Substance Use Disorder Treatment
- Recruiting and Retaining Healthcare Staff
- Improving Housing Affordability
- Increasing Access to Healthcare by improving access to transportation and affordable childcare

The themes identified as areas where healthcare workers need support include the following:

- Connecting the Services provided to reduce duplication of services
- Increase Access for Clients
- Reduce Waitlists to Providers by increasing staff
- Growing Our Own Future Healthcare Workers
- Recruiting and Retaining Employees, especially recruiting mental healthcare providers

The Continuing Education portion of the survey was designed to inform continuing education and training providers with professionals' preferences in methodology, locations and needs for support. Combined with the health equity findings, this report serves as a comprehensive resource for expansion and enhancement of health equity centered continuing education for Alaska's Healthcare Workforce.

Methodology

The survey was open November 21, 2022 through January 31, 2023. It included multiple choice questions, rank order questions, open-ended free text questions, and collected demographic and geographic information. The survey also provided respondents with an opportunity to include their own thoughts which served as an adjunct to the limited-response questions.

In order to reach a broad healthcare worker audience, the survey was distributed widely throughout the AHEC Network to past continuing education/professional development participants as well as the AHEC Statewide Steering Committee and other groups with a vested interest in healthcare workforce issues. Professional health associations within Alaska were also contacted to distribute the survey within their own networks. A preliminary analysis identified underrepresented regions as well as occupations which then were targeted with additional outreach efforts to promote the survey with healthcare facilities and organizations in those regions.

During the 72 days the survey was open**,** 318 survey responses were collected. Similar to the population distribution of the state as a whole, 42% of respondents were from the Anchorage area. While the survey results include a slight overrepresentation of the Southeast and a slight underrepresentation of the Gulf Coast and Mat-Su regions, it illustrates a representation of the population of Alaska.[1]The survey responses also adequately reflected the current distribution of the healthcare workforce of Alaska for race, gender, and age as shown in Table 1 below. Additional demographic information can be found in Appendix A.

Table 1. Demographic distribution

Demographic	Alaska Healthcare Workforce[2]	Survey Respondents
Female	74%	78%
Male	26%	19.6%
White	70%	75%
Median Age	45	45-54

Survey results came from a wide range of professionals, including 15 total occupations and 13 facility types from around the state. Below are the respondents' most common occupations and facility types.

[1] https://live.laborstats.alaska.gov/pop/index.cfm

[2] https://www.alaska.edu/research/wd/plans/health/ASHNHA%20Health%20Care%20Workforce%20Report.pdf

Table 2. Occupations and Facility Types

Occupation		Facility Type	
Nurse	19.2%	Clinic	18%
BH/Social Work	14.5%	Non-Profit Organization in the Social Sector	16%
Health Admin/Manager	13.1%	Other	16%
Director	11.1%	Hospital/Inpatient	11%
Physician/Surgeon	11.0%	Academic Institution	8%
Educator	5.8%	Hospital/Outpatient	7%

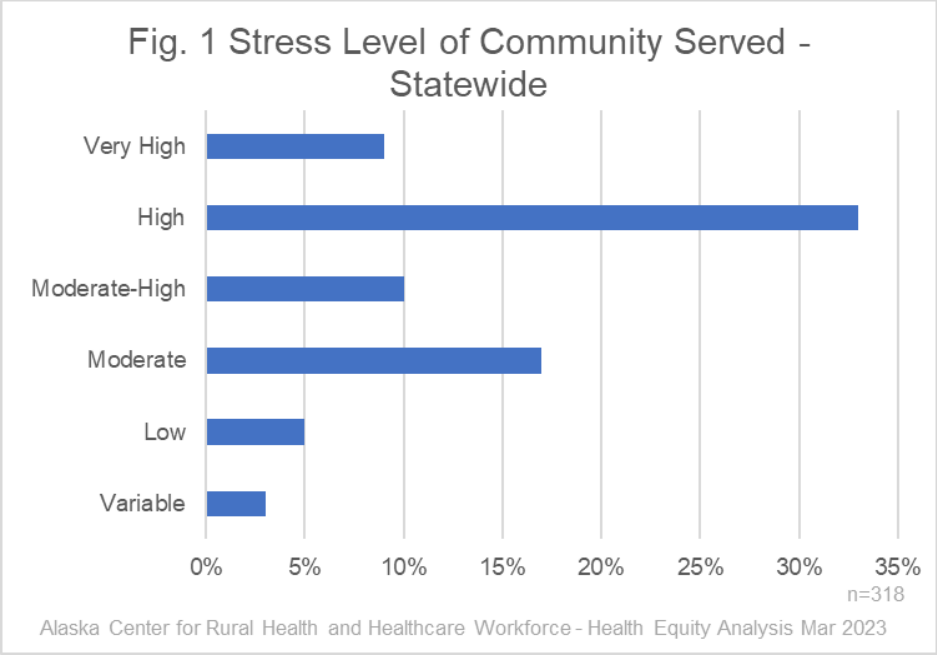
Most of the answers that were listed as other for the facilities were recategorized into existing categories. Those that were not recategorized include tribal, government agencies (outside of the Department of Public Health) community-based facilities, shelter (Homeless/DV) and self-employed.

HEALTH EQUITY SURVEY RESULTS

The health equity survey results provide a diverse overview of topic areas that are most significant to Alaska's healthcare workforce. Overall, the workforce understands the components of health inequities. They are well aware of the impacts of social determinants of health on healthcare outcomes. The main need that arises to the surface is surrounding the applications of best practices and strategies to overcome these challenges to develop a more equitable healthcare landscape for Alaskans.

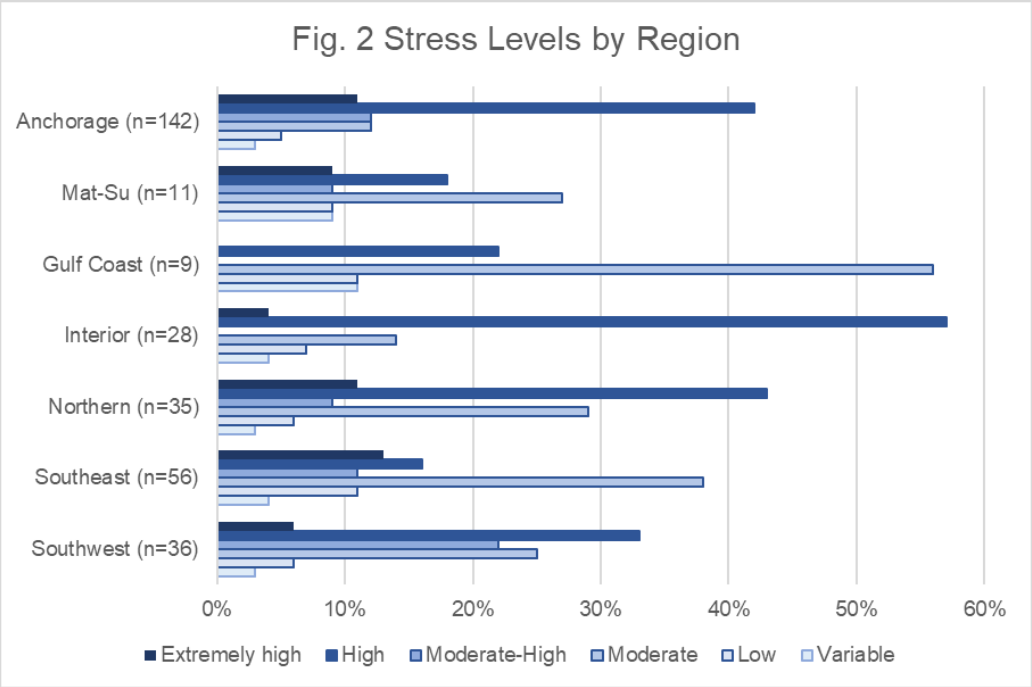
Stress Levels of Communities

The survey asked respondents to describe the stress level of the community in which they serve. This question was a free text response prompt. In order to provide a well-rounded review of all participant responses, staff compiled key words using free text analysis to assign values on a Likert scale to the free text responses. The results are shown in Figure 1.



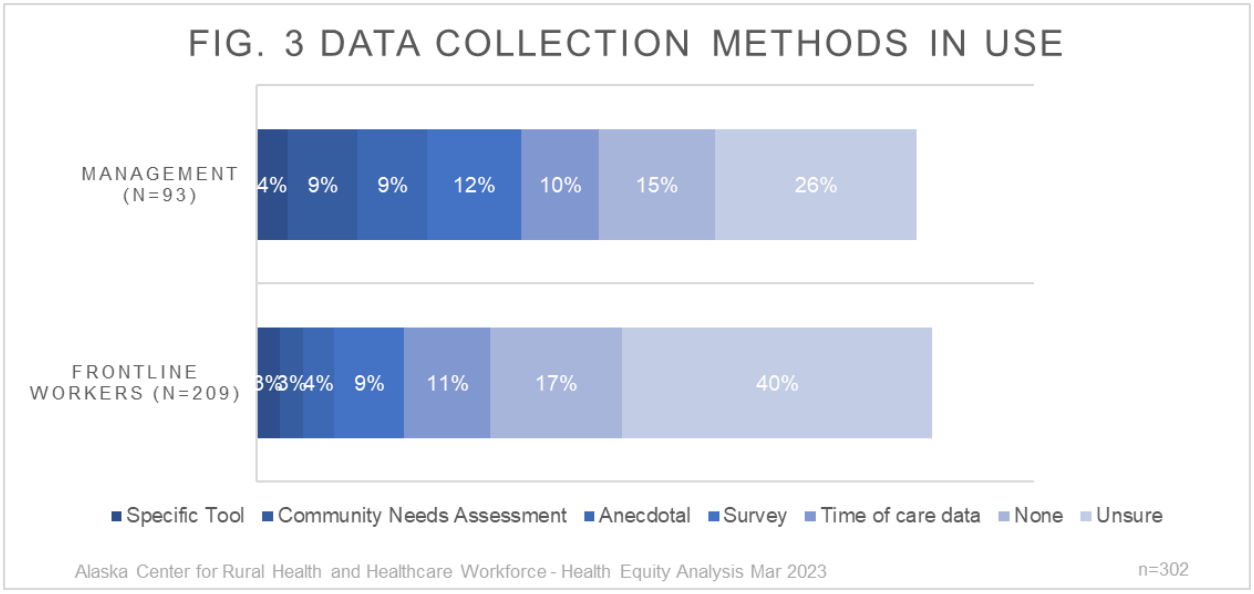
Of the group that responded in a way that was categorized as “variable,” they specifically explained that stress levels are higher among those from lower socioeconomic status and stress levels are lower for those from higher socioeconomic status. This finding supports the relevance of social determinants of health and the need for expanded interprofessional training and collaboration of organizations across sectors to impact meaningful change in healthcare disparities.

There were additional themes presented in the free text responses about stress. Mental health of communities was the most common topic with 11% writing about anxiety, depression, mental health, substance use, alcohol use and domestic violence and suicide as concerns in their community. The survey results showed 7% of people expressing concerns about the cost of living and access to affordable or nutritious food in their community as a factor for stress levels being increased. Figure 2 shows the data by region. The Interior and Northern regions report the highest levels of stress, while Mat-Su (which also has a low response rate) and the Southeast regions show lower levels of stress as compared to the rest of the state. These findings exemplify the impact of accessibility and affordability of nutritious foods in correlation to mental health.



Facility Data Collections Methods

Respondents were asked to describe the data collection methods that are being used at their place of work to collect health equity data. 52% of respondents indicated that they are either unsure of the data collection methods or that their agency does not collect this type of data (none). The most common answers are shown in Figure 3. This finding supports the need for additional training opportunities and technical assistance support for data analytics, informatics and evaluation in the healthcare sector.

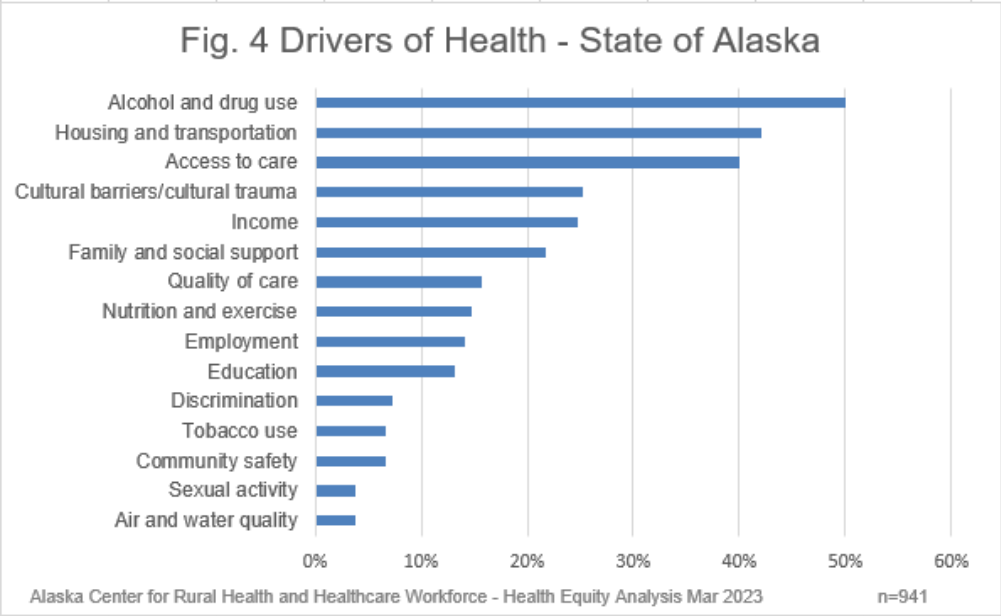


Drivers of Health Impacting Communities

The survey asked participants to consider the following list of drivers of health and then to choose the *top three (n=941)* impacting the community they serve.

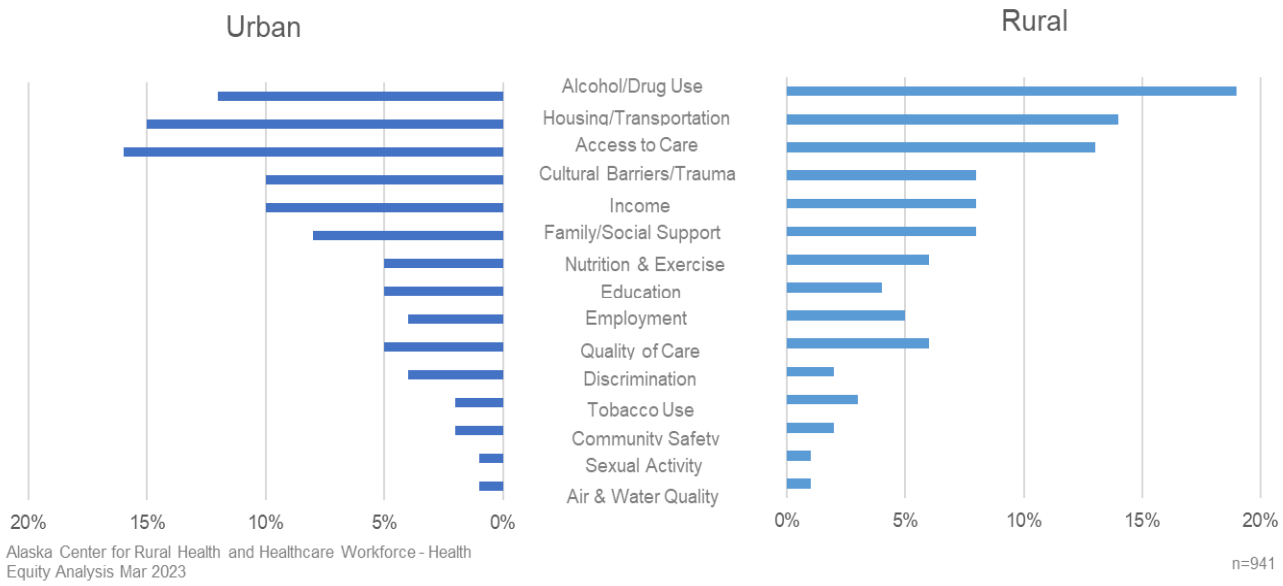
Clinical care - Access to care
Clinical care - Quality of care
Physical Environment - Air and water quality
Physical Environment - Housing and Transportation
Social and Economic Factors - Community Safety
Social and Economic Factors - Family and Social Support
Social and Economic Factors - Income
Social and Economic Factors - Employment
Social and Economic Factors - Education
Social and Economic Factors - Discrimination
Social and Economic Factors - Cultural barriers/Cultural Trauma
Health Behaviors - Alcohol and drug use
Health Behaviors - Nutrition and Exercise
Health Behaviors - Tobacco Use
Health Behaviors - Sexual Activity
Other

Statewide results for this question show that Alaska's healthcare workers are most concerned about alcohol and drug use in their communities, followed by housing and transportation and access to care, as shown in Figure 4 below. Concerns about air and water quality, sexual activity and community safety are among the lowest reported concerns as drivers of health. Most of the answers listed for "Other" were re-categorized within the existing options, those that were not re-categorized included responses regarding affordable quality daycare/childcare, the stress of youth, internet connectivity, and knowledge/understanding of how to utilize healthcare benefits. Once again, these findings support the need for more cross-sector collaboration to impact healthy communities.



This data was also analyzed by each region to show specific concerns in different communities. Rural areas reported higher frequency of Alcohol and Drug Use as a Driver of Health concern than urban areas (urban areas include Anchorage and lower Mat-Su). Urban areas reported higher frequency of Access to Care as shown in Figure 5. Each region's individual top 5 results are shown in Figures 6-12 in Appendix B.

Fig. 5 Drivers of Health - Urban vs Rural



To more thoroughly explore these drivers of health, survey respondents were asked to explain their choices. It was clear in responses that all of these drivers overlap in many ways, and the health realities of Alaskans are complex. In regards to the most common health driver selected– alcohol and drug use– they specifically noted the different factors such as long wait times to see providers, lack of housing, disconnection between different services and households with multiple inhabitants struggling with similar addictions, contribute to the high rates of substance abuse and addiction within the state. Within the overall response pool, 15% identified a healthcare provider shortage across the state, 11% specifically stating that their community had a lack of psychiatrists and mental healthcare providers. In order to impact healthcare workforce shortages, a series of strategies must be implemented simultaneously. Pathways programming for youth and adults, increase of healthcare training programs and continuing education, loan repayment and recruitment of out of state providers are all examples of current workforce development strategies in action.

Respondents reported observing difficulties for patients to secure appointments with providers, and once an appointment is confirmed, additional barriers to care include transportation. 8% of respondents cited transportation as a barrier to health equity. Rural residents often must fly to appointments which is costly and difficult to coordinate. Urban residents may have to rely on public transit or family support. Many individuals must also coordinate with Medicaid travel vouchers. These factors are often out of the control of the patient, and contribute to missing appointments and therefore having inconsistent and interrupted continuity of care. Some

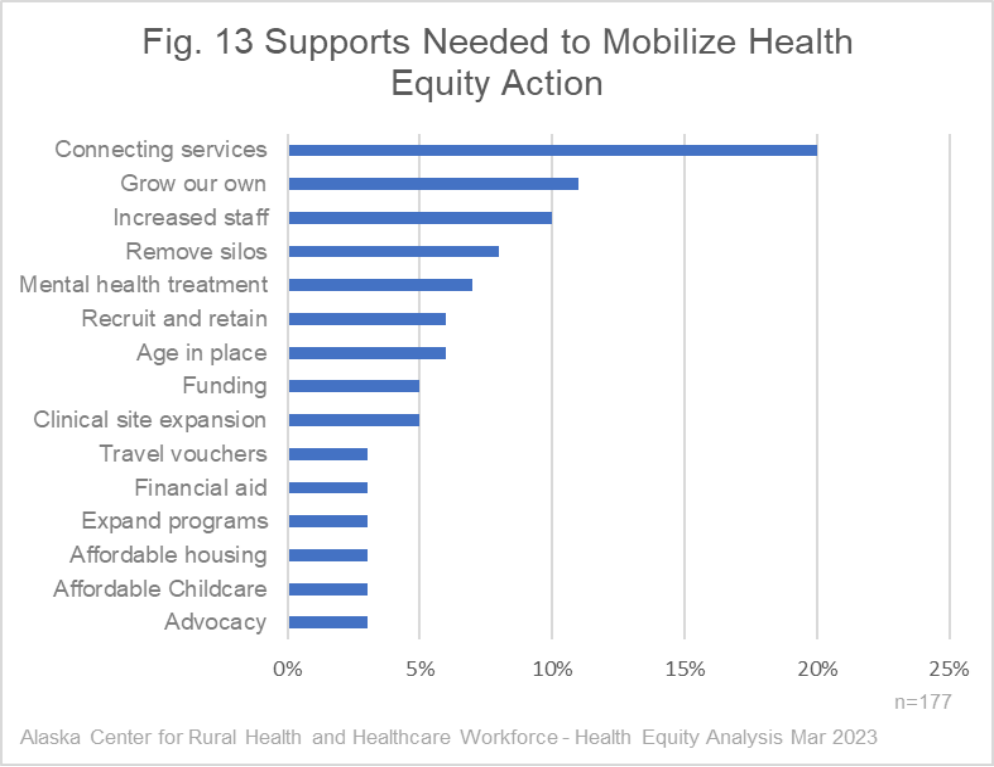
respondents described it as “theoretical access to care” made physically impossible by transportation challenges either due to remote living, distance to providers, lack of reliable public transit, or lack of access to vehicle use.

In addition, housing is scarce in many of these rural areas due to the high cost of building new construction[3]. A lack of adequate housing is often a deterrent for any potential new providers. Not only is this a problem in regards to adequate access to care, but it is a struggle and health driver for the Alaskans in these areas. Affordable housing was cited by 14% of respondents and the lack of affordable childcare was cited by 33% of respondents. Respondents explained that in order to afford housing many families resort to multigenerational or multifamily living arrangements. These living conditions are connected to substance abuse, generational trauma, and a cycle that is repeating. Respondents (6%) explained that the trauma experienced by adults when they were children is now repeating on today’s children, creating the same substance abuse, broken families and poor living conditions. 3.5% of respondents shared that all of the drivers of health choices overlap and are interconnected which made it difficult to rank them. In fact, 7% of respondents simply wrote "all" as their explanation of the drivers of health affecting their community.

Mobilizing Action to Impact Health Equity

The survey asked participants to identify how their staff needs support in mobilizing and taking action around any of these issues. Many respondents misunderstood this question and answered it with a response explaining the actions their agency is *already doing* to help the communities they serve. As a result, the total responses that were applicable to the question at hand was only 56% of total responses. Figure 13 shows the support respondents said were needed in order to mobilize health equity action.

[3] https://www.nrel.gov/news/features/2023/creating-sustainable-housing-and-jobs-in-rural-alaska.html



20% of respondents identified that support was needed in connecting community resources to reduce duplication of services, and increase ease of access for those needing the services. For example, respondents reported that multiple agencies help connect people with housing options and substance abuse treatment options, but if there is a waiting list at one, they may not know that another organization could have an opening. By the time that person has access to services, the window of opportunity where the client was interested in treatment and assistance may have passed. Table 3 in Appendix B shows the support needed to mobilize action organized by region.

In addition to connecting services, respondents were proponents of “Grow Our Own” initiatives and increasing staffing. There are a multitude of “Grow Our Own” healthcare provider programs across Alaska including the Alaska AHEC Program, Alaska Native Science and Engineering Program, Alaska Healthcare Apprenticeship Program, Community Health Worker Initiative and the Alaska Primary Care Association’s Good Jobs Challenge (to name a few). These efforts must be knit together across a variety of partners and sectors to achieve systemic measures of success. Revitalization of the Alaska Healthcare Workforce Coalition would be one step that could be taken to improve and streamline “Grow Our Own” programs.

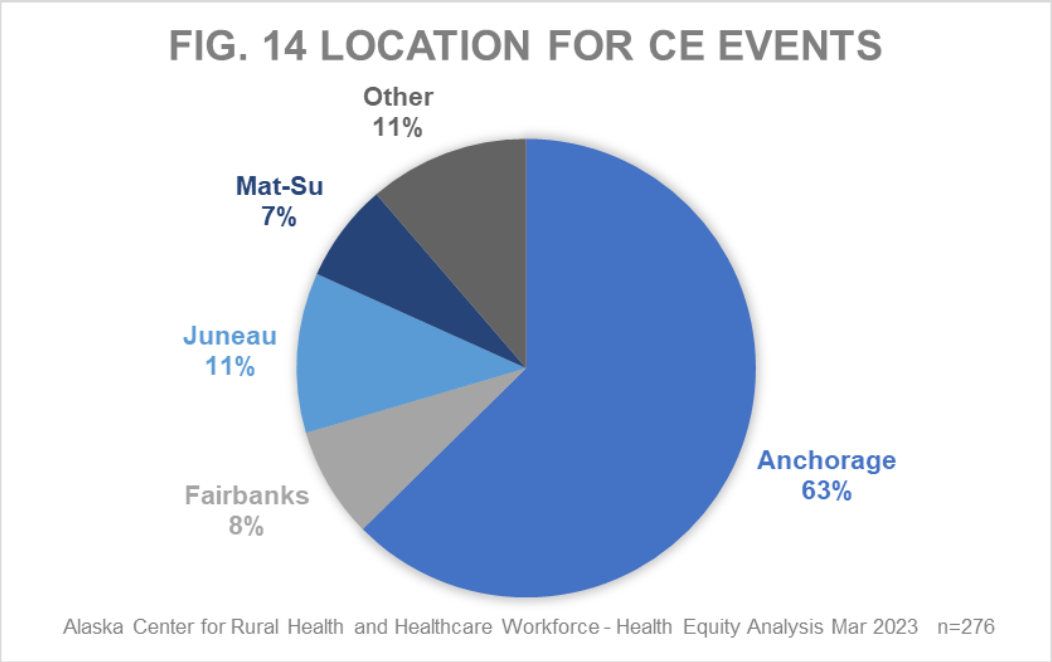
CONTINUING EDUCATION SURVEY RESULTS

The health equity data will be used to aid in the design of future continuing education events for healthcare professionals throughout the state of Alaska. The next section of this report aims to understand instructional methodology to meet our healthcare workforce where they are,

particularly after enduring the extreme stress of the pandemic. The health equity data is designed to be able to be compared to the continuing education data in order to determine the best ways to support the healthcare workforce in making effective changes and improvements to health equity across the state.

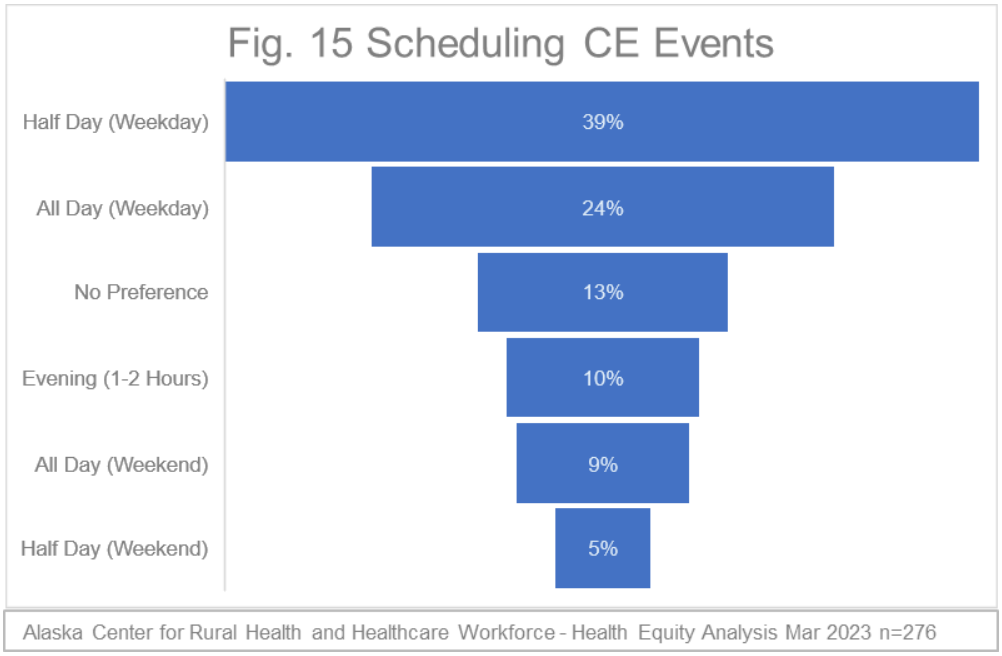
Location for Live CE Events

Figure 14 below shows the overall preferred location for an in-person continuing education event. A specific breakout of locations by occupation is included in Appendix C. Majority of respondents preferred live events in Anchorage. The data from this figure is reflective of the primary locations of the respondents, however it is important to note that Anchorage is a preferred location choice for rural Alaskans to attend live events.



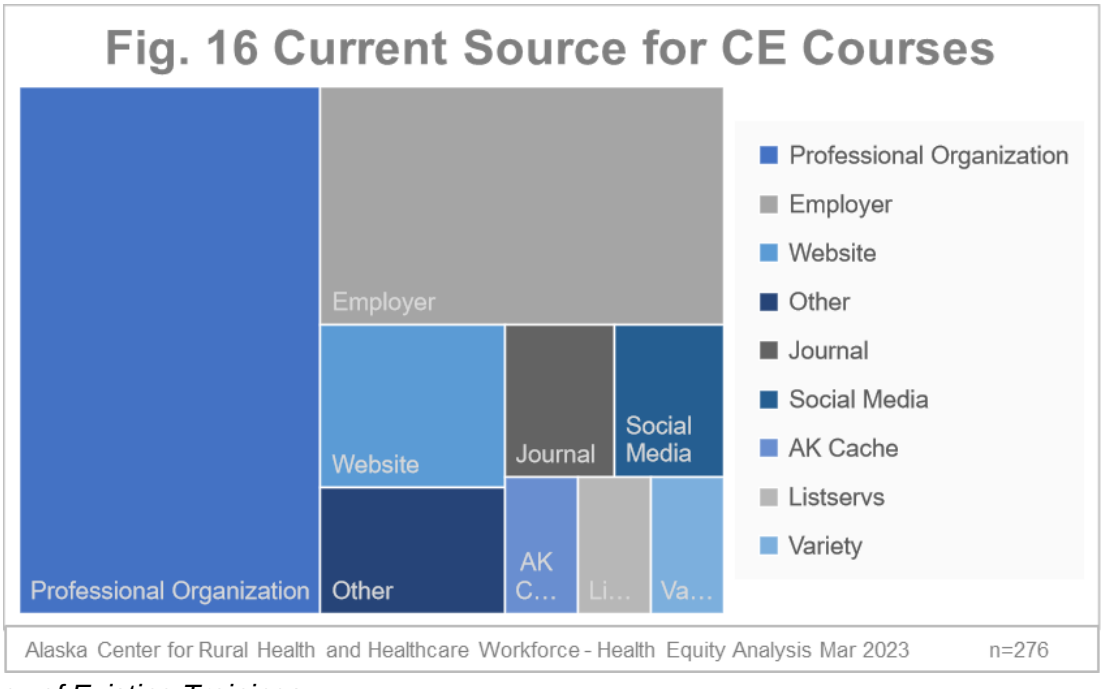
Preferred CE Event Scheduling

Participants were asked to identify their preferred time of the week to participate in a continuing education event; the statewide response data is shown in Figure 15. A detailed display of preferred format for continuing education events is in Appendix C. The summary data for all continuing education questions organized by “Occupation” include only those occupations where the response rate was at least ten and are all detailed data by profession type is included in the Appendix C. Most respondents prefer half day events on weekdays or full week day events over weekend or evening training opportunities.



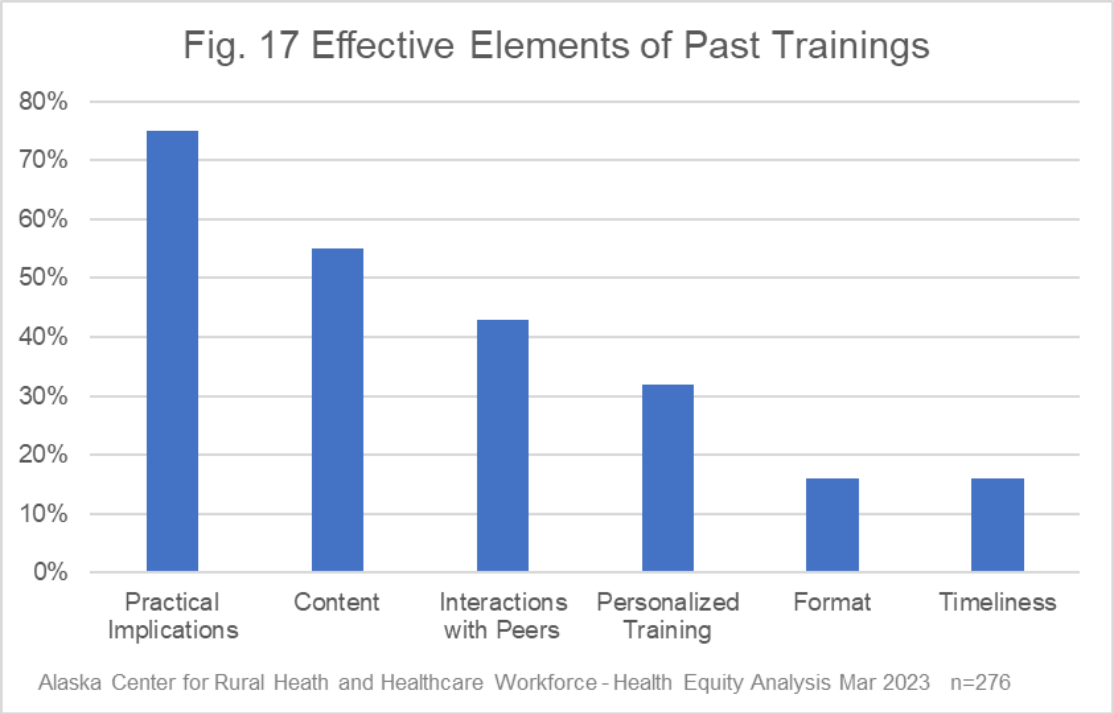
Current Source of CE Credits

Participants were then asked to share their current source for continuing education credits. Most respondents elected a Professional Organization and when asked to list it, the organization was often a nationwide association for their specific occupation. For example, nurses most often listed the American Nurses Association. The full table including a breakdown by individual profession type is included in Appendix C and the statewide summary data is shown in Figure 16 below. This information will be a valuable resource in compiling and marketing training opportunities for the Alaska healthcare workforce.



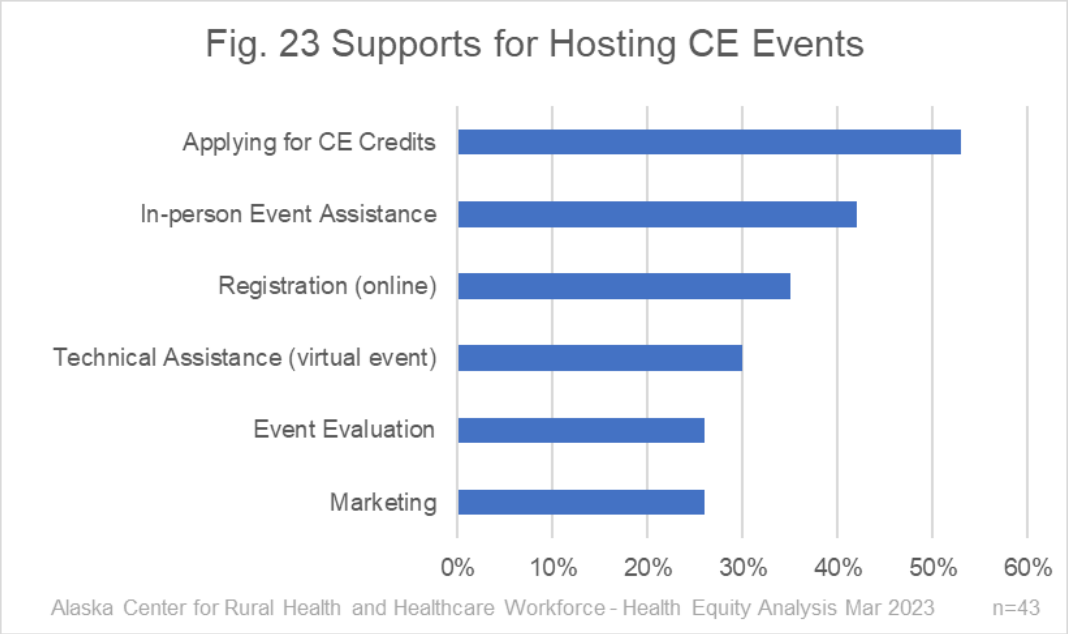
Efficacy of Existing Trainings

Participants were asked to consider any health equity training that they have participated in and choose the elements of that training that were the most effective and/or helpful. The statewide results are shown in Figure 17 below while occupation specific results are included in Appendix C. Respondents were overwhelmingly supportive of trainings that provided practical application in the field containing high quality content that allowed for interaction and engagement with like-minded peers.



CE Support Services

Survey participants were asked if their organization runs or is interested in running a continuing education event and 43 respondents answered “yes.” Those who responded “yes” detailed what support was or would be needed to do so, as shown in Figure 23. Respondents interested in continuing education support shared their greatest need surrounding the area of applying for CEU/CME credits. The multitude of accreditation bodies for various disciplines and limited in-state options for CEU/CME accreditation result in a complex and difficult to navigate landscape. These are areas where statewide cross-sector collaboration could be focused to support continuing education needs.



CONCLUSION

The health equity portion of the survey identified much of a consensus across the state highlighting substance use/abuse disorders and mental health as the primary driver of health impacting Alaskan communities. The primary barriers to healthcare that Alaskans are experiencing include transportation, housing, childcare, and long wait lists for services. Healthcare workers are at the forefront of efforts to improve health equity.

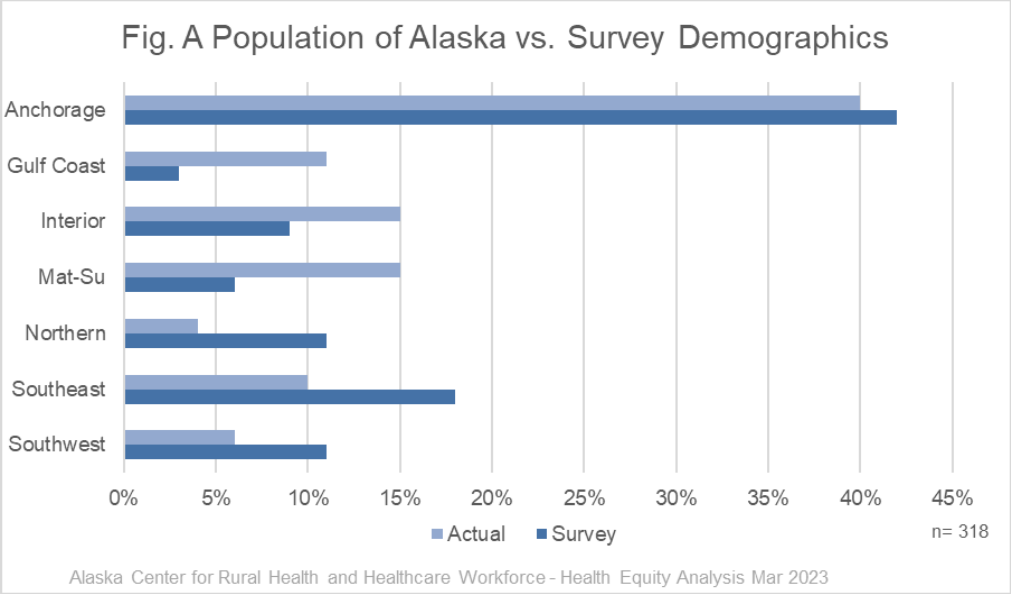
The continuing education portion of the survey focused on identifying meaningful and actionable functions healthcare organizations can focus on to support healthcare workers current training needs. The primary focus of health-related CE/CME should be in practical implications for improving the overall health of the communities. During the pandemic, the focus was heavily on addressing the treatment and prevention of COVID-19. In the current post-pandemic climate, we must recognize that the landscape of healthcare training will never be the same. A multitude of healthcare training options must be offered to ensure accessibility for the broadest range of healthcare providers and staff. The timing of this survey was to serve as a re-starting point for the work being done in health equity across Alaska.

The needs are overwhelming, and even as new facilities are built, new providers are hired and systems are designed to support our most vulnerable populations, health providers will be unable to progress without strategic coordination of efforts. Social determinants of health are global in scope and cannot be addressed without comprehensive and coordinated systems across multiple sectors. If any state has the ability to bring this complex vision of solutions to fruition, Alaska is well poised to do so. Alaska's healthcare workforce has a keen sense of understanding the issues at hand, but must work together across silos to prioritize meaningful systemic change for improvements. The Alaska Center for Rural Health and Health Workforce is committed to utilizing these survey results to create continuing education content that addresses health equity in Alaska.

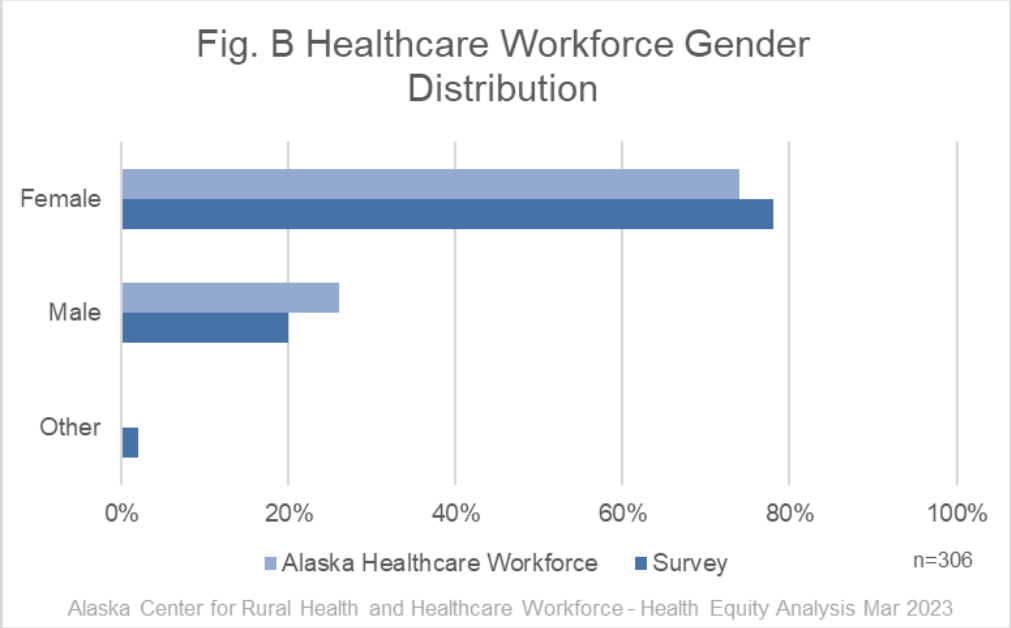
APPENDICES

Appendix A: Demographic Figures

Population of Alaska vs. Survey Demographics



Healthcare Workforce Gender Distribution



Ethnicity of Alaska’s Healthcare Workforce vs. Survey Demographics

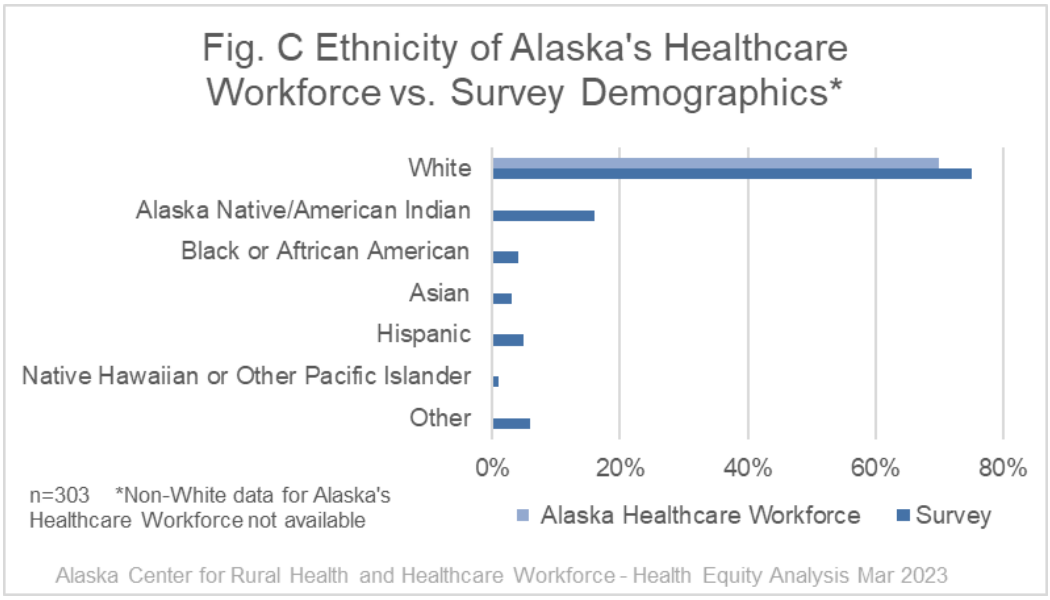


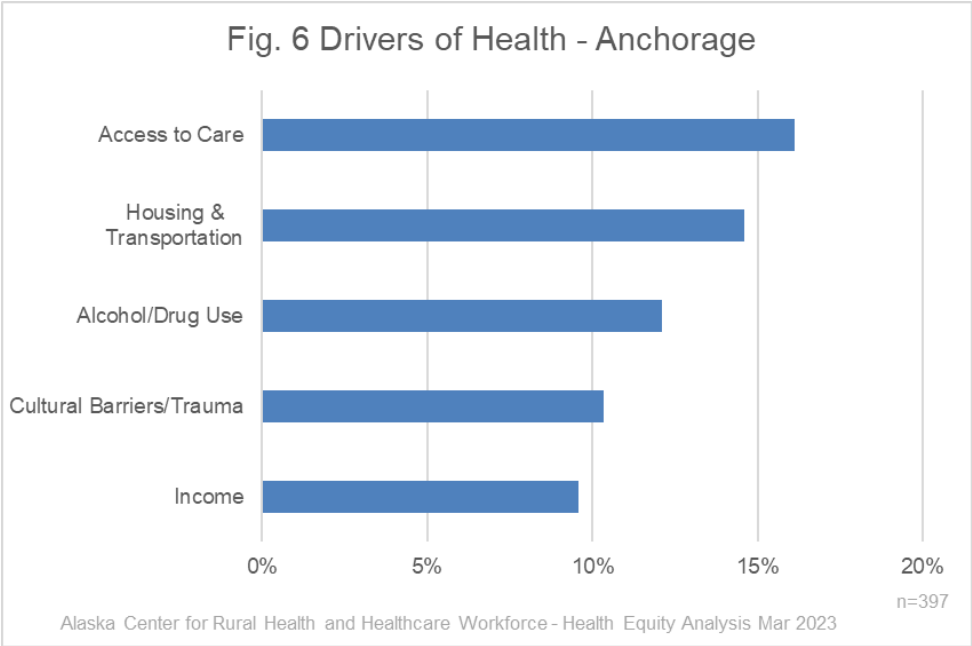
Table 2a. Occupation and Facility Type

Occupation		Facility Type	
Nurse	19.2%	Clinic	18%
BH/Social Work	14.5%	Non-Profit Organization in the Social Sector	16%
Health Admin/Manager	13.1%	Other	16%
Director	11.1%	Hospital/Inpatient	11%
Physician/Surgeon	11.0%	Academic Institution	8%
Educator	5.8%	Hospital/Outpatient	7%
Other - Non Health	5.0%	School	5%
Other - Allied Health	5.0%	Department of Public Health	5%
Other - Health	4.0%	Outpatient Facility	4%
Nurse Practitioner	4.0%	Primary Care Office	3%
Physician Assistant	2.5%	Corrections	3%
CHAP	1.6%	EMS	2%
Physical Therapist	1.2%	Specialist Office	1%
Midwife	1.0%		
Dentist	1.0%		
Pharmacist	<1%		

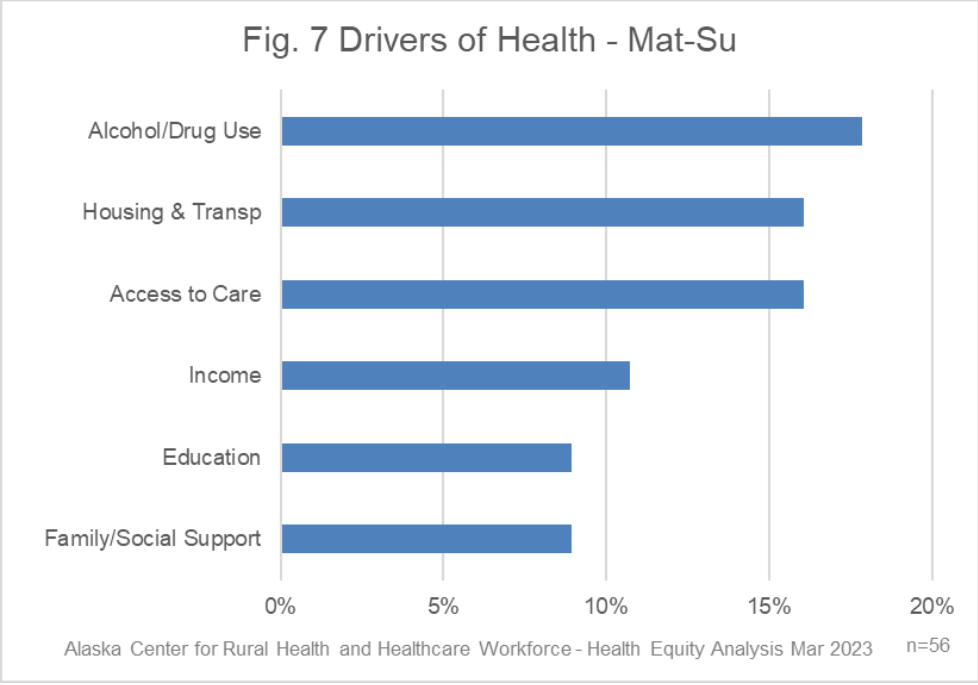
n=318

APPENDIX B: Health Equity

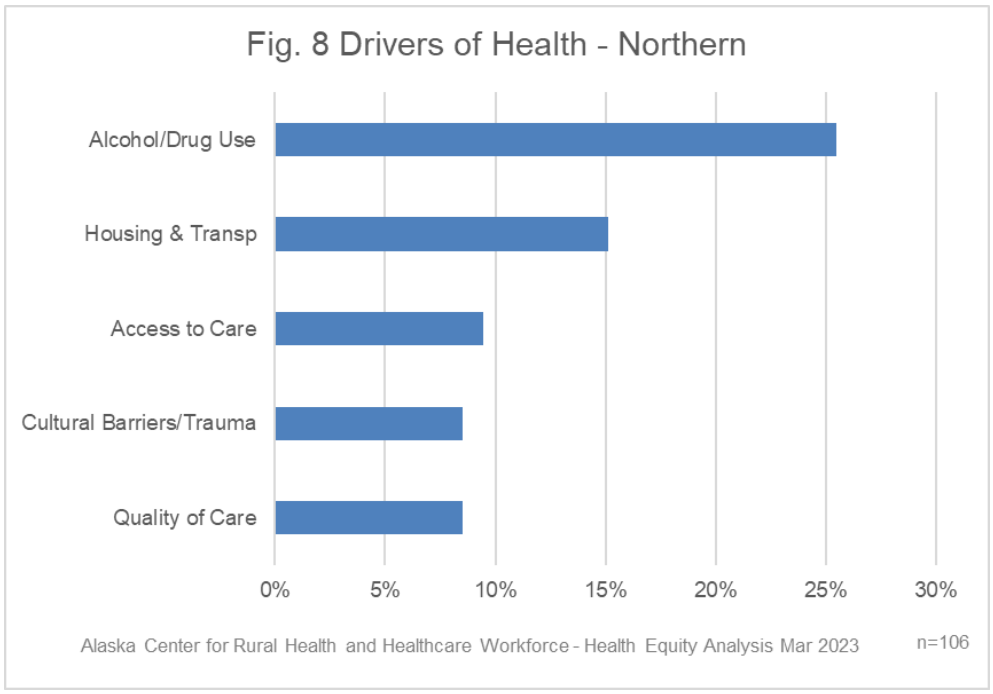
Drivers of Health - Anchorage



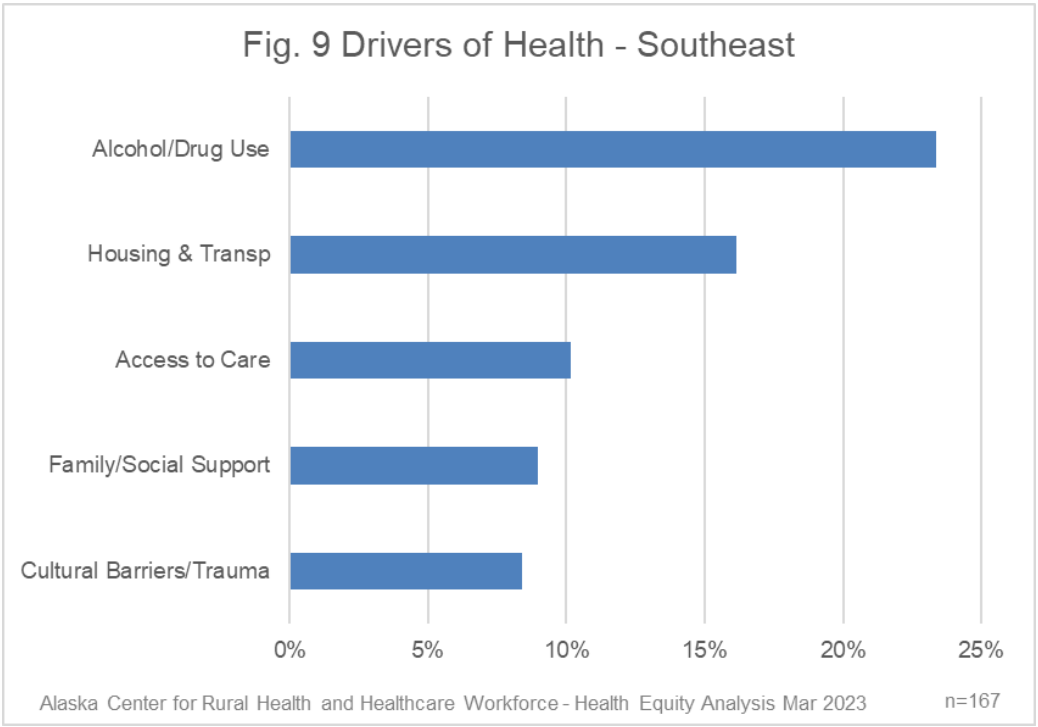
Drivers of Health - Mat-Su



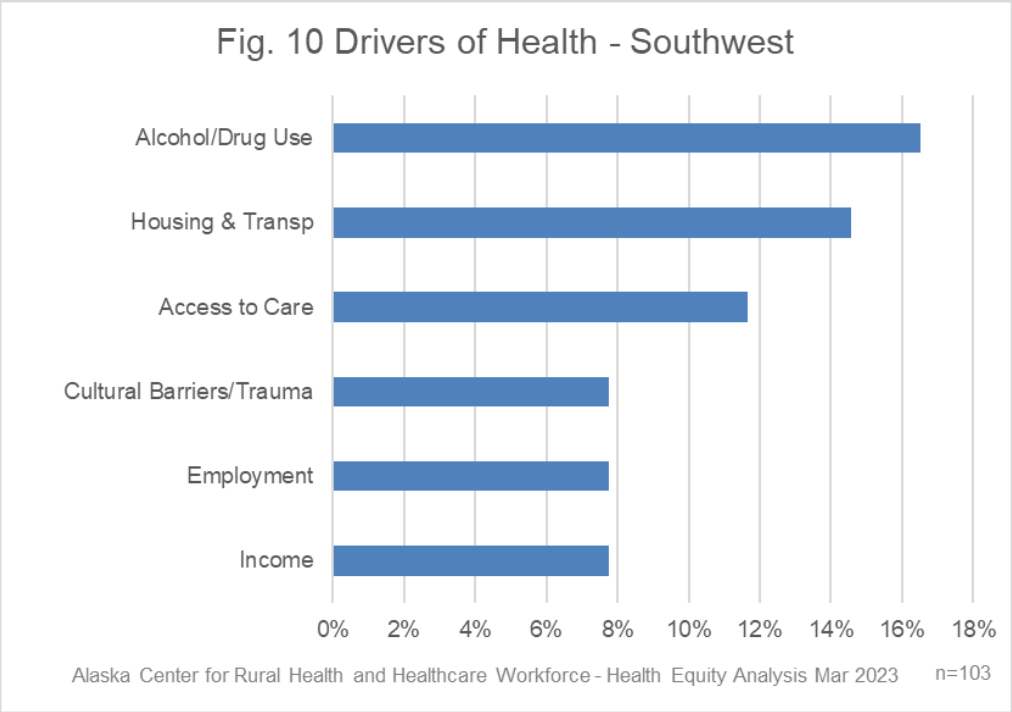
Drivers of Health - Northern



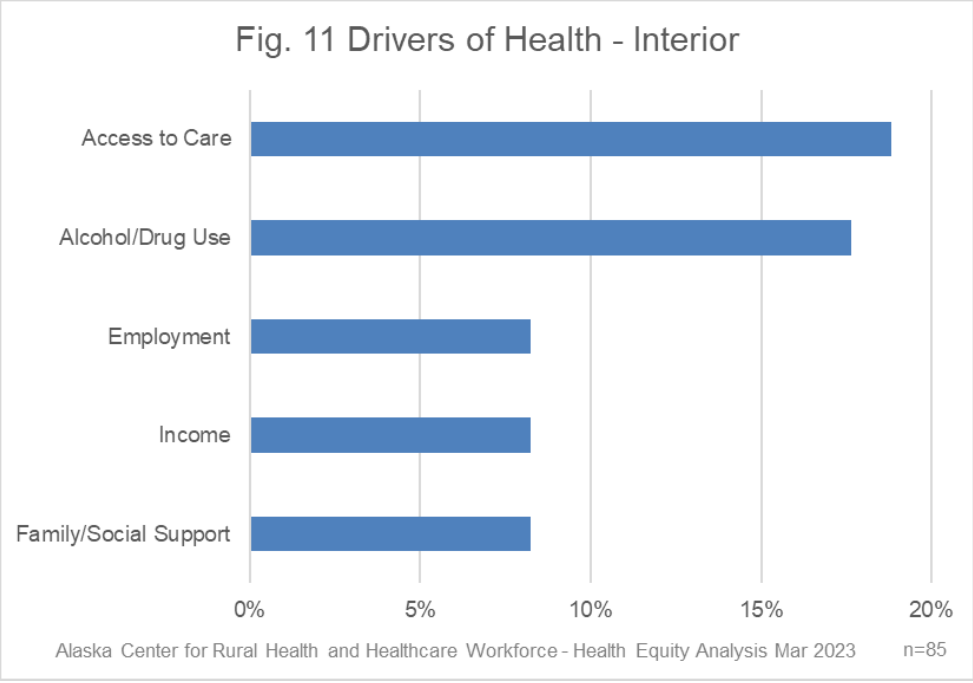
Drivers of Health - Southeast



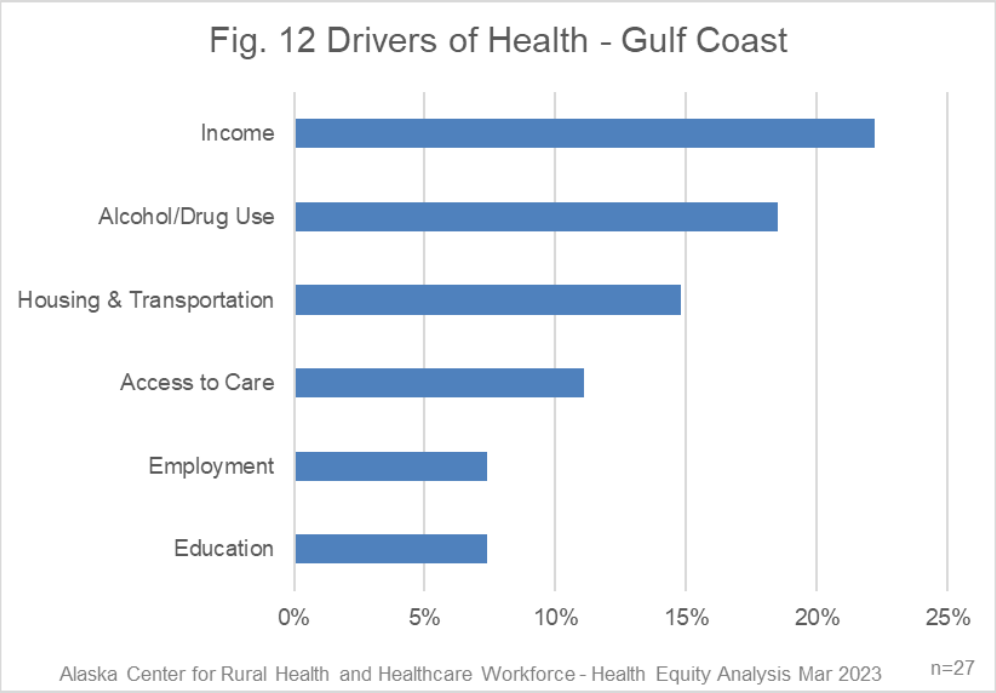
Drivers of Health - Southwest



Drivers of Health - Interior



Drivers of Health - Gulf Coast



Below is a table showing the support needed, by region, to help mobilize action for increased health equity.

Table 3. Supports Needed by Region			
Anchorage n=79		**Northern n=21**	
Connecting Resources	20%	Community Based Services	16%
Increased Staff	14%	Affordable Childcare	12%
Mental Health Treatment	1%	Increased Staff	12%
Affordable Housing	6%	Advocacy	8%
Community Based Services	6%	Affordable Housing	8%
Grow Our Own	6%	Clinical Site Expansion	8%
Mat-Su n=13		Education	8%
Community Based Services	22%	Financial Aid	8%
Funding	22%	Mental Health Treatment	8%
Connecting Resources	14%	**Southeast n=53**	
Increased Staff	14%	Increased Staff	20%
Gulf Coast n=5		Recruit and Retain	15%
Travel Vouchers	40%	Education	13%
Recruit and Retain	20%	Funding	13%
Remove Silos	20%	Community Based Services	9%
Education	20%	**Southwest n=36**	
Interior n=13		Connecting Resources	20%
Advocacy	15%	Education	20%
Connecting Resources	15%	Grow Our Own	15%
Grow Our Own	15%	Cultural Training for Staff	10%
Recruit and Retain	15%	Alaska Center for Rural Health and Healthcare Workforce	
		-Health Equity Analysis Mar 2023	

APPENDIX C: Continuing Education

Figure 18 Scheduling for in-person events

Fig. 18 Preferred Scheduling for In-Person Con't Ed Events - Alaska						
Occupations	**Half day (weekday)**	**All day (weekday)**	**No preference**	**Evening (1-2 hrs)**	**All day (weekend)**	**Half day (weekend)**
BH/Social Work (n=46)	35%	37%	17%	2%	4%	4%
Director (n=34)	44%	32%	6%	9%	9%	0%
Educator (n=18)	61%	17%	0%	6%	17%	0%
Health Admin/Manager (n=40)	55%	18%	18%	5%	0%	5%
Nurse (n=61)	36%	20%	16%	16%	7%	5%
Nurse Practitioner (n=13)	38%	31%	8%	0%	15%	8%
Other - Allied Health (n=15)	33%	27%	7%	20%	13%	0%
Other - Health (n=13)	38%	23%	23%	15%	0%	0%
Physician/Surgeon (n=36)	19%	17%	8%	17%	22%	17%
Grand Total (n=276)	**39%**	**24%**	**13%**	**10%**	**9%**	**5%**

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

Figure 19 Locations for in-person events

Fig. 19 Preferred Location for In-Person Con't Ed Events - Alaska					
Occupations	**Anchorage**	**Fairbanks**	**Juneau**	**Mat-Su**	**Other**
BH/Social Work (n=46)	67%	4%	11%	7%	11%
Director (n=34)	68%	6%	12%	0%	15%
Educator (n=18)	61%	11%	11%	6%	11%
Health Admin/Manager (n=40)	68%	5%	8%	10%	10%
Nurse (n=61)	59%	7%	10%	13%	11%
Nurse Practitioner (n=13)	62%	15%	15%	0%	8%
Other - Allied Health (n=15)	67%	20%	7%	0%	7%
Other - Health (n=13)	38%	15%	15%	0%	31%
Physician/Surgeon (n=36)	69%	6%	17%	0%	8%
Grand Total (n=276)	**72%**	**9%**	**13%**	**8%**	**13%**

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

Figure 20 Preferred format for continuing education

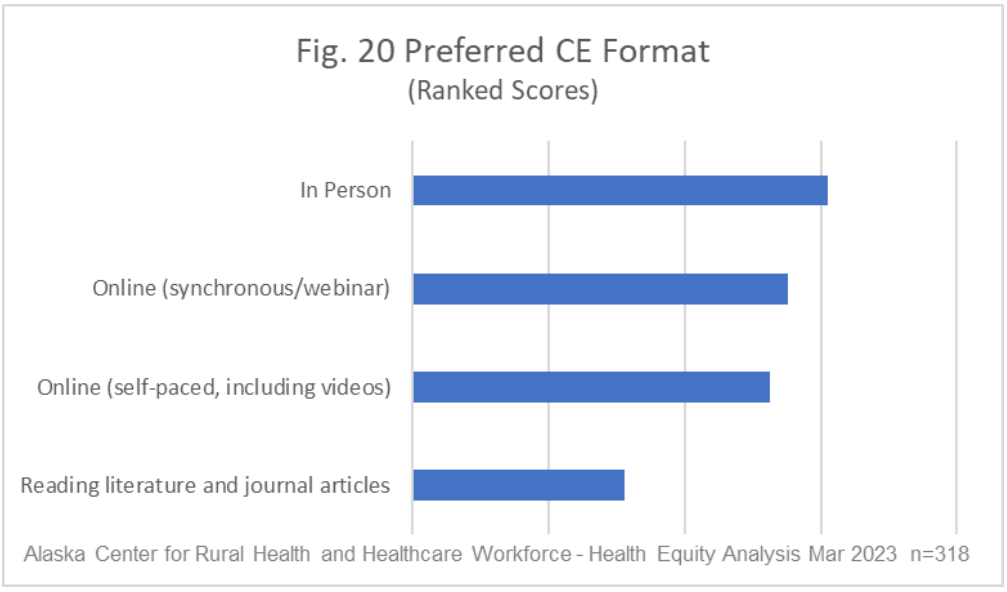


Figure 21 Primary sources for continuing education accredited courses

Fig. 21 Current Primary Source for CE Credit Courses - Alaska									
Occupations	**Prof. Org.**	**Employer**	**Website**	**Other**	**Journals**	**Social Media**	**AK Cache**	**Listservs**	**Variety**
BH/Social Work (n=46)	26%	33%	13%	4%	4%	7%	7%	4%	2%
Director (n=34)	47%	21%	3%	12%	3%	6%	0%	3%	3%
Educator (n=18)	50%	17%	6%	11%	0%	11%	0%	0%	0%
Health Admin/Manager (n=40)	33%	35%	8%	2%	0%	13%	0%	8%	0%
Nurse (n=61)	39%	28%	10%	5%	8%	1%	0%	0%	7%
Nurse Practitioner (n=13)	38%	15%	0%	15%	7%	0%	7%	7%	7%
Other - Allied Health (n=15)	33%	33%	13%	7%	7%	0%	7%	0%	0%
Other - Health (n=13)	15%	46%	7%	0%	0%	15%	7%	0%	0%
Physician/Surgeon (n=36)	67%	3%	8%	6%	11%	0%	0%	3%	3%
Grand Total (n=276)	**48%**	**29%**	**9%**	**7%**	**5%**	**5%**	**3%**	**3%**	**3%**

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

Figure 22 Effective elements of continuing education courses

Fig. 22 Effective Elements of Past Con't Ed Courses/Events - Alaska*						
Occupations	**Practical Implications**	**Content**	**Interactions with peers**	**Personalization of Training**	**Format**	**Timeliness**
BH/Social Work (n=46)	72%	57%	37%	35%	17%	15%
CHAP (n=5)	80%	80%	60%	60%	20%	40%
Dentist (n=4)	50%	50%	0%	0%	0%	0%
Director (n=34)	82%	59%	38%	32%	15%	6%
Educator (n=18)	72%	72%	39%	17%	28%	28%
Health Admin/Manager (n=40)	75%	38%	40%	38%	10%	20%
Midwife (n=3)	100%	33%	33%	67%	0%	0%
Nurse (n=61)	75%	43%	46%	30%	11%	15%
Nurse Practitioner (n=13)	69%	54%	54%	38%	23%	8%
Other - Allied Health (n=15)	80%	60%	53%	47%	33%	40%
Other - Health (n=13)	54%	54%	31%	23%	8%	8%
Physical Therapist (n=4)	100%	100%	50%	50%	25%	25%
Physician Assistant (n=8)	50%	63%	13%	25%	25%	13%
Physician/Surgeon (n=36)	69%	36%	33%	19%	6%	6%
Grand Total (n=276)	**75%**	**55%**	**43%**	**32%**	**16%**	**16%**

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

*Participants could select all that apply; each answer choice has the potential for 100%

Continuing education topics ranked by occupation categories

Figure 24 Behavioral Health Staff

Fig. 24 Behavioral Health Staff	
Con't Education Topic, listed in rank order	**Weighted Score**
Mental and Behavioral Health	110
Alcohol and Substance Abuse	91
Preventive Medicine/Primary Care	68
Cultural Competence and Sensitivity	62
Wellness/Resiliency	51
Diabetes/Nutrition	44
Suicide Prevention	37
Violence and Abuse Prevention	35
Emergency Preparedness/Injury Prevention	25
Infectious Diseases/STDs	23
Geriatric Education	21
Leadership Training	21
Telehealth/Telemedicine	20
Heart Disease and Stroke	12
Palliative Care	11
Oral Health	8
Respiratory Disease	7
Cancer	4

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

Figure 25 Nursing Staff

Fig. 25 Nursing Staff (incl RN's and NP's)	
Con't Education Topics, listed in rank order	**Weighted Score**
Mental and Behavioral Health	191
Alcohol and Substance Abuse	151
Wellness/Resiliency	123
Cultural Competence and Sensitivity	96
Preventive Medicine/Primary Care	81
Violence and Abuse Prevention	79
Diabetes/Nutrition	72
Emergency Preparedness/Injury Prevention	56
Suicide Prevention	55
Leadership Training	39
Heart Disease and Stroke	29
Infectious Diseases/STDs	25
Telehealth/Telemedicine	25
Geriatric Education	23
Palliative Care	20
Oral Health	18
Cancer	15
Respiratory Disease	1

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

Figure 26 Physicians and Physician Assistants

Fig. 26 Physicians/PA's	
Con't Education Topics, listed in rank order	**Weighted Score**
Mental and Behavioral Health	117
Alcohol and Substance Abuse	75
Cultural Competence and Sensitivity	64
Wellness/Resiliency	63
Violence and Abuse Prevention	55
Diabetes/Nutrition	50
Preventive Medicine/Primary Care	40
Suicide Prevention	36
Leadership Training	25
Telehealth/Telemedicine	23
Emergency Preparedness/Injury Prevention	20
Cancer	19
Geriatric Education	15
Oral Health	10
Heart Disease and Stroke	9
Infectious Diseases/STDs	8
Respiratory Disease	6
Palliative Care	2

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023

Figure 27 Administrators and Directors

Fig. 27 Administrators and Directors	
Con't Education Topics, listed in rank order	**Weighted Score**
Mental and Behavioral Health	203
Alcohol and Substance Abuse	138
Wellness/Resiliency	99
Preventive Medicine/Primary Care	90
Cultural Competence and Sensitivity	83
Suicide Prevention	79
Leadership Training	72
Diabetes/Nutrition	69
Violence and Abuse Prevention	62
Geriatric Education	38
Telehealth/Telemedicine	36
Emergency Preparedness/Injury Prevention	31
Infectious Diseases/STDs	23
Oral Health	17
Palliative Care	17
Heart Disease and Stroke	12
Cancer	8
Respiratory Disease	5

Alaska Center for Rural Health and Healthcare Workforce - Health Equity Analysis Mar 2023