

Mat-Su COVID-19 Related Behavioral Health Needs Report

May 2021



MAT-SU HEALTH
FOUNDATION



Actionable Data Consulting

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Acknowledgments

We extend our sincere thanks to the individuals and organizations who made this report possible. They have not only gone above and beyond the call of duty providing services to Mat-Su residents during the pandemic, but they gave of their time for this report. Thank you. You are vital to our community.

Executive Summary

Background

The Mat-Su Health Foundation commissioned this report with the goals of understanding the behavioral health effects of COVID-19 on the Mat-Su frontline workforce and developing recommendations to address the identified needs. Over 400 Mat-Su frontline workers (FLWs) provided information and told their stories for this report. Three hundred and fifty-eight workers completed an online survey, and 32 managers and directors participated in interviews. Four group interviews took place at community meetings.

The pandemic has affected Mat-Su and the work of the frontline staff in many ways. While the spread of the virus covered the whole borough, affecting 10,603 people as of April 13, 2021, the core area was most affected. One hundred and thirty-two residents were hospitalized due to the virus, and 37 died. Fifteen percent of FLWs surveyed (55 people) reported having tested positive for the virus.

The media and research literature has primarily focused on the frontline healthcare workforce; however, this report also includes workers from the following sectors who delivered essential services during the pandemic:

- Behavioral Health
- Child Welfare/Domestic Violence/Sexual Assault (CW/DV/SA)
- Early Learning/Childcare
- Emergency Services
- Physical Health
- Social Supports
- Youth Resilience Programs
- Education

Gratitude for Frontline Workers

Responding to the pandemic required immediate, creative, and sometimes enormous changes in Mat-Su organizations and agencies. Under normal circumstances, this type of change would take months

to years of planning, along with strong leadership and extensive staff and client training. In March of last year, as Americans were told to “hunker down” in their homes, Mat-Su frontline organizations moved quickly to figure out how to deliver services safely while protecting their workers. One of the most impressive findings from this study was what did not happen – no organization abandoned the people they served. Instead, directors and workers figured out new ways to do things. Their hearts went out to the people they serve who were struggling, and they provided services regardless of the stresses they faced at home.

Service Delivery

At the start of the pandemic, executive and program directors scrambled to figure out how to change service delivery to offer protection to their workers. The programs that could shut down and go virtual did so. The programs that needed to stay open, such as inpatient/residential programs, shelters, and transitional housing, changed their service delivery protocols and, in many cases, cut down on the number of services they offered and the number of available beds.

New delivery methods worked great for some clients/patients and not well for others. Virtual provision of services did not work well for substance-use-disorder treatment groups, youth groups, and those who could not afford phone minutes or could not afford or did not have access to high-speed internet. Children had less interaction with mandated reporters of child maltreatment, and some shelters and transitional housing programs had to decrease the number of beds to achieve physical distancing.

Program directors, managers, and staff stated that they saw a different pattern in the number of clients/patients/students/families served and their level of need during the pandemic. The following is a description of the patterns for different types of services.

1. Physical health organizations saw a decrease in patients early on when the hospital stopped providing elective surgical services. As the pandemic continued, outpatient and inpatient physical health care volume increased.
2. Child welfare workers said that it was “eerily quiet” at the beginning of the pandemic. As the pandemic continued, they saw an uptick in the number of severe cases. Additionally, domestic violence workers reported an increase in people needing their services.
3. Overwhelmingly, social service organizations reported that the need for their services (food, housing, referrals, case management) had increased, and they were seeing clients they had never seen before, including those who did not need their services before the pandemic.
4. Senior service providers reported that older residents experienced an increase in isolation and therefore had an added need for connection, on top of their needs for food and other assistance.
5. Many frontline organizations reported serving people with more complex cases.
6. Behavioral health agencies reported an increase in clients, including those with substance use disorders who had relapsed.

Overwhelmingly, the most pronounced effect on clients, patients, and students, an effect that spanned all sectors, was that of isolation and emotional disconnect from workers, family, and friends. Some of the precautions that all workplaces took (wearing masks and other protective equipment) blocked the view of the full face and facial expressions. The ability to see full facial expressions is important when relating to people, especially young children. Inpatient and residential facilities had no visitors, and home visits for disabled individuals and families were largely eliminated and are only now slowly coming back. Seniors have been painfully isolated.

Unequal Effects of the Pandemic on Organizations

The effects of the pandemic weighed differently on organizations depending on their pre-pandemic financial stability and capacity. Small, less financially stable organizations that offer lower wages, few benefits, and less paid time off (PTO) to their workers were more susceptible to crises. Their workers had higher levels of financial stress, and some employees quit because they could earn more money collecting unemployment. Some of these organizations had less robust technological infrastructure, making a move to online services more difficult. Some organizations had less-than-adequate physical space or infrastructure for infection-control practices. For example, organizations without a working bathroom with running water had difficulties implementing the required procedures.

Silver Linings

Frontline directors and managers identified pandemic “silver linings.” These included: new ways to deliver services, improved infection-control practices, more time for reflection and planning, more access to training and conferences through virtual platforms, and the realization that staff could successfully work from home. Additionally, COVID-19 related funding was invaluable to these organizations and enabled their continued provision of services. The primary silver lining for clients was the virtual delivery of services, which helped improved access to care for people without reliable transportation. Other silver linings were mentioned. These were:

- Better infection-control practices
- Greater access to virtual training and conferences
- Increased efficiency
- Increased teamwork
- Less micromanaging of staff
- More recognition of the importance of public health
- More time to step back and plan
- Obtaining COVID-19 funding
- Recognition of different work styles/schedules
- Smaller class sizes
- Virtual delivery of services eliminating the transportation barrier

The Stress and Behavioral Health of Frontline Workers

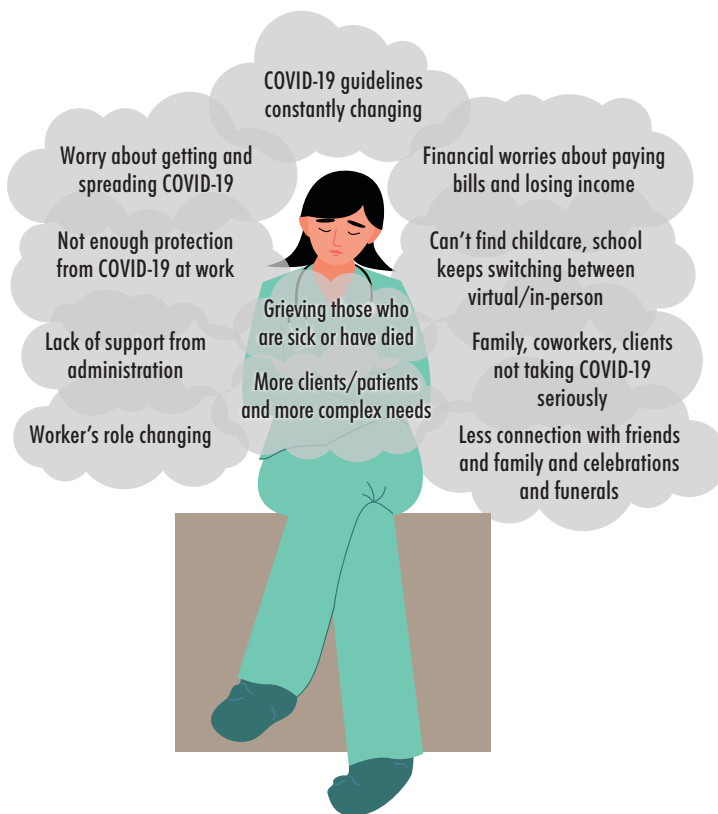
Several factors affected the behavioral health of frontline workers during the pandemic.¹ These included all types of stress and the inability to utilize the usual self-care/protective practices that mitigate stress. During the pandemic, the support practices of connecting with family and friends and gathering for celebrations, rituals of grieving, and other cultural practices were severely limited.

The Unequal Effects of the Pandemic on Workers

This study shows that many frontline workers were stressed by not feeling financially secure and worried about making ends meet. Two subpopulations of frontline workers in Mat-Su were examined: non-White workers and workers from households that earn less than \$50,000 (\$50K) per year. These subpopulations were chosen because research has shown that non-White and low-income individuals have poorer health outcomes than their comparison groups. Adults with income below the poverty level are five times more likely to report poor or fair health than those with incomes at least 400% of the federal poverty level. Low-income workers are more likely to struggle with mental and emotional health and concerns over jobs, income stability, and health care coverage.

Additionally, low-income individuals have higher rates of chronic illness, such as heart disease, diabetes, and stroke. A person's race is also a predictor of their health status. Black, Hispanic, and American Indian people in the United States have shorter life expectancies and higher rates of chronic health conditions than White people. The effects of income and race intersect because people of color tend to have lower income than White Americans (Khullar et al., 2018). There is a relationship between race and pay levels in the United States. According to a research study by the Economic Policy Institute, when controlling for age, gender, education, and region, Black workers are paid 15% less than White workers (Gould, 2020). It is important to note this because, before the pandemic, these groups

FIGURE 1
TYPES OF STRESS EXPERIENCED
BY FRONTLINE WORKERS



experienced lower income levels and poorer health outcomes; thus, the effects of the pandemic occurred on top of that baseline. The data collected for this study are not extensive enough to ascertain all the factors contributing to the higher financial stress experienced by non-White workers compared to White workers. However, the observed disparity highlights the need for further research to ensure that programs developed to support workers will effectively meet the needs of all workers, including these subpopulations.

This study shows that FLWs experienced high stress levels due to the pandemic. The areas where non-White workers and workers from lower-income households differed the most from their comparison groups related to finances (see Figure 2). Twenty-four percent of FLWs experienced moderate/extreme stress about not having enough food, and almost 37% worried about not paying rent/mortgage.

¹ Behavioral health is defined here as the promotion of mental health, resilience, and well-being, the treatment of mental and substance use disorders, and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

When looking at the non-White subpopulation, these percentages rose to 35%/50%, and, for lower-income workers, they rose to 51%/63%. Workers in the CW/DV/SA and Early Learning/Childcare sectors reported the most financial stress. The FLWs in these sectors typically have lower wages than other sectors surveyed in this report. Almost half of all FLWs (43%), and higher percentages of non-White (63%) and lower-income workers (64%), were stressed by losses in wages or PTO resulting from quarantine requirements. The nature of the work of FLWs makes possible exposures to COVID-19 inevitable, and they are the ones bearing the brunt of the financial implications of that exposure. Over half of all non-White and lower-income workers experienced moderate/extreme stress caused by fear of one or more of the following events: someone in their household losing their job, being unable to pay the rent/mortgage, losing money or PTO due to required quarantine(s), difficulties finding childcare during school closings.

Other Stressors for Frontline Workers

In addition to financial worries, frontline workers were stressed by many of the same issues that have been reported in national studies. These additional stressors included: the fear of becoming infected, the fear of infecting others, the stress related to personal protective equipment (PPE) shortages, and stress related to taking on new roles. Additional issues mentioned by Mat-Su FLWs that caused considerable stress included disagreement with others over the risks of COVID-19, pandemic guidelines constantly changing, and not being able to see family and friends (Figure 3). A worker's race and income level did not affect these areas of stress.

Additionally, FLWs were asked if they had trouble accessing behavioral health care during the pandemic. Seventeen percent of FLWs stated that they needed behavioral health care and were not receiving it (30% for lower-income FLWs and 20% for non-White workers). Just over half of FLWs who were surveyed reported that they had not needed behavioral health care during the pandemic.

FIGURE 2
PERCENTAGE OF WORKERS WHO REPORT MODERATE/EXTREME STRESS DUE TO CHILDCARE AND FINANCIAL WORRIES

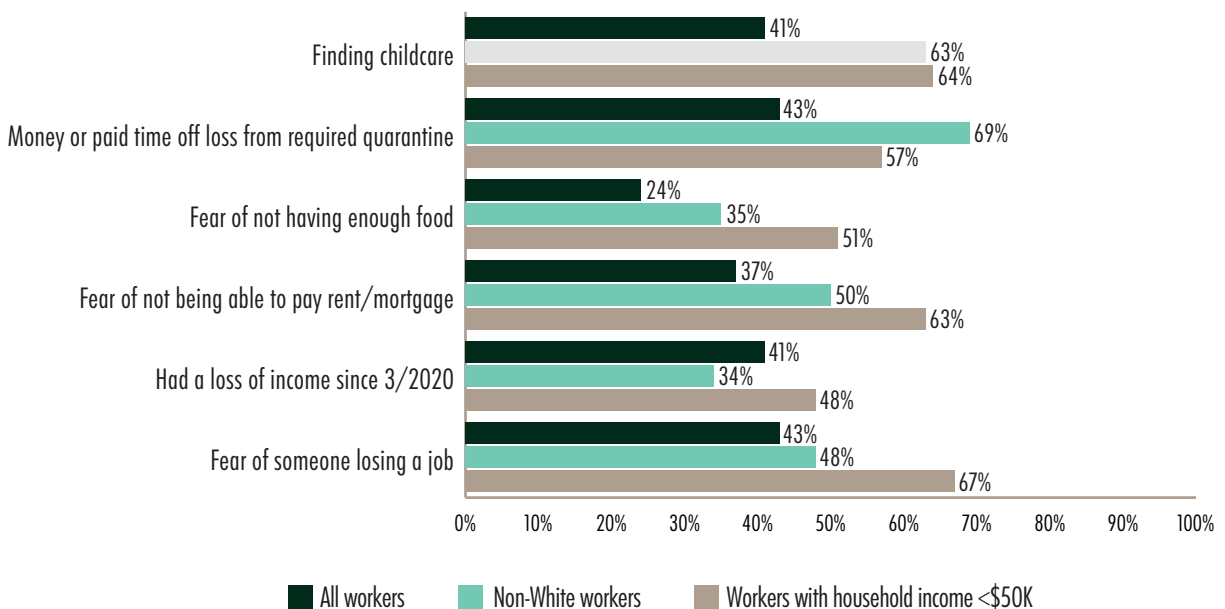
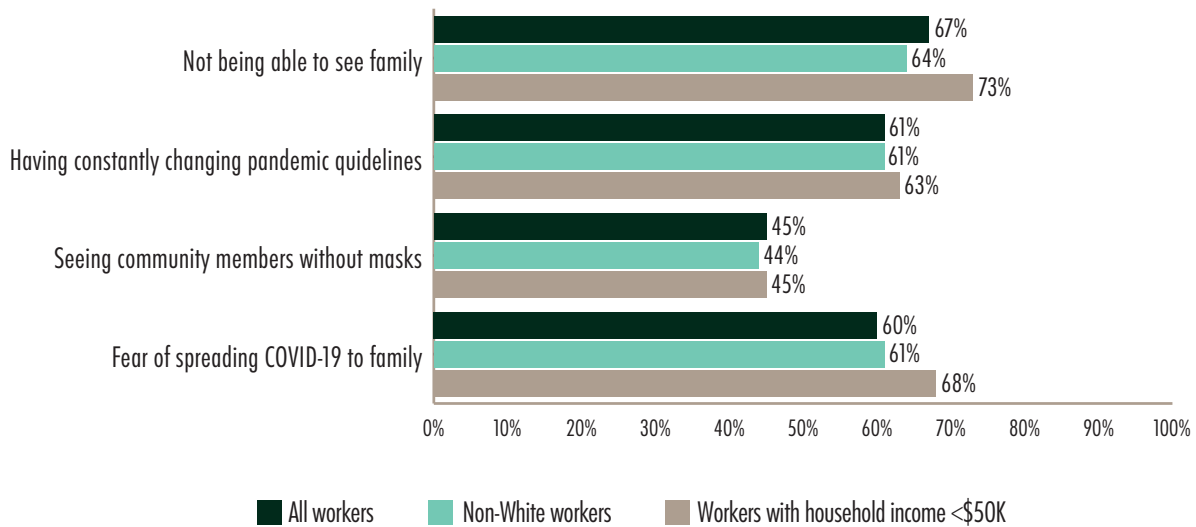


FIGURE 3
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS DUE TO COVID-19 RESTRICTIONS



Worker Support

Frontline organizations supported each other by sharing information and PPE, and by collaborating in service delivery. Information sharing and collaboration were often done by coming together for regularly scheduled meetings. Directors supported staff by allowing them to work from home, by providing opportunities for self-care or celebratory activities (i.e., massage chair, special meals), by increasing staffing levels, and by holding one-on-one meetings. A small percentage of organizations provided bonuses and extra time off. The supports most requested by the FLWs surveyed were the opportunity to work from home, monetary bonuses, and additional paid time off. When directors were asked what they would do if they had unlimited funding, they listed: providing self-care opportunities to their staff, offering health insurance and Employee Assistance Plans (EAPs), and increasing access to behavioral health support. They also wanted to pay their workers more, improve the infrastructure of their places of employment, and retain some of the practices made possible by COVID-19 funding, such as putting up homeless clients in hotels.

Summary of Recommendations

These recommendations can be viewed from multiple perspectives: during the pandemic, in the “aftermath” of the pandemic, and before the next pandemic or other public health crisis. The recommendations below address all three perspectives.

Community/Statewide Infrastructure Recommendations

1. Assist in the creation of local and state public health data, strategy, and management plans to address future public health crises:
 - a. In collaboration with Matanuska-Susitna Borough, fund the cost-benefit analysis of the borough adopting public health powers.
 - b. Continue to advocate for sufficient funding to support a robust public health infrastructure in Alaska. This includes the support of public health funding in the State budget, the staffing of public health offices, and support of local public health efforts.
 - c. Advocate for the necessary state and federal policy and regulatory changes that allow for virtual delivery of primary care, medication management, and behavioral health.

2. Promote health equity, especially racial equity, through ongoing health-equity assessment and work internal to the Foundation. With Foundation funding and backing, convene a community-wide advisory group to begin the process of discussing and promoting health equity in Mat-Su.

Organization-Level Recommendations

3. Proactively provide funding to bring frontline organizations up to a minimum standard of operations, including paying workers a living wage and providing access to health insurance and employee assistance plans.

Worker-Level Recommendations

4. Assist organizations with funding to continue to pay furloughed workers, workers who must quarantine, or whose hours have been cut. Support organizations in providing severance packages to help workers being laid off.
5. Provide discretionary grants to organizations to be used for self-care, healing, and cultural activities.
6. Create a system that ensures that frontline workers have access to behavioral health support.
 - a. The Foundation should identify and help fund sources of behavioral health support available to all frontline organizations for their workers. Ideas for support include:

- i. Virtual access to life coaches
 - ii. Virtual access to behavioral health counseling and medication management
 - iii. The creation of a “Code Lavender” program that offers rapid response emotional support to frontline workers from trained practitioners (Stone, 2018)
 - iv. Make training/webinars available to directors and staff to help workers cope with the effects of the pandemic (American Hospital Association, 2020)
 - v. Provide all frontline workers with access to a “warm line.” A warm line is a free, confidential line that workers can call for support and to talk with trained staff. This type of line is used when a worker’s situation does not require a crisis line, but they still need help and someone to listen (Mental Health American 2021).
- b. Provide organizations the resources needed to prevent and identify worker burnout, compassion fatigue, and vicarious trauma.
7. Celebrate and appreciate the entire frontline workforce.

ABBREVIATIONS

The acronyms used in this report are defined below.

BH	Behavioral Health
CDC	Centers for Disease Control and Prevention
CW/DV/SA	Child Welfare, Domestic Violence, Sexual Assault
EAP	Employee Assistance Program
EMS	Emergency Medical Services
FLW	Frontline Worker
HCW	Healthcare Worker
Mat-Su	Matanuska-Susitna Borough
MAP	Mat-Su Agency Partnership
MSBSD	Matanuska-Susitna Borough School District
MSHF	Mat-Su Health Foundation
PPE	Personal Protective Equipment
PTO	Paid Time Off

Methods: Who Are the Frontline Workers Heard from in this Report?

Over 400 Mat-Su frontline workers (FLWs) provided information and told their stories for this report. Three hundred and fifty-eight workers completed an online survey; 33 managers and directors

participated in interviews, and four group interviews took place at community meetings. Table 1 shows how many FLWs from each sector participated and how their voices were heard.

TABLE 1 - MAT-SU FRONTLINE WORKERS WHO PARTICIPATED, BY SECTOR AND SURVEY METHOD

Sector	Completed Surveys (# of Organizations Participating)	Program Director Interviews	Meetings with Sector Representatives
Education	73 (1)	1	
Emergency Services	72 (3)	1	1
Behavioral Health	59 (6)	5	
Early Learning/Childcare	50 (3)	2	
Physical Health	43 (4)	8	
Social Supports	29 (11)	11	2
Child welfare/domestic violence/sexual assault (CW/DV/SA)	18 (4)	4	
Youth Resilience	10 (1)	1	1
Unknown	4		
Total	358	33	4

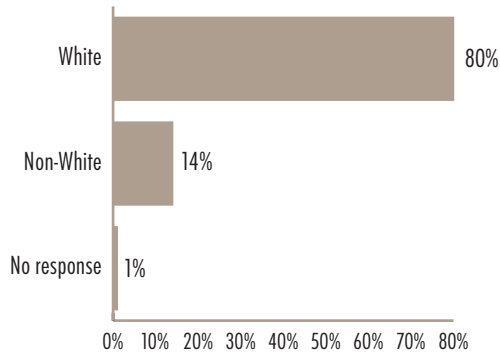
The names of the respondents and organizations are not included in this report. Data are reported by sector. The survey respondents were demographically diverse. The majority stated that they were White (85%), female (78%), between the ages of 25-49 years (65%), and had a household size of 1-3 people. The survey sample included frontline workers of all education levels, with 12% having a high school education, 34% having some college or a technical degree, 28% having a bachelor's degree, and 26% having some graduate school.

The income level of the frontline workers varied. Seven percent made less than \$25,000 per year, and the following three income categories captured 21%

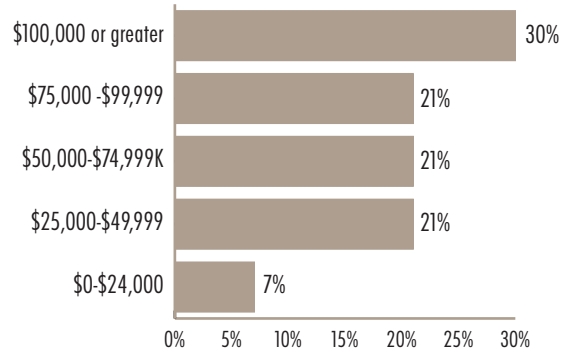
each of respondents: \$25,000-\$49,000; \$50,000-\$74,000; and \$75,000-\$99,999. The remainder (30%) made over \$100,000. Most respondents had some form of health insurance. Fifty-six percent had insurance from their employer, 30% from a family member's employer, and 30% had another type of coverage. Only 1% had no coverage.

Respondent roles varied. Twenty-one percent were frontline physical or behavioral health providers, 11% were managers/directors, 17% were administrative staff, 10% were educators, and 41% were another type of frontline staff.

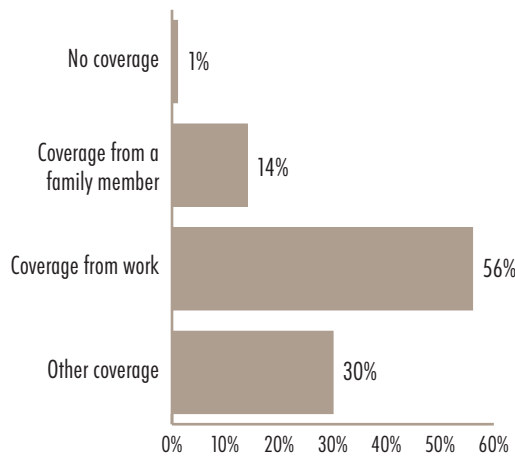
**FIGURE 4
RACE/ETHNICITY OF SURVEYED FRONTLINE WORKERS**



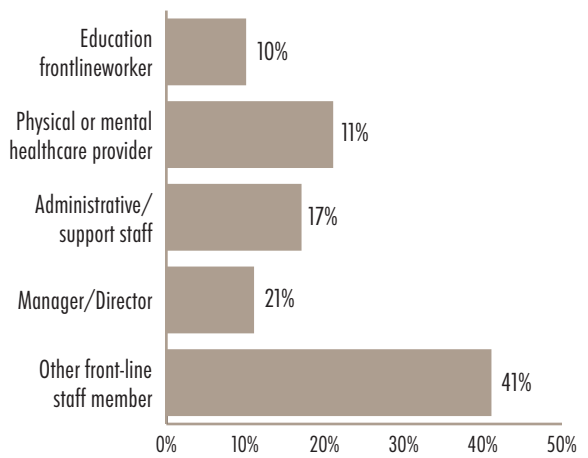
**FIGURE 5
SURVEYED FRONTLINE WORKERS HOUSEHOLD INCOME**



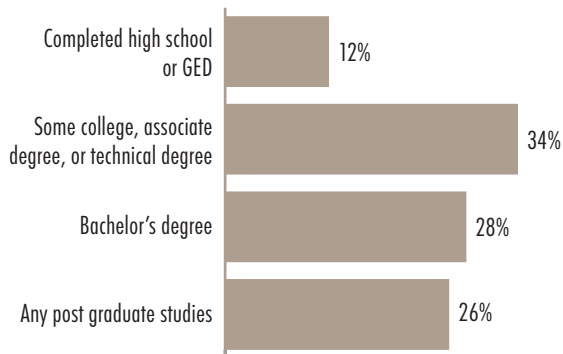
**FIGURE 6
SURVEYED FRONTLINE WORKER INSURANCE STATUS**



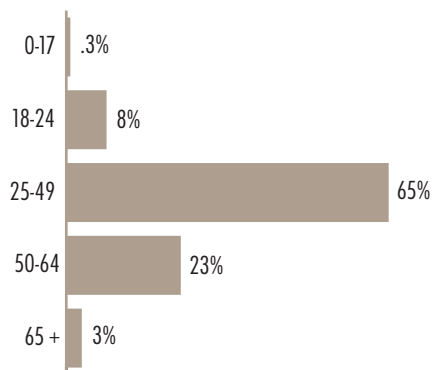
**FIGURE 7
SURVEYED FRONTLINE WORKER ROLE**



**FIGURE 8
EDUCATION OF SURVEYED FRONTLINE WORKERS**



**FIGURE 9
AGE OF SURVEYED FRONTLINE WORKERS**



Introduction

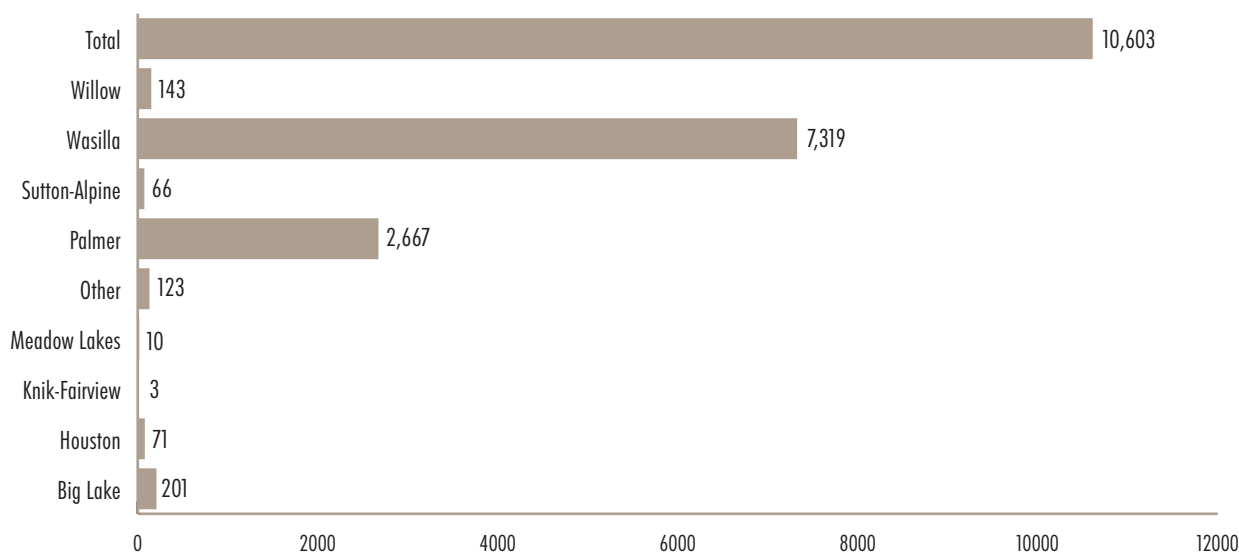
The Mat-Su Health Foundation commissioned this report with the goals of understanding the behavioral health effects of COVID-19 on the Mat-Su frontline workforce and developing recommendations to address the identified needs. To this end, this report will present the voices of frontline workers in eight sectors that deliver support to families and individuals in Mat-Su. Throughout the report, direct quotes from the frontline workers (FLWs) describe their experiences.

Viewing data from respondents as a whole can be useful but misses key insights about subpopulations of the Mat-Su Borough. The pandemic has affected subpopulations differently depending on the existence of underlying illness and conditions, access to healthcare, race/ethnicity, and income level. To better understand these nuances, data will be reported for the overall population and, where

applicable, by race and income level and/or by sector. Due to the small number of respondents who identify as a race other than White, the comparison category used for race is “non-White.” This category includes those who identified as Alaska Native/Indigenous (14), African descent (7), Asian descent (10), Hispanic (5); Indian American (5); Latin American descent (8); Native American/Indigenous Native Hawaiians (10); and Pacific Islanders (1).

The other subpopulation examined was workers from households that earn less than \$50,000 (\$50K) per year. Such categorization is a crude measure of income because it fails to capture the impact of household size on income. This income category is not the same as the poverty level. However, it offers some insight into the subpopulation of lower-income workers (28% of the sample).

FIGURE 10
GEOGRAPHIC DISTRIBUTION OF COVID-19 CASES IN MAT-SU (4/13/2021)



In the non-White category, 49 respondents out of 336 respondents stated their race/ethnicity. There is some overlap between the two subpopulations. Approximately 19% of those who were low income were non-White. Thirty-seven percent of those who were non-White were low income. The survey did not use random sampling to select respondents; therefore, statistical significance testing cannot be used to identify “differences” between groups.

Survey respondents were asked what type of job they held. The percentages of education frontline jobs and physical/behavioral health provider positions held by non-White and by White workers were similar. More non-White workers held administrative positions (20% vs. 15%) or manager/director positions (14% vs. 10%) than White workers, while

more White workers (43%) selected the category of “other frontline worker” as compared to non-White workers (33%)

The pandemic has affected Mat-Su and the work of the frontline staff in many ways. Figure 10 outlines the number of COVID-19 cases by community-of-residency for Mat-Su through April 13, 2021. While the spread of the virus covered the whole borough, affecting 10,603 people, the core area was most affected. Figure 12 identifies the cases that resulted in hospitalization (132) and death (37). Fifteen percent (55) of FLWs surveyed reported having tested positive for the virus.

FIGURE 11
MAT-SU FRONTLINE WORKERS WHO TESTED POSITIVE FOR COVID-19

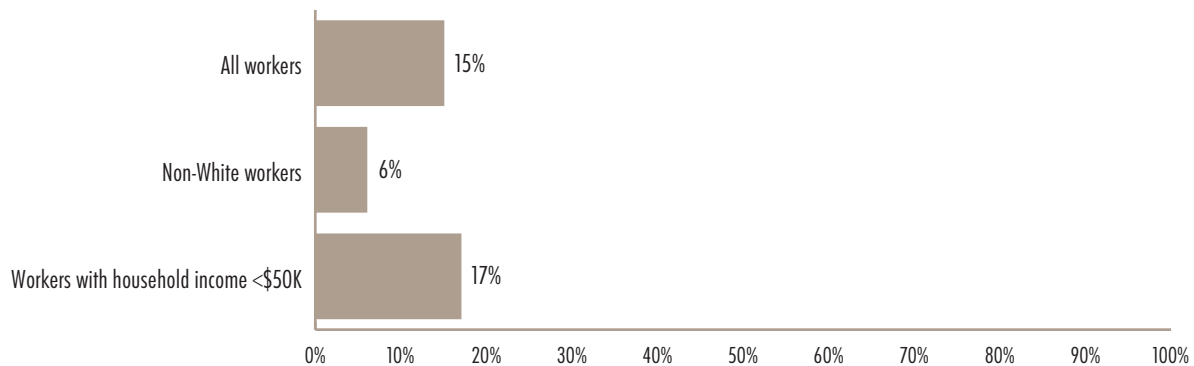
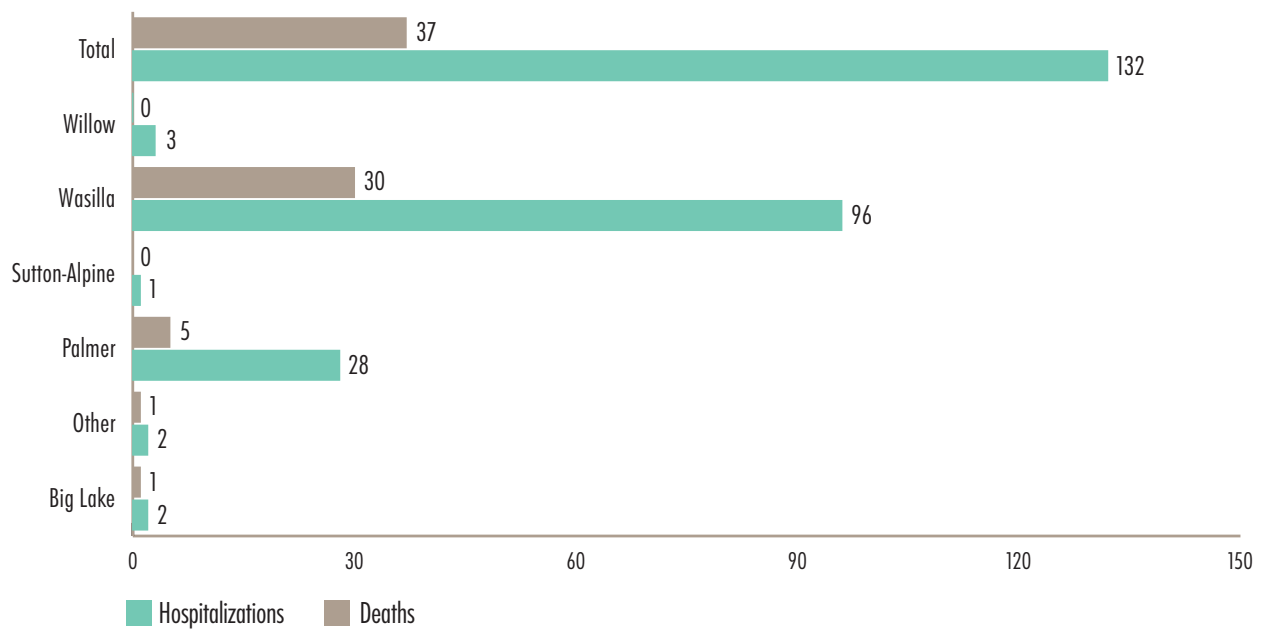


FIGURE 12
GEOGRAPHIC DISTRIBUTION OF COVID-19 DEATHS AND HOSPITALIZATIONS, (4/13/2021)



Source: Alaska COVID-19 Information Hub, <https://alaska-coronavirus-vaccine-outreach-alaska-dhss.hub.arcgis.com/>

This project is unique in that it broadly defines the frontline workforce to include the following sectors: Behavioral Health, Child Welfare/Domestic Violence/Sexual Assault, Early Learning/Childcare, Education, Emergency Services, Physical Health, Social Supports, and Youth Resilience Programs. The current research and literature in the United States and abroad are primarily focused on frontline healthcare workers.

During the pandemic, all families have been under stress in Alaska, especially those living on the edge of or in poverty. Data from the US Census, Household Pulse Survey for Alaska revealed that for adults living in households with children (2020):

- Fifty-two percent of Alaska households had lost some employment income since March 13, 2020 (Kids Count, 2020).
- Thirty-nine percent of Alaska households reported that eviction/foreclosure in the next two months was very likely or somewhat likely (Kids Count, 2020).
- Thirty-three percent of households surveyed had a member who felt nervous, anxious, or on edge for more than half or nearly every day in the

past week (Sept. 30-Oct. 26, 2020) (U.S. Census, 2020).

- Nineteen percent of households had a member who felt down, depressed, or hopeless for more than half of the days or nearly every day for the past week (Oct. 14-Nov. 9, 2020) (U.S. Census, 2020).

For households surveyed in December 2020 (US Census, 2020):

- Thirty percent of families expected a loss of employment for someone in their household in the next four weeks.
- Eleven percent stated they sometimes or often did not have enough to eat in the last week.
- Seven percent were not current on rent or mortgage payments or did not have confidence that they could pay the rent in the following month.
- Thirty-four percent had difficulty paying for usual household expenses during the pandemic.

Literature Review

A review of the literature was conducted using the following keywords: COVID-19, trauma, mental health, healthcare workers, frontline workers. Inclusion criteria included a publication date of 2020 or later and availability in English as a full text. Popular press articles related to COVID-19 in the United States were included due to the limited availability of pertinent peer-reviewed articles having completed the publishing process.

Two main themes were identified in the literature review:

- behavioral health effects associated with the COVID-19 pandemic
- strategies to mitigate the behavioral health impact of COVID-19

Behavioral Health Effects Associated with COVID-19 Pandemic

Initial studies related to the impact of COVID-19 on HCWs were developed in China and were quickly followed by studies in other countries as the pandemic spread worldwide (Vizheh et al., 2020). A review of studies performed from December 2019 to May 2020 by Braquehais et al. (2020) showed a high rate of anxiety (30-70%) and symptoms of depression (20-40%) in HCWs. Insomnia, stress, irritability, fear, anger, burnout, and vicarious trauma were other HCW symptoms consistently noted in the literature as being associated with the COVID-19 pandemic (Peters, 2021; Troglia da Silva et al., 2020; Franza et al., 2020).

Braquehais et al. (2020) identified the following categories of factors that could affect the mental health of COVID-19 pandemic HCWs: COVID-19 exposure, epidemiology, public health policies, material resources, human resources, and personal factors. The risk and protective factors for adverse mental health outcomes due to COVID-19, as noted by Braquehais et al. (2020), De Kock et al. (2021), Troglia da Silva et al. (2020), Benfante et al. (2020), Vizheh et al. (2020), are listed below for these categories:

- **COVID-19 exposure:** For first line-of-care HCWs, HCWs with high responsibility levels, individuals who had been infected, and those

with peers who had succumbed to COVID-19, infection risk increased with higher levels of anxiety and depression. Distress related to the fear of infecting others, having to quarantine, and vicarious trauma experiences increased risk. Working remotely and working in second-line clinical care were protective factors.

- **Epidemiology:** There was a positive correlation between higher incidence rates and higher anxiety and depression prevalence. Experience with other pandemics was associated with less distress.
- **Public health policies:** Transparency of public health data, public health strategy and system coverage, and the existence of a government management plan were protective factors.
- **Material resources:** Many were concerned that the shortage of personal protection equipment (PPE) would lead to disease spread. The limited capacity of health organizations and treatment resources added to stress levels. The opportunity for self-care, e.g., hotel rooms for HCWs to rest, was noted as a protective factor.
- **Human resources:** Close contact with infected patients, high responsibility level, having to function in new and unfamiliar roles, and excessive work hours were associated with insomnia, as well as with mental/emotional distress and exhaustion. The availability of psychological support resources was protective.
- **Personal factors:** Female HCNs, younger individuals, people with children and/or aging family members, and those with less work experience were at higher risk. Pre-existing mental illness and negative coping skills such as drug and alcohol use were risk factors, while positive coping skills such as exercise offered protection. Social support or the-lack-thereof were protective factors and risk factors, respectively (Braquehais et al., 2020; Ide et al., 2021). Braquehais et al. (2020) indicated that older HCWs tend to be more worried about death. Franza et al. (2020) reported that higher education levels could protect against stress and hopelessness.

Researchers studying the effects of earlier pandemics and other infectious diseases, such as 2003 Severe Acute Respiratory Syndrome (SARS), 2009 H1N1 influenza, 2015 Middle East Respiratory Syndrome, and Ebola, reported consistent symptoms of anxiety and depression in HCWs throughout and after the outbreak (Ide et al., 2021; Braquehais et al., 2020, Benfante, et al., 2020). Symptoms of post-traumatic stress, depression, and misuse of substances were reported by HCWs for “months and years after the SARS outbreak” (p. 615), especially in those with high-risk exposure or requiring quarantine (Braquehais et al., 2020).

Benfante et al., 2020, state “the COVID-19 pandemic is classifiable as a traumatic event of exceptional magnitude that transcends the range of normal human experience with exposure to risk of death” and “[the COVID-19 pandemic] will have long-term effects on mental health according to previous studies of epidemics and quarantine” (p.1-2). Bridgland et al. (2021) and Benfante et al. (2020) note that the traumatic stress associated with COVID-19 can trigger mental health disorders such as Acute Stress Disorder, Vicarious Traumatization, and Post-Traumatic Stress Disorder.

Vicarious trauma, also known as “secondary traumatic stress” (p. 2), impacts the fundamental worldview of helping professionals through repeated exposure to the narratives and emotional pain of individuals who have experienced trauma (Thew, 2020). Vicarious trauma affects many kinds of professionals, including those not on the front line, e.g., social workers, case managers, and rehabilitation specialists (Thew, 2020). Thirteen percent of 1,040 respondents in a COVID-19 impact poll of the general Australian population were classified as PTSD-positive. The authors noted that exposure to negative thoughts, images, and potential threats of the pandemic resulted in emotional distress, worry and/or generalized anxiety, and depression (Bridgland et al., 2021).

In 2020, the COVID-19 pandemic had a large impact on the emotional health of people living in the United States. A national survey to study the effects of the pandemic on adults in the United States was performed in May 2020, utilizing the

16-question Pandemic Emotional Impact Scale (PEIS). Ninety percent of participants reported experiencing pandemic-related emotional distress (Palsson et al., 2020). Nearly 80% of respondents reported frustration with not being able to participate in customary pleasurable activities and reported worry about their health. Almost 90% expressed concern about the health of loved ones compared to pre-pandemic. Higher levels of emotional distress related to COVID-19 were reported by racial and ethnic minorities, particularly by Hispanic/Latinx people. Men and women reported similar COVID-19 emotional impact levels. However, women with children aged less than 18 years reported more anxiety, and men with children aged less than 18 years were more likely to report depressive symptoms. Interestingly, adults less than 50 years of age reported a greater COVID-19 pandemic emotional impact than older adults (Herbert, 2020; Nelson, 2020).

The COVID-19 pandemic has taken an enormous toll on the most vulnerable in Alaskan communities. In 2020, the Alaska Child Abuse Response and Evaluation Services (Alaska CARES), a clinic at Providence Alaska Medical Center, reported a 220% increase in the number of severe child abuse cases requiring hospitalization and requiring visits from Alaska CARES staff. Families struggling before COVID-19 experienced exacerbating stressors, such as isolation due to “lockdown orders,” school closures, family and caregiver stress due to job loss and financial insecurity, and diminished access to support systems such as home visiting programs (Aina, 2021). These and the other findings noted above are important in helping to determine the best course of action, given the pandemic’s potential emotional and mental impact on current and long-term well-being, especially for those in the frontline workforce.

Strategies to Mitigate COVID-19 Behavioral Health Impact

The stigma surrounding mental health care, a tendency toward stoicism in HCWs, heavy workloads, and access to care are some of the barriers that may inhibit individuals from seeking behavioral health care (Nelson, 2020). When employers support timely access to services and resources and integrate them

into their emergency response plans, they support FLWs and their ability to continue to provide care and frontline services (Burdick et al., 2020). Various strategies to help mitigate the mental health impact of the COVID-19 pandemic and to improve access to care were identified in the literature. Vizheh et al. (2020) highlighted five types of behavioral health interventions for HCWs: (1) supportive, (2) encouragement and motivation, (3) protective, (4) education and training, and (5) use of technology and online platforms.

Interventions falling in these categories were consistently referenced throughout the literature.

Supportive Interventions

- Screen for and assess behavioral health problems (Pfefferbaum et al., 2020).
- Provide access to work-based EAPs and behavioral health services, including in-person, online, and crisis intervention services (Burdick et al., 2020; Vizheh et al., 2020; Pfefferbaum et al., 2020; Dreher et al., 2021).
- Strategies from the United States Department of Defense programs for combat stress and resilience were adapted to civilian health care. These adaptations resulted in programs such as New York City's "Helping Healers Heal" that provided clinical workers with trained peer-support in facility-based teams, including an "anonymous behavioral health hotline," "wellness respite rooms," and "wellness rounds" (Nelson, 2020, p. 598).
- Two mental health approaches that have been reported effective in stressed and traumatized HCWs are:
 - EMDR (eye movement desensitization and reprocessing therapy) which can be utilized through in-person or online therapy, and
 - Group therapy, where sharing experiences can help with feelings of numbness and detachment.
- Establish a peer support system and work toward decreasing the stigma of mental health care (Burdick et al., 2020; Vizheh et al., 2020; Braquehais et al., 2020).
- Health care systems that were attentive to staff opinions and feedback concerning staffing and

other COVID-related issues and open to altering schedules and expectations were more effective in mitigating COVID-related mental health impacts (Vizheh et al., 2020; Pfefferbaum, 2020).

Encouragement and Motivational Interventions

- Ensure that the efforts of HCWs are recognized by the health care system and by government and community entities
- Promote HCW use of relaxation and other self-care techniques such as compassion for self, exercise, journaling, and hobbies (Vizheh et al., 2020; Phillips, 2021).

Protective Interventions

- Ensure adequate and protective PPE.
- Provide for HCW needs such as rest, healthy nutrition, and hydration.
- Provide support for issues related to childcare, family health, and finances.
- Promote teamwork (De Kock et al., 2021; Vizheh et al., 2020; Dreher et al., 2021).

Education and Training Interventions

- Support clear, accurate, and rapid communication from politicians and agencies.
- Provide behavioral health education online.
- Develop and publish relevant directives, guidelines, documents, and manuals.
- Provide mindfulness, assertiveness, self-awareness, and protection/disease-control training (Vizheh et al., 2020; Dreher et al., 2021; De Kock et al., 2021).
- Provide resiliency training and education about the mental health impacts of COVID-19 and PTSD symptomology (Burdick et al., 2020).

Technology and Online Platform Services

- Minimize face-to-face contact and infection transmission risk using the internet and online tools such as Zoom and smartphones for telemedicine, education, and behavioral health interventions (Vizheh et al., 2020; Nelson, 2020; Braquehais et al., 2020).

In summary, the literature revealed clear evidence of negative behavioral health impacts associated with the COVID-19 pandemic on HCWs. There was a deficit in the literature about the behavioral health impact of the COVID-19 pandemic on frontline workers who were not HCWs, for instance, social

service workers and other frontline workers such as those involved in retail services. Multiple strategies to mitigate the behavioral health impact of the COVID-19 pandemic on HCWs were identified in the literature. Many of those strategies can be generalized to other groups of frontline workers.

Mat-Su Frontline Organizations and COVID-19 Response

Changes in Service Delivery

During the pandemic, frontline organizations had to figure out which services were essential and how to deliver those services safely for both the client/patient/student and the worker. The types of services researched in this report fell into five categories:

1. Inpatient/residential services: These include hospitals, skilled nursing/assisted living homes, residential treatment programs, and domestic violence shelters.
2. In-home services: These include early learning home visiting programs, Emergency Medical Services, Office of Children's Services, and home-based services for people with disabilities.
3. Education, childcare, and center-based programs: These include early learning programs, pre-K and K-12 schools, childcare centers, and senior centers.
4. Outpatient physical and behavioral health services
5. Social support services that offer assistance at their office, via phone, and through home delivery

At the start of the pandemic, executive and program directors scrambled to figure out how to change service delivery to offer protection to their workers. The programs that could shut down and go virtual did so. The programs that needed to stay open, such as inpatient/residential programs, shelters, and transitional housing, changed service delivery and, in many cases, cut down on the number of services they offered and the number of beds that would be available.

Some practices cut across almost all programs and services. These include the development of mitigation plans to reduce the threat of COVID-19 infection, the use of protective protocols including personal protective equipment (PPE), social distancing, increasing ventilation, and intensive cleaning and disinfecting. Organizations and agencies moved to "touchless" delivery of services as much as possible and moved to virtual meetings and communications. Many agencies sought and received COVID-19 funding.

Table 2 lists changes in services delivery methodologies reported by respondents and the effects of those changes on clients. Throughout this section, both specific challenges and "silver linings" (practices borne of the pandemic including changes organizations have said they will continue after the pandemic) are noted. Figure 13 lists the pandemic silver linings.

The changes made in the delivery of services enabled the continuation of those services but had some negative impacts on both FLWs and the people they serve. The overall effect of these changes has been to isolate the client/patient/student either physically or through the wearing of PPE. Fewer services and lower levels of oversight were provided to high-risk children and families. In some instances, fewer people were served. Additionally, workers were distanced from their coworkers. One silver lining noted was that some residents, especially those without a reliable means of transportation, had better access to certain services via virtual delivery. At the same time, residents with limited internet and phone access might be expected to have the least access to services during the pandemic.

TABLE 2 - CHANGES IN SERVICE DELIVERY AND THE EFFECT ON CLIENTS, PATIENTS, STUDENTS, FAMILIES

Changes in Service Delivery
Increase focus on infection control, testing, quarantine
No visitors/family in hospital or nursing home
No home visiting services
No center-based groups, meals, exercise classes
Drive-thru pick up or home delivery of food
Virtual school, home visits, medical and behavioral health appointments
Reduced capacity in domestic violence shelter and less oversight of at-risk children
No public showers, laundry, communal meals
Only high-risk child maltreatment cases investigated, less family visitation
Effects on People
Reduced help for children and families at risk
Isolation/less connection for seniors, families, children and youth
Inpatients isolated
Increased access to care for those without transportation
No services for those without phone/internet

Personal Protective Equipment and Infection Control

“We’ve become very proficient at infection control.”

One of the major stressors for organizations, staff, patients, clients, and students was the constant shifting in mandates, policies, and procedures related to the pandemic. Additionally, in facilities with high-risk inpatients, the necessary precautions took time away from connecting with the patient in other ways and physically created separation. One inpatient facility director said that the focus on infection control had been a trade-off with taking care of the whole person and their connection to staff and family.

All the frontline service sectors had to adapt those services related to personal protective equipment, cleaning, ventilation, and social distancing. At the beginning of the pandemic, personal protective equipment was scarce, and the community came together to provide masks to critical organizations. Several organizations benefited from a group called the Alaska Mask Makers, which began in March 2020 with 4,900 individuals in the state making 38,000 masks for distribution. One large

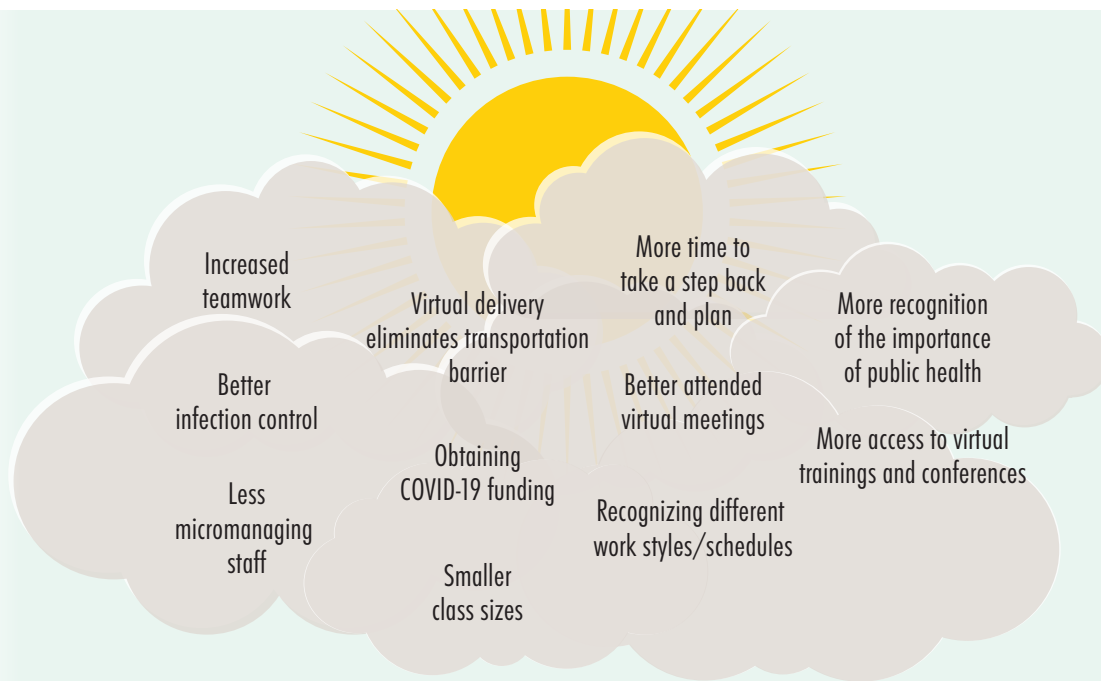
organization reported sending someone out-of-state in search of PPE.

Silver Lining: An emergency room doctor stated that medical staff previously had thought that some transmission of illness between patient and provider was inevitable. They stated that now it has been proven that more can be done to prevent transmission.

Virtual Meetings

Almost all agencies moved to virtual meetings and working from home whenever possible. For some organizations, this was a steep learning curve; for others, it was just expanding the number of existing virtual meetings. Mat-Su has many social services and first responder coalitions and networking groups that normally meet in person. These include the Crisis Intervention Team Coalition, multi-disciplinary teams, and the Mat-Su Agency Partnership (MAP). All these groups moved to virtual meetings. Additionally, Mat-Su Health Foundation and the United Way of Mat-Su created a virtual collaborative meeting with representatives from all frontline sectors and local and state government to coordinate COVID-19

FIGURE 13
PANDEMIC SILVER LININGS



responses. Initially, this collaborative met weekly, and as of April 2021, it meets monthly.

One “silver lining” survey response:

“So staff don’t have to come into the office as much. Only for certain things. We’ve been talking about this for years and there’s been a lot of pushback on it. Pandemic hit, then all of a sudden, we can all telecommute, like, you know, it went from, well, we can only give VPNs to managers [to allowing them for other staff.]”

Some managers found that they could manage better virtually, through online meetings. These managers said they were less likely to micromanage and more likely to let staff handle the work, and this led to good outcomes.

“It’s easier to manage from afar almost like I’m not stuck in the weeds all the time. I can kind of have a more ‘overview’ type of check-in with everybody. So, I feel like that distance helps me and keeps me from getting stuck in the weeds. I have a broader focus because there is more area to cover. I don’t know how to explain it, but I feel like I manage better this way.”

A couple of large organizations with multiple sites found that they could have better-attended meetings with the entire organization, which they felt led to better-connected staff and coordinated services.

“We have also found that by having virtual meetings our participation has grown. For example, we have a wellness committee and a safety committee, and previously staff would travel from one of our six locations to wherever the meeting was. And that sometimes limited the number of people that could participate. Now that the meetings are online, we’re getting very good participation and more input on what we should be doing for staff wellness and also for safety considerations. We’re just finishing up our emergency preparedness binder and having that input from multiple people, it’s just really made the product so much better.”

Several organizations implemented virtual training for their staff working from home for part of the pandemic, which allowed staff to get the training needed for their work. Additionally, attending virtual conferences traditionally held in-person in the lower 48 states became more affordable, making it feasible for more staff to attend.

“One of the things that they [staff] can do is training. So we found so much more available. For example, conferences that we used to have to travel to. And we, maybe we could send one or two people because they were kind of pricey. Now we can have more people attend. So, the amount of training that staff have gotten has really increased.”

Other organizations said that, with virtual meetings, they could invite guest speakers from all over the country, including those they never thought to invite to in-person meetings.

Working from Home and Virtual Service Delivery

The agencies that were not delivering inpatient, residential services or critical social supports that needed physical or face-to-face delivery had their workers work from home. The reviews from workers working from home were varied. Some were thankful and felt more productive; others said they were less productive and needed more home/work separation. Several organizations/agencies said they had contemplated having staff work from home, and the pandemic pushed them in that direction. As a result, they overcame some reluctance about the efficiency and appropriateness of this practice. Many organizations said that they would continue to incorporate some level of staff working from home in the future.

Agencies stated that they never imagined they could deliver services virtually on this scale. Some organizations reported that this is not an ideal way to reach all clients because some are stranded and isolated, lacking the phone minutes or internet connection to attend virtual services.

“We’ve had some folks that we are able to treat through the telephone and zoom and it has been a godsend. It has eliminated a lot of transportation, dilemmas, and barriers. They have really been able to take advantage of that. Other folks have just really been stranded and isolated because they don’t have the minutes, or they don’t have the tech.”

Also, some staff found that individuals were more prepared for virtual meetings when they had been emailed documents and forms to be filled out and submitted before the meeting.

Staff report that managers have recognized different work styles and schedules.

“Personally, I’ve appreciated the acknowledgement of how we can have nontraditional work styles or schedules. I have worked from home much of the time - my kids are here. So, my schedule some nights I will be working till the wee hours of the morning. I think as professionals, we’re learning to become more accustomed to just different work styles.”

For some patients, virtual delivery of services at their home has eliminated transportation barriers and allowed the provider to see the home environment, something they were not privy to before.

“The promotion and the use of tele-health has been a really positive thing.”

“As a clinician, I have had to work from home for much of this time. Having the access to health and video options for my work has been a silver lining. I could jump on for check-ins or shortened sessions, especially my first episode psychosis work. It is increasing contacts.”

“As an independent living specialist, we teach courses for our teams and we’ve been able to connect with kids statewide, which not only means we as workers are able to connect, but also the peers are able to build relationships across the state.”

“We have had a little bit more consistency and I think attendance and follow through because of [no need for] transportation.”

“We have better access for clients from remote areas.”

“A silver lining was the realization that some services can be delivered virtually.”

“One of the things we’ve recognized is, again, not every interaction does have to be in person and we can certainly make sure that services are provided in a timely and direct way without having that. So, our childcare assistance and family services have all found work arounds that have worked for the families that they’re serving.”

While moving staff to working from home was a good choice and not difficult for many organizations, it

was difficult for organizations that did not have the technological infrastructure or that have workers who live in areas with slow internet service. Services for youth, peer-to-peer services, and group treatment services were difficult to provide virtually. The effectiveness of virtual behavioral health services depended on the client being able to have privacy in their home during their session. With other family members and children working and learning from home, that could be difficult.

"We used to meet in person regularly. Building a pro-social community environment for LGBTQ+ young people is really essential to programming, not only from the perspective of those participants, but also from peer-to-peer support for our volunteers that are hosting young people. I would say that, you know, zoom just doesn't cut it."

One of the most severe difficulties was obtaining resources for clients because many state offices, including the court system, were not open and/or their services were virtual. When services had staff working from home, insufficient communication within the state office sometimes resulted in the need for multiple calls to assist a client with an open case.

"It's just kind of a terrible, terrible time to visit an entry point. The operatory example is that the Office of Public Assistance is completely closed to the public, period. So, if you're a person who does better on paper, you can't just walk in and fill out a paper application and have somebody help you do it."

"It takes like 18 and a half emails to, to figure out where somebody is in the system. You know a lot of the other resource agencies are also working from home. And so, you can't get all the people in one office. [It takes] 20 phone calls just to figure out who was the last person that talked to someone or tried to help them through the system. So, it's just, really onerous and [it feels like] you're not really making progress for your clients."

COVID-19 Funding

Many frontline service organizations had access to local, state, and federal funds related to the pandemic. Directors needed to become experts on finding out where these funds were, determining if

their agency was eligible, and filling out applications. One organization received \$1.2 million, which allowed them to expand services and buy new, easier-to-clean furniture. The funds helped agencies implement their mitigation plans with the appropriate staffing. Expanded services allowed shelters and transitional housing providers to put up more individuals and families in hotels. Several agencies were able to hire more staff, and others could buy needed equipment and delivery vehicles.

"Because of the Cares Act funding we're able to hire people who could actually reach out and [help us meet the need] that has increased."

"That's kind of what has allowed our [organization] to kickstart our behavioral health program, our learning center and our childcare. Because of that [funding], we've been able to basically hire people so that we can actually implement these things and see our vision and mission come to life."

"Honestly, [our agency] is doing the best financially than we have probably ever in our existence. We got the PPE or the PPP funding that helped."

Staffing

Frontline service providers handled staffing during the pandemic in multiple ways.

- Some furloughed employees early on when they cut or suspended services.
- Some cut the number of staff that worked in the facility at any given time to improve physical distancing.
- Most agencies suspended their volunteer programs, including those that were key to service delivery.
- Some continue to cut staff hours when the inpatient census decreases.
- There have also been staff shortages.

The furlough and cut in staff hours have been very stressful for FLWs. This is discussed more extensively in FLW Behavioral Health Section. Some older staff have decided not to risk COVID-19 exposure and not return to work. Two organizations have mentioned severe shortages of personal care attendants.

Time, Planning, and Creativity

Some workers felt they were given a “gift of time” because they could attend meetings and provide services virtually without the usual travel time.

“I used to spend some days driving for hours to get to see people and clients in their homes. And now suddenly I have all this free time, like just going to court would eat up an hour of my time with driving. Now just being able to do that by phone or zoom has allowed me a lot more time on my schedule to get other things done.”

Several directors noted that the pandemic allowed them to step back and think about their services they were providing and allowed them to assess their delivery system and plan strategically.

“I think in general; it was an opportunity for people to set up, step up, get a little closer and reevaluate a whole new clinical consideration in the clinical model. As well, for me as a supervisor, I’ve learned a lot about how to connect with my staff and it reinforced the whole concept that in behavioral health, everything really comes down to your ability to develop a relationship with somebody.”

“We’ve had so many positives and being able to be incredibly nimble and respond to totally unexpected circumstance has been the biggest one. We always knew we had a creative workforce, but our staff has been phenomenal. I am also very pleased to see that the other thing we are learning is that every client doesn’t need to have a face-to-face interaction.”

“As an organization we had a chance to just take a big breath while we weren’t doing as many services and we found significant areas of efficiency and made some significant steps towards long-term financial security by correcting some areas [where] we were inefficient.”

Recognition

Some FLWs said there had been a greater recognition of the importance of nursing and public health as professions.

Teamwork and New Partnerships

Some organizations have said that the pandemic has brought staff together, and they are working more as

a team. Other organizations have said that they feel distanced from each other physically and emotionally due to differing opinions on the pandemic, the use of PPE, and not always working in the same space. Some managers have increased the frequency of staff and one-on-one meetings because they can be held virtually.

“I think we’ve learned a lot about our team, and I’ve gained a great appreciation for them. This being on the front lines is hard no matter what, but with the pandemic going on to see the way that they’ve responded has been great.”

“As far as staff is concerned - people pulled together more, there’s a more sense of teamwork, more than we previously had.”

Additionally, new partnerships between agencies, as well as with the community, have evolved. For example, a food provider with multiple feeding sites agreed to deliver library books while the library was closed.

“A lot of new partnerships were forged as a result of the pandemic because we can’t get out and do what we normally do. And so, you, you have to keep the work going. You have to find new ways to do it with new partnerships.”

“I observed that COVID has really helped to bring our community together. One of the main parts of my job is making community connections with stakeholders. And that has been difficult in the past. Everyone was so busy with their own piece and their own work, but now there’s a lot more cooperation and reaching out and working together. Even people who have nothing to do with healthcare really want to help with the pandemic and we can find a role for them.”

More on “Silver Linings”

Most of the silver linings mentioned related to the organizations as a whole. Surveyed workers stated that the most common silver lining for their work was a new way to deliver services and more access to COVID-19 funding. About a quarter of workers felt there was no silver lining. Fifteen to 25 percent of workers agreed with at least one of the following: They worked more as a team; They felt more supported; They were more efficient at work.

Table 3 - Percentage of Surveyed Workers Mentioning Silver Linings

46%	New way to deliver services
40%	Additional funding for organization
25%	I can't think of anything
25%	Staff working more as a team
17%	Staff feel more supported
15%	Work is conducted more efficiently

The following are other silver lining themes that came up in the interviews.

- More high-risk youth were accepted back into their families of origin
- Lower teacher/student ratios in classes
- Young people are sticking together and showing resilience and adaptability

What Will Be Kept After the Pandemic?

Frontline organizations were asked which pandemic-related changes they would keep when the pandemic was over. They replied:

Knowledge

- More awareness of respiratory illness and infection-control

Equipment

- Furniture, equipment, and vehicles
- Plastic barriers at service counters

Procedures

- Video conferencing/meetings
- How I conduct staff meetings
- Being more intentional with meeting with different organizations and groups

- Always thinking creatively of how to serve people differently
- Drive-through food box pick-up
- Telehealth
- Better hand hygiene and cleaning practices
- Less reliance on in-person meetings
- Virtual team activities
- Considering working from home as self-care
- Telecommuting
- Morning huddles
- Distance learning
- Increased use and capabilities of technology
- Housing homeless people in hotels

Effects of Client Needs

FLWs were asked about their perceptions of client needs (no clients were surveyed for this report). Program directors, managers, and staff all stated that they saw a different pattern in the number of clients/patients/students/families served and their level of need over the pandemic.

The following are a description of the patterns for different types of services.

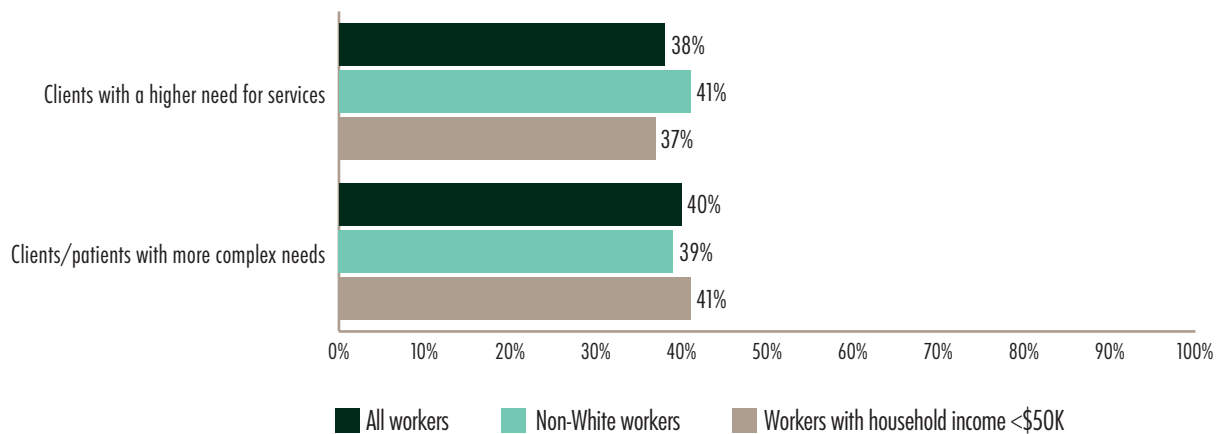
1. Physical health providers saw a decrease in patients early on when there was a significant fear of being infected with the virus and the hospital had stopped providing elective surgical services. As the pandemic wore on, outpatient and inpatient physical health care volume increased. In Mat-Su, a skilled nursing home reported being 100% full for the whole year.
2. Child welfare workers said that it was “eerily quiet” at the beginning of the pandemic. As the pandemic continued, they saw an uptick in very serious cases. Schools and many early learning/

childcare facilities all closed at the beginning of the pandemic, and not all their students returned when schools reopened. Domestic violence workers reported an increase in people needing their services.

“We have been seeing the families we’ve had prior – maybe not a lot though. We are seeing those that have had no prior history and they are really, really bad. Before we would get some hints that a family was struggling or had challenges and we would divert them into other community services. But now we’re finding out about families that [are] in crisis when the house is ‘on fire’. We have to do something to make sure those kids are safe.”

“We’re already dealing with families with minimal coping mechanisms, and they are stuck at home together. Their coping mechanisms, if they are unhealthy, have increased. Then on top of that, the behaviors that go along with them, increase. So, child abuse is a little more prevalent and there is a higher

FIGURE 14
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS RELATED TO CLIENT/PATIENT NEEDS



risk of that occurring in the home. Plus, we don't have teachers with the eyeballs on the kids. When they do have those eyes on the kids, we are getting those phone calls. [We get called now when] its already got to the escalating point. Oh man, if the child had been in school, we probably could have gotten to them sooner and this may not have happened."

"The number of domestic violence and sexual assault cases has definitely increased. Early on people were basically in lockdown in their homes with their perpetrators and fewer resources were available. The phone calls pretty much have not really ever stopped. They just keep coming."

3. Youth resilience programs have seen continued and increased enrollments.
4. Overwhelmingly, social service organizations reported that the need for their services increased and that they were seeing clients they had never seen before. Food pantries are serving more residents. A Wasilla-based pantry went from 200 food boxes and 300 meals a week in January to 450 food boxes and a maximum of 900 meals a week in the summer. An Upper-Su provider reported that her area experienced more individuals in poverty because of their dependence on tourism, which ceased during the pandemic. The need for food at her pantry has increased by 95% - from 269 clients in October 2019 to 525 clients in October 2020. Other social service providers stated:

- "I have placed [in housing] several people who normally wouldn't be homeless but ended up homeless."
- "We have been seeing a lot of people who have never had to access social service programs and resources before. So, there's that extra level of handholding that needs to happen."

- "There are people who are basically "normal" who have had really good coping skills through most of their life and they are able to deal without tapping into the professional system. Now their adaptive functional coping systems are not working, and they have to go ask for help and they have no idea where to go."

- "In the last year, I have been seeing a hundred percent more families who are saying 'my wife lost her job', or the hardest are when the husbands speak to us and say, 'I've lost my job. My wife is now supporting us for the first time ever'. And the husbands are distraught, and it's really heartbreaking."

- "What I have seen during the pandemic...is families that never before had to be on any kind of social services. They're confused and they're lost and they're scared and they're humiliated to be here."

5. Older residents experienced increased isolation, and with that, a greater need for connection, in addition to their needs for food and other assistance. For example, a delivery person for Thanksgiving Day pies said that it was such a sad day for her because, many times, when she delivered a pie, the elder would break down into tears. One senior center reported an increase of 22% for their services compared to before the pandemic.
6. Frontline organizations reported serving people with more complex cases.
7. Behavioral health agencies reported an increase in clients. One provider stated:

"We've always had self-referrals, but we are seeing a lot more of self-referrals for relapsing on alcohol - people who had 10 years sobriety."

Mat-Su Frontline Workers and the Effect of Working Through a Pandemic

Overall Impact

About half of the workers reported moderate/extreme overall stress related to COVID-19, and over three-quarters said there had been a moderate to severe impact on their day-to-day lives (Figure 16). On average, 47% of FLWs felt COVID-19 had a moderate/severe impact on their daily lives, with the greatest impact seen for workers in the Education and CW/DV/SA sectors (53%-56%) and the least impact

for workers in the Behavioral Health and Social Sciences sectors (36%-38%). The majority of FLWs felt that COVID-19 caused a moderate/severe change in their daily activities (78%), with the greatest change seen by FLWs in the Education sector (84%) and the smallest change for FLWs in the Early Learning/Childcare sector (68%).



FIGURE 15
THE STRESS OF THE FRONTLINE WORKER

FIGURE 16
PERCENTAGE OF WORKERS AFFECTED BY COVID-19 STRESS

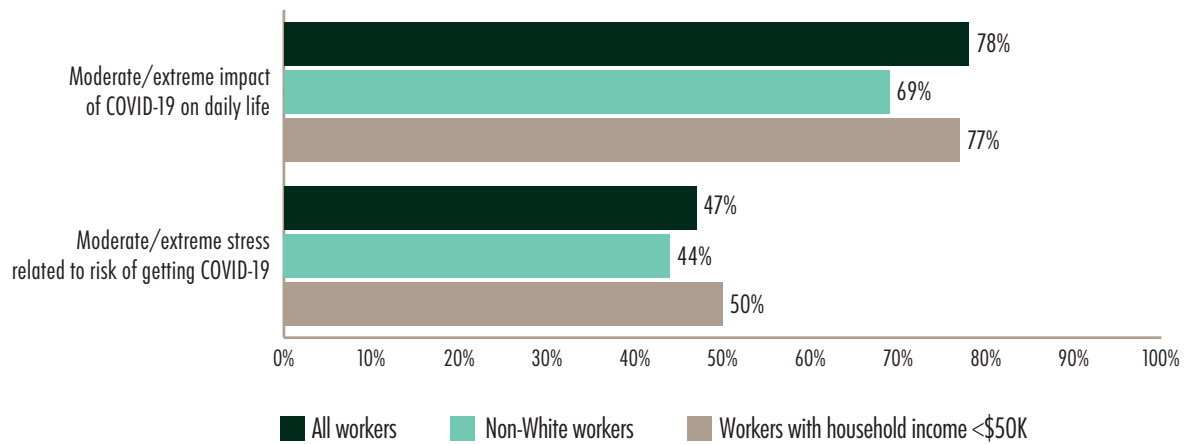


FIGURE 17
PERCENTAGE OF WORKERS BY SECTOR REPORTING MODERATE/EXTREME DAILY IMPACT FROM COVID-19

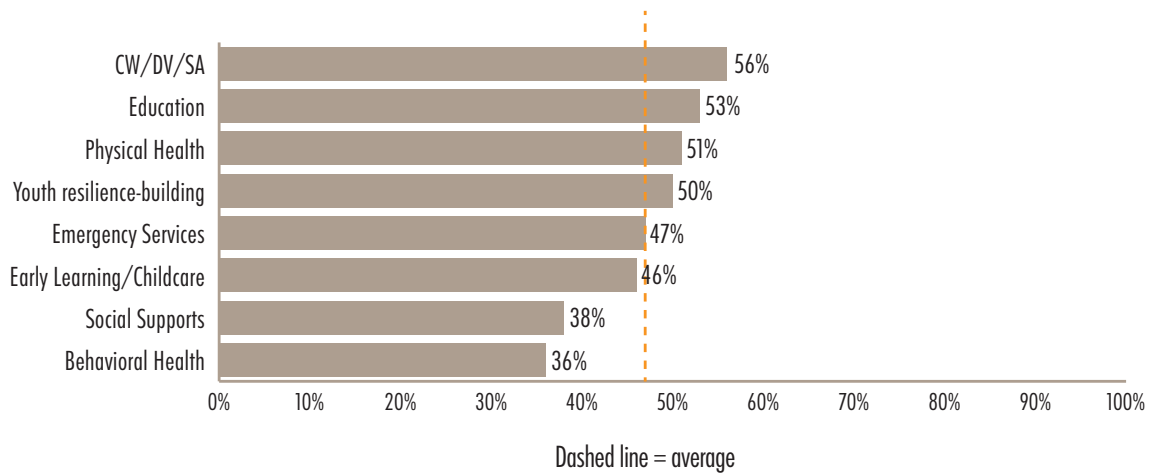
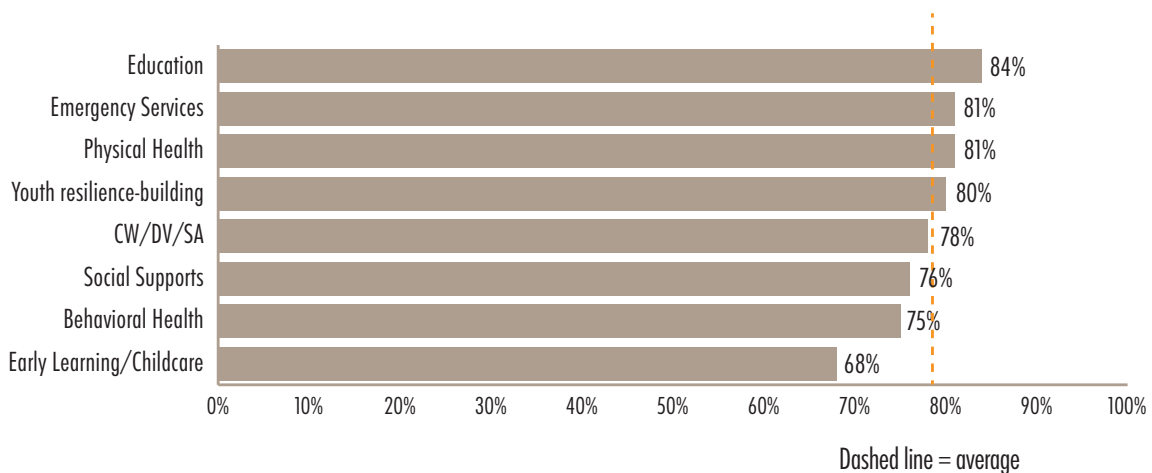


FIGURE 18
PERCENTAGE OF WORKERS BY SECTOR REPORTING MODERATE/EXTREME CHANGE IN DAILY ACTIVITIES FROM COVID-19



Behavioral Health

Behavioral health is defined here as: the promotion of mental health, resilience, and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

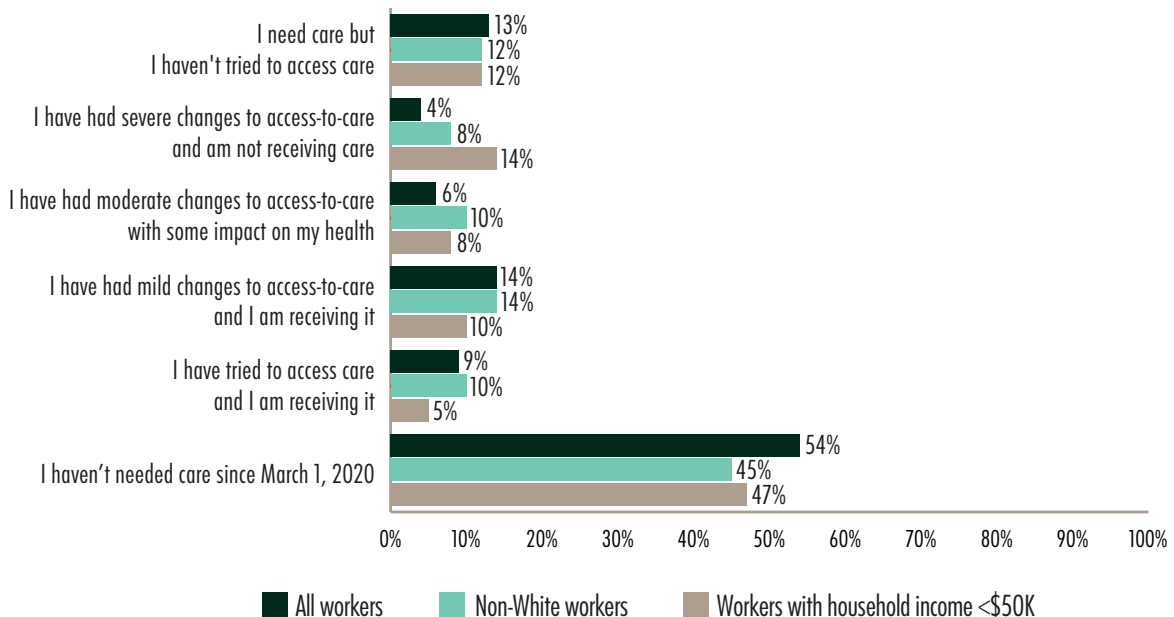
Several factors affected the behavioral health of FLWs during the pandemic. Negative factors included stress of all kinds; positive factors included support from family, friends, coworkers, administrators, and the public. Mat-Su FLWs said that some of the hardest things about working during the pandemic were:

- Fear of COVID-19 exposure
- Feeling conflict with coworkers, family, friends, and the public over COVID-19 risk
- Financial stresses due to COVID-19 exposure and quarantine
- Not being as connected to:
 - A support system of family and friends
 - Clients/patients/students/families
 - Coworkers

- Not feeling supported at work by:
 - Not having the necessary protections
 - Not having administrative support
- Financial stress in general
- Childcare stress

Just over half of FLWs who were surveyed reported that they had not needed behavioral health care during the pandemic. Approximately 17% of FLWs said they would like care but had not sought it or had had severe changes in their ability to access care, which prohibited them from receiving care. Another 20% were receiving care with only mild to moderate changes in access. There was a similar pattern of responses for the subpopulations examined; however, the percentage of FLWs who wanted care and could not or did not access it was 30% for workers from lower-income households and 20% for non-White FLWs as compared to 17% for all respondents.

FIGURE 19
HOW HAS YOUR ACCESS TO MENTAL HEALTH CARE CHANGED SINCE MARCH 1, 2020?



When directors and managers were asked about the behavioral health of staff, several themes came up. They reported that staff were:

- feeling frustrated and angry when coworkers, community members, and leaders do not take the pandemic seriously, while they risk their lives treating people who have been seriously affected by the virus
- grieving for family members who had been infected with COVID-19
- saddened by the death(s) of family and friends and being unable to attend funerals and/or perform traditions such as the Potlatch
- stressed, exhausted, and feeling overwhelmed
- feeling like there is no end in sight to the pandemic
- feeling isolated as a new staff member
- feeling underappreciated
- worrying about aging parents
- anxious about being infected at work
- isolated and depressed
- stressed dealing with the stress of their children
- experiencing a loss of social networks
- crying for no reason
- exhibiting stress-related PTSD
- anxious waiting for continuous mandate changes

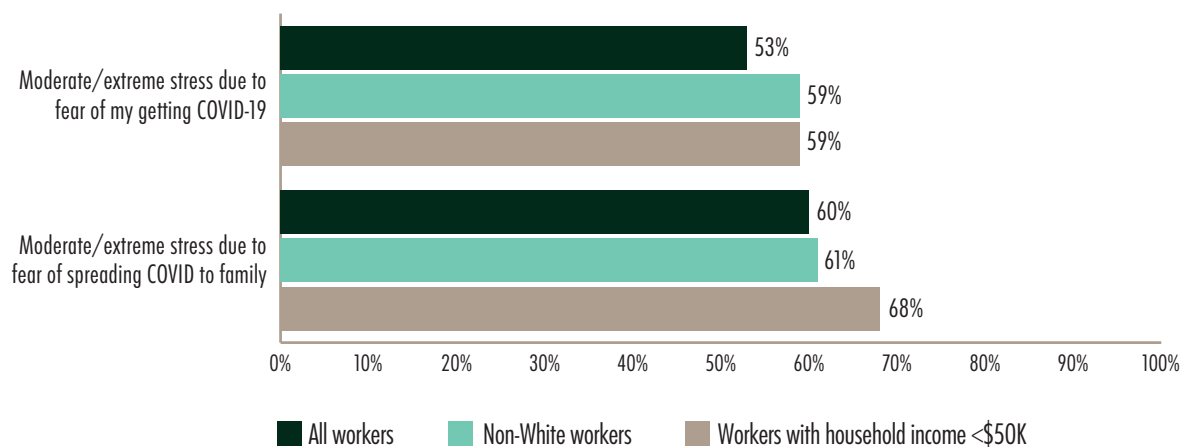
The stress levels of frontline workers have increased significantly throughout the pandemic. The following sections dissect the causes of some of the stress.

Frontline Worker COVID-19 Exposure Stress

Frontline worker stress related to COVID-19 was complex and involved the following components.

1. There was fear over contracting the virus, having family/friends who get it, and spreading the virus from exposures at work or home.
2. There was stress over taking required precautions and losing money and PTO crucial to their household. Those precautions could be related to their children not being able to attend school after exposure or to the worker being exposed and having to quarantine at home.
3. There was frustration over the person's family, workmates, and community not sharing their risk assessment of the virus.
4. There was stress over the fact that guidelines on protecting workers and clients and delivering services were constantly changing.

FIGURE 20
PERCENTAGE OF WORKERS REPORTING MODERATE/EXTREME STRESS OVER GETTING AND SPREADING COVID-19



Frontline workers who were asked about their stress levels due to the risk of getting COVID-19, having family/friends contract it, or spreading it themselves stated that they had a great deal of stress related to this. They were more worried about transmitting it to others (60%) than getting it themselves (53%). There were minor differences for the subpopulations. Compared to all FLWs, workers from lower-income households had more stress over both situations, and a slightly higher percentage of non-White workers feared contracting the infection. There was not much variation in the amount of stress for these situations among staff in different sectors. One director described the stress that many FLWs mentioned as follows:

"I think the health staff had the experience of the stress of interacting with the elders and knowing that whatever they did in their home lives, they could potentially be bringing to the elders. So, I know there's a lot of anxiety around being safe in their own homes and what they were doing and how that could impact the elders because they still had to go into their homes and care for them in their homes. And then they also had the experience of the people that they're looking after in the homes, the people that are also visiting or living there, they're not taking it seriously. Trying to explain and educate and protect their elders that they're working with is really difficult."

FLWs responded with the following stories related to fear of getting or spreading COVID-19 when asked what the hardest thing about the pandemic has been.

"Having to break protocol because I work with individuals with disabilities for whom the protocol doesn't work and my mask gets pulled off frequently and [I experience] physical interactions that put me in direct contact with students (biting, scratching, spitting, hair pulling, toileting)."

"In November, I contracted COVID at work and brought it home to my family. It was devastating to watch my husband suffer severe symptoms, knowing I was the cause. Thankfully, he recovered but I have persistent symptoms. If my community cared for me and my health all of this could have been avoided."

"The stress and anxiety of being close to the COVID patients in the back of an enclosed ambulance. I also have feared getting COVID and bringing it back home to my family. Stress and lack of sleep makes us more susceptible to getting sick."

"Knowing people who are positive and have symptoms that refuse to quarantine that are spreading the virus. Watching people pass at the hospital from COVID and seeing the families mourning, watching my grandfather pass from COVID. Knowing I was going to get the virus and infect my family which did happen, fear of paying bills due to this and getting a new job. Burnout at the hospital and with coworkers after seeing so much death and suffering due to this virus and knowing the general public is not seeing this and does not understand."

This phenomenon was seen in all sectors. One director said that her nurses were gatekeepers at work and gatekeepers at home. She described it as:

"I heard a quote the other day and I keep saying it over and over again because it resonates so much: every parenting decision takes a NASA level risk assessment. Can my kid participate in this activity? Can my kid do this? Okay. What's the risk to our family? What's the risk to our community? What's the risk to them if they don't participate -like depression and anxiety and things like that?"

In all sectors, workers mentioned experiencing family and friends who had been sick or died. Alaska Native workers mentioned the difficulty of not being able to return to a rural area for a funeral to grieve with their community. Other workers could not travel outside Alaska to attend funerals or to be with relatives who were hospitalized.

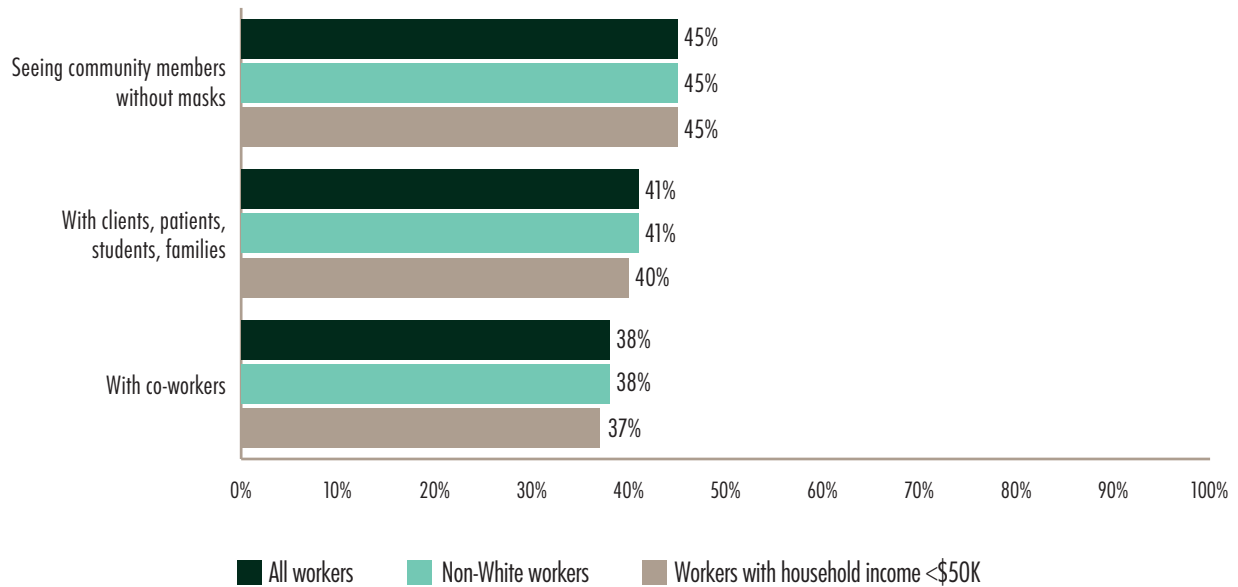
Frontline Worker COVID-19 Risk Assessment Conflict

The divide in Mat-Su over whether COVID-19 presents a risk is evident in the workplace. Some workers did not agree with the protective measures they needed to take to "prevent" the virus because they did not think there was a significant risk. These workers did not always feel comfortable expressing their

skepticism. Other staff felt at risk when they worked with staff or clients who did not use precautions against COVID-19. Approximately 4 out of 10 workers felt stress over differing perceptions of risk. Stress

related to differing perceptions of risk was most apparent in the CW/DV/SA, Education, Physical Health, and Emergency Services Sectors.

FIGURE 21
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS OVER DIFFERENT PERCEPTIONS OF COVID-19 RISK



Here is what workers are saying about the conflict they experienced related to differing views on the risk of COVID-19. They made these comments when they were asked to share what was the hardest thing about the pandemic.

- “Caring for my patients/students and having the parents of said students shrug this off as nothing or having the parents curse at me and call me names for sending their ill child home.”
- “Watching us cater to policies and rules that hurt the people we serve in the process. Feeling completely disconnected with staff and like I am walking on eggshells if I am not wearing a mask and accidentally see someone.”
- “Working hard to protect my community and seeing local officials and community members not care about participating in wearing a mask. I have encountered local police officers, who are sworn to protect and serve the public not wearing masks.”
- “The fear of catching COVID and bringing it home to my spouse. Luckily, my organization advocated for us to get the vaccine early, which reduced my stress immensely. The other hard part is the conflict with people I know—such as family members and friends who do not take the pandemic seriously and believe it is a politicized hoax. I find it very disrespectful that they rant at me about how it is not real after I have treated and transported COVID patients who have taken a turn for the worst.”

Frontline Worker Financial Stress due to COVID-19 Exposure

Concerns about exposure risk and adherence to pandemic guidelines were heightened by the significant consequences of getting sick or being exposed. Workers' financial worries were not just confined to these consequences. Many had their hours cut or were furloughed due to a low patient/client census. Additionally, household members lost jobs. Worker financial stress is described more thoroughly later in the report. The financial worry that accompanies the loss of pay and paid time off was most pronounced among non-White workers and those with lower household incomes.

Here is what workers said about this type of financial stress when they responded to the question, "What has been the hardest thing about the pandemic?"

- *"(I work with students with behavioral challenges and rarely have a situation where I can social distance and do my job; We just have to take the risk of being close to our students in order to do our job effectively.) My biggest concerns with the pandemic are not having enough paid time off, getting COVID again (and having to take leave without pay), and carrying the virus to family members."*

- *"Being a single mom, my employment is our sole income. When school/daycare closures happen, I must take time off work to be with my children and I financially struggle every time this happens."*
- *"Getting a cough but not COVID and yet needing to quarantine. Loss of money, no work no pay."*
- *"Seeing others not take it seriously. The potential to lose paychecks or time off."*
- *"Figuring out how to pay my bills when I was unable to work from home when I got COVID."*

Changing COVID-19 Mandates and Procedures

A major stressor related to the handling of the pandemic was the constant flux in mandates and policy on how to deliver services and protect staff and clients/patients during the pandemic. In the interviews and the surveys, this came up as individuals described the hardest things they had to deal with. Constant changes in mandates and policies not only made FLWs' work lives unpredictable but added to conflict with clients/patients/families over differing COVID-19 risk assessments. This continual change at work was superimposed on a rapidly and ever-changing world outside of work.

FIGURE 22
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS RELATED TO COVID-19 AND INCOME

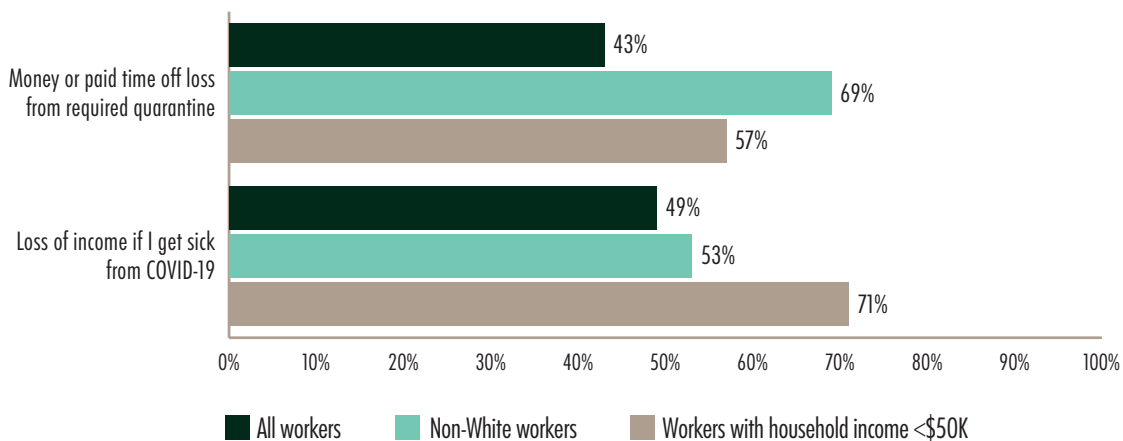
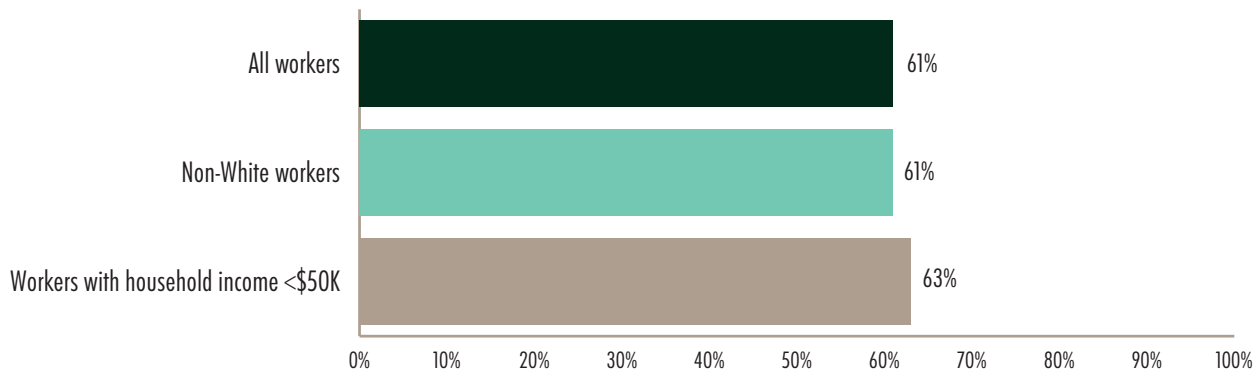


FIGURE 23
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS OVER CHANGING COVID-19 GUIDELINES



Here is what workers said has been difficult for them at work:

- *“You can’t just like turn the boat on its side every five minutes because new information comes out. You know, it’s just really, really difficult for us to make those adjustments. Like someone has a broken hip, this is how you care for them. These are their medications. These are their healthcare conditions. Well, when you do that in the middle of a pandemic and you change every, almost every single week both major and minor stuff, it just is. It’s just very tough.”*
- *“Having to be the face of the policies that have changed at our organization to parents, making sure parents are following the new guidelines. Dealing with being the frontline person that is blamed for all of the changes.”*
- *“I think the measures we have taken are to some degree unnecessary. It has caused undo mental stress on the staff to be in full PPE so much of the day. The policies keep changing. We have to cater to the most frightened staff member.”*
- *“The hardest thing, for me during this pandemic, has been not knowing what will happen. I never know when we will shut down next, or who will be in class or at work. I never know what to expect, and that is what stresses me out the most.”*

“Lack of Connection” Stress

Frontline workers are also members of the community, and they have felt the effect of the pandemic in all areas of their lives. When asked, frontline workers reported moderate/extreme stress from the inability to see family (67%) and friends (61%) during the pandemic. Workers also mentioned that providing services virtually or with protective gear and social distancing created disconnection with clients, patients, students, and families. Non-White and lower-income workers missed seeing friends slightly more than all FLWs. Lower-income workers also missed seeing family slightly more.

The following themes were mentioned when talking about the connections disrupted by the pandemic:

- Not having the support of family because they cannot spend time with them in person
- Not having the usual social connection with coworkers, including not having the formal and informal exchanges that come from seeing coworkers in person by working in the same space
- Lack of connection with patients, clients, students, and families due to virtual service delivery, or wearing a mask, or social distancing

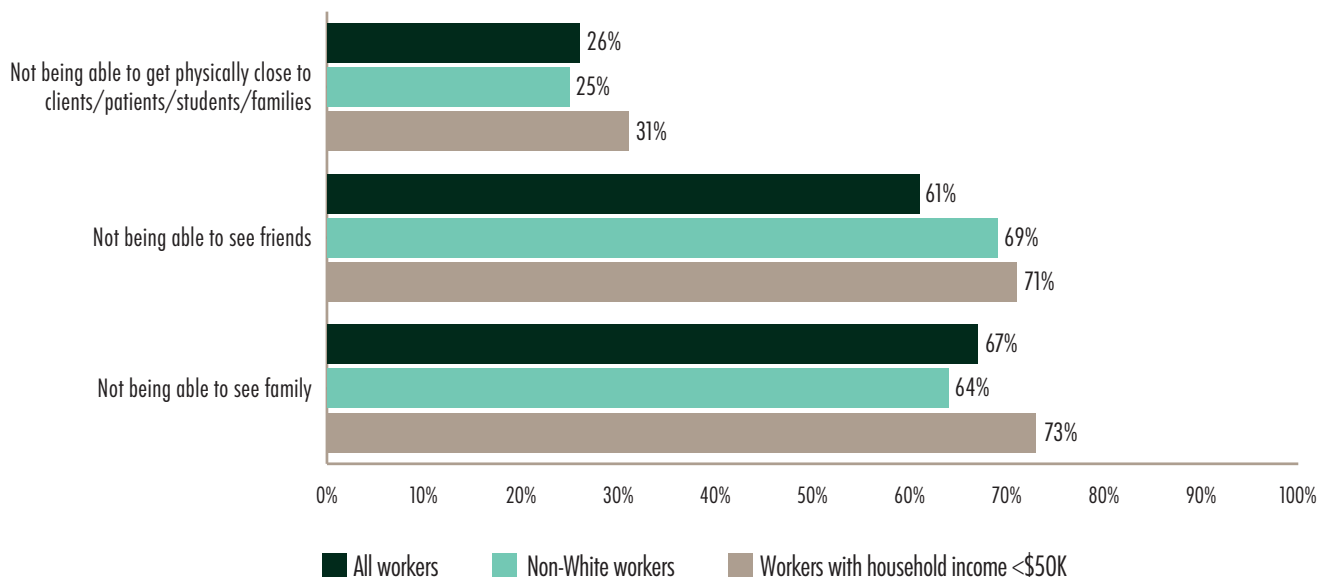
Many workers described missing seeing family and friends:

- *“The hardest thing for me has been the lack of ability to travel to see family/friends and not having businesses open. The population has turned against themselves and everyone is ‘judged’ harshly for their own, personal decisions and choices. I honestly feel that this entire ‘pandemic’ has stolen from me my basic, human rights that were once free.”*
- *“We went home for a funeral.... That was my first funeral at home and just seeing everybody and being there and we usually do potlatches and have a big dinner and everybody’s cooking and you’re grieving with other people. You’re singing traditional songs and laughing and remembering funny stories and then remembering sad stories and crying. It’s usually a three-day grieving process. None of that is happening now because of COVID, but it was still nice to see people and they had a church ceremony, and everybody was socially distanced and, and they had a graveside service.”*

Some FLWs described the lack of social connection with coworkers as one of the hardest things about the pandemic:

“The piece for me, that’s hardest about this [lack of connection] is that we would have these, these big potlucks and everyone would come, and they’d bring a dish, and we would break bread together and we’d talk about work stuff. We talked about life stuff and we would just bond. We haven’t been able to do that. And, you know, you feel disconnected from your coworkers who became family. And because of that disconnection, we start siloing ourselves and working on our own projects and trying to meet our own deadlines. And we forget that there’s all these other programs that we have and that if we worked together, we could really create a web of comfort and support for the people that we work with. So, I think for me personally, that has been a rough thing. Cause I, I love relationships, with people. I love getting to know them and not having that has been really difficult.”

FIGURE 24
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS OVER LACK OF CONNECTION



Directors and staff talked about the disruption in formal and informal work-related connection and support:

- *“We were working real hard as an organization, the six, eight months prior to the pandemic to ensure we were eliminating the silos within the organization, that we were really are one heart, one mind serving seniors in the community and with the pandemic changes, it forced siloing. And I think as staff, even as the leader, there is a lot of disconnection. So, a lot of what had been built up of, uh, you know, knowing what’s going on in people’s lives and their families and knowing what was going on in the senior’s lives has really disseminated or disappeared.”*
- *“The hardest part was when we weren’t in the office, that was really difficult. Having that communication and not having those daily interactions with each other, to be able to process, you know, what was going on or to be able to talk about a tough case we just had, or having that connection with each other in person.”*

These workers described the difficulties with having to connect with clients virtually:

- *“It is difficult, especially now having been in this job and starting in a pandemic to build those connections in the same way. I mean, I didn’t get into this work to be on zoom. I didn’t choose to work with youth to not see youth. I think that that’s been the biggest struggle for me because that’s something that fills my cup. And as much as they are not getting, we’re at our capacity with giving our services to them. And then I’m getting zoom fatigue. That’s a huge one with the kids and having partners, you know, say like, you know, we are at our limit right now in operating in our own adaptability.”*
- *“I think everybody has had experiences with people who, if they are in a hard spot, it’s very hard to connect to somebody through a phone or to even get them to respond. So not being able to just show up at somebody’s house and say, get in the car, let’s go get coffee, or let’s go for a walk- has really made it hard to reach my kids when I feel like they need it the most. I can get good surface*

level conversation or I’m getting good connection with people who are in a healthiest headspace.”

- *“I think the volunteers are affected because they can’t have that connection with the families that they’re used to having. Right? That has been the hardest heartache from the pandemic is how it’s affected our volunteer connection with our families. Staff, I think are okay.”*
- *“We can’t host social events for the children & their families at the school this year. I find this makes it difficult for me to establish connections with the families of students.”*
- *“I work with infants and toddlers and it’s so hard because masks are so important to prevent the virus but the children I work with need facial expressions and assurance since a lot of them have been abused in some way in the past and have trust issues.”*

Staffing, Changing Roles, Managerial Support and Lack of Appreciation

When they were asked, “what is the hardest thing for you during the pandemic?” many of the answers from FLWs mentioned having their role change, not getting the support they need from administration, and cuts in staffing and staff hours.

Some FLWs said that the hardest thing they faced during the pandemic was a change in their roles:

- *“My role has shifted from someone who partners with parents regarding their child’s health to more of a gatekeeper for all the COVID symptoms.”*

Other FLWs said that decreased staffing was the hardest thing that they faced during the pandemic:

- *“The increased call volume with increased responsibilities and not additional help to assist with the increased demand/responsibilities. Also keeping up constant changing guidelines and policies regarding the pandemic.”*
- *“Decreased staffing right when we are all so burned out and really needing extra staff/support/assistance from our workplace. Also, travel restrictions have been really hard because*

I'm not able to de-stress by seeing family out-of-state, or vacation with my family. Increased workload specific to the pandemic."

- *"Keeping the center fully staffed, unemployment pays people more than I can pay them and we have more things to do throughout the day it makes difficult to stay open considering we have requirements for ratios and prescreening and extra disinfection. I have had jobs posted since April of last year. Not being successful in finding the staff that we need to be able to not have our current staff stressed out has been the biggest challenge. Staff quit wanting to sit on unemployment instead since the government made it an option so they can be home with their children."*

Some FLWs said that it was difficult when they didn't feel supported and appreciated by the administrators in their organization. Additionally, some workers were frustrated by having their hours cut, which affected their ability to make ends meet.

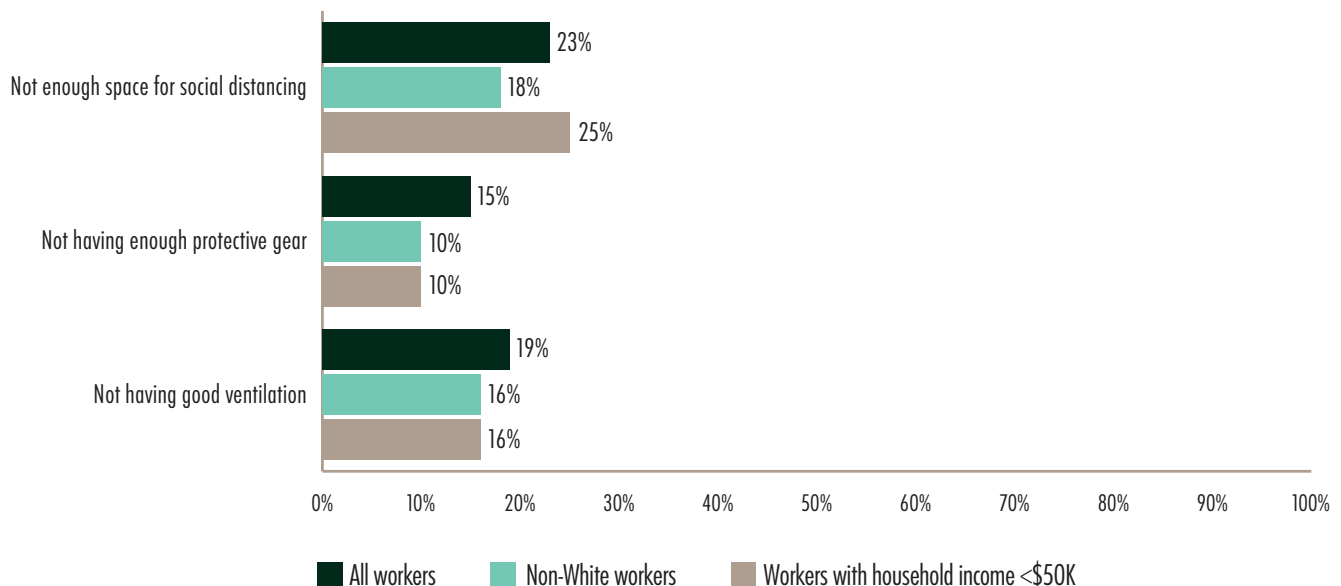
- *"Lack of reinforcement or follow through from management in enforcing precaution protocols inside the building/business. Lack of clarity and communication from management. Absence of leadership due to managers being spread thin and having many new tasks they must focus on."*

- *"So many things come to mind. I guess it would be a feeling of not doing enough, or not being appreciated for what I am doing."*
- *"I think that when people say it's a "hoax" that makes people feel unappreciated and discouraged. I think they [frontline healthcare workers] could use some more appreciation."*

Personal Protective Equipment Stress

The stress over insufficient protective measures at work differed depending on the sector. Inadequate ventilation was an issue for emergency services (26%), education (21%), physical health (23%), and CW/DV/SA workers (22%). The sectors with the highest percentage of workers who reported not enough space for social distancing were CW/DV/SA (30%), youth resilience (30%), and emergency services (28%). The top sectors reporting insufficient PPE were emergency services (30%), education (22%), and physical health (17%).

FIGURE 25
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS DUE TO WORKPLACE COVID-19 PROTECTION



Managers and directors reported that they scrambled for PPE supplies at the beginning of the pandemic. Many community groups and agencies helped each other out with making and sharing supplies. Many directors and managers mentioned that as a surprise or a silver lining, the community and other organizations stepped up to make and supply masks, food, and other support to the frontline workers. When asked what the most challenging thing during the pandemic had been, some workers stated that it was hard to do their jobs wearing protective gear and having to distance themselves physically. Other responses included:

- *“Working with those special cases that have a hard time hearing and or rely on lip reading and are unable to do so due to masks.”*

- *“Being forced to wear a mask because of someone else’s fear but the company not caring about my worry of what health factors masks will have on me.”*
- *“My ears get really sore after a few hours in a mask.”*
- *“Wearing a mask all day, the children can’t see me laugh/smile hard to breathe also, also social distancing with other staff.”*

Financial Stress

The U.S. Census Pulse Survey reported that 42% of Alaska households had experienced a loss of employment income since March 13, 2020 (as of Week 25). For the surveyed FLWs in Mat-Su, that percentage was 24%, with 4% of workers not being able to meet their basic needs (see Figure 27).

FIGURE 26
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS OVER FINANCES

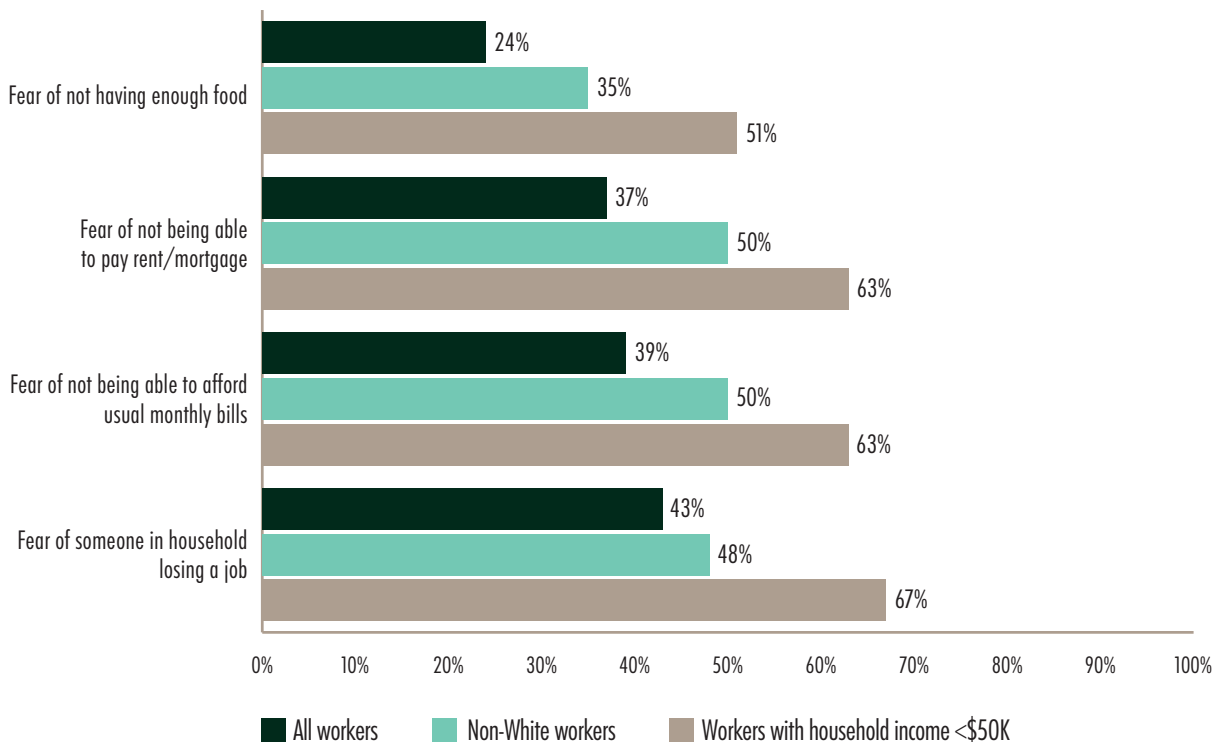
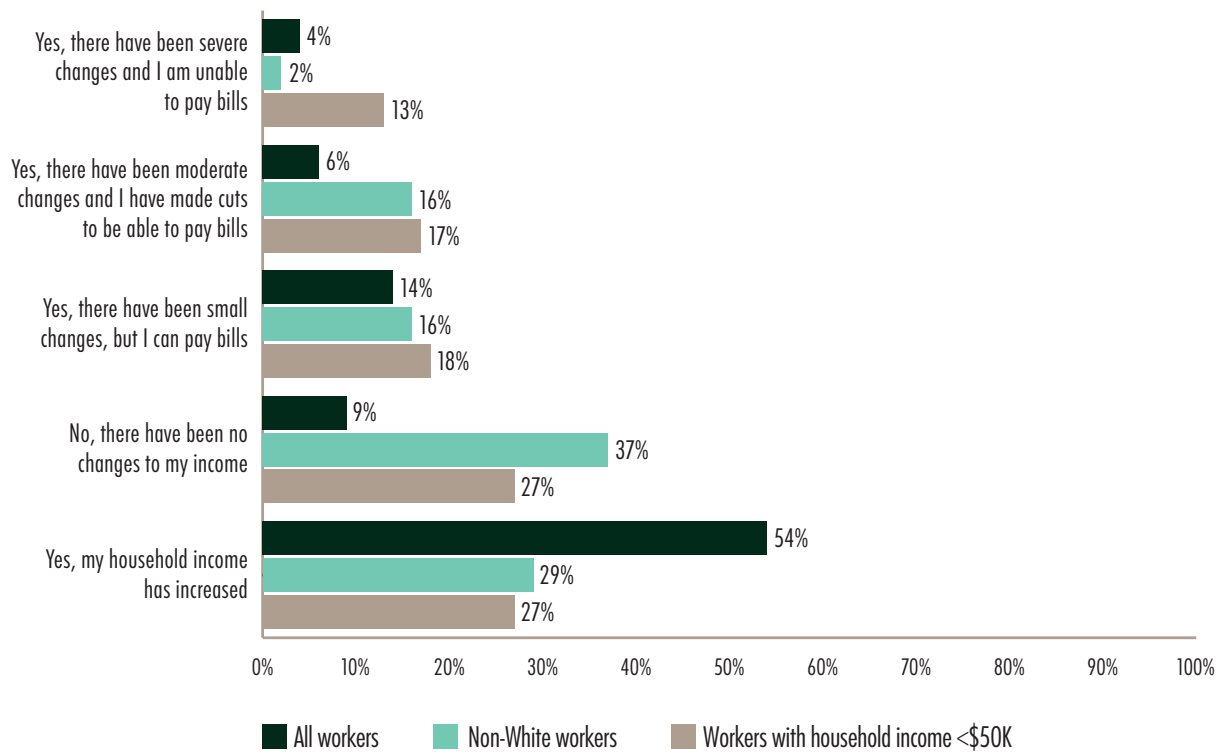


FIGURE 27
INCOME CHANGES DURING THE PANDEMIC



There was considerable financial stress among FLWs. Thirty-seven percent had moderate to extreme stress over not being able to continue to pay their rent/mortgage, and 39% were similarly stressed over not being able to afford their usual household bills. One in four frontline workers was moderately to extremely stressed about not having enough food. The non-White and lower-income FLW subpopulations were affected to a much greater extent for this type of stress. Fifty percent or more of non-White and lower-income workers were afraid they would be unable to pay usual monthly bills or their rent or mortgage. Fifty-one percent of lower-income workers feared they would not have enough food. These subgroups were also more worried about a household member losing their job.

The sectors that had the highest percent of FLWs reporting significant stress over their ability to pay bills were the Early Learning/Childcare (34%), Social Supports (28%), and Youth Resilience sectors (30%). The sectors that reported the most stress over being unable to pay rent/mortgage or buy food were the

Early Learning/Childcare and CW/DV/SA sectors. These sectors have low-paid workers doing vital work – protecting our families and children and starting children on their learning journeys.

Over half of all FLWs had their household income stay the same or increase during the pandemic. The rest had a decrease, with approximately 10% having a moderate to severe reduction that affected their ability to pay their bills. Income reduction had a moderate/severe effect for workers from lower-income households (30%) and for Non-White workers (18%). FLWs reported stress related to food insecurity (24%). There was a notable disparity for FLWs in the Early Learning/Childcare sector, with 61% reporting fears of not having enough food (Figure 28). In the CW/DV/SA sector, 35% of FLWs shared this fear. A similar trend is evident in Figure 29; workers in the CW/DV/SA and Early Learning/Childcare sectors feared not being able to pay routine bills much more often than FLWs as a whole (75% and 69%, respectively, compared to an average of 42%).

FIGURE 28
WORKERS WHO REPORTED MODERATE/EXTREME STRESS OVER FEAR OF NOT HAVING ENOUGH FOOD (%)

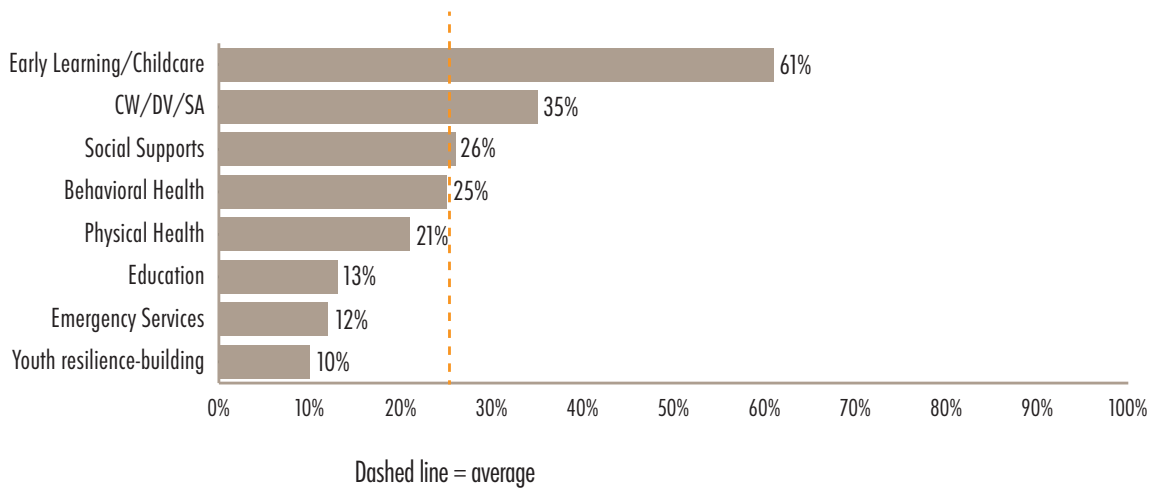
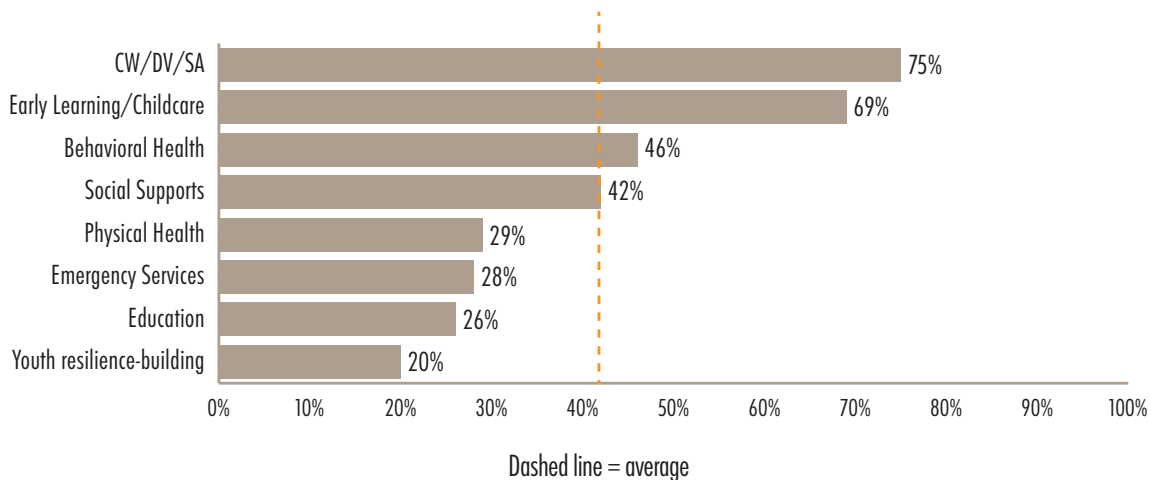


FIGURE 29
WORKERS WHO REPORTED MODERATE/EXTREME STRESS OVER FEAR OF NOT BEING ABLE TO PAY RENT/MORTGAGE (%)



Childcare and Schooling

The Matanuska-Susitna School District held school virtually for the last quarter of the 2019-2020 school year and returned to in-person schooling for the 2020-2021 school year. Families had the option to have their children attend either virtually or in person. Students attending in person were required to wear a mask and to follow their school’s social distancing requirements. Parents were required to keep their children at home if they felt sick or were experiencing COVID-19 symptoms. If a child received a positive test result, they were required to notify the school nurse as soon as possible. Each school

had a mitigation plan, and the school’s COVID-19 risk status was categorized as low-risk, medium-risk or high-risk. Based on risk category, different components of the plan were implemented. When a school reached a high-risk level due to the number of active COVID-19 cases, it faced a short-term closure. Parents at each school were notified when a positive case had been located, and the Mat-Su Public Health nurses performed contact tracing. Families of the close contacts of an infected student were required to quarantine. Some of these protocols are still in place as of April 2021. If a child was a close contact or had COVID-19, working parents had to find

immediate childcare and quarantine according to the following guidelines (see <https://www.matsuk12.us/Page/44962>).

1. If there is a positive test, they must quarantine at home and have 24 hours without symptoms.
2. If they are a close contact of a confirmed case, they must have seven days at home without symptoms and a negative test no earlier than Day 6 OR have ten days home without symptoms OR have 14 days at home if symptoms were present earlier.

Many of the surveyed FLWs said that it was stressful to handle virtual schooling and the unpredictability

of not knowing when a school might close or if their child would have a close contact with a COVID-19 case. On average, 58% of FLWs stated they had moderate to severe stress having to accommodate school switching between virtual and in-person learning, and 47% had a similar stress level finding and keeping childcare (see Figures 30 and 31). A considerably higher percentage of non-White FLWs and FLWs living in lower-income households reported these same stressors (Figure 32). Difficulty with finding and keeping childcare was more prevalent in the DV/SA/CW, and Social Supports sectors, while the switching of school delivery was more stressful in the Physical Health and Social Supports sectors.

FIGURE 30
WORKERS WHO REPORTED MODERATE/EXTREME STRESS OVER FINDING/KEEPING CHILDCARE (%)

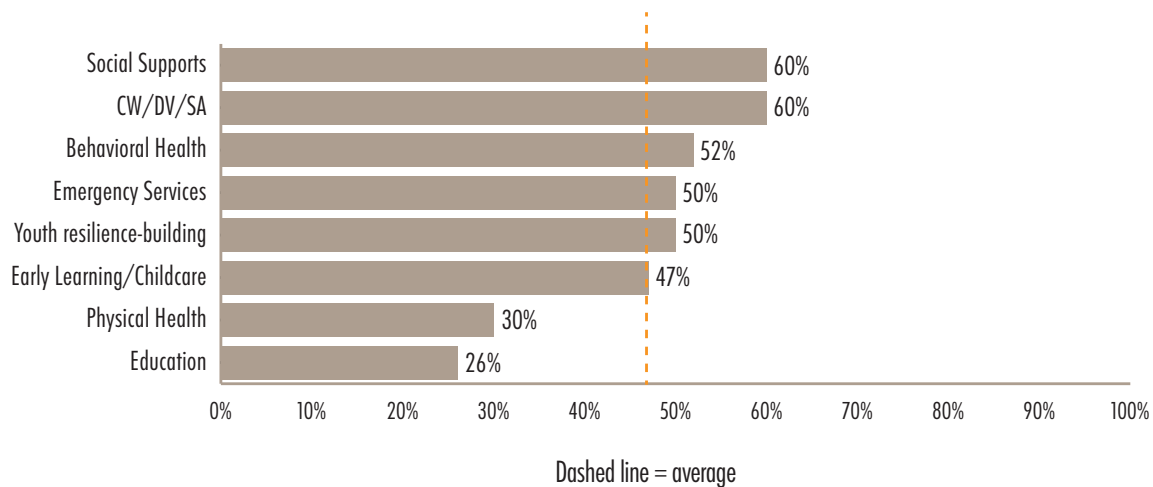


FIGURE 31
WORKERS WHO REPORTED MODERATE/EXTREME STRESS OVER THEIR CHILD'S SCHOOL SWITCHING BETWEEN VIRTUAL AND IN-PERSON LEARNING (%)

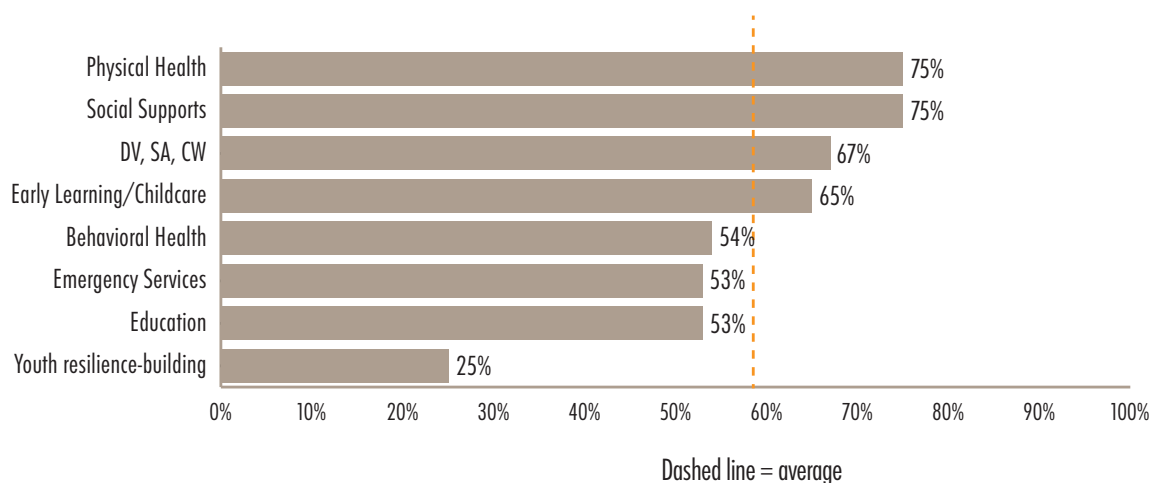
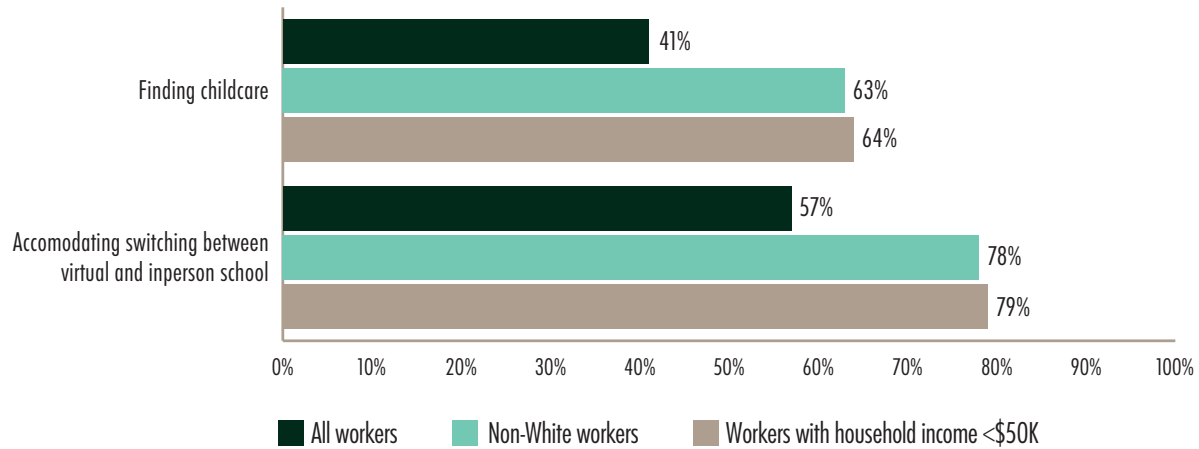


FIGURE 32
PERCENTAGE OF WORKERS WITH MODERATE/EXTREME STRESS DUE TO CHILDCARE ISSUES



Frontline Worker Support

The most common support that employers provided was to allow workers the flexibility to work from home (44%). A small percentage of employees received a monetary bonus (12%), and others received extra paid time off (8%), a warm line to talk to a counselor (8%), and work time for social connection (8%). The most popular type of support employees wanted was a monetary bonus, extra paid time off, and the flexibility to work from home. The stress levels for FLWs were exceedingly high due to financial worry – this correlated with the top two requests (monetary bonus and more PTO).

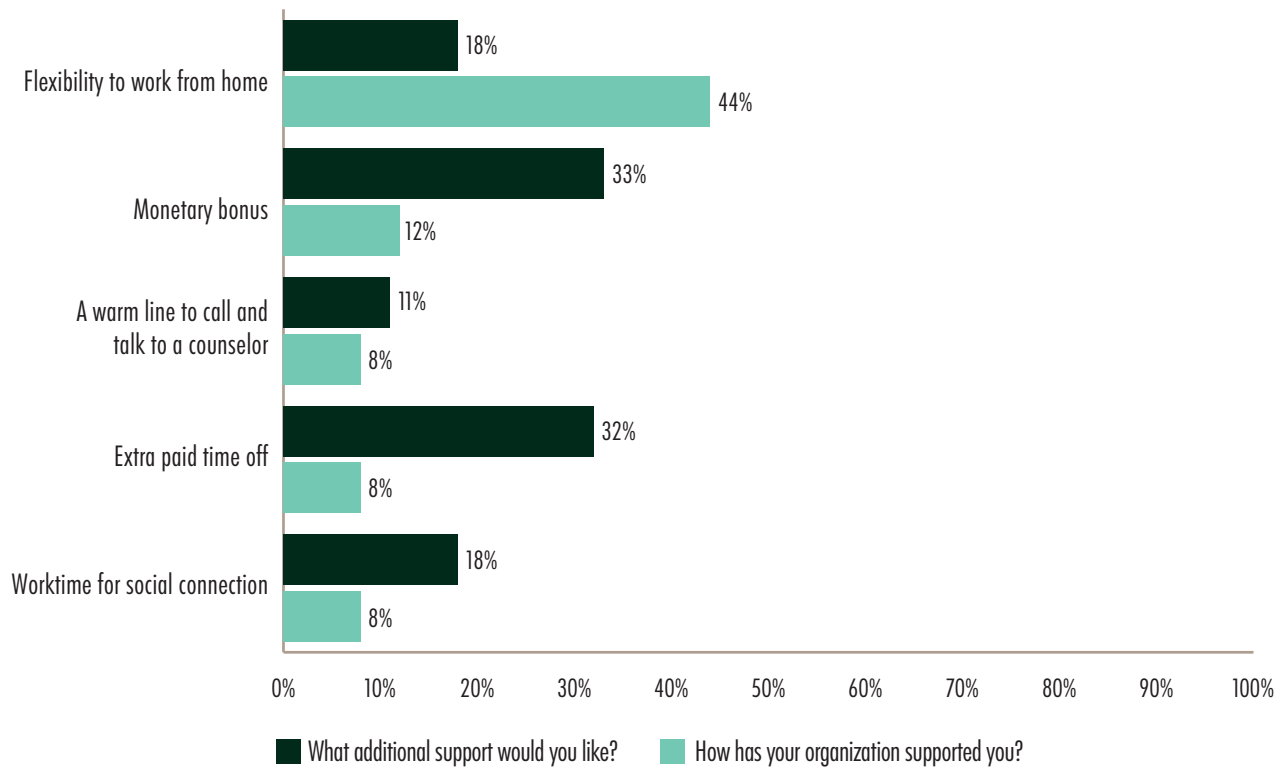
Supervisors mentioned other support they provided their workers, including an Employee Assistance Plan (EAP), opportunities to talk with behavioral health providers, appreciation gifts, more one-on-one check-ins, more all-staff meetings, and more funds and/or opportunities for self-care and work-related social connection opportunities.

When supervisors were asked what they would do with unlimited funds to support their staff, the following themes came up:

- Self-care assistance and training
 - funds to bring someone in to do yoga, meditation, etc. with staff
 - funds for a staff retreat
 - PTO for self-care
 - a sunny vacation
 - cake for staff
 - staff funding for exercise experiences (gym membership, skiing, etc.)
 - lessons learned from elders who have experienced widespread societal disruption, i.e., during World War II
 - life coaching for staff
 - funding for holiday celebrations (holiday party, picnics, etc.)
 - replacement staff so workers can take time off
- Healthcare-related
 - being able to offer health insurance
 - access to behavioral health care for staff and families: a line people could call, same-day appointments, a behavioral health provider who could come on-site
 - funding for an EAP
 - behavioral health coaching

- Working conditions
 - infrastructure development of workspace, i.e., more space, expanded facilities, running water, and a bathroom
 - smaller school classes
- Organizational capacity
 - coaching for director
- Monetary assistance
 - raises
 - discretionary funding
 - funding to keep up extra staff and practices that have been working well during the pandemic
- Capital and equipment
 - better technology (computers, technical assistance, upgrades)
 - high-speed internet connections at home

FIGURE 33
HOW HAS YOUR ORGANIZATION SUPPORTED YOU? WHAT ADDITIONAL SUPPORT WOULD YOU LIKE?



Discussion

Gratitude for Frontline Workers

Responding to the pandemic required immediate, creative, and sometimes enormous changes in Mat-Su organizations and agencies. Under normal circumstances, this type of change would take months to years of planning, strong executive and board leadership, and extensive staff and client training. In March of last year, as Americans were told to “hunker down” in their homes, Mat-Su frontline organizations moved quickly to figure out how to deliver crucial services safely while protecting their workers. One of the most impressive findings from this study was what did not happen – no organization totally abandoned the people they served. Instead, directors and workers figured out new ways to do things, their hearts went out to the people they serve who were struggling, and they provided services regardless of the stresses they faced at home.

Unequal Effects of the Pandemic

The effects of the pandemic weighed differently on organizations and individuals depending on their pre-pandemic financial stability and capacity. Small, less financially stable organizations that offered lower wages, few benefits, and less paid time off were more susceptible to crises. Their workers had higher levels of financial stress, and some employees left, possibly because they could earn more money collecting unemployment, with more time to attend to the needs of their families. Some of these organizations had poorer technological infrastructure, making the move to online services more difficult. Some organizations had less-than-adequate physical space or infrastructure for infection-control practices. For example, organizations without a working bathroom and running water had difficulties implementing the required procedures.

This study showed that many frontline workers were stressed by not feeling financially secure and were worried about making ends meet. Two subpopulations of frontline workers in Mat-Su were examined: non-White workers and workers from households that earn <\$50K per year. Research has shown that non-White and low-income individuals

have poorer health outcomes than their comparison groups. Adults with income below the poverty level are five times more likely to report poor or fair health than those with incomes at least 400% of the federal poverty level. Low-income workers are more likely to struggle with mental and emotional health and concerns over jobs, income stability, and health care coverage.

Additionally, low-income individuals have higher rates of chronic illness, such as heart disease, diabetes, and stroke. A person’s race is also a predictor of their health status. Black, Hispanic, and American Indian people in the United States have shorter life expectancies and higher rates of chronic health conditions than White people. The effects of income and race intersect because people of color tend to have lower income than White Americans (Khullar et al., 2018). There is a relationship between race and pay levels in the United States. According to a research study by the Economic Policy Institute, when controlling for age, gender, education, and region, Black workers are paid 15% less than White workers (Gould, 2020). It is important to note this because before the pandemic, these groups, in general, experienced lower income levels and poorer health outcomes; thus, the effects of the pandemic occurred on top of that baseline. The data collected for this study are not extensive enough to ascertain all the factors contributing to the higher financial stress experienced by non-White workers compared to White workers. However, the observed gap highlights the need for further research to ensure that programs developed to support workers will effectively meet the needs of all workers, including these subpopulations.

For Mat-Su’s non-White workers and workers from households that earned <\$50K/year, high percentages of workers were worried about having enough food and housing (non-White workers 35%/50% and lower-income workers 51%/63%). There is a certain irony that those on the frontlines trying to help residents experiencing a crisis, experienced financial crises themselves.

Other Stressors for Frontline Workers

Other than finances, the frontline workers in the Mat-Su study were stressed by many of the same issues reported in national studies, such as fear of getting infected or infecting others, PPE shortages, and having new roles. Issues that caused considerable stress, mentioned by Mat-Su FLWs, included conflict with others over the risk of COVID-19, pandemic guidelines constantly changing, and difficulty finding childcare. Workers were equally stressed by the loss of many protective factors that typically help a person cope during difficult times, such as being disconnected from friends and family and being unable to collectively perform cultural practices in times of celebration and sadness. Finally, 17% of FLWs stated that they needed behavioral health care and were not receiving it (30% for lower-income FLWs and 20% for non-White workers).

The Pandemic's Effect on Clients/Patients/Students

This study did not collect data from clients/patients/students/families in Mat-Su. The information reported here reflects the impressions of service providers. Changes in service delivery (i.e., the virtual delivery of services, the physical barriers that masks and other PPE create) altered the level of connection FLWs have with the people they serve. Virtual delivery of services helped those without transportation and appeared to work well for some services; however, doing group work or making casual connections with peers and others in center-based services became almost impossible when those centers closed. Populations severely affected by changes in service delivery appeared to be high-risk children, older residents, and people with disabilities – all groups that have lower levels of contact with service providers and teachers.

Supporting Workers

Frontline organizations supported each other and came together for regularly scheduled meetings, sharing information, PPE, and collaborating on

service delivery. Directors supported staff by allowing them to work from home, providing opportunities for self-care or celebratory activities (i.e., massage chair, special meals), and having one-on-one meetings. A small percentage of organizations provided bonuses and extra time off. The most common supports that FLWs requested were the opportunity to work from home, monetary bonuses, and extra paid time off. When directors were asked what they would do if they had unlimited funding, their answers focused on providing self-care opportunities to their staff, offering health insurance and Employee Assistance Plans, and increasing access to behavioral health support. They also wanted to pay their workers more, to improve the infrastructure of their places of employment, and to retain some of the practices made possible by COVID-19 funding, such as putting up homeless clients in hotels.

In summary, some of the key findings from this study are:

- Frontline organizations successfully figured out a way to continue to deliver services. Some of those discoveries have had silver linings and may continue after the pandemic.
- Frontline workers, especially non-White workers, and those from low-income households, experienced financial and childcare-related distress at higher levels than other workers.
- Some frontline workers did not feel appreciated, which was further exaggerated by conflict within their community, families, and workplaces over people not agreeing about the risk of COVID-19.
- As of the date of this report, there is a group of FLWs who are exhausted, experiencing compassion fatigue, burnout, or secondary trauma who needs behavioral healthcare and support.

The following section will provide recommendations on how the Mat-Su Health Foundation can help to support frontline organizations and workers.

Recommendations

The recommendations were created in response to the findings of this report. They should be viewed from multiple perspectives: during the pandemic, in the “aftermath” of the pandemic, and before the next pandemic or other public health crisis. The recommendations address all three situations.

Community/Statewide Infrastructure Recommendations

1. Assist in the creation of local and state public health data, strategy, and management plans to address future public health crises:

a. In collaboration with Matanuska-Susitna Borough, fund the cost-benefit analysis of the borough adopting public health powers.

Organizations and service providers mentioned the stress caused by constantly changing mandates and guidelines related to COVID-19 and the struggle to meet the immediate need for PPE. Stress levels were exacerbated by the national politicization of the risk that COVID-19 posed. It is crucial to have a local and trusted science-based source that helps in the immediate response to a public health crisis. A centralized regional approach to public health, led by the borough government, could streamline the response to future public health crises by channeling the mandates from the Centers for Disease Control and Prevention and the Alaska Department of Health and Social Services into one local and trusted social media platform. This would allow the borough to issue local mandates, coordinate the public health emergency response boroughwide, and maintain an emergency stockpile of PPE and other public health supplies. For the borough to secure “health powers,” residents must concur in a ballot initiative, or the legislature could vote to grant the powers to the borough.

b. Continue to advocate for sufficient funding to support a robust public health infrastructure in Alaska, including the

support for increased public health funding in the State budget, robust staffing of public health offices, and the encouragement of local public health efforts.

A robust public health system can reduce mortality from preventable causes, like COVID-19 or other infectious diseases, and from the chronic underlying conditions that make these diseases more deadly. The system does this by implementing prevention, preparedness, and surveillance systems. State public health funding in 2014 was \$28 million per year for public health nursing and \$7.6 million for epidemiology. In 2020, this spending was \$22 million and \$2 million. While the 2014 budget included funds for 110 public health nurses, the 2020 budget funded only 90 nurses, and not all these positions were filled (Associated Press, 2020). Alaska has high percentages of residents having Adverse Childhood Experiences, higher death rates for non-Whites, lower rates of childhood and adult flu vaccinations, low healthcare provider-to-resident ratios, and higher smoking rates. These risk factors can all exacerbate a public health crisis like the recent pandemic (County Health Rankings, 2021).

c. Advocate for the necessary state and federal policy and regulatory changes that allow for virtual delivery of primary care, medication management, and behavioral health.

Study findings revealed that the virtual delivery of physical and healthcare services helped decrease the longstanding transportation barrier that prevented some Mat-Su residents from receiving services. The 2016 Mat-Su Community Health Needs Assessment found that lack of transportation was the leading social determinant of health preventing residents from receiving healthcare (Mat-Su Health Foundation, 2016).

2. Promote health equity, especially racial equity, through ongoing health-equity assessment and work internal to the Foundation. With Foundation funding and backing, convene a community-wide health equity advisory group to carry forward this work for community change.

National and Alaskan data show that people from racial and ethnic minority groups are at increased risk of contracting COVID-19 and dying from the disease. Nationally, American Indian and Alaska Native people have died at 1.4 times the rate of White people. Many individuals who identify as American Indian/Alaska Native have experienced levels of social determinants of health that predispose them to economic, physical, and emotional health risks and disease. According to the CDC, the factors that contribute to risk are discrimination, lack of access due to being uninsured, lack of transportation, difficulty affording childcare, or lack of PTO. Other barriers include communication, language, and cultural differences between patients and providers, along with high levels of distrust among minority groups for healthcare systems and providers. A community-wide effort supported by the MSHF should focus on promoting equitable access to healthcare and ensuring that people have the necessary conditions to maintain health and wellness, including earning a living wage and not having to live with daily discrimination (CDC, 2021).

Organization-Level Recommendations

3. Proactively provide funding to bring frontline organizations up to a minimum standard of operations, including paying workers a living wage and providing health insurance and employee assistance plans.

The pandemic laid bare the inequalities in our society as was apparent at both the organizational and individual worker levels. Organizations with emergency funds, discretionary income, capacity to write

proposals for COVID-19 funding, and robust virtual and physical infrastructure had an easier time making changes quickly and supporting their workforce.

Promoting a living wage can benefit both the Mat-Su community and the frontline workers who provide invaluable services to the community. Workers whose households earned greater than \$50K per year had less financial stress during this time and fewer worries over childcare issues. Mat-Su has an income inequality ratio of 4.5 compared to a ratio of 3.7 for the top U.S. county and 4.1 for Alaska as a whole. This ratio compares the household income of residents in the 80th percentile to the income of residents in the 20th percentile. The higher the ratio, the greater the divide between the high and low ends of the household income spectrum. Inequality is not only detrimental for the lowest-earning residents, but it also has broad health impacts on mortality, poor health status, and increased cardiovascular disease risk. From a community perspective, high levels of inequality can decrease social connectedness, trust, and a sense of community for all residents (County Health Rankings, 2020). The sectors most affected by financial stressors were the early learning/childcare sector and the CW/DV/SA sector. These sectors have consistently paid low wages, although their workers do crucial work for our community.

Worker-Level Recommendations

- 4. Provide organizations with funding to continue to pay furloughed workers, workers who must quarantine, and those whose hours have been cut. Additionally, support organizations in providing severance packages to help workers who are laid off.** Many nonprofit organizations do not have funds for severance packages when they lay off workers or to pay workers who have run out of PTO or sick time during a furlough.
- 5. Provide discretionary grants to organizations to be used for self-care, healing, and cultural activities.** Self-care and cultural activities

build self-regulation, mindfulness, and social connectedness, all of which help mitigate the impacts of stress and foster wellness and connectedness in times of heightened stress and isolation. Some healthcare facilities have established calming places at work for staff to recover on difficult days with tranquil music and areas to stretch and meditate. Discretionary grants to frontline organizations can further these practices and help boost employee morale, connection, and self-care.

6. Create a system that ensures that frontline workers have access to behavioral health support.

a. The Foundation should identify and fund sources of behavioral health support that could be made available to all frontline organizations for their workers. Due to a workforce shortage of behavioral health providers in Mat-Su, it is necessary to use virtually-delivered behavioral healthcare services from outside of Mat-Su and, possibly, Alaska. By offering to fund these services for all organizations, the cost of time and effort for individual organizations to create their own will be avoided. For example, Johnson & Johnson Foundation has committed \$300 million to support communities and FLWs with resources that include mental health supports such as free access to tools and apps and a warm line for behavioral health support. Other ideas for support include:

- i.** Access to virtual life coaches
- ii.** Access to virtual behavioral health counseling and medication management
- iii.** The creation of a “Code Lavender” program that offers rapid response emotional support to frontline workers from trained practitioners (Stone, 2018)
- iv.** Make available training/webinars to directors and staff to help them cope with the effects of the pandemic (American Hospital Association, 2020)

- v.** Provide all FLWs with access to a “warm line.” A warm line is a free, confidential line that workers can call for support and to talk with trained staff. These are used when the worker’s situation does not require a crisis line, but they still need support and someone to listen (Mental Health American, 2021)

b. Provide organizations the resources needed to prevent and identify worker burnout, compassion fatigue, and vicarious trauma.

A common emotion that was seen in survey comments and interviews was one of exhaustion. Frontline workers had to deal with stress, fear, and worry at work, in addition to financial, child-related, and other pandemic stressors at home. Even before the pandemic, there was no organized effort to support Mat-Su’s workers experiencing the secondary and vicarious trauma inherent in their line of work. Vicarious trauma is defined as negative changes in the worker’s self-image, view of others, and the world, due to repeated exposure and empathic engagement with client/patient stories of trauma. Caring for people in crisis can cause compassion fatigue that results in empathetic strain and exhaustion. These conditions can be screened for and assessed, and workers can be provided personal and professional support. Trained consultants can identify tools and educate organizations on proper protocol for addressing burnout, compassion fatigue, and vicarious trauma. A good resource is the Headington Institute (Headington Institute, 2020). Additionally, a supportive organizational culture can help build stress-resistance by including worker well-being as an organizational value along with the values of personal, family, and work-life balance (Quitangon, 2019).

One source of assistance with this recommendation may be the faith community in Mat-Su. The American Hospital Association recommends using spiritual and emotional care services to address vicarious trauma. (American Hospital Association, 2020).

7. Celebrate and appreciate the frontline

workforce. Several frontline workers mentioned the “lunch hugs” provided by the Foundation as a wonderful show of support. A “lunch hug” is when the Foundation delivered food to the frontline organization to show appreciation and support. During the pandemic, nationally, most of the attention focused on frontline healthcare workers. In an interview, a child welfare worker stated that her profession feels like an unrecognized frontline worker. All the sectors included in this report should

be appreciated for going “above and beyond” in service to their community during the pandemic. The show of appreciation could be provided directly to the organization and communicated to the entire community. The Foundation could show appreciation to other frontline workers, like child welfare workers, through a media campaign with printed signs, radio interviews, and spotlights and social media campaigns highlighting the “unsung” heroes of COVID-19.

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Appendix B: Interview Guide

Name of organizations:

Position of interviewee:

Hello, my name is _____ and I am working with Actionable Data Consulting to do a project for the MSHF. The MSHF is very concerned about the toll that the pandemic is taking on our community – especially the frontline workers in both healthcare and social services, such as yourself. We are doing interviews and a survey or focus groups with the health and social services workforce to find out more about the behavioral health effects of the pandemic on workers. The goal of this project is to understand how MSHF can support our local workforce with the stress and other behavioral health needs that have been caused or amplified by the pandemic for themselves, their families, and the people they serve.

I would like to talk to you today to understand what you have been seeing at your organization - and also to see if you would like to have your staff participate in a survey where they can tell us about their experience. Our interview today will only take about 30-45 minutes. Your answers are confidential and will not be associated with your name – we will report results by the sector of the work – such as education, senior services, behavioral health, physical health, etc. Would you like to participate?

1. We are interested in both the positive and negative effects of the pandemic on your organization and work. I am going to start with the positive. In your opinion, has there been a “silver lining” for your organization related to this pandemic? If so, please explain.
2. Is there anything that you would want to keep doing that has been started during the pandemic?
3. What has surprised you the most related to your work during the pandemic?
4. How has the pandemic affected how you do your work?

5. Has the need for your services increased during the pandemic? If so, please explain.
6. Have the characteristics of the client/patients you serve changed during the pandemic?
7. What has been the hardest thing for your organization related to the pandemic?
8. How has this experience affected the behavioral health of you and your staff/volunteers?
9. Are certain employees/volunteers affected more than others? If so, who and please explain.
10. What about the behavioral health of your clients/patients?
11. How has your organization been working to support staff/volunteers during this time?
12. If you had unlimited funding to support your staff to make it through this time, what would you do for them?
13. Is there any assistance you need to make sure that your staff can get behavioral health care and support during this time? (also ask if their staff has health insurance benefits)
14. What else would you like the Mat-Su Health Foundation to know?
15. Would you be interested in having your staff fill out a survey related to this project? Would you rather have us do a focus group that you set up with your staff, (we could do it at a staff meeting)?

If they say “yes” to – say that we will be in touch to arrange the next steps. We will send them a survey link that they can send to their staff/volunteers. If they want a focus group - we will be in touch and we will ask them to schedule the group and then we will attend virtually.

Appendix C: Worker Survey

Mat-Su Health Foundation COVID-19 Workforce Survey

1. In what sector do you work? (select the one that represents the majority of your work)

- Early learning and childcare
- Education
- Behavioral health
- Physical health
- Social supports
- Youth prevention and resilience-building
- Emergency Services
- Domestic violence, sexual assault, and/or child welfare

2. Overall, considering all the possible ways your life may have been impacted by the COVID-19 pandemic, how much has the pandemic impacted your day-to-day life?

- It has not impacted my life at all
- It has impacted my life a little
- It has moderately impacted my life
- It has extremely impacted my life

3. Have you been diagnosed with COVID-19 illness?

- Yes, I was diagnosed and had no or minimal symptoms
- Yes, I was diagnosed and managed symptoms effectively at home
- Yes, I was diagnosed, with severe symptoms and required brief hospitalization
- Yes, I was diagnosed, with severe symptoms that required me to be in the hospital on a ventilator
- No, I have not had COVID-19

4. Have you experienced stress related to the pandemic?

- No, no stress at all.
- Yes, mild stress such as occasional worries or minor stress-related symptoms such as feeling a little anxious, sad, angry, or mild trouble sleeping.
- Yes, moderate stress with frequent worries, often feeling anxious, sad, or angry, or some trouble sleeping.
- Yes, severe stress with constant worries or feeling extremely anxious, sad, or angry, or frequent trouble sleeping.

5. This question is related to your stress level related to **general pandemic practices**. Please identify your level of stress for each topic.

	0 - This doesn't apply to me	1 No stress	2 A little stress	3 Moderate stress	4 A lot of stress	5 Extreme stress
Not being able to get the vaccine soon enough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to wear a mask out in public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeing others not wearing a mask out in public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My children having to attend school in-person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My children having to attend school virtually	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a loss of income if I get sick from the coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conflict between family members in my household	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to get together as much or at all with family members during the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to get together as much or at all with friends during the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not having places to socialized indoors in my community that are open	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to travel away on vacation due to the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. This question is related to your stress level related to the **COVID-19 virus**. Please identify your level of stress for each topic.

	1 No stress	2 A little stress	3 Moderate stress	4 A lot of stress	5 Extreme stress
The risk of me getting COVID-19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The risk of family/friends getting COVID-19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The risk of me carrying the virus and giving it to someone else	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. How has your access to mental health care changed since March 1, 2020?

- I haven't needed care since March 1, 2020.
- I need care but I haven't tried to access care
- I have tried to access care and I am receiving it
- I have had mild changes to how I access care, such as appointments moved to telehealth instead of in-person visits.
- I have had moderate changes to how I access care, such as delays in my appointments or getting prescriptions with some impact on my health.
- I have had severe changes to how I access care; I have been unable to access needed care with impact on my health.

8. How many paid employees does your organization have?

- 0-9
- 10-24
- 25-49
- 50-74
- 75-100
- More than 100

9. What is your role in the organization?

- Physical or Mental Healthcare Provider
- Administrative/Support staff
- Manager/Director
- Other front-line staff member
- Other - Write In

10. Some organizations have reported that the pandemic has had some positive effects on their work. Please check all answers that apply to your organization.

- I can't think of anything
- We have a new way(s) to deliver services
- My organization has received additional funding
- Staff are more connected to each other using virtual means
- Work is conducted more efficiently
- I feel more supported as a staff member
- Staff are working more as a team
- Other - Write In

11. What has your organization done to support staff during this time?
(Check all that apply)

- Extra paid time off
- Monetary bonus
- Flexibility to work from home
- A "warm-line" I can call to talk to a counselor
- Free, unlimited visits with a counselor
- Paying for high speed internet service at my house (for my work)
- Paying for high speed internet service at my house (for my family)
- Funds for each staff member to spend on healing and self care activities
- Incentives/assistance for staff to get vaccinated
- Special meals/food
- Work time for social connection with other staff
- More one-on-one check-ins with my supervisor or team meetings
- Discretionary funds for the organization for staff self care, food, and social connection activities
- I can't think of anything
- Other - Write In

12. What additional support would you like at work? (Check all that apply)

- Extra paid time off
- Monetary bonus
- Flexibility to work from home
- A "warm line" where I can call to talk to a counselor
- Free, unlimited visits with a counselor
- Paying for high speed internet service at my house (for my work)
- Paying for high speed internet service at my house (for my family)
- Funds for each staff member to spend on healing and self care activities
- Incentives/assistance for staff to get vaccinated
- Special meals/food
- Work time for social connection with other staff
- More one-on-one check-ins with my supervisor or team meetings
- Discretionary funds for the organization for healing, food, and social connection activities
- I can't think of anything
- Other - Write In

13. This question is related to your stress level **about general pandemic practices at work**.

Please identify your level of stress for each topic.

	0 - This doesn't apply to me	1 No stress	2 A little stress	3 Moderate stress	4 A lot of stress	5 Extreme stress
Having to work from home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to work in-person and fearing being infected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

and feeling being infected

Having to wear a mask (and/or other protective gear) at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not having a large enough space at work to social distance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not having enough protective gear to wear at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not having good ventilation at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to get physically close to clients/patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a higher need for the services we provide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having clients/patients with more complex needs during the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling conflict with coworkers about the level of risk presented by the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling conflict with clients/patients about the level of risk presented by the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having guidelines related to the coronavirus constantly changing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeing clients/patients struggle more during the pandemic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The risk of getting the coronavirus at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The risk of bringing the coronavirus home to my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Money and/or "paid time off" lost from having to quarantine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. What has been the hardest thing for you as a worker during this pandemic?

15. What do you think has been the hardest thing for your clients/patients?

16. How old are you?

17. Are you currently covered by any of the following types of health insurance or health coverage plans? Check all that apply.

- Insurance through my current employer
- Insurance through a former employer
- Insurance through a family member's employment
- Insurance purchased directly from an insurance company, including marketplace coverage (through yourself or another family member)
- Medicare, for people 65 and older, or people with certain disabilities
- Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability
- TRICARE or other military health care
- VA (including those who have ever used or enrolled for VA health care)
- Indian Health Service
- Other - Write In

18. What is your current gender identify?

- Male (men and boys)
- Female (women and girls)
- Non-binary/third gender
- Transgender
- Intersex people (indistinctly identifiable gender)
- Self-identify

- Prefer not to answer

19. What is your race - defined as groups of people who identify with each other based on common ties of ancestry, homeland, or culture or by certain traits? (Check all as appropriate)

- Alaska Native/Indigenous
- African descent (i.e. Black/African America)
- Asian descent (i.e. Chinese/Japanese/Korean/Philippine/Thai)
- European descent (i.e. Caucasian/White)
- Eastern Europe descent (i.e. Russian, Ukrainian)
- Hispanic (Mexican American/Latino)
- Indian American
- Latin American descent (i.e. Spanish/Portuguese)
- Middle Eastern descent (i.e. Arabian/Egyptian/Syrian)
- Native American Indians/Indigenous Native Hawaiians
- Pacific Islanders (i.e. Guam/Samoa)
- Other - Write In

20. What is the highest level of education you have completed?

- Less than high school
- Some high school
- Completed high school or GED
- Some college, associate degree, or technical degree
- Bachelor's degree
- Any post graduate studies

21. Please check the box that most closely reflects your household yearly gross income (income before taxes),

- \$0-\$24,999
- \$25,000 - \$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- \$100,000 or greater

22. How many family members are supported by the household income you just reported?

23. Has your household income changed since March 1, 2020?

- Yes, my household income has increased
- No, there have been no changes to my household income
- Yes there have been small changes, but I am able to meet all my needs and pay bills
- Yes, there have been moderate changes and I have made cuts, but I am able to meet basic needs and pay bills
- Yes, there have been severe changes and I am unable to meet basic needs or pay bills

24. This question is related to your stress level related to things that you are worried may happen. Please identify your level of stress for each possibility.

	Not applicable to me	1 No stress	2 A little stress	3 Moderate stress	4 A lot of stress	5 Extreme stress
Someone in my household (including me) losing their job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to continue to pay rent or mortgage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to afford my usual household bills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not having enough food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to afford my medical bills if I get sick from coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a loss of income if I get sick from the coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conflict between family members in the household	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to do at home learning with my children while working as well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to accommodate for my child's school switching between home and at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Finding/keeping needed childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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