Dignity Health.
St. Joseph's Hospital and Medical Center

A member of CommonSpirit

2025 Community Health Needs Assessment

Dignity Health St. Joseph's Hospital and Medical Center

Adopted April 2025

MARICOPA COUNTY
PUBLIC HEALTH

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Executive Summary

Community Health Needs Assessment (CHNA) Purpose Statement

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by Dignity Health St. Joseph's Hospital and Medical Center (SJHMC). The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a CHNA at least once every three years.

CommonSpirit Commitment and Mission Statement

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

CHNA Collaborators

SJHMC partnered with Maricopa County Department of Public Health to conduct this CHNA, which was developed by Maricopa County Department of Public Health. Another key collaborator is Synapse, a coalition of non-profit and federally qualified health care providers that work together to collect data and conduct CHNAs to guide community investments. The following organizations are part of the Synapse Coalition:

- Adelante Healthcare
- Banner Health
- City of Hope
- Circle the City
- Dignity Health
- Mayo Clinic
- Native Health
- Neighborhood Outreach Access to Health
- Phoenix Children's
- Valleywise Health
- Vitalyst Health Foundation

Community Definition

Located in the heart of Phoenix, Arizona, SJHMC defines its community as Maricopa County, since the primary service area (PSA) spans the entire county. The PSA is defined by the top 80% of SJHMC's inpatient and outpatient discharges and is outlined by zip codes that encompass all populations, including low-income and underserved groups.

SJHMC is located in Maricopa County, the fourth most populous county in the nation, with a population of over 4.4 million people.[i, ii] Maricopa County spans 9,202 square miles and nearly five percent of Indigenous land from tribes such as the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation.[iii, iv]

Assessment Process and Methods

The health needs of SJHMC were identified through an analysis of primary and secondary data collected by Maricopa County Department of Public Health. To ensure a comprehensive understanding of the community's needs, two rounds of input were gathered from both internal stakeholders and external community partners.

Primary data sources for this assessment include the 2023 community survey,[v] focus groups,[vi] and key informant interviews.[vii] The first round of data collection, conducted in the spring of 2023, encompassed all three data sources.

Secondary data sources include health and social indicators from local, state, and national datasets, covering health outcomes, economic factors, health behaviors, the physical environment, and health care delivery.

Process and Criteria to Identify and Prioritize Significant Health Needs

Phase One

Indicator Review and Simplification

SJHMC's Community Benefit team reviewed a list of common health indicators, streamlining it from 57 to 27 indicators to identify key areas of focus. These areas were chosen based on local leadership priorities and the indicators that reflected the greatest disparities in Maricopa County.

Phase Two

CHNA Prioritization Workshops

In collaboration with Maricopa County Department of Public Health, SJHMC facilitated three virtual, interactive workshops. These workshops engaged both internal and external community stakeholders through the Community Benefit Health Equity Committee (CBHEC) and Health Equity Alliance (HEA). The goal was to align on and prioritize significant health needs. Structured feedback from these workshops helped SJHMC finalize its prioritized health needs.

Phase Three

Final Consensus of CHNA Priorities

In the final phase, input gathered from Phase Two was reviewed and consensus was developed on seven CHNA priorities, which also included several sub-priorities. Throughout the entire process, a health and social equity lens was applied to better help identify health disparities that disproportionately impact certain communities.

List of Prioritized Significant Health Needs

The following statements summarize the priority areas identified by SJHMC, based on data and insights gathered from both primary and secondary sources. While recognizing the health disparities present in the communities they serve, SJHMC focused on areas where they could make the most significant impact.

Mental Health

According to 2022 age-adjusted overall rates, all mental and behavioral disorders ranked #1 for inpatient hospitalization (IP) and #3 for emergency department (ED) visits in the Maricopa County.[viii] The 2023 CHNA survey highlighted anxiety (38.5%) and depression (33.5%) as the top two health issues that had the most impact on respondents and/or those they lived with or cared for.[v]

Social Determinants of Health (Housing, Heat)

The 2022 Maricopa Association of Governments Point in Time Count revealed that the Central Valley experienced the third-highest growth rate for unsheltered homelessness increasing by 78% from 2018 to 2022.[ix] According to the Maricopa County Public Health Heat Dashboard, there were 466 confirmed heat caused and heat contributed deaths in Maricopa County for 2024.[x] The 2023 CHNA survey found that almost 3 in 4 (71.9%) respondents rated access to affordable housing and almost 1 in 2 (47.9%) rated access to places to stay cool during hot months as "Fair" or "Poor" where they live.[v]

Access to Care

In 2022, 11% of the population in Maricopa County were uninsured.[xi] The 2023 CHNA survey found that almost 2 in 5 (35.8%) indicated that in the past 12 months, they were "Sometimes" or "Never" able to get medical care when they need to.

Chronic Conditions (Diabetes, Cardiovascular Disease, Chronic Kidney Disease)

According to 2022 age-adjusted overall rates, diabetes ranked #5 for IP and #7 for ED. Cardiovascular disease ranked #2 for IP, #2 for ED, and #1 for death.[viii] Chronic kidney disease did not rank top 10. The 2023 CHNA survey revealed that over 1 in 4 (25.6%)

indicated diabetes and over 1 in 8 (12.6%) respondents indicated heart disease as health issues that had the most impact on respondents and/or those they lived with or cared for.[v]

Substance Use

According to 2022 age-adjusted overall rates, all drug overdoses ranked #8 for IP, #9 for ED, and #4 for death. Additionally, opioid overdose was ranked #8 for death.[viii] The 2023 CHNA survey revealed that almost 1 in 10 (8.7%) indicated alcohol/substance misuses as a health issue that had the most impact on respondents and/or those they lived with or cared for.[v] Almost 7 in 10 (67.8%) of survey respondents rated access to substance use treatment services as "Fair" or "Poor" in their community.[v]

Cancer

According to 2022 age-adjusted overall rates, all cancers ranked #2 for deaths in Maricopa County.[viii] Cancers with high rates of death in Maricopa County include lung cancer (among the total population); breast cancer (among the female population); and prostate cancer (among the male population).[viii] The 2023 CHNA survey highlighted cancer (13.4%) as one of the top 10 health issue that had the most impact on respondents and/or those they lived with or cared for.[v]

Maternal and Child Health (Preterm Births)

In 2022, there were 5,052 preterm births in Maricopa County, representing 10 percent of live births.[xii] The 2023 CHNA survey highlighted sexual and reproductive health issues (5.2%) as a health issue that had the most impact on respondents and/or those they lived with or cared for.[v]

Violence and Injury Prevention (Fall-related, Assault-related Injuries)

According to 2022 age-adjusted overall rates, fall-related injuries ranked #4 for IP and #1 for ED visits in Maricopa County.[viii] Assault-related injuries ranked #6 for IP, #6 for ED, and #3 for death.[viii] The 2023 CHNA survey identified unintentional/accidental injuries (5.5%) and intentional injuries (2.8%) as health issues that had the most impact on respondents and/or those they lived with or cared for.[v]

A data snapshot of the prioritized health needs selected by SJHMC is summarized below **(Table 1)**. Health indicator disparities are highlighted for each indicator across subgroups by race, age, and sex and by IP ([1]), ED ([2]), and death ([3]) when available. The data on identified significant health needs demonstrate that specific segments of the community are affected differently, experience worse outcomes or elevated risks. This evidence can help ensure that actions to address needs do not overlook those who are disproportionately affected.

Significant Health Needs by Disproportionately Affected Populations			
Indicator	**Race/Ethnicity**	**Age (years)**	**Sex**
Mental Health (Maricopa County data, Source: 2022 HDD[viii], only hospitalization data were reported)			
All Mental and Behavioral Disorders	Black/African American [1] American Indian/Alaska Native [2]	15-24 [1] 25-44 [2]	Male [1,2]
Social Determinants of Health (Maricopa County data, Sources: Maricopa Association of Governments Point-in-Time Count[x], Maricopa County Heat Dashboard[xi])			
Housing and Homelessness	White/Caucasian	25+	Male
Heat-related Illness	White Non-Hispanic	65+	
Heat-related Death		35-49	
Access to Care (Maricopa County data, Source: 2022 U.S. Census ACS[ix])			
Access to Care (Uninsured)	Hispanic/Latino	19-64	Male
Chronic Conditions (Maricopa County data, Sources: 2022 HDD[viii] and 2022 Death Data)			
Diabetes	Black/African American [1,2] American Indian/Alaska Native [3]	45-64 [2] 65+ [1,3]	Male [1,2,3]
Cardiovascular Disease	Black/African American [1,2,3]	65+ [1,2,3]	
Chronic Kidney Disease			

Table continued on next page

Substance Use (Maricopa County PSA data, Sources: 2022 HDD[viii] and 2022 Death Data)			
All Drug Overdoses	Black/African American [1,2] American Indian/Alaska Native [3]	15-24 [1,2] 25-44 [3]	Female [1,2] Male [3]
Indicator	**Race/Ethnicity**	**Age (years)**	**Sex**
Opioid Overdoses	Black/African American [1] American Indian/Alaska Native [2,3]	25-44 [1,2,3]	Male [1,2,3]
Cancer (Maricopa County data, Source: 2022 Death Data[viii], only death data were reported)			
Lung Cancer	Black/African American [3]	65+ [3]	Male [3]
Colorectal Cancer			
Breast Cancer			Female [3]
Maternal and Child Health (Maricopa County data, Source: 2022 Birth Data[viii])			
Preterm Births	American Indian/Alaska Native	N/A	N/A
Violence and Injury Prevention (Maricopa County data, Sources: 2022 HDD[viii] and 2022 Death Data)			
Fall-related Injuries	American Indian/Alaska Native [1] Black/African American [2] White [3]	65+ [1,2,3]	Female [1,2] Male [3]
Assault-related Injuries	American Indian/Alaska Native [1,3] Black/African American [2]	65+ [1] 15-24 [2] 25-44 [3]	Male [1,3] Female [2]

Table 1. Health Indicator Disparities by subgroups of residents living in Maricopa County

Disparities related to *social determinants of health* and *access to care* are presented as **proportions**, with the subgroups showing the highest proportions highlighted. Data for *mental health*, *chronic conditions*, *substance use*, *cancer*, and *violence and injury prevention* are presented as **rates per 100,000 people** from hospital discharge data (HDD), with the highest rates for inpatient hospitalization (IP [1]), emergency department (ED [2]), and deaths [3] identified by subgroup.[viii]

Resources Potentially Available

SJHMC evaluated current programs, partnerships, and resources related to each of the selected health priorities. These resources include community organizations, facilities, and programs, as well as hospital-provided services, that could help address the identified health needs.[xiii] Resources potentially available to support these priorities span various sectors, including community and healthcare organizations, local government agencies, and social services.

The Health Improvement Partnership of Maricopa County is a collaborative effort involving Maricopa County Department of Public Health, public entities, and private organizations around the county, aimed at addressing priority health issues identified through a community health improvement plan. With over 100 partner organizations, the Health Improvement Partnership of Maricopa County is a valuable resource for SJHMC, enabling the sharing of resources, knowledge, and expertise to align efforts for improving health in Maricopa County.

Report Adoption, Availability, and Comments

This CHNA report was adopted by SJHMC's community board in April 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at SJHMC's Community Benefit and Health Equity Department. Written comments on this report can be submitted to the SJHMC's Community Benefit and Health Equity Department at 3033A N. 7th Avenue Phoenix, Arizona 85013 or by e-mail to CommunityHealth-SJHMC@DignityHealth.org.

End of Executive Summary

Introduction

Founded in 1895 by the Sisters of Mercy, St. Joseph's Hospital and Medical Center (SJHMC) was the first hospital in the Phoenix Area. SJHMC is a member of Dignity Health, which is a part of CommonSpirit Health. St. Joseph's is a nationally recognized center for quality quaternary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Norton Thoracic Institute, Center for Women's Health, the Dignity Health – Cancer Institute at St. Joseph's Hospital and Medical Center, and a Level I Trauma Center verified by the American College of Surgeons. The hospital is also a respected center for orthopedics, internal medicine, primary care and many other medical services. U.S. News & World Report routinely ranks St. Joseph's among the top hospitals in the United States for neurology and neurosurgery. As of 2024, SJHMC has 5,743 employees, 512 Employed Faculty Physicians, and 1,135 Credentialed Community Physicians.

Community Health Needs Assessment

Hospitals like SJHMC are required to conduct a community health needs assessment (CHNA) every three years to identify and analyze a community's health needs and resources. This enables the hospitals to develop targeted interventions and improve community health outcomes. In addition to meeting the Internal Revenue Service requirements under the Affordable Care Act, this CHNA reflects Dignity Health's commitment to the community by ensuring that health needs are identified and addressed. The assessment uses the most recent available data for the service area to address the following:

- *Define the community it serves*
- *Assess the health needs of that community and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health*

The CHNA is a comprehensive report on the community's health, identifying the main causes of illness and death and which groups are most affected. SJHMC uses the CHNA to develop its implementation strategy, which outlines how the facility plans to address the identified health needs through available activities, resources, and programs.

Community Definition

SJHMC is located in Maricopa County, the fourth most populous county in the U.S., with a population of over 4.4 million people.[i, ii] Covering 9,202 square miles, Maricopa County is comprised of nearly five percent of Indigenous land from tribes such as the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation.[iii, iv]

SJHMC's community is defined as Maricopa County (outlined in orange below) due to the broad expanse of SJHMC's primary service area (PSA). The PSA is defined by the top 80% of SJHMC's inpatient and outpatient discharges and is outlined in pink by zip codes that encompass all populations, including low-income and underserved groups. During fiscal year 2024, the top 80% of patient encounters at SJHMC came from zip codes listed in **Appendix B. Figure 1** displays a map of SJHMC's defined community.

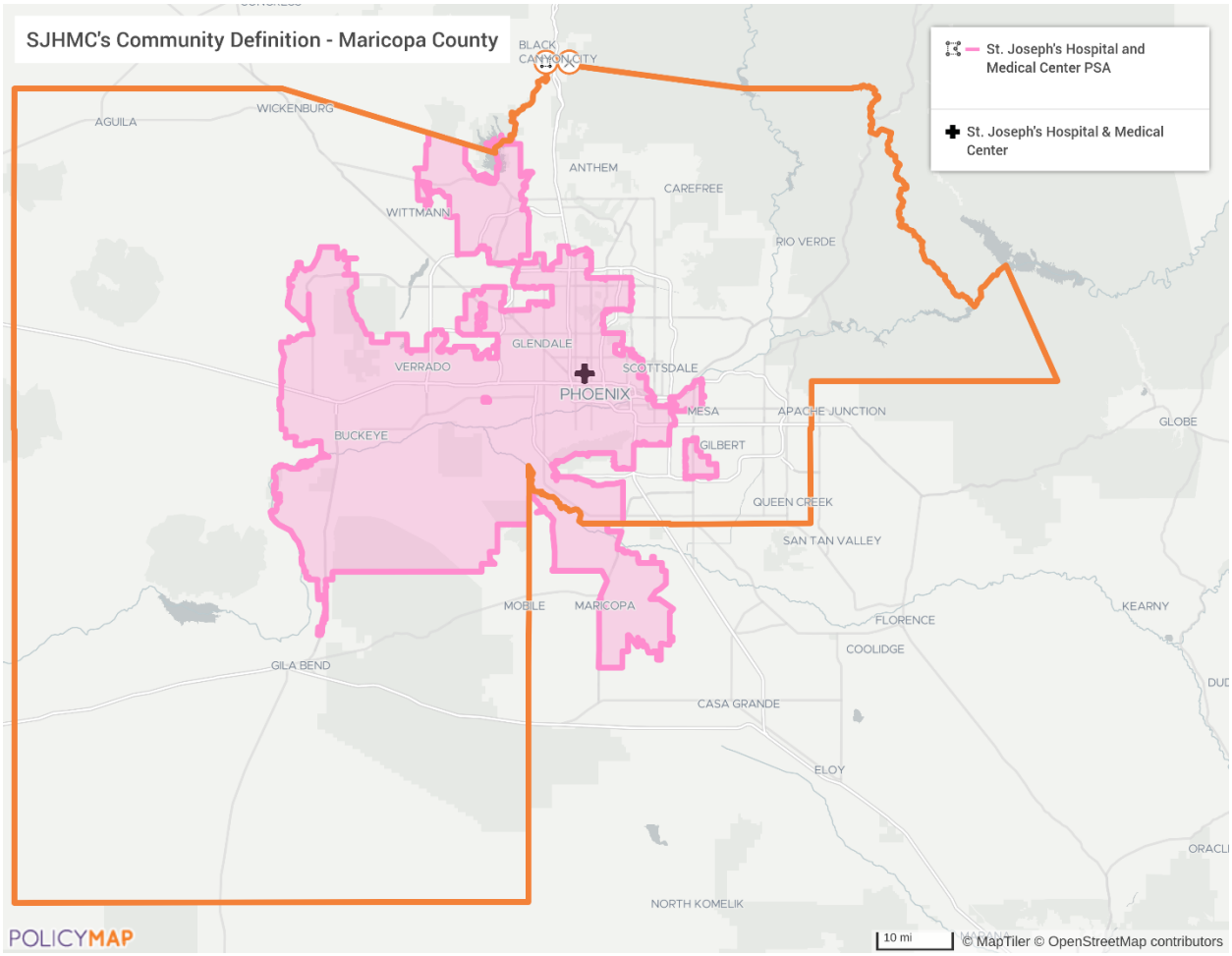


Figure 1. SJHMC's Community Definition – Maricopa County

Demographic and Socioeconomic Profile

Table 2 describes the 2022 demographic and socioeconomic profile of residents in Maricopa County and Arizona.[ix] Maricopa County and Arizona are predominantly an urban and rural community.

	Maricopa County	Arizona
Total Population Size	4,430,871	7,172,282
Population by Race/Ethnicity		
American Indian/Alaska Native (non-Hispanic)	1%	4%
Asian and Native Hawaiian/Pacific Islander (non-Hispanic)	4%	3%
Black/African American (non-Hispanic)	5%	4%
White (non-Hispanic)	53%	53%
Hispanic/Latino	32%	32%
Population by Sex		
Male	50%	50%
Female	50%	50%
Population by Age Group		
0-14 years	19%	18%
15-24 years	14%	14%
25-44 years	28%	26%
45-64 years	24%	24%
65+ years	16%	18%
Languages, among those 5 years and over		
Non-English Languages Spoken at Home	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over		
Less than 9th grade	5%	5%
9th – 12th grade, no diploma	6%	6%
Employment Status		
Unemployed	5%	5%
Median Household Income		
Income	$80,675	$72,581
Poverty		
Below poverty level all ages	12%	13%
Below poverty level all ages under 18 years	16%	18%
Health Insurance Coverage		
Uninsured	11%	11%
Health Insurance Type		
Medicaid	18%	21%
Health Professional Shortage Area	Yes	Yes
Medically Underserved Area	Yes	Yes

Medically Underserved, Low Income, Minority Populations	Medically Underserved, Low Income	
Number of Other Hospitals Serving the Community - 2023	66	138

Table 2. Maricopa County and Arizona Demographic and Socioeconomic Profile - 2022 ACS Census, HRSA MUA Finder, PolicyMap

Medically Underserved Areas

Medically underserved groups are those experiencing health disparities or inadequate access to care, often due to being uninsured or underinsured, or facing barriers, such as language, geographic location, financial constraints, and stigma. This also includes people with limited English proficiency and those who encounter difficulties in accessing care due to transportation issues or cost.[xiv] The Arizona Medically Underserved Areas report, prepared biennially by the Arizona Department of Health Services, helps plan the delivery of primary care services. **Table 3** displays the medically underserved areas from the 2024 Arizona Department of Health Services Arizona Medically Underserved Areas Report.[xv]

Alhambra Village	Laveen Village
Avondale	Maryvale Village
Buckeye	Mesa Central
Camelback East Village	Mesa West
Central City Village	North Mountain Village
El Mirage and Youngtown	Salt River Pima-Maricopa Indian Community
Estrella Village and Tolleson	South Mountain Village and Guadalupe
Fort McDowell Yavapai Nation	Surprise North and Wickenburg
Glendale Central	Tempe North

Table 3. Medically Underserved Areas in Maricopa County

The section uses PolicyMap to show medically underserved areas within Maricopa County, using data from the Health Resources and Services Administration. These areas are designated based on criteria such as a shortage of primary care providers, high infant mortality, high poverty rates, and/or a high elderly population. Medically underserved populations are designated when specific groups face a shortage of primary care health services and encounter barriers, including economic, cultural, or language challenges. **Figure 2** displays medically underserved areas in Maricopa County which include *Wickenburg*, *Gila Bend*, *Sun City*, *Glendale*, and *Phoenix*.[xiv]

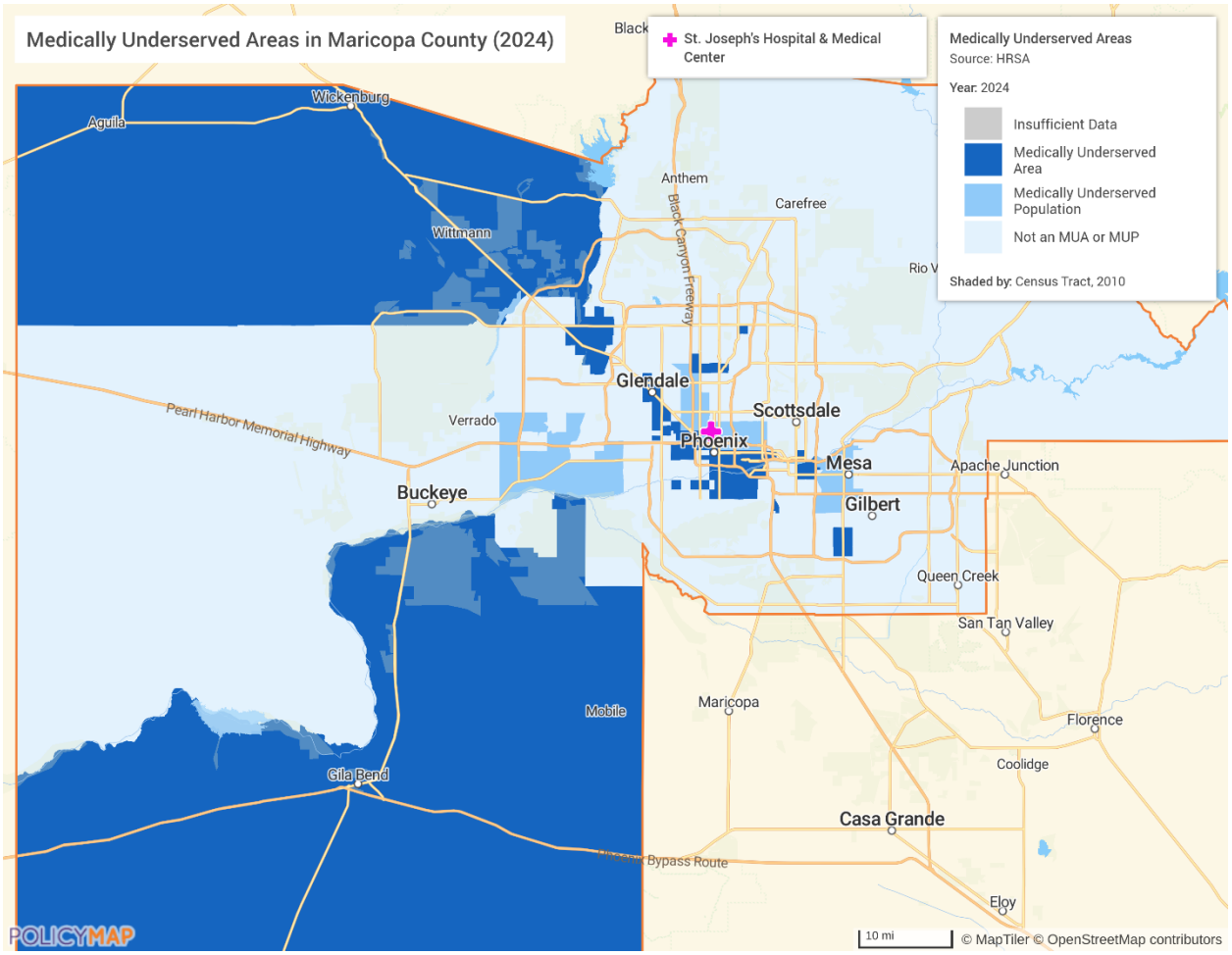


Figure 2. Medically Underserved Areas in Maricopa County

Primary Care and Mental Health Professional Shortage Area (HPSA) Status

Health professional shortage areas impact health care access and overall health outcomes. While these shortages are more common in rural areas due to limited providers and facilities, they also exist in urban communities, driven by poverty, lack of public transportation, and insufficient insurance coverage.[xvi] Identifying these areas helps target underserved communities needing more healthcare resources. According to the Health Resources and Services Administration, health professional shortage areas are defined by three criteria: the ratio of population to healthcare providers, the proportion of the population below the federal poverty level, and travel time to the nearest source of care outside the health professional shortage areas.[xvii]

Figure 3 displays the primary care health professional shortage areas status in Maricopa County in 2023 which include *Aguila*, *Gila Bend*, *Glendale*, *Mesa*, and *Phoenix*. Primary care health professional shortage areas also consider infant mortality rate and low birth weight rate.[xiv]

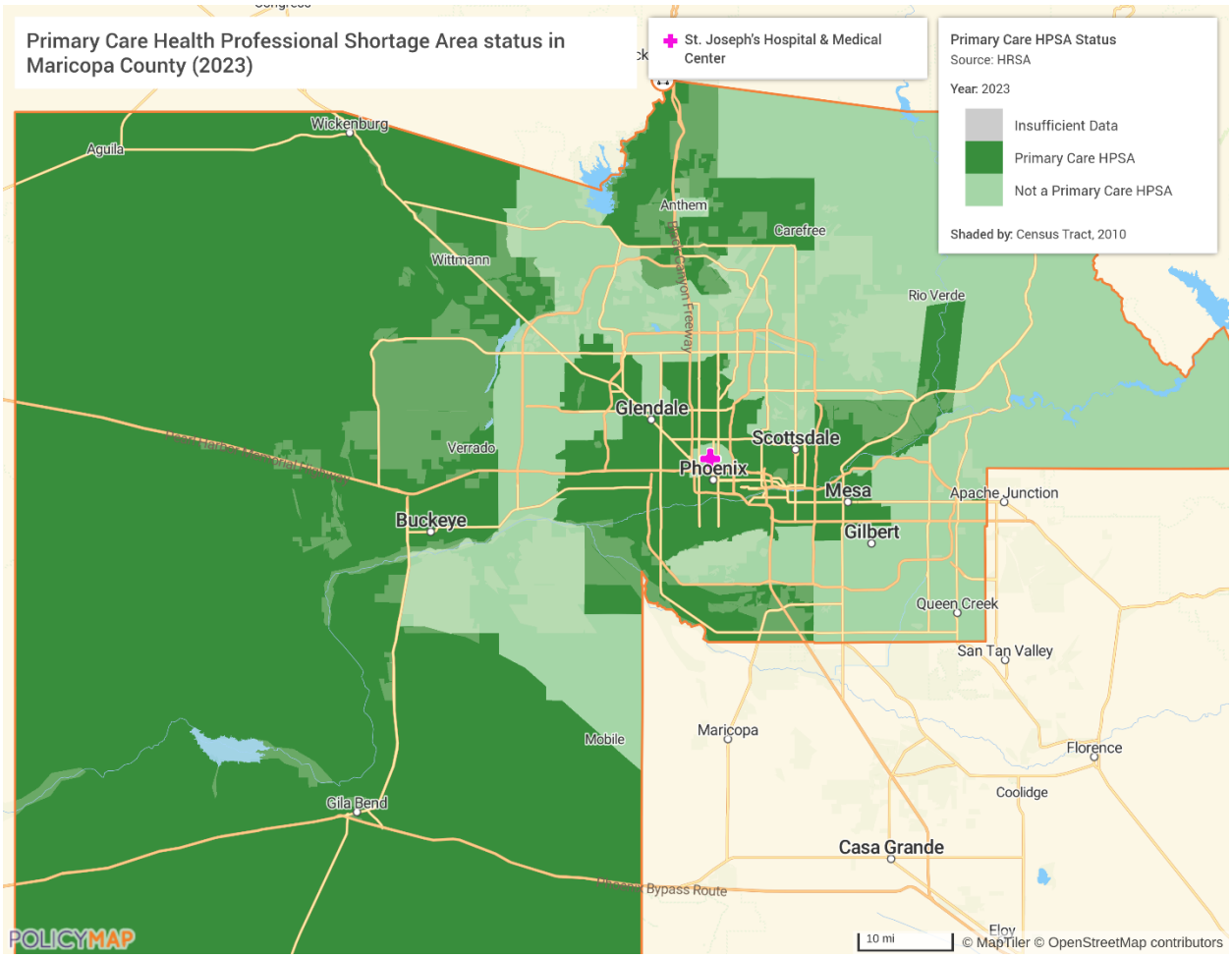


Figure 3. Primary Care Health Professional Shortage Areas Status in Maricopa County

Figure 4 displays the mental health professional shortage areas status in Maricopa County in 2023 which include *Wickenburg*, *Glendale*, *Tempe*, *Mesa*, and *Queen Creek*. Mental health professional shortage areas consider substance and alcohol abuse prevalence, and proportion of the population over age 65 years or under age 18 years.[xiv]

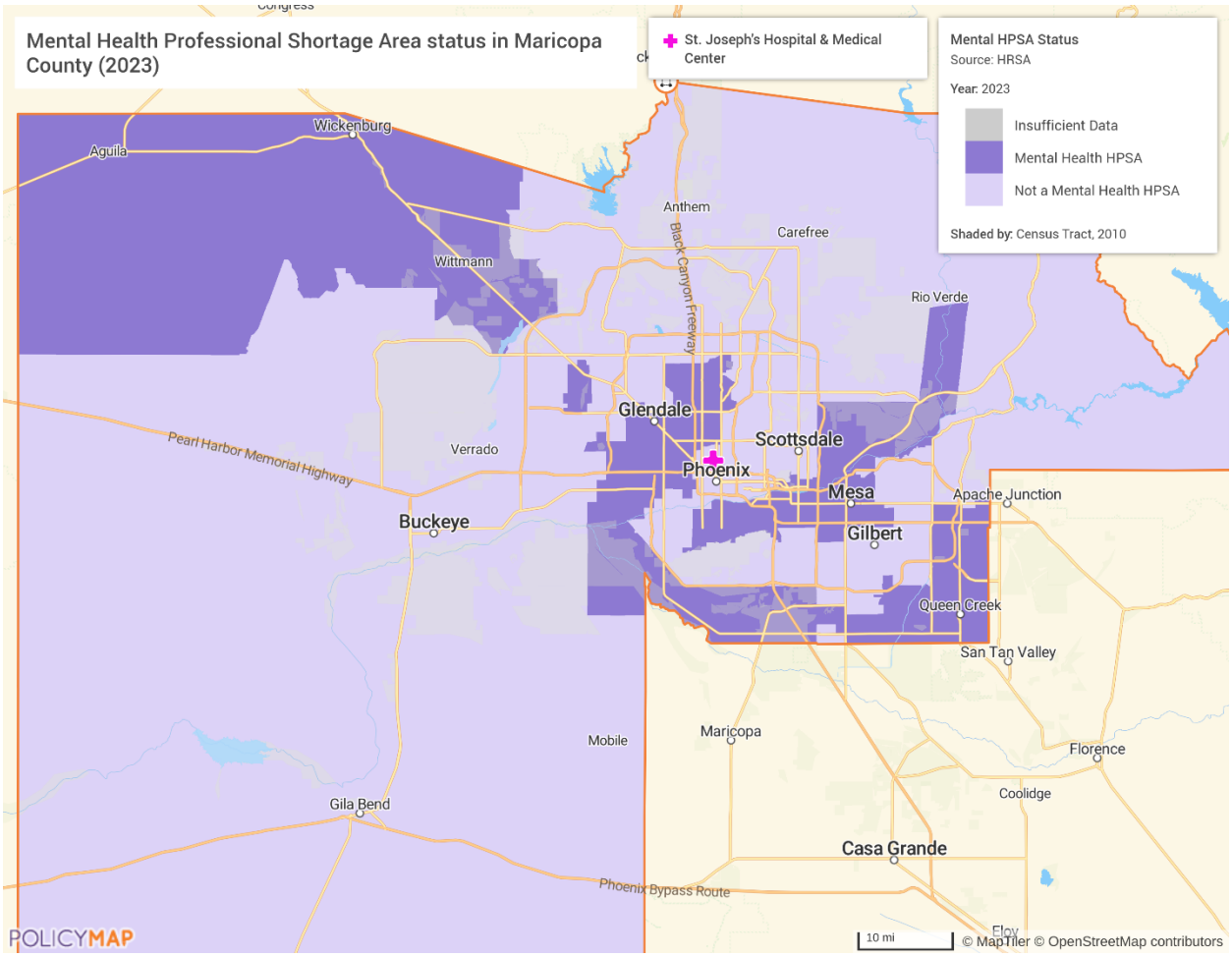


Figure 4. Mental Health Professional Shortage Areas Status in Maricopa County

Assessment, Process, and Methods

Maricopa County health centers and hospitals play a vital role in enhancing the region's health and economy. Beyond providing high-quality medical care, these institutions implement programs that address community-specific needs. Many health care partners serve overlapping populations, leading to collaboration across Maricopa County. As a result, Adelante Healthcare, Banner Health, Circle the City, City of Hope, Dignity Health, Mayo Clinic, Native Health, Neighborhood Outreach Access to Health, Phoenix Children's, and Valleywise Health partner with Maricopa County Department of Public Health through the Synapse Coalition to identify community strengths and address the most pressing health needs through a coordinated CHNA.

As a member of the Synapse Coalition, SJHMC partnered with Maricopa County Department of Public Health to conduct the CHNA process using a mixed-methods approach. This included gathering primary data – such as community input from focus groups, surveys, and key informant interviews – and secondary data, including hospital discharge and vital records data. By integrating both data types, the process ensured high-quality insights through cross referencing multiple sources, allowing for a more comprehensive understanding of community health needs. The following section provides an overview of the primary and secondary data sources.

Primary Data
Community Health Survey | Focus Groups | Key Informant Interviews

2023 Maricopa County Community Health Needs Assessment Survey Overview[v] (Appendix C)

During March— June 2023, Maricopa County Department of Public Health conducted the 2023 CHNA survey and collected over 18,000 surveys. The survey was offered both on paper and online using Alchemer©. It was available in over 14 languages and Braille. The 2023 CHNA survey questionnaire was designed around the following categories:

- Health Rating (Physical/Mental/Connection with Others)
- Experiences with Healthcare
- Health Issues
- Experiences with Discrimination
- Paying for Essentials
- Community Health Rating
- Demographics
- Additional Health Experiences (write-in)

This comprehensive data collection process — from building the survey tool to conducting survey outreach — was accomplished through cross-sector collaboration and expertise between Maricopa County Department of Public Health, CHNA outreach grant recipients, Synapse healthcare partners, and Health Improvement Partnership of Maricopa County community partners. Maricopa County Department of Public Health mobilized intradepartmental staff and an extensive network of community partners to conduct the following:

- Develop an accessible, inclusive, and culturally relevant survey tool through the implementation of a community-based survey tool pilot program
- Build and pivot with regional outreach strategies to aid in collecting survey responses with proportional representation from diverse populations
- Promote and distribute the CHNA survey at community events and in the communities that partners serve

2023 CHNA Focus Groups Overview[vi] (Appendix C)

During June—August 2023, Maricopa County Department of Public Health and its partners contracted with the Southwest Interdisciplinary Research Center at Arizona State University to conduct 46 in-person and virtual focus groups with 366 participants and 309 CHNA supplemental surveys. The purpose of focus groups is to collect more in-depth data about community residents' lived experiences, opinions, and proposed solutions. The focus group design and execution proceeded through five phases: (1) focus group discussion guide development; (2) focus group recruitment and location securement; (3) focus group data collection; (4) analysis and findings methods; and 5) report writing and presentation of findings.

2023 Maricopa County Key Informant Interviews[vii] (Appendix C)

During January—May 2024, Maricopa County Department of Public Health contracted with the OMNI Institute to carry out 24 key informant interviews for the CHNA. The 24 participants who were identified for key informant interviews were selected using purposive sampling. Participants were chosen across geographical regions around the county, and they were in key leadership and senior management roles and could speak to their organization's work in communities (e.g., Executive Director, Deputy Director, Community Outreach and Engagement Supervisor, etc.). Findings from this assessment were grouped into three main categories: community strengths and assets, built environment, and forces of change.

To read the primary data reports listed above, visit maricopahealthmatters.org.

Secondary Data
Hospital Discharge | Vital Records | Supplemental Population Data Sources

Population Health Framework

Many of the complex health issues facing the United States in the 21st century require a focus on the health of entire communities, not just individuals. This need has spurred the adoption of a "population health" perspective. According to the Institute for Healthcare Improvement, population health refers to "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[xviii] The focus on population means addressing the factors that affect both individual and community health. Population health is shaped by a community's social and economic conditions, as well as the quality of its medical care. This CHNA report uses a population health framework to allow for a comprehensive analysis of health determinants and disparities.

Hospital Discharge Data (HDD)

Maricopa County Department of Public Health receives HDD bi-annually from the Arizona Department of Health Services.[viii] HDD includes inpatient hospitalization (IP) and emergency department (ED) discharge data from Arizona hospitals. These data only cover facilities within Arizona, so hospitalizations and ED visits of Maricopa County residents outside the state are not captured. Facilities, such as Veteran Affairs, Indian Health Services, and Outpatient services, are excluded from the HDD. The data presented in this report are specific to Maricopa County residents and are collected based on the patient discharge dates. Since 2015, diagnoses have been coded using the International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10-CM). Hospital discharges represent the number of discharges from facilities in Arizona during a calendar year and do not represent unique patients. Therefore, if an individual was hospitalized multiple times within the year, then they would appear multiple times in the dataset. Most hospitals bill under the "72-hour rule," meaning if a patient visits the emergency department and is admitted as an inpatient within 72-hours, the visits are combined into a single billing account. In this case, the patient would be recorded as an inpatient. However, there are a few exceptions, such as critical access hospitals and certain insurance carriers that use "split billing," which would result in the same patient appearing in both the IP and ED datasets.

Vital Records Data

Maricopa County Department of Public Health receives annual vital records for birth and death data from Arizona Department of Health Services for the previous year. The data in this report pertain to deaths of Maricopa County residents only, including those who

passed away within Maricopa County and those who passed away elsewhere. However, some out-of-state deaths of Maricopa County residents may not be captured due to data sharing between states. Data are reported based on the date of death. Causes of death are defined by using International Classification of Disease, Tenth Revision (ICD-10) codes.

Birth data include all births in Maricopa County, regardless of the mother's residency status. The data presented in this report include births to mothers residing in Maricopa County, even if the births did not occur there. Data are reported based on the date of birth.

Population Data

The American Community Survey by the U.S. Census Bureau measures the social and economic characteristics of U.S. populations. For this assessment, 2022 five-year estimates were used to report demographics for Maricopa County and Arizona. PolicyMap provides geographic data on demographic, social, and health indicators across the U.S. and was used in this assessment to evaluate social indicators within Maricopa County, including medically underserved areas and health professional shortage areas. Healthy People 2030 sets data-driven national objectives to improve health and well-being, and it was used in this assessment to support specific data elements within the CHNA process.

Calculating Rates

Overall rates were calculated for the health indicators in this report, which were derived from the Maricopa County HDD and death data. Additionally, rates by race/ethnicity, sex, and age were calculated to demonstrate health disparities. The rates for the total population and by race/ethnicity and sex were age-adjusted using the 2000 Standard Population to account for variation in age within different groups. The birth indicator (preterm birth rate) was calculated using the total number of live births as the denominator.

Initial Round of Health Indicators

Primary and secondary data were used to assess the current needs of the community they serve. SJHMC's Community Benefit team engaged internal leadership to gather input on the initial round of health indicators. **Table 4** displays the list of 27 health indicators that SJHMC selected for initial evaluation, which doesn't reflect any ranking. For the indicators, hospital discharge and PolicyMap data were used for analysis.[viii, xiv]

Heat	• Heat-related Illness and Death	
Mental Health	• All Mental and Behavioral Disorders	
Chronic Conditions	• Cardiovascular Disease • Chronic Kidney • Diabetes	• Chronic Obstructive Pulmonary Disease • Overweight/Obesity
Substance Use	• Alcohol-related • All Drug Overdose	• Opioid Overdose
Injury	• Assault-related Injuries • Self-Harm/Suicide	• Fall-related Injuries
Birth	• Inadequate Prenatal Care • Low Birth Weight	• Preterm Births
Cancer	• Lung Cancer • Breast Cancer	• Colorectal Cancer
Access to Health Care	• Health Care Coverage • Poverty	• Primary Payer Type
Social Determinants of Health	• Access to Food • Housing; Homelessness • Income	• Transportation • Violence-related

Table 4. SJHMC's Initial Round of Health Indicators

Building on the initial round of health indicators, SJHMC began their CHNA prioritization process, focused on identifying and narrowing down their significant health needs through a health equity lens. This approach was applied during three data presentations, which highlighted the most pressing health disparities within their community. By analyzing indicators stratified by race/ethnicity, age, and sex, SJHMC aimed to ensure a comprehensive assessment of community needs.

Input Solicitation

SJHMC worked closely with key groups, including Maricopa County Department of Public Health, internal committees, and community partners, to ensure the CHNA process identified pressing community needs. Maricopa County Department of Public Health provided detailed health data specific to Maricopa County, including HDD/vital records, social determinants of health, and health behaviors, alongside community-specific data highlighting local and social needs. These data helped identify health disparities and prioritize pressing health issues. Additionally, Maricopa County Department of Public Health supported the development of a prioritization strategy, incorporating best practices from similar activities facilitated with other healthcare partners. The activities were designed to engage stakeholders and ensure their interests were reflected in the process.

The Community Benefit Health Equity Committee (CBHEC) is a subcommittee of SJHMC's community board. It comprises members who provide stewardship and direction for the hospital as a community resource. The Health Equity Alliance (HEA) is a large group of community organizations that SJHMC's community benefit staff bring together quarterly to work on the shared goal of improving the health and well-being of Maricopa County residents while reducing health disparities. For this prioritization process, SJHMC organized three meetings with members of CBHEC and HEA to leverage their expertise and community insights. The full prioritization process is shared in the section "Prioritized Description of Significant Community Health Needs."

CHNA Prioritization Meetings

May 16, 2024 – CBHEC: During this meeting, a scoring activity was conducted to narrow down 27 indicators to 12 indicators. These 12 indicators proceeded into the next phase of the prioritization process.

September 18, 2024 – CBHEC: This meeting involved a similar scoring activity, where the top eight indicators were revealed from the 12 data indicators established at the May meeting. After results were shared, Maricopa County Department of Public Health facilitated a discussion with the committee on whether the identified priorities aligned with their perspectives and experiences. From this discussion, four priorities were finalized, and five additional priorities (from the top 12 reviewed) were identified for consideration in the final phase of the prioritization process.

October 1, 2024 – HEA: During this meeting, data were presented for the top eight indicators established at the September prioritization meeting. Instead of having participants score the indicators, feedback was compiled through an interactive exercise facilitated on Menti. Participants were asked to share their agreement on a scale of one

(strongly disagree) and five (strongly agree) about whether SJHMC should prioritize the presented health needs.

A full list of participating organizations in the prioritization meetings can be found in **Appendix A**. SJHMC invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received. Details of the prioritization process can be found under the section "Prioritized Description of Significant Community Health Needs."

Assessment Data and Findings

This section presents data and findings from the health indicator analysis, community survey, focus groups, and key informant interviews, providing a comprehensive view of the community's key issues and concerns. Where possible, a health equity lens was applied to highlight disparities by race/ethnicity, age, and sex.

Population Indicator Data for Initial Round of Health Needs

Of the 27 total health indicators reviewed by SJHMC during the initial round of prioritization, **Table 5** below ranks 15 indicators with available HDD data (IP/ED) or Death data based on 2022 overall age-adjusted rates per 100,000 population.[viii] Higher rankings below indicate a higher priority in Maricopa County. Color gradients visually distinguish the rankings, while "—" indicates unavailable data. Indicators that ranked **top five** across multiple categories included: *all mental/behavioral disorders, cardiovascular disease, and fall-related injuries*.[viii]

IP/ED/Death Ranking Legend	Top 5	6-9	10+

Indicator	IP	ED	Death
All Mental and Behavioral Disorders	1	3	*
Cardiovascular Disease	2		1
Chronic Kidney Disease	**		
Diabetes	5	7	**
Chronic Obstructive Pulmonary Disease	9	10	6
Overweight/Obesity	**		
Alcohol-related	10	**	9
All Drug Overdose	8	9	4

Opioid Overdose	**		8
Assault-related Injuries	6		3
Self-Harm/Suicide	**		
Fall-related Injuries	4	1	*
Lung Cancer	*		10
Breast Cancer			**
Colorectal Cancer			**

Table 5. Top Health Issue Indicators in Maricopa County

** Only nonfatal (IP and ED) rates were analyzed for All Mental and Behavioral Disorders and only fatal (death) rates were analyzed for cancers.*

*** Indicator did not rank top 10.*

Table 6 displays the initial set of health indicators alongside the populations who experienced the greatest health disparities in IP, ED, and deaths in Maricopa County.[viii] These 2022 age-adjusted rates per 100,000 allow for similar comparisons across groups. The data reveals disparities in Maricopa County.[viii]

- **Race/Ethnicity:** Black/African American and American Indian/Alaska Native populations experienced higher rates across many health conditions such as all mental and behavioral disorders, cardiovascular disease, all drug overdose, assault-related injuries, and cancer.

- **Age:** Older adults (65+ years) had higher rates of cardiovascular disease and fall-related injuries. Youth (15-24 years) and younger adults (25-44 years) showed higher rates of self-harm/suicide and substance use.

- **Sex:** Males had higher rates of all mental and behavioral disorders, cardiovascular disease, and alcohol-related injuries. Females showed disparities in health conditions like chronic obstructive pulmonary disease.

Recognizing these disparities helps SJHMC to create targeted solutions that address the unique needs of each group. By addressing these inequities, SJHMC strives to build a more equitable healthcare system where everyone has the support and resources needed for improved health outcomes. The data below on significant health needs demonstrate that specific segments of the community are affected differently, experience worse outcomes or elevated risks. This evidence can help ensure that actions to address needs do not overlook those who are disproportionately affected.

<table>
<tr><th colspan="4">Significant Health Needs by Disproportionately Affected Populations</th></tr>
<tr><th></th><th>Race/Ethnicity</th><th>Age (years)</th><th>Gender</th></tr>
<tr><td>All Mental and Behavioral Disorders**</td><td>IP: American Indian/Alaska Native
ED: Black/African American</td><td>IP: 15-24
ED: 25-44</td><td>IP/ED:
Male</td></tr>
<tr><td>Cardiovascular Disease</td><td rowspan="2">IP/ED/Death:
Black/African American</td><td rowspan="2">IP/ED/Death:
65+</td><td rowspan="3">IP/ED/Death:
Male</td></tr>
<tr><td>Chronic Kidney Disease</td></tr>
<tr><td>Diabetes</td><td>IP/ED: Black/African American
Death: American Indian/Alaska Native</td><td>IP/Death: 65+
ED: 45-64</td></tr>
<tr><td>Chronic Obstructive Pulmonary Disease</td><td>IP/ED: Black/African American
Death: White</td><td>IP/ED/Death:
65+</td><td>IP/ED/Death:
Female</td></tr>
<tr><td>Alcohol-related</td><td>IP/ED/Death:
American Indian/Alaska Native</td><td>IP/Death:
45-64
ED: 25-44</td><td>IP/ED/Death:
Male</td></tr>
<tr><td>All Drug Overdose</td><td>IP/ED: Black/African American
Death: American Indian/Alaska Native</td><td>IP/ED: 15-24
Death: 25-44</td><td>IP/ED: Female
Death: Male</td></tr>
<tr><td>Opioid Overdose</td><td>IP: Black/African American
ED/Death: American Indian/Alaska Native</td><td>IP/ED/Death:
25-44</td><td>IP/ED/Death:
Male</td></tr>
</table>

	Race/Ethnicity	Age (years)	Gender
Assault-related Injuries	IP/Death: American Indian/Alaska Native ED: Black/African American	IP: 65+ ED: 15-24 Death: 25-44	IP/Death: Male ED: Female
Self-Harm/Suicide	IP/ED: Black/African American Death: American Indian/Alaska Native	IP/ED: 15-24 Death: 45-64	IP/ED: Female Death: Male
Fall-related Injuries	IP: American Indian/Alaska Native ED: Black/African American Death: White	IP/ED/Death: 65+	
Low Birth Weight*	Black/African American	N/A	N/A
Preterm Births*	American Indian/Alaska Native	N/A	N/A
Lung Cancer**	Black/African American	65+	Male
Breast Cancer**			Female
Colorectal Cancer**			Male

Table 6. Populations with the Greatest Rates of IP/ED/Death in Maricopa County

** Birth indicators do not have nonfatal or fatal data available.*

*** Only nonfatal (IP and ED) rates are analyzed for All Mental and Behavioral Disorders and only fatal (death) rates are analyzed for cancers.*

Community Input

The previous section's population data highlighted key health issues contributing to hospitalization and death. This section shifts focus on community-based data, shedding light on the social context and health concerns most affecting residents in Maricopa County. Maricopa County Department of Public Health's 2023 CHNA survey provides insight into the services, opportunities, and information that SJHMC could use to improve community health and wellness.

Figure 5 displays 2023 CHNA survey data, highlighting the proportions of top health issues, access to care solutions, and the lowest and highest rated community assets as reported by survey respondents and/or the people they lived with or cared for.[v]

Top Health Issues		Top Access to Care Solutions	
Anxiety	39%	Evening or weekend appointments	46%
Depression	34%	Lower out of pocket costs for services	42%
High Blood Pressure	32%	More appointments available	38%
Lowest Rated Community Assets		**Highest Rated Community Assets**	
Access to affordable housing	37%	Access to parks and green spaces	56%
Access to quality public transportation	30%	Opportunity to participate in religious, spiritual, or cultural events	55%
Access to quality and affordable childcare	28%	Feeling safe in your home	55%

Figure 5. 2023 CHNA Survey Top Outcomes

During the 2023 CHNA survey, participants rated various aspects of their community using the options "Very Good," "Fair," "Poor," or "Not applicable." In Maricopa County, the lowest and highest-rated community assets by race/ethnicity and special population are summarized below.[v] **Appendix F** displays the lowest and highest-rated community assets for **all** race/ethnicity and special populations.[v]

Lowest-Rated Community Assets

Race/Ethnicity:

- *Access to affordable housing* received the lowest rating by all race categories
- *Ability to communicate with local leadership* was the lowest rated community assets by those who identified as American Indian or Alaska Native, Multiracial, Black or African American, and Middle Eastern or North African.
- *Access to quality public transportation* was the lowest rated community asset by those who identified as Asian and White.

Special Population:

- *Access to affordable housing* was the lowest rated community asset for those who identified as Lesbian, Gay, Bisexual, Transgender, or Questioning or Queer (LGBTQ), foster youth/former foster youth, homebound, seniors living in a group, persons with a disability, persons experiencing homelessness, and refugee, immigrant, and migrant populations.
- *Quality public transportation* was the lowest rated community asset for those who identified as elderly and military member/veterans. While *access to quality and affordable childcare* was identified by those who identified as caregivers.

Highest-Rated Community Assets

Race/Ethnicity:

- *Feeling safe in your home* and *access to parks and green spaces* were the first or second highest rated community assets by participants of all race/ethnicities.

Special Population:

- *Feeling safe in your home* and *opportunity to participate in religious, spiritual, or cultural events* were the first or second highest rated community assets by participants of most special populations.

Figure 6 highlights themes identified from the 2023 CHNA focus groups with 366 participants from underserved and minority populations.[vi]

Figure 6. 2023 CHNA Focus Group Themes

Figure 7 highlights key themes from the 2024 key informant interviews with 24 key informants from 15 business, health, and community sectors.[vii]

Community Strengths and Assets

Community strengths: resiliency, resourcefulness, commitment, knowledge, connections, pride, cultural cohesion

Organizational/agency strengths: robust health network, non-profit organizations, government efforts, educational institutions

Opportunities for growth: barriers to basic needs, environmental and criminal justice disparities, lack of awareness of services, racism, diversity, illicit substances

Utilizing community strengths: embracing local cultural practices, fostering passion of community members, strengthening existing communication channels

Built Environment

Physical assets and resources: healthcare, community centers, parks, trails, highway expansion, bike lanes

Challenges with built environment: geographic disparities in public transportation, limited bicycle paths, socioeconomic and racial disparities – high-income areas have green spaces and well-maintained infrastructure, low-income areas lack basic amenities

Barriers with the built environment: lack robust transportation, language barriers

How the built environment affects health disparities: need for affordable housing to combat heat issues, more green spaces, and access to healthy foods

Forces of Change

Current forces of change: environmental (heat), economic (housing affordability), political, and social

Major events and trends: COVID-19 pandemic and climate change led to societal shifts

Future forces of change: housing issues, substance use, rising temperatures, political divide, advances in medical diagnostics

Disproportionately impacted communities: Black, Indigenous, People of Color, LGBTQ, immigrant, families with low income, people who are unhoused, working class

Addressing forces of change: addressing discrimination, leveraging community connectedness, applying data-driven approaches, sharing community voices

Figure 7. 2024 CHNA Key Informant Interview Themes

Social Vulnerability Index

Social vulnerability describes populations at higher risk of harm from disasters, climate change, and extreme weather. To identify and support these areas, the Center for Disease Control and Prevention's Geospatial Research, Analysis, and Services Program created the Social Vulnerability Index. This index highlights communities that may need extra help during and after crises, focusing on four vulnerability categories: socioeconomic status, household composition and disability, minority status and language, and housing and transportation.[xix] In Maricopa County, the following cities showed high to moderate social vulnerability levels: *Buckeye*, *Glendale*, *Gila Bend*, *Phoenix*, and *Mesa.*[xvii]

Vizient Vulnerability Index

The Vizient Vulnerability Index is a tool designed to measure and analyze social determinants of health that contribute to community vulnerability. It provides a comprehensive way to assess factors influencing health disparities and identify areas where targeted interventions are most needed. The index provides the overall vulnerability index for each census tract and zip code in the U.S. for nine domains of social needs:[xx]

- **Economic**: Individuals below 200% poverty rate, unemployment, lower median income
- **Education:** Adults without college degrees, lower high school/preschool enrollment
- **Healthcare Access:** Percent uninsured, provider shortages, distance to a hospital
- **Neighborhood Resources:** No park access, food deserts, broadband availability and household broadband subscriptions, alcohol sales, opioid dispensing
- **Housing:** Lower rates of homeownership, homes with incomplete plumbing, crowded housing, low-income households with housing expenses >50% income
- **Clean Environment:** Air/water pollution, hazardous waste and spill risk
- **Social Environment:** Lower rates of voting participation, single-parent families and incarceration rates
- **Transportation:** Households with no access to automobile or public transit
- **Public Safety:** Violent crime, gun violence

High vulnerability neighborhoods have barriers to care that exceed the national average and face greater challenges in accessing healthcare and resources.[xx] **Appendix D** highlights the high vulnerability domain areas and zip codes in Maricopa County.

Climate and Health

CommonSpirit Health's mission emphasizes improving the health of the communities they serve in mind, body, and spirit. A healthy environment is crucial for achieving better health outcomes, as access to clean air, fresh water, and fertile soil for growing food is fundamental to well-being. To foster healthier communities, CommonSpirit Health is committed to environmental sustainability efforts.[xxi] SJHMC identified social determinants of health, among those heat, as a significant health need in the CHNA.

Heat, climate, and health are interconnected as the rising temperatures from climate change can increase heat-related illness, such as heat exhaustion and heat stroke. Additionally, hot temperatures can contribute to deaths from heart attacks, strokes, and other forms of cardiovascular disease.[xxii] Derived from the Climate and Economic Justice Screen Tool, **Figure 8** displays disadvantaged communities that face burdens in climate change in Maricopa County.[xiv] A census tract is considered disadvantaged if it meets thresholds in areas like environment, climate, housing, or health, has a socioeconomic burden (income/education), is surrounded by disadvantaged areas, and has over 50% low income.[xxiii] Communities like *Aguila*, *Buckeye*, *Maricopa Village*, and *Komatke* have increased vulnerability to climate change.[xiv]

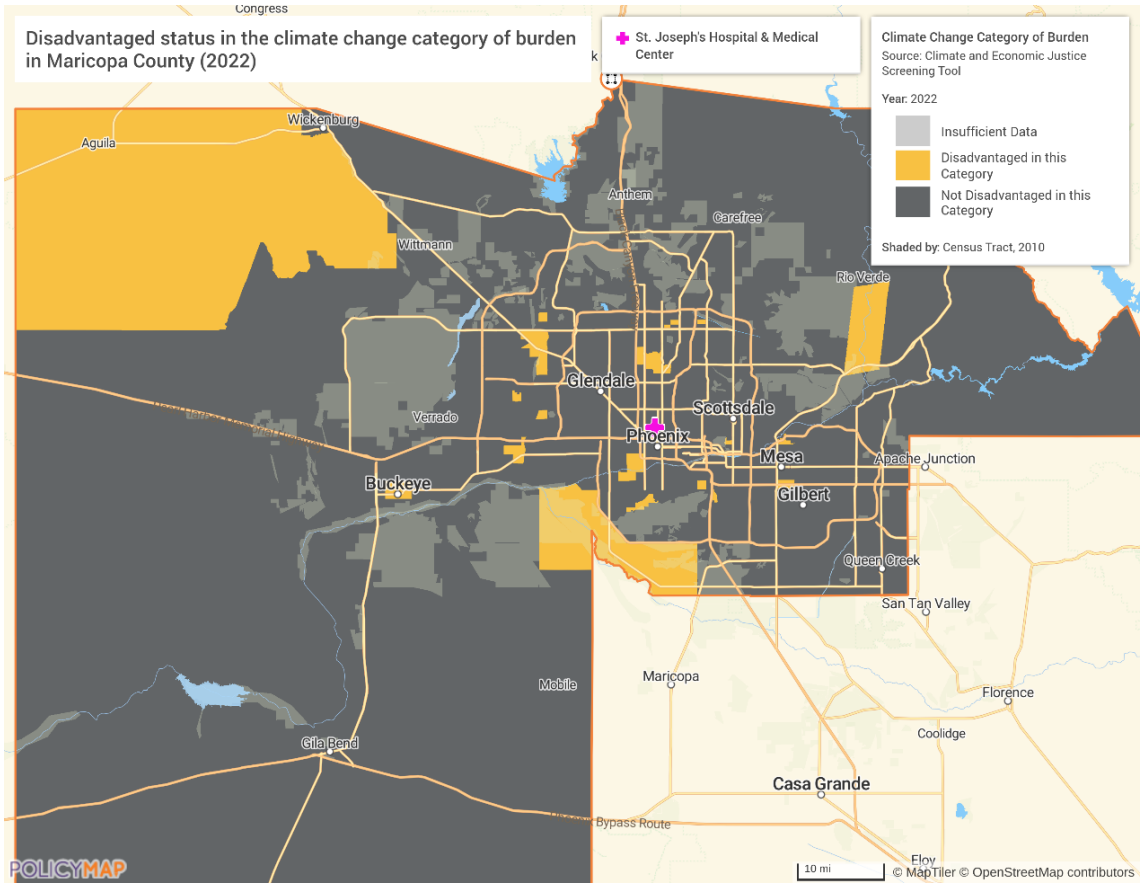


Figure 8. Climate Change Burden in Maricopa County

Equity Lens

Addressing health disparities and promoting equity requires overcoming challenges beyond closing resource gaps. Progress depends on communities reaching a shared definition of equity. By applying a health[xxiv], social[xxv], and racial[xxvi] equity lens to the CHNA priorities, SJHMC can gain a better understanding of the strengths and challenges faced by communities. Through the analysis of quantitative and qualitative data, this CHNA highlights community needs and strengths by examining key health metrics and the lived experiences of residents within Maricopa County. This comprehensive approach can support the development of programs, ensures equitable distribution of resources, and fosters inclusive decision-making, ultimately improving community health outcomes.

Health Equity

...is achieved when all people have the opportunity to attain their full health potential and no one is disadvantaged from realizing this goal because of their race, income level, gender, zip code, or other socially determined circumstance.

Social Equity

...is the fair, just and equitable management of all institutions serving the public directly or by contract; and the fair and equitable distribution of public services, and implementation of public policy; and the commitment to promote fairness, justice, and equity in the formation of public policy.

Racial Equity

...is the process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color.

Process to Prioritize Significant Community Health Needs

An effective and engaging prioritization process is key to a successful CHNA, as it supports the collaborative identification of the community's most pressing health needs. For SJHMC's CHNA, the process of scoring and narrowing down health indicators relied on prioritization criteria, existing disparities, and perspectives of internal and external stakeholders, whose expertise with the populations they serve played a vital role.

A total of 27 health and social indicators were established by SJHMC and selected based on review of hospital discharge data and disparities analyzed by race/ethnicity, sex, and age in Maricopa County. Of the indicators that were analyzed, a top 10 ranking chart along with more detailed data for IP, ED, and death were presented to CBHEC, HEA, and Community Grants Committee. SJHMC and Maricopa County Department of Public Health co-designed and implemented a three-phased prioritization process **(Figure 9).**

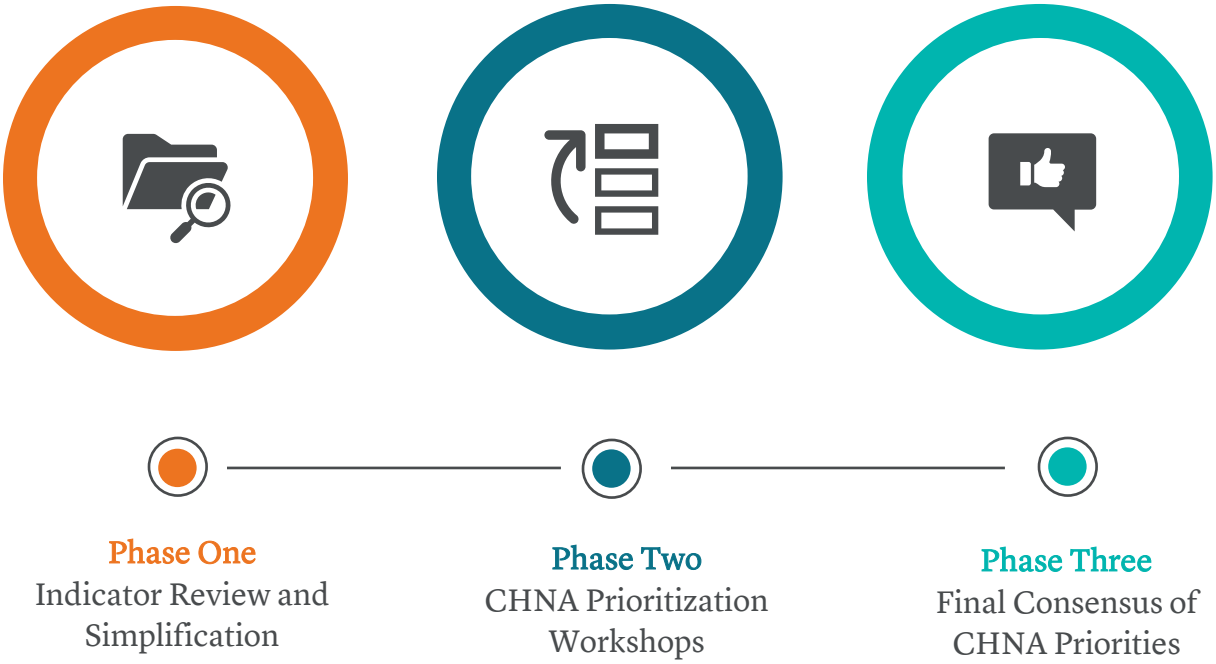


Figure 9. Phases of SJHMC's Prioritization Process

Phase One

In Phase One, SJHMC's Community Benefit team reviewed a comprehensive data workbook containing 57 health and social indicators provided by the Maricopa County Department of Public Health Division of Epidemiology and Informatics. To streamline the process, the team identified 27 indicators, prioritizing those that highlighted existing disparities and aligned with the focus areas of SJHMC. These 27 indicators were selected for further in-depth analysis in the CHNA process to identify the most pressing needs within the community.

Phase Two

In Phase Two, Maricopa County Department of Public Health facilitated three prioritization workshops to begin narrowing down the 27 data indicators. Before the workshops, SJHMC collaborated with Maricopa County Department of Public Health to develop a set of prioritization criteria **(Table 7)** to guide the process. The criteria, used with various other Synapse partners throughout their prioritization process, were tailored to meet the needs of SJHMC and the workshop participants.

Population Data	Community Expressed Need	Feasibility	Organization Readiness & Alignment	Partner Alignment
Criteria Definitions				
Primary service area population data demonstrates community health needs **Data Sources:** Hospital Discharge Data, PolicyMap	*Community survey, focus group, and committee feedback demonstrates community health need* **Data Sources:** CHNA Survey/Focus Groups, Dignity Health CBHEC	*SJHMC has ability to mobilize action to address need* **Data Sources:** CBHEC experience and expertise	*SJHMC has desire & adequate infrastructure to address need* **Data Sources:** Dignity Health's mission/vision/values & internal community health programs	*Strategic/impactful alignment with community partners to address need* **Data Sources:** Synapse Partner's CHNA Priorities
▪ Disproportionate indicator rates (2022, percent change between 2022 & 4-year average) ▪ Classified as top 10 indicator by overall rate ▪ Indicator disparities displayed by mapping tool (as available)	▪ Top health/social issues from CHNA survey ▪ Community experiences from CHNA focus groups ▪ Alignment from CBHEC on health needs based on lived experiences	▪ Practicality of implementing immediate services and programming to address priority area based on available prevention and treatment ▪ Possibility to make improvements in 3 years based on available resources ▪ Ability to track and measure progress to determine effectiveness.	▪ Organization risks in supporting or expanding priority (insurance, policies & compliance implications) ▪ Alignment to hospital mission, purpose, scope, and current/planned services ▪ Staff/leadership capacity, financial ability, tools & technology, data collection/reporting ability	▪ Community partners and/or MCDPH are already addressing this need and SJHMC can support their work. Will addressing this priority overburden an already over-taxed partner organization? Are there ways to sustainably support partner referrals and build infrastructure? ▪ Lack of partners in community addressing need, SJHMC would need to spearhead effort ▪ Ability to track and measure progress across agencies addressing this need

Table 7. Prioritization Criteria

Prioritization Meeting 1

This virtual workshop included members of CBHEC and Maricopa County Department of Public Health provided a detailed review of the data for the 27 identified initial indicators. After reviewing the data for each indicator, committee members were invited to score each

indicator based on the established criteria on a scale of one (does not meet the criteria) and five (meets criteria). The scoring activity was facilitated in Google Sheets **(Figure 10)**. The google sheet allowed the committee to score at their individual pace, rescore indicators if needed, and gave both the Maricopa County Department of Public Health and SJHMC's Community Benefit team an indication of current progress.

	For heat, please rate the following criteria (1- does not meets criteria to 5-meets criteria):				
Name	Population Data	Community Expressed Need	Feasibility	Organization Readiness & Alignment	Partner Alignment

Figure 10. Prioritization Activity #1 Google Sheet

Once scores for each criteria were provided for all indicators, the average score for each individual criteria was calculated. Then, the average scores for each criteria were combined to determine an overall average for each data indicator. The indicators were ranked in descending order based on their overall averages to identify the top 12 indicators, which advanced to the next round of prioritization in September **(Table 8)**.

CBHEC Prioritization Meeting 1	
Indicator	Average Rating
Cardiovascular Disease	4.68
Health Care Coverage	4.50
Poverty	4.46
Opioid Overdose	4.36
Diabetes	4.36
Breast Cancer	4.20
All Drug Overdoses	4.20
Colorectal Cancer	4.14
Preterm Births	4.12
Housing & Homelessness	4.12
Mental Health	4.12
Primary Payer Type	4.09

Table 8. Top 12 Health Indicator Rankings

After the resulting 12 indicators were shared, a few participants were surprised that some of the other initial indicators were not ranked in the top 12. As a result of this conversation, Maricopa County Department of Public Health collaborated with SJHMC to develop a survey for the committee, which asked what additional indicators from the initial list they would like to see a deeper data dive on in the next presentation. Committee members had the option to select up to two additional indicators. Results were reviewed by Maricopa County Department of Public Health and the top four indicators were identified to be included in the September prioritization workshop: (alcohol-related hospitalizations, inadequate prenatal care, self-harm/suicide, and heat-related illness and death). **Figure 11** displays the final results from the survey shared with the committee.

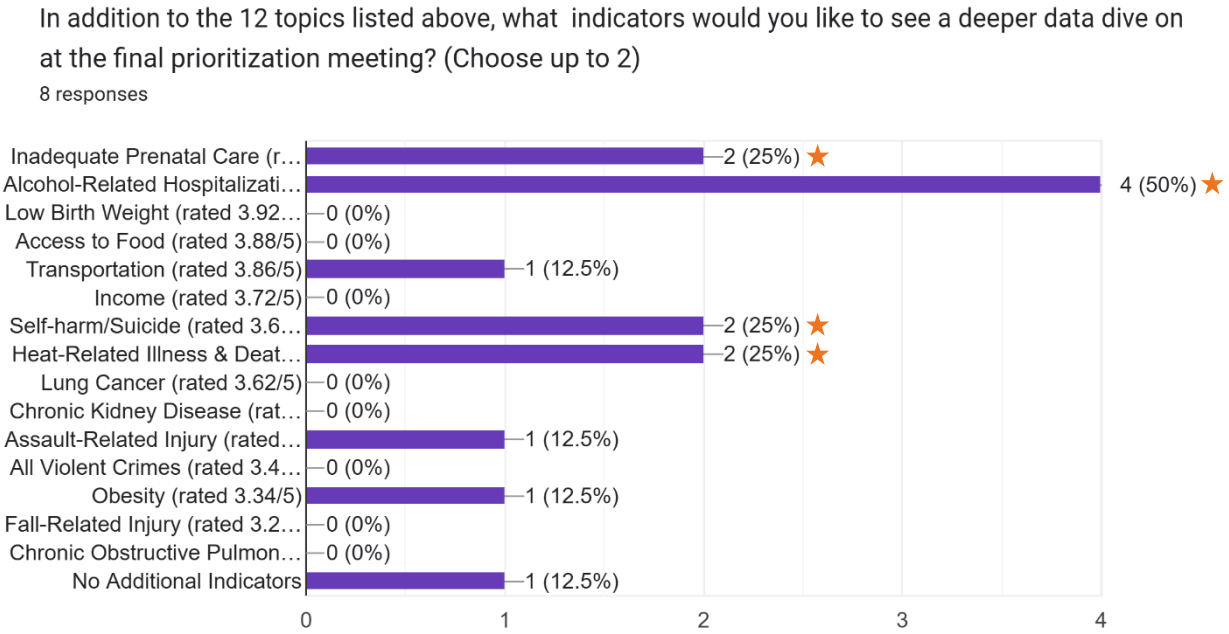


Figure 11. Top 4 Additional Indicators Selected for September Prioritization Meeting

Prioritization Meeting 2

At this virtual workshop, Maricopa County Department of Public Health presented to CBHEC on the 12 indicators identified from the first prioritization meeting and four indicators identified from the indicator survey. The goal of this workshop was to simplify from 16 indicators to eight or less. Similar prioritization criteria were used however, based on feedback received from the first workshop, the criteria definitions were simplified for clarity. Google Sheets was used again to score each indicator based on the successful outcome from the first workshop. After all scores were added, the Maricopa County Department of Public Health team compiled all the average scores, and the results were shared with the committee **(Table 9)**.

CBHEC Prioritization Meeting 2	
Indicator	**Average Rating**
Health Care Coverage	4.48
Mental Health	4.43
Diabetes	4.42
Cardiovascular Disease	4.38
Poverty	4.37
Primary Payer Type	4.24
All Drug Overdoses	4.24
Opioid Overdose	4.06

Table 9. Top 8 Health Indicator Rankings

After results were revealed, Maricopa County Department of Public Health facilitated an interactive discussion with the committee using Mural, a virtual whiteboard used to brainstorm ideas. The goal of this discussion was to build consensus on the top ranked indicators and hold a space to finalize the CHNA priorities. The following questions were asked throughout the discussion:

- *Does this priority order resonate with you?*
- *What issues stand out as the most important or have the biggest impact for Dignity Health to focus on?*
- *Thinking about the criteria that we used to score today, do you think these priorities will be feasible for the organization to address in the next 3 years?*
- *Are there any priorities that can be grouped together?*
- *Are there any priorities that didn't make it, that should be considered?*

Committee members resonated with most of the top ranked indicators and established four main priorities along with their sub-priorities **(Figure 12)**. Additionally, there were five additional priorities that were shared for consideration. These priorities were shared by a few committee members based on existing data and current need in the communities that they serve. There was also consensus established among the other members provided via verbal agreement or through the thumbs-up reaction feature on Zoom.

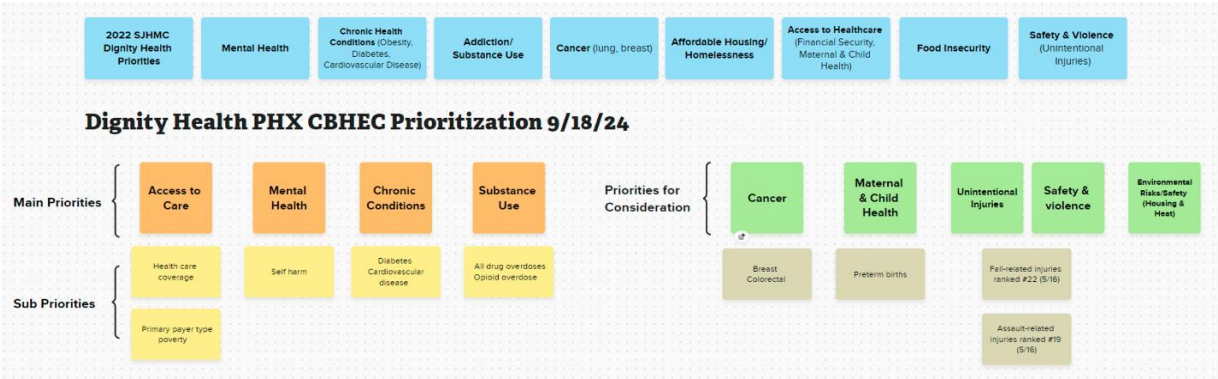


Figure 12. Prioritization Meeting #2 Discussion Mural Activity

Prioritization Meeting #3

At this virtual workshop, Maricopa County Department of Public Health presented to the HEA on data disparities from the top eight indicators narrowed down at the September CBHEC prioritization meeting. The purpose of this workshop was to compile feedback from HEA members on whether the top eight priorities should be prioritized by SJHMC. Feedback was compiled through Menti, an interactive voting platform. After data was presented for each indicator, participants were encouraged to share their agreement on a scale of one (strongly disagree) and five (strongly agree) for the prioritization of each indicator. **Figure 13** demonstrates an example of the voting activity in Menti.

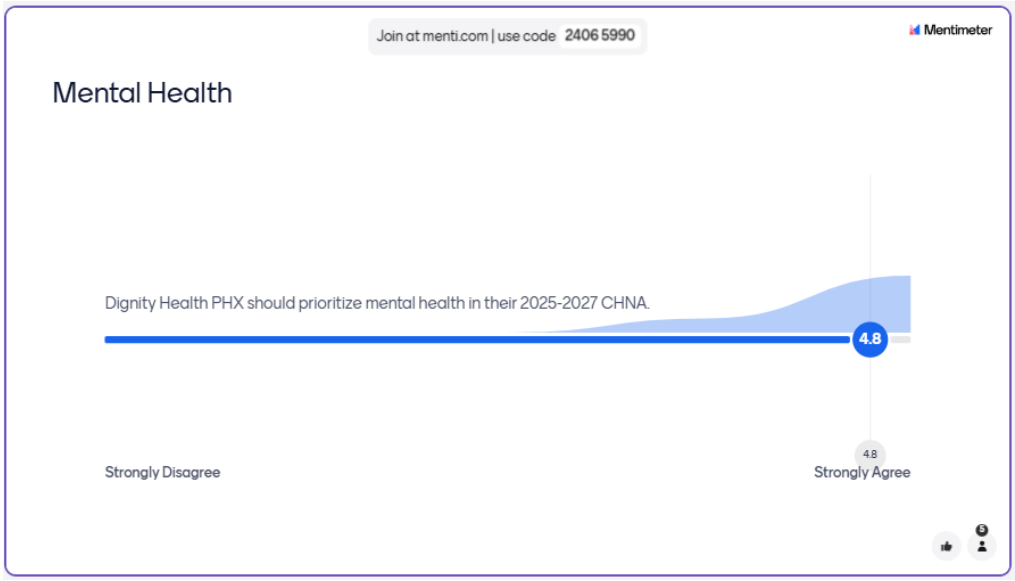


Figure 13. Prioritization Meeting #3 Menti Voting Activity

After the voting activity, members of the HEA were asked to share about:

- *What stood out to you the most about the eight identified health needs?*
- *Dignity Health's community board also considered a few additional CHNA priorities. Please indicate your agreement.*
- *Are there any additional priorities that should be considered and why?*

SJHMC also distributed a brief survey to their Community Grants Committee to compile additional feedback on the data indicators presented at the HEA prioritization meeting. Similar data and polling questions were included on the survey. **Tables 10 and 11** display the average scores for the top eight indicators. All feedback was reviewed by the SJHMC's Community Benefit team to help inform the selection of the final CHNA priorities.

HEA Prioritization Meeting 3	
Indicator	Average Rating
Mental Health	4.8
Health Care Coverage	4.8
Cardiovascular Disease	4.6
Poverty	4.4
All Drug Overdoses	4.2
Opioid Overdose	4.0
Diabetes	3.8
Primary Payer Type	3.0

Table 10. Health Equity Alliance Top Eight Health Indicators Rankings (Agreement)

Community Grants Committee Prioritization Survey	
Indicator	Average Rating
Poverty	4.6
Health Care Coverage	4.4
Mental Health	4.2
Cardiovascular Disease	4.0
Diabetes	4.0
All Drug Overdoses	3.9
Primary Payer Type	3.4
Opioid Overdose	3.3

Table 11. Community Grants Committee Top Eight Health Indicators Rankings (Agreement)

Phase Three

In Phase Three, SJHMC's Community Benefit team finalized the CHNA priorities. Seven main priorities with sub-priorities were approved by members of CBHEC **(Figure 14)**. After further consideration, CBHEC agreed to have "access to care" be a main priority, rather than the proposed sub-priority.

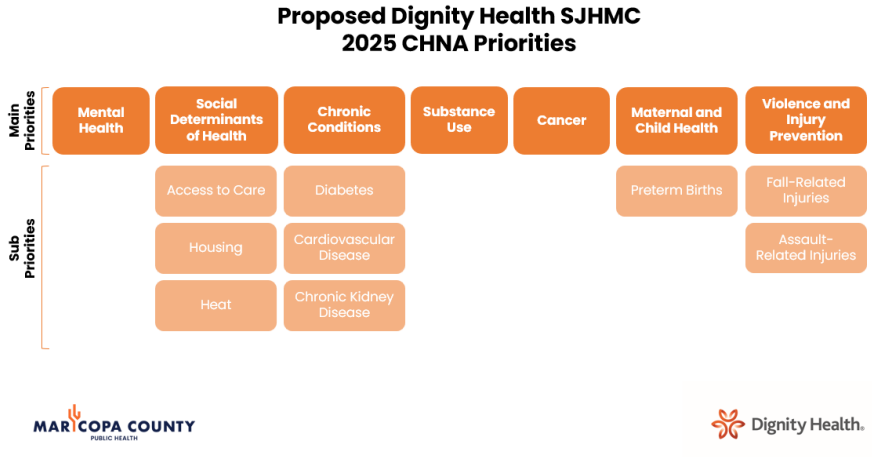


Figure 14. Identified and Approved CHNA Priorities

Prioritized Community Health Needs

The following section provides detailed primary and secondary data for each of SJHMC's CHNA priorities and sub-priorities **(Figure 15)**. Recognizing disparities in health outcomes based on factors like race/ethnicity, sex, and age is crucial to achieving equitable access to healthcare and improving health outcomes.

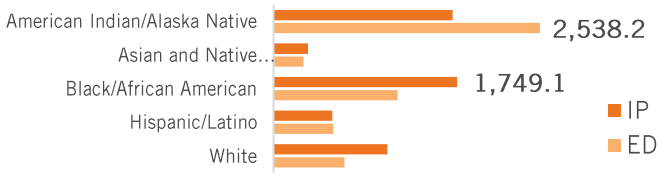
Figure 15. SJHMC's Final CHNA Priorities

Importance and Impact in Maricopa County

Mental health was selected as a significant health need for SJHMC. All mental and behavioral disorders are defined as the primary diagnosis of a mental, behavioral, or neurodevelopment disorder.[xxvii] Mental health encompasses emotional, psychological, and social well-being. It influences thoughts, feelings, actions and plays a key role in coping with stress, interacting with others, and making decisions.[xxviii] Mental health is a vital component of overall well-being, yet many individuals face barriers to accessing care, including stigma, lack of resources, and limited mental health providers.

Disparities by Race/Gender/Age

In 2022, **American Indians/Alaska Natives** had the highest age-adjusted rate of ED visits due to all mental health and behavioral disorders per 100,000 people. **Black/African Americans** had the highest rate of IP hospitalizations.



Males had the highest IP and ED rates.

Those aged **25-44 years** had the highest ED rate. Those aged **15-24 years** had the highest IP rate.

Source: 2022 Hospital Discharge Data[viii]

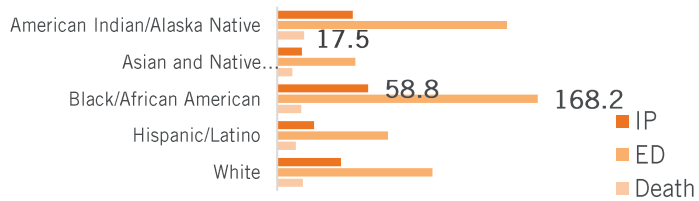
Figure 16. All Mental and Behavioral Disorders – Maricopa County

Self-Harm and Suicide

Self-harm, suicide, and mental health are deeply interconnected, often stemming from common underlying issues such as emotional distress, trauma, or mental health disorders. For many, self-harm offers a temporary sense of relief and is used to cope feelings of loneliness, anger, or hopelessness.[xxix] Self-harm behaviors, suicide attempts, and suicidal ideation are significant global mental health challenges due to their rising prevalence and severity.[xxx]

Disparities by Race/Gender/Age

In 2022, **Black/African Americans** had the highest age-adjusted rates of IP hospitalizations and ED visits due to intentional self-harm per 100,000 people. **American Indians/Alaska Natives** had the highest death rate.



Females had the highest IP and ED rates. **Males** had the highest death rate.

Those aged **15-24 years** had the highest IP and ED rates. Those aged **45-64 years** had the highest death rate.

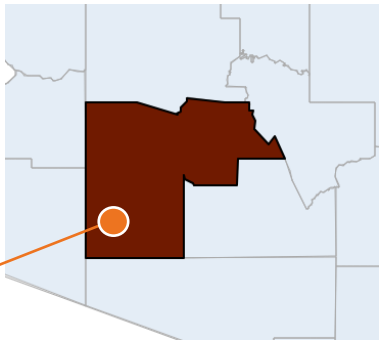
Source: 2022 Hospital Discharge Data[viii] & 2022 Death Data

Figure 17. Self-Harm/Suicide – Maricopa County

Poor Mental Health Days[xxxi]

Maricopa County

In 2022, adults reported an average of **4.3** days in the past month when their **mental health** was **not good**, slightly below the national average of 4.5 days.



Community-Identified Issues in Maricopa County

Mental Health Rating

Over **half (52.9%)** of survey respondents rated their **mental health** such as their mood and how they handle stress day to day as **"Fair"** or **"Poor."**

Top Health Issues

Almost **4 in 10 (38.5%)** survey respondents indicated **anxiety** and **1 in 3 (33.5%)** indicated **depression** as the top two health issues that have the most impact on them and/or the people they live with or care for.

Almost **1 in 10 (8.7%)** indicated **alcohol/substance misuses** and under **1 in 20 (2.8%)** indicated **intentional injury** as health issues.

Unmet Mental Health Needs

Focus group participants reported the inability to receive **adequate formal mental health care** (treatment or support) is due to lack of providers and increasing costs of living and long work hours. **Substance use** was a common challenge as it's used as a **coping mechanism**, with a **lack of access to care**, more people are **self-medicated**. Substance users included youth, adults, and people living with homelessness.

Existing Stigma and Illicit Substances

Key informant interviewees shared that those living with mental health conditions face **stigma**, leading to **poor treatment** by service providers and/or **decreased engagement** with services. There is also a **lack of services** for those with substance use disorders, the unhoused , and the undocumented populations.

> *The biggest struggle that I have found is finding a therapist or a psychiatrist who are willing to see transgender patients, even when it does not have to do with gender affirming care. Even it's just depression or anxiety, I've been turned away for the simple fact that I'm transgender, even though it had nothing to do with why I was going to need the mental health professional.*
>
> - 2023 LGBTQ+ Focus Group Participant

> *Then, there's also a lack of understanding of how mental health affects physical health. There's a lot of cultural bias, in certain communities, against mental health. They think oh, no, we're not crazy. We just have this, we have that. There's a lot of education and reintroducing the understanding of mental health is a condition, just like diabetes. It's a medical condition. These are all conditions. Lack of resources, but also lack of understanding, and some misunderstandings of what mental health is.*
>
> - 2023 Religious Minority Focus Group Participant

Sources: 2023 CHNA Survey, Focus Groups, Key Informant Interviews[v, vi, vii]

Importance and Impact in Maricopa County

Social determinants of health, specifically *housing* and *heat* were selected as significant health needs for SJHMC. According to Healthy People 2030, social determinants of health are the conditions where people are born, live, work, play, worship, and age that impact their health quality-of-life.[xxxii] Housing and heat are closely tied to economic stability and the neighborhood and built environment. For housing, it can lead individuals to reside in substandard housing conditions. Economic instability can also limit access to cooling resources and for those working in agriculture or construction, in that can increase their risk of heat-related illness. The neighborhood and built environment affect housing and heat exposure by influencing infrastructure and housing quality. Communities with limited green spaces increase vulnerability to greater heat exposure.[xxxi]

Housing - Severely Cost Burdened Renters

Housing quality and location can impact stress, mental health outcomes, and environmental risks.[xxxiii] Evaluating data on severely cost burdened renters helps provide insight into housing insecurity and highlights economic challenges within the community. "Severely cost burdened renters" is defined as renter households for whom gross rent is 50% or more of household income. In Maricopa County, cities such as *Aguila*, *Wickenburg*, *Anthem*, *Glendale*, and *Phoenix* contain areas with higher proportions of severely cost burdened renters **(Figure 18)**.[xiv]

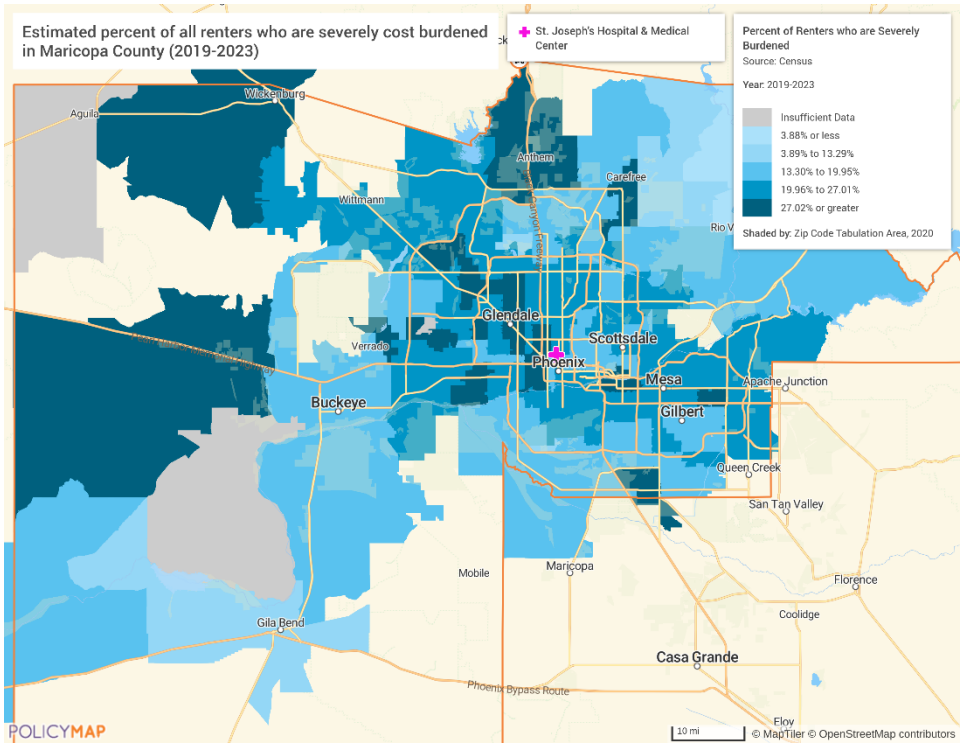


Figure 18. Severely Cost Burdened Renters – Maricopa County

Housing - Homelessness

Homelessness can impact various social determinants of health, which can create barriers to health, stability, and well-being. The annual Point-in-Time homeless count tracks the number of people experiencing homelessness in Maricopa County during a given point in time. In 2022, there were 9,026 people experiencing homelessness in Maricopa County. From 2018 to 2022, the Central region in Maricopa County had the third highest growth rate for unsheltered homelessness (*on the streets or other place not meant for human habitation*) in the County, which increased by 78%. The municipalities with the highest unsheltered count in 2022 are listed below, all of which are within Maricopa County.[x]

Top Municipalities in Maricopa County - Unsheltered Count

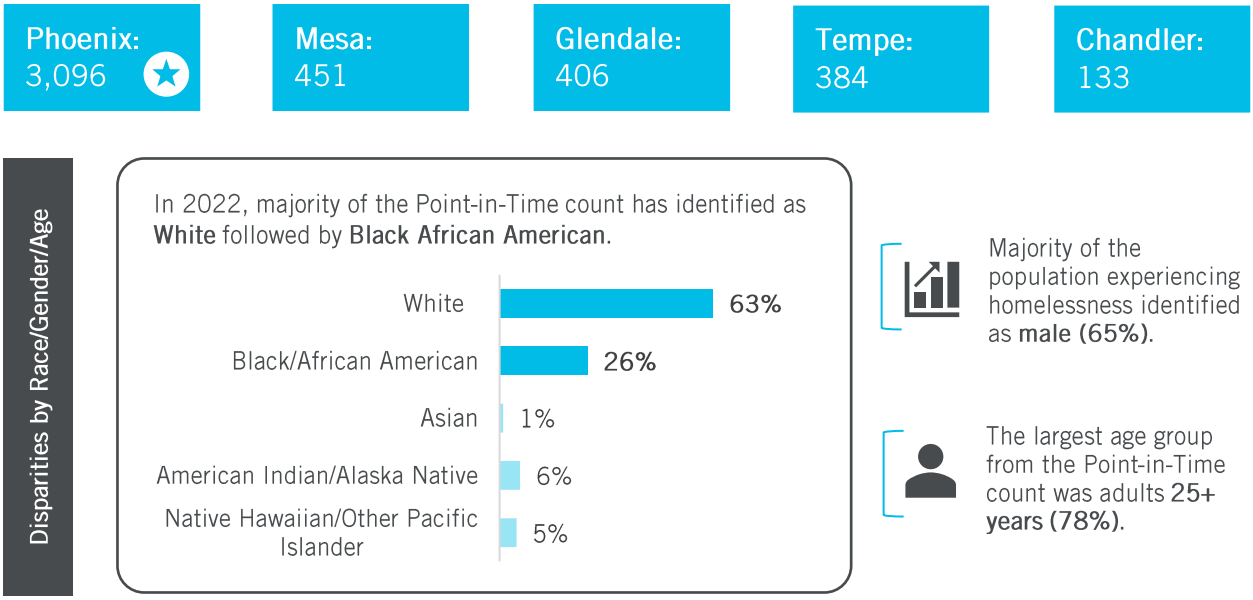


Figure 19. 2022 Maricopa County Point-in-Time Count by Race/Ethnicity

Heat

The number of people experiencing extreme heat is rapidly increasing across all regions as a result of climate change.[xxxiv] Heat stress, the leading cause of weather-related deaths, can exacerbate underlying illnesses such as cardiovascular disease, diabetes, mental health disorders, and asthma.[xxxiv] Heat-related illnesses and deaths are preventable and are a large concern because prolonged exposure to extreme temperatures can lead to serious health risks. As of 10/26/2024, there were 466 total confirmed heat-caused and heat-contributed deaths in Maricopa County during 2024 (preliminary data).[xi] **Figure 20** displays data on heat-related illness and deaths in Maricopa County for 2024.

	By Race, Age, Sex	Overall Risk Factors
Most frequent Heat-related Illness	White (Non-Hispanic) 54% 65+ years 19% Male 71%	Unhoused 11.9% Drug Use 2.7%
Most Frequent Heat-related Death	White (Non-Hispanic) 55% 35-49 years 28% Male 80%	Unhoused 47% Drug Use 57% Alcohol Use 12%

Figure 20. 2024 Heat-Related Illness and Death - Maricopa County

Heat impacts communities differently based on geography, infrastructure, and socioeconomic conditions. Urban areas with fewer green spaces often face higher temperatures due to the urban heat island effect, where developed areas are warmer than nearby rural areas.[xxxv] Identifying communities most affected by heat helps focus resources and prepare for health risks. **Figure 21** shows the 2024 heat and health index rank in Maricopa County , which consider historical temperature, heat-related illness, and community characteristics to highlight vulnerable areas.[xiv] In Maricopa County, cities such as *Buckeye*, *Glendale*, *Phoenix*, and *Mesa* contain areas with a higher rank, indicating greater vulnerability to heat-related health risks.[xiv]

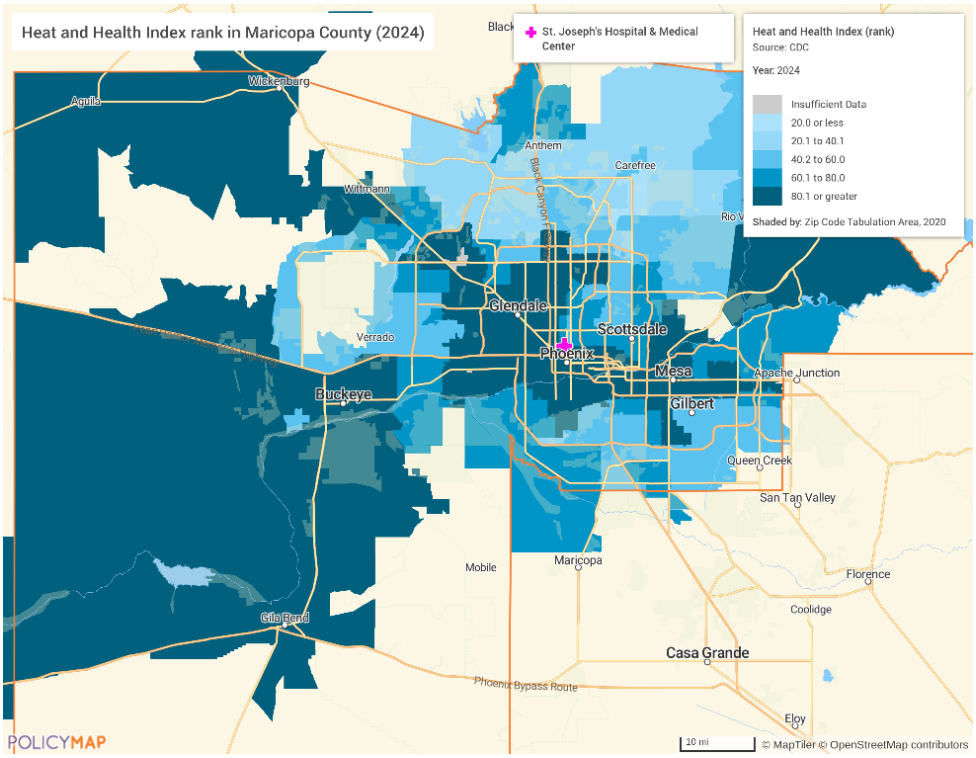


Figure 21. Heat and Health Index Rank – Maricopa County

Community-Identified Issues in Maricopa County

Top Health Issues

Almost **1 in 20 (3.1%)** survey respondents indicated **heat-related illness** as a health issue that has the most impact on them and/or the people they live with or care for.

Rating Community Assets

Over **7 in 10 (71.9%)** survey respondents rated **access to affordable housing** as **"Fair"** or **"Poor"** where they live.

Housing & Homelessness

Over **2 in 5 (42.7%)** focus group participants shared that they spend **more than half** of their **monthly income** on **housing** (mortgage or rent). Additionally, participants from groups all across the valley mentioned **homelessness** as one of their main **concerns**.

Climate Change and Heat-Related Deaths

Key informant interviewees shared about the increase of **heat-related deaths** in the county among the **unhoused** and **low-income** populations. There's concern about **poor air quality** and the inability to afford to **pay for electricity** for **air conditioning**.

> *This is the hottest heat index…in Maricopa County, right here in Phoenix…it was record-setting for the amount of time that we had triple-digit temperatures. And these triple-digit temperatures were not dropping. Why? Because of urban development. You see the asphalt and the radiating heat from the concrete, and it gets to like 115 [degrees] in the morning instead of it cooling down at night.*
>
> - 2024 CHNA Key Informant Interviewee

> *It is difficult to find affordable housing, and I ensure I pay rent and utilities before anything health related. The increase in cost of living for rental units has negatively affected my ability to receive Healthcare because I have privatized insurance that asks me to pay out of pocket for a high deductible. This has led to a decrease in my health over the last few years.*
>
> - 2023 CHNA Survey Participant

Sources: 2023 CHNA Survey, Focus Groups, Key Informant Interviews[v, vi, vii]

Importance and Impact in Maricopa County

Access to care was selected as significant health need for SJHMC. Social determinants of health like economic, social, cultural, and geographic factors can create barriers to healthcare services like receiving preventative care and treatment. There are also aspects of access to care that aren't directly influenced by social determinants of health. In the current landscape, access to care is becoming more important due to various factors like reducing health disparities in communities, managing chronic diseases, and improving health outcomes. Inadequate health insurance coverage is one of the largest barriers to health care access, which contributes to disparities in health.[xxxvi] Primary payer type is crucial because it affects access to services, cost, and health outcomes – all of which play a key role in overall health and well-being.

Health Care Coverage and Primary Payer Type

Health insurance coverage supports the health and well-being of individuals and communities as studies confirm that it improves access to care; supports positive health outcomes; incentivizes appropriate use of health care resources; and reduces financial strain.[xxxvii] In Maricopa County, cities such as *Gila Bend*, *Glendale*, *Phoenix*, and *Mesa* contain areas with higher proportions of people without health insurance **(Figure 22)**.[xiv]

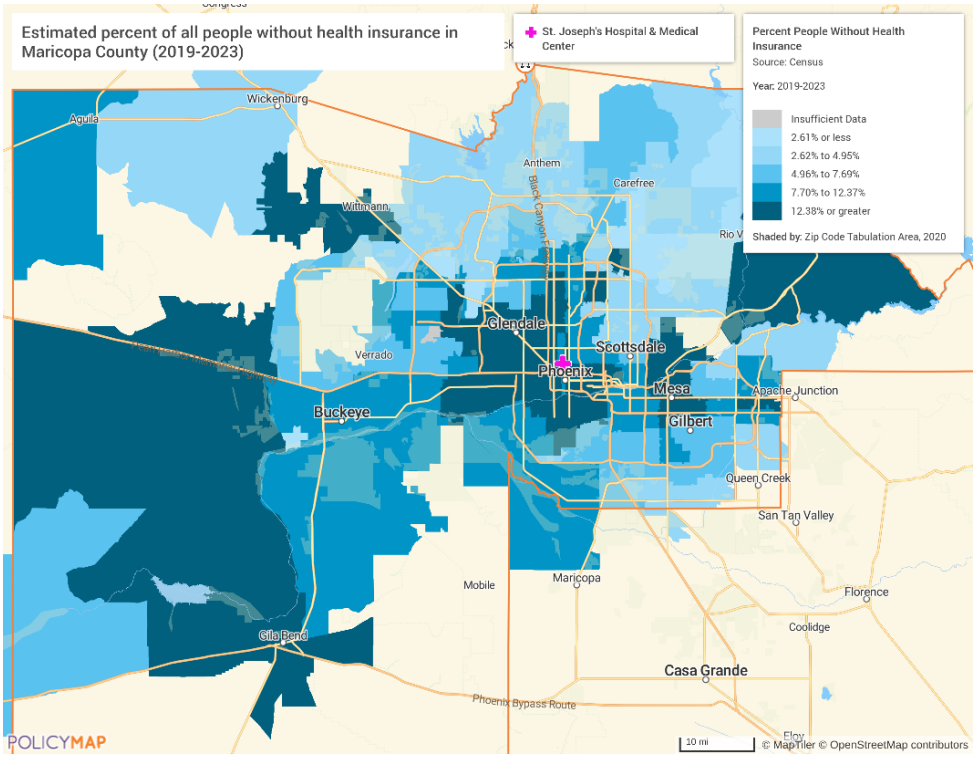


Figure 22. People Without Health Insurance – Maricopa County

Knowing primary payer type data is crucial for determining individuals' access to healthcare services based on their insurance coverage. It also helps providers understand financial barriers, ensuring appropriate care for those with different insurance statuses. **Figure 23** displays the top three primary payer types for inpatient hospitalization (IP) and emergency department (ED) visits and breakouts by race/ethnicity in Maricopa County.[viii]

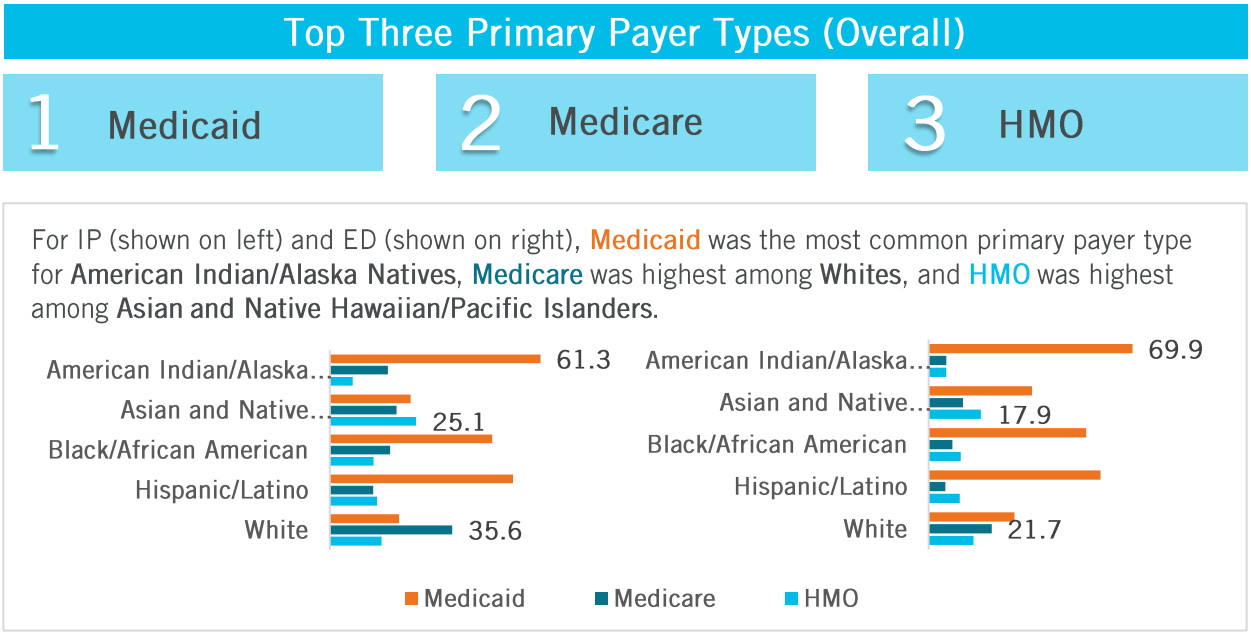


Figure 23. Top Three Primary Payer Types by Race/Ethnicity – Maricopa County (2022)

Poverty

Poverty is a vital social determinant of health as it impacts nearly every aspect of an individual's well-being. It can limit access to basic needs and also increase exposure to risks such as environmental hazards, contributing to poorer health outcomes. In Maricopa County, 11.5% of people in Maricopa County were living below the poverty level in 2022.[ix] **Figure 24** displays the top three racial/ethnic and age groups living below the poverty level.[ix]

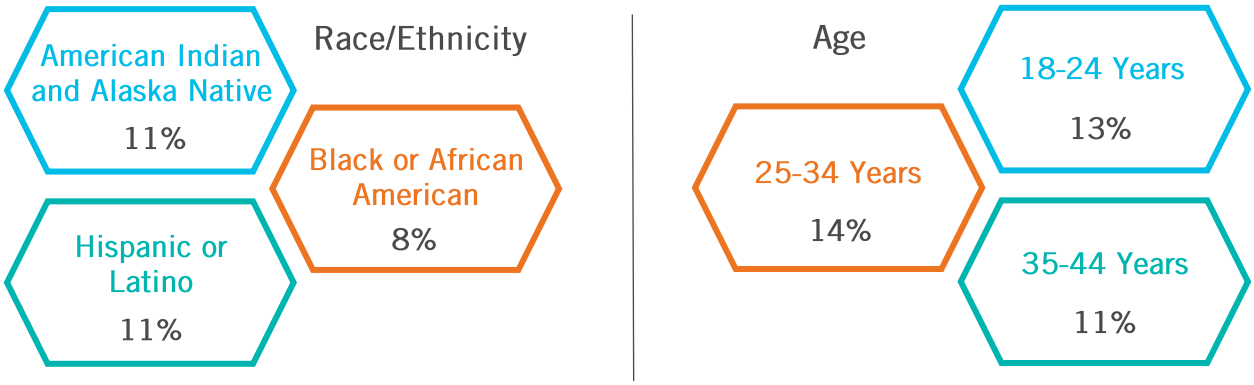


Figure 24. Top Three Racial/Ethnic and Age Groups Living Below the Poverty Level – Maricopa County

Community-Identified Issues in Maricopa County

Health Care Solutions

Almost **half (45.7%)** of survey respondents indicated that having **evening or weekend appointments** would help them get the care they need. Over **2 in 5 (41.9%)** indicated **lower out of pocket cost for services**.

Accessing Medical Care

Almost **2 in 5 (35.8%)** survey respondents were **sometimes** or **never** able to **access medical care** in the **past 12 months** when needed.

Health Care Access and Quality

Focus group participants shared barriers such as: **long wait times** for procedures and appointments with providers, **difficulties using insurance**, high **cost of care**, **limited medical facilities** equipped for emergencies or specialized needs, **inadequate provider training**, and **unreliable transportation**.

Leveraging Technology to Improve Care

Key informant interviewees shared that **technology** could be **leveraged** to foster better **collaboration** between organizations, enhance understanding of **gaps in care**, provide more information on **cost** and **service pricing**, and **increase access to care**.

> *My comment was the cost of healthcare is outrageous. It's like you're taking a business model and trying to let the business practices rule how the care is delivered. Luckily, we have resources that, but if you don't have resources, then the answer is I can't do it. Where are the low-cost options?*
>
> - 2023 CHNA Focus Group Partiicpant

> *Healthcare accessibility has been declining since 2020.. fewer physicians, fewer supporting staff, centralized appt. phone lines - (i.e.-cannot speak directly with Dr. office in many cases); Long wait times for urgent (but not Emergency) issues, as well as routine/preventative, healthcare appts. General decline in availability of appropriate healthcare in a timely manner. I know that this is a nation-wide issue, not just Maricopa County and no easy/quick solution.*
>
> - 2023 CHNA Survey Participant

Sources: 2023 CHNA Survey, Focus Groups, Key Informant Interviews[v, vi, vii]

Importance and Impact in Maricopa County

Chronic conditions, specifically *diabetes*, *cardiovascular disease*, and *chronic kidney disease* were selected as significant health needs for SJHMC. Cardiovascular disease is defined as the primary diagnosis of acute rheumatic fever and the following diseases: chronic rheumatic heart, hypertensive, ischemic heart, pulmonary heart, pulmonary circulation, cerebrovascular, arteries, arterioles, capillaries, and other forms of heart disease.[xxxviii] Diabetes is defined as the primary diagnosis of type 1 and 2 and other specified diabetes mellitus.[xxxix] Diabetes and cardiovascular disease are closely connected, as they share common behavioral risk factors, such as lack of physical activity and poor dietary patterns.[xl, xli, xlii] The leading cause of kidney failure is diabetes, followed by high blood pressure.[xliii] Focusing on prevention and early intervention can lower the risk of developing other chronic disease, ultimately improving overall quality of life.

Disparities by Race/Gender/Age

In 2022, **Black/African Americans** had the highest age-adjusted rates of **IP** hospitalizations and **ED** visits due to diabetes per 100,000 people. **American Indian/Alaska Natives** had the highest **death** rate.

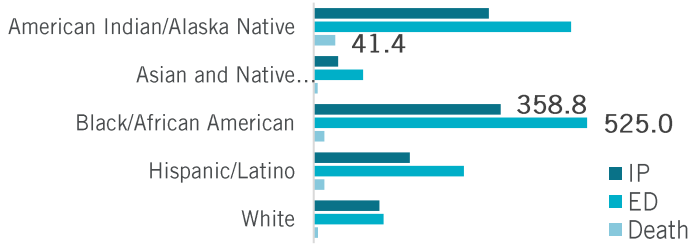


Figure 25. Diabetes – Maricopa County

Males had the highest **IP**, **ED**, and **death** rates.

Those aged **45-64 years** had the highest **ED** rate. Those aged **65+ years** had the highest **IP** and **death** rates.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death data

In 2022, **Black/African Americans** had the highest age-adjusted rates of **IP** hospitalizations, **ED** visits, and **death** due to cardiovascular disease per 100,000 people.

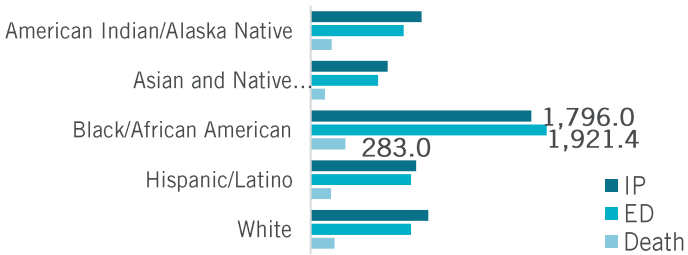


Figure 26. Cardiovascular Disease – Maricopa County

Males had the highest **IP**, **ED**, and **death** rates.

Those aged **65+ years** had the highest **IP**, **ED**, and **death** rates.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death data

Disparities by Race/Gender/Age

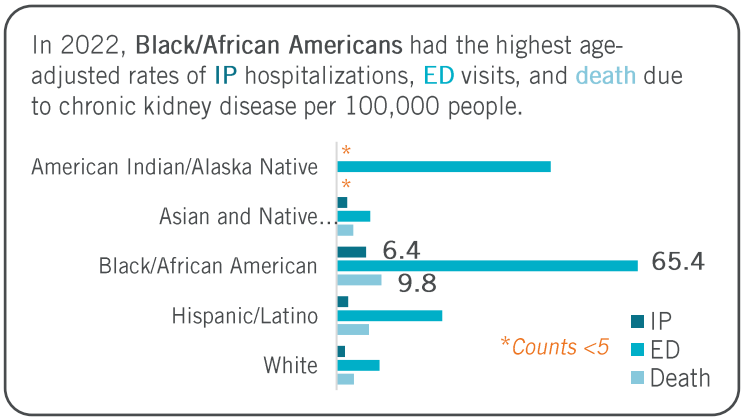


Figure 27. Chronic Kidney Disease – Maricopa County

Males had the highest IP, ED, and death rates.

Those aged **65+ years** had the highest IP, ED, and death rates.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death data

Community-Identified Issues in Maricopa County

Top Health Issue

Over **1 in 4 (25.4%)** survey respondents indicated **diabetes** and over **1 in 8 (12.6%)** indicated **heart disease (33.5%)** as health issues that have the most impact on them and/or the people they live with or care for.

Physical Health Rating

Over **half (55.4%)** of survey respondents rated their **physical health** such as how their body feels day to day, as **"Fair"** or **"Poor."**

Prevalence of Diabetes

Many focus group participants across many age groups also reported having or knowing someone who had diabetes and highlighted problems with **accessing medication**, due to **cost, supply,** or getting in with a **specialist.**

Experiences with Chronic Disease

Focus group participants reported people in their communities were experiencing chronic diseases. Barriers included having **too many unhealthy eating options** available and **wait times to get into a doctor** or get **necessary testing** to find solutions.

> *Well, right now, I'm fighting with these doctors, far as my diabetes is concerned…My doctor took me off of this one medicine, 'cause it wasn't doing right. Then she sent me to a specialist. Well, the specialist never called me…Well, my diabetes is over 200, and I'm not hearing from any of these doctors to get in, to get new medicine. I went back on my old medicine because I don't wanna die…*
>
> - 2023 Seniors Focus Group Participant

> *I tried answering these questions with my mom in mind whom I take care of. Although pretty active at 82, she needs a lot of Medical care and Dr. Visits for her Diabetes, high cholesterol, high blood pressure, heart issues, lung issues, knee issues, etc. She is on Medicate / AHCCCS and there are not many drs in Fountain Hills that accept that. So we have to drive to Scottsdale, Mesa 30, 40 minutes to see a specialists…It would be good to have more facilities / Dr.s that accept Medicate / AHCCCS here in town…*
>
> - 2023 CHNA Survey Participant

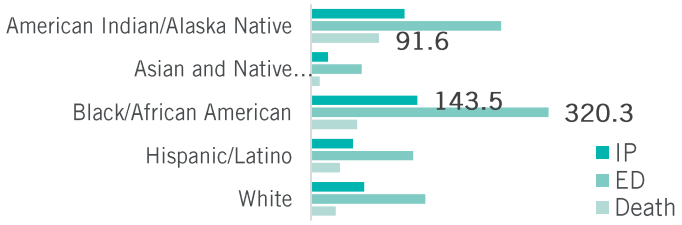
Sources: 2023 CHNA Survey, Focus Groups[v, vi]

Importance and Impact in Maricopa County

Substance use was selected as a significant health need for SJHMC. Substance use disorders are linked with many health issues and significantly increase the risk of overdose and death. Opioid use disorder, has seen a sharp increase in fatalities in recent years, highlighting the need for prevention and treatment efforts.[xliv] Beyond health, substance use impacts families, burdens healthcare systems, and impacts economic productivity and public safety. Addressing substance use requires a comprehensive approach, including prevention, early intervention, treatment, and recovery support services, as well as efforts to reduce stigma and promote education.[xlii]

Disparities by Race/Gender/Age

In 2022, **Black/African Americans** had the highest age-adjusted rates of IP hospitalizations and ED visits due to all drug overdoses per 100,000 people. **American Indian/Alaska Natives** had the highest death rate.



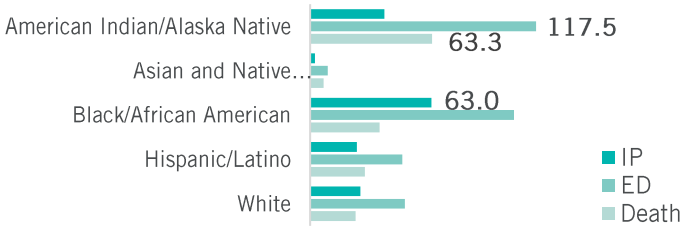
Females had the highest IP and ED rates. **Males** had the highest death rate.

Those aged **15-24 years** had the highest IP and ED rates. Those aged **25-44 years** had the highest death rate.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death Data

Figure 28. All Drug Overdose – Maricopa County

In 2022, **Black/African Americans American Indians** had the highest age-adjusted rate of IP hospitalizations due to opioid overdose per 100,000 people. **American Indian/Alaska Natives** had the highest rates of ED visits and deaths.



Males had the highest IP, ED, and death rates.

Those aged **25-44 years** had the highest IP, ED, and death rates.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death Data

Figure 29. Opioid Overdose – Maricopa County

Opioid Overdose and Drug and Alcohol Treatment Facilities

In 2022, Maricopa County had a rate of **27 opioid overdose deaths per 100,000 people**. The urban areas, such as *Phoenix*, *Glendale*, *Scottsdale*, *Mesa*, and *Gilbert* have a higher density of drug and alcohol treatement facilities compared to more rural areas, such as Wickenburg, Buckeye, Gila Bend, and Fountain Hills.[xiv]

Community-Identified Issues in Maricopa County

Top Health Issue

Almost **1 in 10 (8.7%)** survey respondents indicated **alcohol/substance misuses** as a health issue that had the most impact on them and/or the people they live with or care for.

Substance Use as a Common Challenge

Focus group participants shared that substance use (drugs, smoking, vape pens, fentanyl, alcohol, other mind-altering substances) had an impact on users like **youth**, **adults**, and **homeless** individuals. A common reason for using substances was **coping**, with a **lack of access to care**, more people are **self-medicated**.

Rating Community Assets

Almost **7 in 10 (67.8%)** survey respondents rated **access to substance use treatment services** as **"Fair"** or **"Poor"** where they live.

Growth in Illicit Substances

A few key informant interviewees described the impact that substance use has had on the **unhoused population** and how a **lack of treatment centers** had led individuals with substance use disorders to use drugs in public locations. This increases **concerns with safety** and worsen the increasing **heat index**.

> *I believe we need more substance abuse and mental health assistance. Too many of my children's friends have died due to these issues. They have nowhere to turn no funding and the ones I have seen are a bit scary. Maricopa county needs to spend more on mental health care, or we will all pay with the horrible incidents that are occurring everywhere USA. Hire more school counselors to help identify the issues prior to suicide or self-medication overdosing.*
>
> - 2023 CHNA Survey Participant

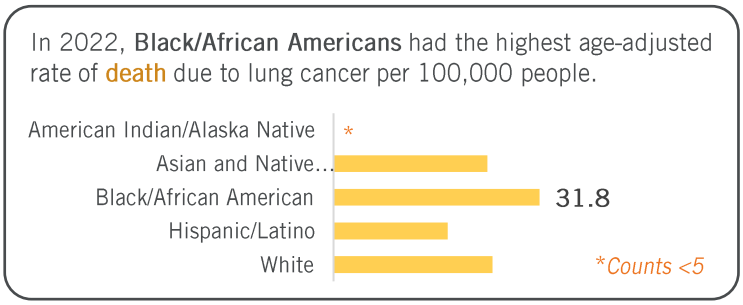
> *What got me sad about the community that I see around me is substance abuse and the homeless on the street, and the people that are in need that fell, that can't get up again. What I can see is there are a lotta places that people can go get help at, like CBI and St. Joseph the Worker. There's programs that showed up in my community that I really see as a very good thing to have.*
>
> - 2023 Rural Focus Group Participant

Sources: 2023 CHNA Survey, Focus Groups, Key Informant Interviews[v, vi, vii]

Importance and Impact in Maricopa County

Cancer was selected as a significant health need for SJHMC. According to the World Health Organization, cancer is a large group of diseases characterized by uncontrolled growth of abnormal cells that can invade nearby tissues and spread to other parts of the body. The cancer burden continues to increase, placing significant physical, emotional, and financial strain on individuals, families, communities, and healthcare systems.[xlv] Some risk factors for cancer can be avoided (alcohol and tobacco), but many cannot (family health history and human papillomavirus).[xlvi] Cancers with high rates of death in Maricopa County include lung cancer (among the total population); breast cancer (among the female population); and prostate cancer (among the male population).[viii]

Disparities by Race/Gender/Age

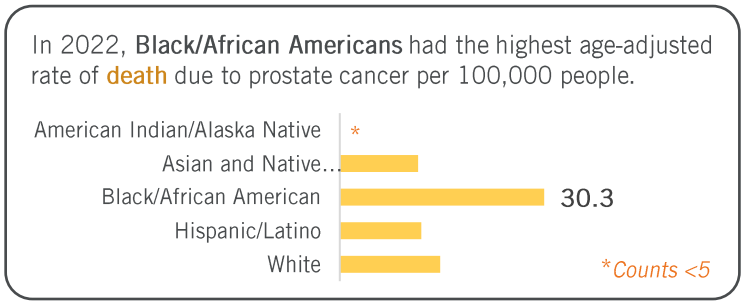


Males had the highest **death** rate.

Those aged **65+ years** had the highest **death** rate.

Source: 2022 Death Data

Figure 30. Lung Cancer – Maricopa County

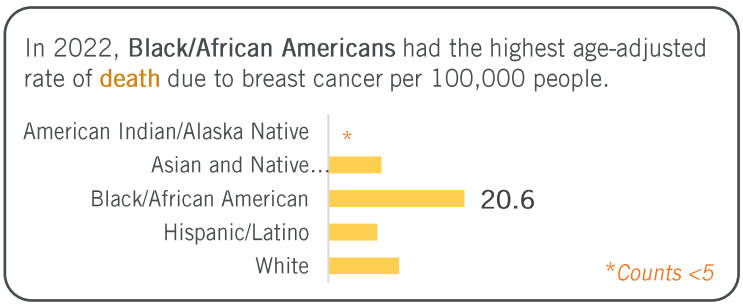


Males had the highest **death** rate.

Those aged **65+ years** had the highest **death** rate.

Source: 2022 Death Data

Figure 31. Prostate Cancer – Maricopa County



Females had the highest **death** rate.

Those aged **65+ years** had the highest **death** rate.

Source: 2022 Death Data

Figure 32. Breast Cancer – Maricopa County

Cancer Screening

Cancer prevention through lifestyle changes, vaccinations, and regular screenings can help reduce cancer prevalence and promote overall health. Colorectal cancer develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can detect abnormal growths and identify colorectal cancer early when treatment is most effective. The U.S. Preventive Services Task Force recommends that adults aged 45 to 75 years be screened for colorectal cancer.[xlvii] For breast cancer, the Task Force recommends that women who are 40 to 74 years and are at average risk for breast cancer get a mammogram every two years.[xlviii] By following recommended screening guidelines and making preventive lifestyle choices, individuals can significantly reduce their risk of cancer and improve chances for early detection and effective treatment. **Figure 33** displays the prevalence of colorectal and breast cancer screening in Maricopa County.[xiv]

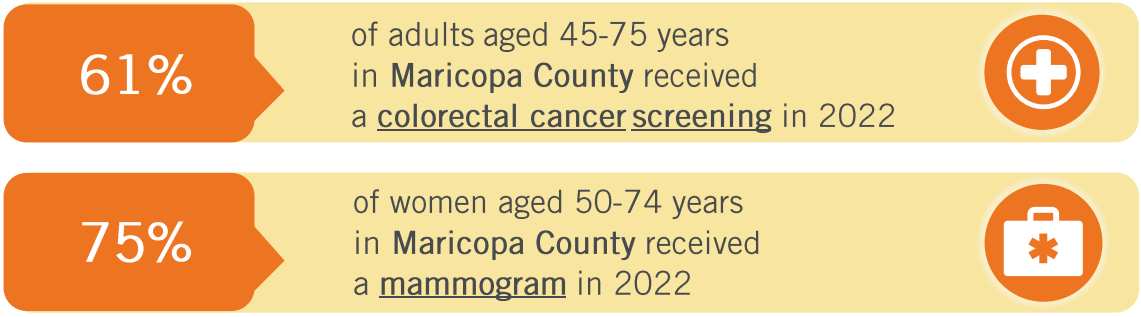


Figure 33. Colorectal and Breast Cancer Screening in Maricopa County

Community-Identified Issues in Maricopa County

Top Health Issues

Over **1 in 10 (13.4%)** survey respondents indicated **cancer** as a top health issue that most impacted them and/or the people they lived with or cared for.

Rating Community Assets

Over **half (54.5%)** of survey respondents rated **access to quality medical care** as **"Fair"** or **"Poor."**

Cancer in the Community

Focus group participants shared their experiences about multiple cancers, but **breast** and **skin** cancer were the most common. **Without insurance**, they did not have access to **quality care**. For those with insurance, **wait times for authorization** were long.

Environmental Disparities

Key informant interviewees shared **air quality issues** and related health issues such as **asthma** and **cancer**.

> *There needs to be better support for all cancer patients. Cancer is not a choice. Hospital and specialist fees, even with insurance have caused me to almost be homeless and now financially unstable.*
> - 2023 CHNA Survey Participant

> *I believe the insurance are not good either, because sometimes you have a problem, medical problem, and you need to wait to be approved by the insurance. It takes months sometimes. I have a sister-in-law with cancer, and she couldn't have an appointment right away* - 2023 Rural Focus Group Participant

Sources: 2023 CHNA Survey, Focus Groups, Key Informant Interviews[v, vi, vii]

Importance and Impact in Maricopa County

Maternal and child health, specifically *preterm births*, was selected as a significant health need for SJHMC. Maternal and child health is critical for ensuring the well-being of families and communities. Early health interventions and care during pregnancy, childbirth, and the child's early years lay the foundation for a child's long-term physical, emotional, and cognitive development. Preterm birth, defined as a live birth before 37 completed weeks of gestation, is a critical component of maternal and child health.[xii] Preterm birth can lead to long-term intellectual and development disabilities for babies, such as learning and communicating, in addition to long-term health conditions such as mental health conditions and dental problems.[xlix] Ensuring access to quality care during pregnancy, childbirth, and early childhood reduces maternal and infant mortality, prevents complications, and promotes healthy development.

Disparities by Race

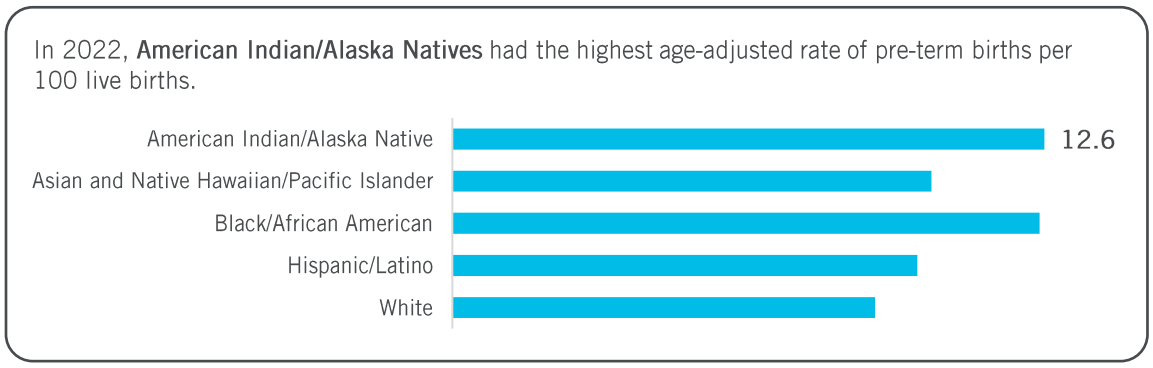


Figure 34. Preterm Births – Maricopa County

Source: 2022 Birth Data

Maternal Vulnerability Index

The U.S. Maternal Vulnerability Index, created by Surgo Ventures, helps identify where and why mothers are vulnerable to poor health outcomes. The index ranks geographies on overall vulnerability to poor pregnancy outcomes and six themes: reproductive health, physical health, mental health and substance abuse, general healthcare, socioeconomic determinants, and physical environment. All related indicators are standardized on a scale from **0** (least vulnerable) to **100** (most vulnerable).[l] **Figure 35** demonstrates the overall maternal vulnerability index score in 2024 for Maricopa County. In Maricopa County, the overall maternal vulnerability index score was 60.3, which indicates a higher level of vulnerability. Additionally, cities such as *Gila Bend*, *Glendale*, *Phoenix*, and *Mesa* have a score of at least 81 or greater, demonstrating greater maternal vulnerability.[xiv]

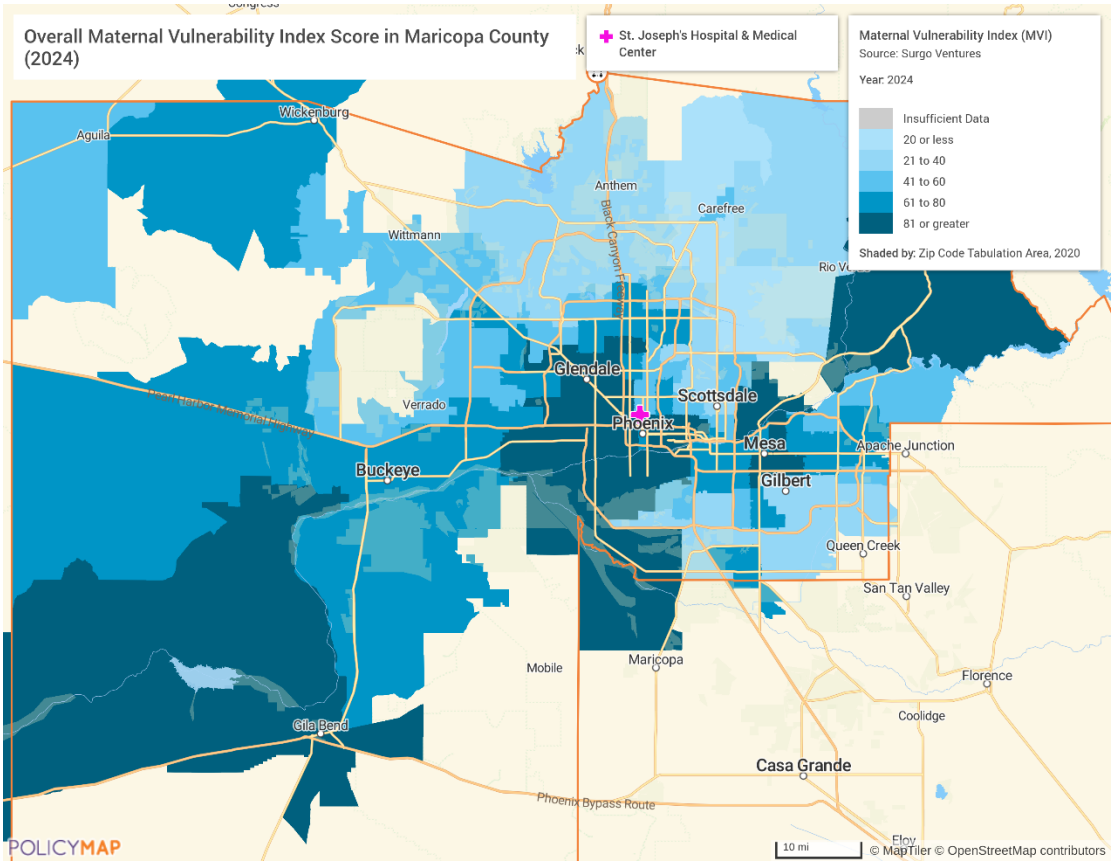


Figure 35. Overall Maternal Vulnerability Index – Maricopa County

Community-Identified Issues in Maricopa County

Top Health Issues

Over **1 in 20 (5.2%)** survey respondents indicated **sexual and reproductive health issues** as a top health issue that most impacted them and/or the people they lived with or cared for.

Paying for Essentials

Over **2 in 5 (43.4%)** survey respondents reported that they **"Sometimes"** or **"Never"** had enough money to pay for healthcare services in the past 12 months.

> *I'd say access to reproductive health. I know for myself, it's because my name and gender have all been legally changed, but I really, really needed to see an OBGYN. I was having a lot of issues, and I called 10 places that refused to treat me, which is crazy, because they all accepted AHCCCS…I feel like they should be mandated to be educated on trans healthcare needs. I don't know, but I don't know how they could enforce it, but yeah. Definitely access to care.*
>
> - 2023 Queer, Transgender, Black, and Indigenous People of Color Focus Group Participant

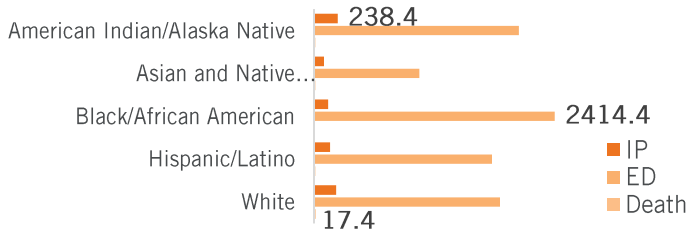
Sources: 2023 CHNA Survey, Focus Groups[v, vi]

Importance and Impact in Maricopa County

Violence and injury prevention, specifically *fall-related* and *assault-related injuries*, was selected as a significant health need for SJHMC. Injuries are caused by various factors, including road traffic accidents, falls, drowning, burns, poisoning, and acts of violence, whether self-inflicted or directed at others.[li] Falls are preventable and can result in injuries such as broken bones, like wrist, arm, ankle, and hip fractures.[lii] Assault-related injuries can lead to physical and emotional trauma. Exposure to trauma, especially in childhood, can lead to an increased risk of mental illness, suicide, substance abuse, chronic disease, and social issues like violence. Preventing injuries and violence can reduce physical harm, healthcare costs, and enhance quality of life in communities.[l]

Disparities by Race/Gender/Age

In 2022, **American Indian/Alaska Natives** had the highest age-adjusted rate of IP hospitalizations due to fall-related injuries per 100,000 people. **Black/African Americans** had the highest rate of ED visits. **Whites** had the highest death rate.



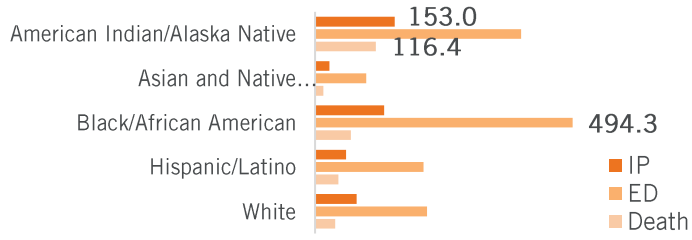
Females had the highest IP and ED rates. **Males** had the highest death rate.

Those aged **65+ years** had the highest IP, ED, and death rates.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death Data

Figure 36. Fall-related Injuries – Maricopa County

In 2022, **Black/African Americans** had the highest age-adjusted rate of ED visits due to assault-related injuries per 100,000 people. **American Indian/Alaska Natives** had the highest rates of IP hospitalizations and death.



Males had the highest IP and death rates. **Females** had the highest ED rate.

Those aged **15-24 years** had the highest ED rate. Those aged **65+ years** had the highest IP rate. Those aged **25-44 years** had the highest death rate.

Source: 2022 Hospital Discharge Data[viii] & 2022 Death Data

Figure 37. Assault-related Injuries – Maricopa County

Compiled from local law enforcement agencies, **Figure 38** displays all incidents in 2022 related to assault-aggravated (orange marker), assault-simple (green marker), and sexual assault (blue marker) within Maricopa County. Assault-related incidents were more concentrated around cities such as north and south *Phoenix*, *Tempe*, *Mesa*, and *Chandler*.[liii]

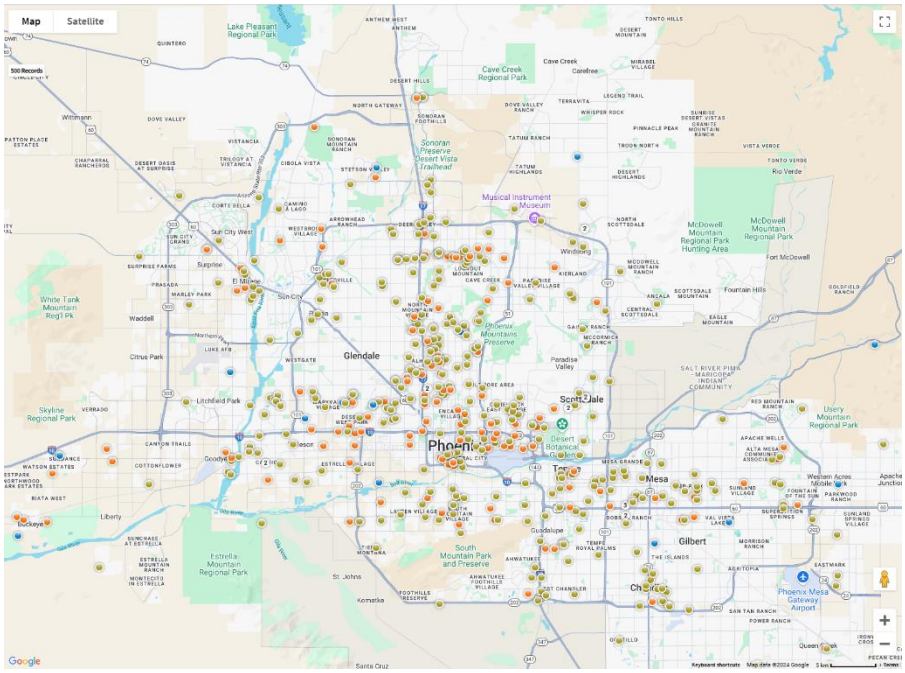


Figure 38. Assault-Related Incidents - Maricopa County (2022)

Community-Identified Issues in Maricopa County

Top Health Issues

Over **1 in 20 (5.5%)** survey respondents indicated **unintentional/accidental injury** and **2.8%** indicated **intentional injury** as top health issues that most impacted them and/or the people they lived with or cared for.

Rating Community Assets

Over **2 in 5 (45.2%)** survey respondents rated **feeling safe in their home (not worrying about burglary, domestic violence, etc.)** as **"Fair"** or **"Poor"** where they live.

Community Safety

Some focus group participants shared that they felt safe, while others described **crimes** and other **threats to personal safety**. **Gun violence** and **access to weapons** were mentioned as safety concerns. Participants agreed that more **cohesive** neighborhoods were safer. Others expressed that places don't feel as safe as they did in the past.

> *As a member of the LGBTQ+ community, I rarely feel comfortable expressing my true self in public spaces due to the fear of harassment and assault, as many community members have demonstrated homophobia throughout the years. As young queer and bisexual adult, accessing mental health services is even more difficult due to the lack of attainability in Fountain Hills; I feel as though I prioritize other needs before my mental health despite its deterioration. Especially when you bring in homophobia, the concern that mental health service providers will won't understand or accept my challenges, such as discrimination, as a problem or valid experience, plays a very large role in my decision to seek out help from service providers.*
>
> - 2023 CHNA Survey Participant

Sources: 2023 CHNA Survey, Focus Groups[v, vi]

Resources Potentially Available to Address Needs

SJHMC is addressing key needs identified in its CHNA, including mental health, social determinants of health, chronic conditions, substance use, cancer, maternal and child health, and violence and injury prevention. Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community-based organizations. Resources include access to hospital emergency and acute services. Federally Qualified Health Centers, food banks, homeless shelter, faith communities, transportation services, health navigators, and prevention-based community education. SJHMC participates in the Health Improvement Partnership of Maricopa County — a collaborative effort between Maricopa County Department of Public Health and a diverse array of over 100 public and private organizations addressing healthy eating, active living, linkages to care, and tobacco-free living. The Health Improvement Partnership of Maricopa County is also a valuable resource to help SJHMC connect to other community-based organizations that are addressing similar health priorities. **Table 12** identifies community and hospital resources potentially available to address the identified significant health needs. SJHMC partners with several of the community organizations and hospital departments to provide connected care to the Maricopa County community.

Priority	Community Resources	Hospital Resources
Mental Health	• Arizona Crisis Response Network • Copa Health • Phoenix Indian Center - mental health services • Human Services Campus - mental health services • Maricopa County - crisis hotlines • Mercy Care (Regional Behavioral Health Authority) • Mental Health Arizona - Support groups • Native American Connection - behavioral health services • One-n-Ten • Suicide Prevention Resource Center • Solari 24/7 Crisis Line • Trinity Integrated Care • Community 43 - Behavioral health outpatient clinic • Mind 24/7	• Community Partnerships (Contracted or Community Grant) • Community Health Worker Program

Social Determinants of Health (Housing, Heat)	• Foundation for Senior Living • Chicanos Por La Causa - Housing • Catholic Charities - Affordable housing and social services • Maggie's Place • Central Arizona Shelter Services (CASS) - Homeless Shelter • Phoenix Rescue Mission - Homelessness • Circle the City - Respite Care, Homelessness • Key to Change • Phoenix Indian Center - Job preparedness, workforce development • Phoenix Rescue Mission - Housing / Homelessness • St. Vincent de Paul - Rent and utility assistance, medical and dental clinic. • Tanner Community Development Corp • Valley of the Sun United Way - Workforce Development and education	• Community Health Worker Program • Unite Us (community referrals) • Homeless resource navigator • CATCH (Internal Medicine Clinic) • CASS Hospital Transition Beds • Transportation Services (Lyft)
Access to Care	• Chicanos Por La Causa / Keogh Health Connection - Enrollment Assistance, Social Services, Economic Development • Foundation for Senior Living • Mission of Mercy - mobile clinic • Mountain Park Health Center - access to healthcare • Adelante Healthcare - access to healthcare • Elaine - Transportation for homeless and underserved • Native American Connection - Medical and health services, oral health • St. Vincent de Paul – Medical and dental clinic • Wesley Community & Health Centers - access to healthcare	• Community Health Worker Program • MOMobile • Financial Assistance Committee • ACTIVATE & Kindness Closet • Mission of Mercy (primary care to uninsured) • Keogh enrollment specialist • Cancer patient navigator

Chronic Conditions (Diabetes, Cardiovascular Disease, Chronic Kidney Disease)	• American Diabetes Association - Diabetes education and support • Arizona Diabetes Foundation - Education programs • Healthier Living Program - Chronic disease education program, cooking class • National Kidney Foundation of Arizona • Valley of the Sun YMCA - Diabetes Education program • Wesley Community & Health Centers - Acute and chronic disease management • Salud en Balance	• Healthier Living with Chronic Conditions / Tomando Control de tu Salud • Diabetes Empowerment Education Program • Muhammed Ali Parkinson's Center Programs
Substance Use	• Overdose Data to Action Partnership • Alcoholics Anonymous in Maricopa County • Narcotics Anonymous in Maricopa County • Nicotine Anonymous Meetings in Arizona • Hushabye Nursery • Maricopa County Crisis Line • Arizona 24/7 Crisis Line • National Substance Use and Disorder Issues Referral and Treatment Hotline (SAMHSA) • Arizona Overdose Assistance Referral Line • Terros Health: Substance use treatment • Crossroads Substance Abuse, Recovery & Relapse Prevention Centers • Community Bridges • Community Medical Services • NAMI Valley of the Sun	• Substance Use Navigator • Community Health Worker Program

Cancer	• Cancer Support Community of Arizona - Cancer Resource Navigator, access to care • American Cancer Society • The Froth and Bubble Foundation • Phoenix Cancer Support Network • Co-pay Relief Program • CancerCare Financial/Co-pay Assistance	• Patient Navigator (American Cancer Society) • Lifestyle management workshops • Medication assistance • Support groups • Transportation support • SJHMC Cancer patient navigator (Cancer Support Community of Arizona)
Maternal and Child Health (Preterm Births)	• Maggie's Place • Maricopa SHIFT • Hushabye Nursery • Women's Health Innovations - Maternal child health services	• MOMobile • Breastfeeding Support Groups • Pregnancy & Postpartum Support Group • Birthing & Baby Care Classes • Infant & Child CPR • Boot Camp for New Dads
Violence and Injury Prevention (Fall-related, Assault-related Injuries)	• A New Leaf - Domestic violence • Bloom365 - Dating violence • Control Alt Delete - Domestic violence • International Rescue Committee - Human trafficking • Jewish Family & Children's Service - Domestic violence • Phoenix Dream Center - Human trafficking • Streetlight USA - Human trafficking • The Faithful City - Domestic Violence, trafficking	• Stop the Bleed • Human Trafficking Taskforce • Trauma Injury Prevention Program • Barrow – Baseline Concussion Testing • Barrow – Brainbook • Barrow – Health professions education (concussion education for athletic trainers) • Balance Masters • Hospital-Based Violence Intervention Program

Table 12. Resources Potentially Available to Address Needs

Impact of Actions Taken Since the Preceding CHNA

Since the completion of SJHMC's 2022 CHNA, SJHMC has worked to address identified health priorities through targeted programs and initiatives. The following needs were identified and intended to be addressed by SJHMC: access to healthcare, cancer, and chronic health conditions. Due to limited capacity of hospital staff, available hospital services, and limited resources, SJHMC chose not to address these significant health needs: *addiction/substance abuse*, *affordable housing/homelessness*, *food insecurity*, *mental health*, and *safety and violence*. While SJHMC didn't directly address these needs, it will indirectly support work being done in the community to address these needs through strategic grant making and investments.[liv] The following is an overview of addressed priorities in 2022 for SJHMC, priority descriptions, and key community benefit programs that had an impact since the preceding CHNA.[liii]

Significant Need #1: Access to Healthcare (Maternal and Child Health, Financial Security)

Access to healthcare is defined as the timely use of health services to achieve the best possible health outcomes. Many people face barriers that prevent or limit access to needed health care services.[liii]

- MOMobile
- Financial Assistance Committee
- Transportation Services
- Keogh enrollment specialist
- CATCH Program
- Community Health Worker Program
- ACTIVATE & Kindness Closet
- Mission of Mercy Mobile Clinic Support
- Prenatal & Parenting classes
- CASS Hospital Transition Beds
- Unite Us
- Circle the City Homeless Resource Navigator
- Human Trafficking Taskforce
- Barrow – Baseline Concussion Testing
- Barrow – Brainbook
- Barrow – Health Professions education
- Barrow – Concussion Telemed

Significant Need #2: Cancer

Cancer is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.[liii]

- Cancer patient navigator
- SJHMC Cancer patient navigator
- Lifestyle management workshops
- Medication assistance
- Support groups

Significant Need #3: Chronic Health Conditions (Obesity, Diabetes, Cardiovascular Disease)

Chronic health conditions are health conditions or diseases that are persistent or otherwise long-lasting in their effects.[liii]

- Healthier Living with Chronic Conditions
- Tomando Control de tu Salud
- Diabetes Empowerment Education Program
- Equity Heals: Addressing Chronic Kidney Disease
- Muhammed Ali Parkinson's Center Programs
- Stop the Bleed
- CPR Classes
- Viva! A Family Centered Obesity and Diabetes Prevention Program

Conclusion

The 2025 Community Health Needs Assessment for SJHMC is a collaborative effort that helps shape health improvement strategies. Using a range of primary and secondary data sources, this assessment provides an overview of the community's health, guides leadership and staff engagement, and informs the hospital's priorities for the next three years **(Figure 39)**.

This needs assessment used a health equity lens to assess community health, focusing on inequities that disproportionally impact some communities more than others. The findings in this report will be used to guide the development of SJHMC's Implementation Strategy. Through this plan, SJHMC is able to make meaningful impact in the communities that they serve.

Figure 39. SJHMC's 2025 CHNA Priorities

Appendices

The appendix includes the following documents:

Appendix A
Participating Organizations in the Prioritization Meetings

Appendix B
SJHMC Primary Service Area Zip Codes

Appendix C
CHNA Assessment Tools and Reports
2023 CHNA Survey Methods
Survey Report
2023 CHNA Focus Group Methods
Focus Group Report
2023 CHNA Key Informant Interviews
Key Informant Interview Report

Appendix D
Vizient High Vulnerability Zip Codes

Appendix E
Top 10 Leading Causes of Death in Maricopa County (2018-2022)

Appendix F
Rated Community Assets in Maricopa County - Race/Ethnicity & Special Population

Appendix G
CHNA Data Source Crosswalk

Appendix H
References

Appendix A: Participating Organizations in the Prioritization Meetings

The Community Benefit Health Equity Committee and the Health Equity Alliance *participated* in the prioritization process by providing feedback through multiple iterations of a virtual data presentation. The participating organizations are listed below. The Community Grants Committee participated in the prioritization process by providing their feedback through an anonymous survey. Therefore, committee members who were *invited* to complete the survey will be listed.

Community Benefit Health Equity Committee	Health Equity Alliance	Community Grants Committee
Catholic Charities	Greater Phoenix Urban League	Chicanos Por la Causa
LISC Phoenix	Families Raising Hope	Mercy Care Arizona
MercyCare	Froth and Bubble Foundation	Foundation for Senior Living
Trinity Integrated Care	Peer Solutions	Salud En Balance
Arizona State Housing Department	Jacobs Hope	Promotores Hope Network AZ
Dignity Health	Wesley Community and Health Center	Peer Solutions
Chicanos Por La Causa	Maggie's Place	Helping Families in Need
PV Health Solutions	Cancer Matters	March of Dimes
Gonzalez Consulting LLC	March of Dimes	AZ Housing Coalition
Children's Action Alliance	State of Black Arizona	Jacobs Hope
	Promotores Hope Network AZ	Valley of the Sun YMCA
	Unlimited Potential AZ	Cancer Support Community Arizona
	Elaine AZ	Families Raising Hope
	AZ Housing Coalition	State of Black Arizona
	Mercy Care AZ	Froth and Bubble Foundation
	Foundation for Senior Living	Wesley Community and Health Center

Appendix B: SJHMC Primary Service Area Zip Codes (2024)

85003	85018	85035	85281	85338
85004	85019	85037	85282	85339
85006	85020	85040	85283	85340
85007	85021	85041	85301	85345
85008	85022	85042	85301	85351
85009	85023	85043	85303	85353
85012	85027	85044	85304	85383
85013	85029	85051	85304	85392
85014	85031	85053	85308	85395
85015	85032	85138	85323	85396
85016	85033	85201	85326	86301
85017	85034	85225	85335	86314

Appendix C: CHNA Assessment Tools and Reports

2023 CHNA Survey Methods

Methodology: Survey Questionnaire

The foundation for this survey questionnaire was developed by the National Association of County and City Health Officials.[lv] The survey was modified from its original version by Maricopa County Department of Public Health (MCDPH) staff, members of the Synapse Coalition, and the Health Improvement Partnership of Maricopa County (HIPMC). Additional questions and response options were added and modified from the 2019 and 2021 survey formats to improve inclusivity and to explore additional health and social concepts more granularly. The 2023 CHNA survey included 17 questions around demographics, perspectives on quality of life, and essential issues and behaviors impacting the health of the individual and community.

The questionnaire was available in both a paper format and a virtual format on the digital platform Alchemer and publicized on the Maricopa Health Matters website (maricopahealthmatters.org). The survey was offered in 14 languages — selected to align most closely with the Maricopa County population and communities served — including Arabic, Burmese, Chinese, Dari, English, French, Kinyarwanda, Korean, Lao, Navajo, Spanish, Swahili, Thai, and Vietnamese.

To increase accessibility, MCDPH provided large-font printed paper surveys, offered verbal survey taking over the phone through the CARES Line, and partnered with SAAVI Services for the Blind to develop surveys in Unified English Braille.

Methodology: Survey Recruitment

With Maricopa County's population exceeding 4.5 million residents, MCDPH mobilized community-based agencies and hospital/healthcare partners to develop a regionalized outreach strategy (Northeast, Northwest, Central, Southeast, Southwest) to help reach the survey goal of 15,000 diverse responses.

Using convenience sampling, MCDPH promoted the survey digitally through Facebook advertisements, professional networks, and in-person by attending events and tabling. MCDPH also provided funding to 23 community organizations serving focus populations underrepresented in data collection efforts, including those who are disabled, LGBTQ+, low-income, rural, immigrants, migrants, youths, seniors, unsheltered, and Veterans.

MCDPH staff identified and attended 187 community events across the county to promote and distribute the survey among identified focus populations, supported by MCDPH staff, MCDPH Medical Reserve Corps, Arizona State University (ASU) student volunteers, community agencies and healthcare partners. Survey participants at events were eligible to

receive a giveaway bag of their choice (summer safety, emergency, everyday essentials, or pre-packaged snacks).

Every week, MCDPH reviewed the status of data collection (progress to goal) and staff feedback to identify areas of underrepresentation. This process helped build a comprehensive and targeted outreach effort to ensure that all regional areas and focus populations in Maricopa County were reflected during data collection.

Methodology: Survey Analysis

Eight data entry assistants were trained for paper survey data entry. A protocol and an instruction manual were developed to standardize the paper survey data entry process. When possible, MCDPH staff members fluent in the additional languages entered paper surveys directly to mitigate errors. A third party was contracted to translate write-in responses from the surveys. After the survey cycle ended, raw data were exported from Alchemer into SAS. From there the Epidemiology team created an import code, cleaning code, and analysis code.

An "Other" or "Prefer to self-describe" selection was provided for 12 of the 17 survey questions. Most of the write-in responses to these selections were cleaned and categorized to an existing selection. New selections were created for write-in responses that were high in frequency ($n > 50$) and could not be categorized to an existing selection. A codebook was developed inductively based on the response data, and new selections were finalized with the consensus of the Epidemiology team and input from MCDPH subject matter experts. There were 8,127 write-in responses and 100% of them were analyzed.

The MCDPH Epidemiology team analyzed the cleaned survey data, excluding individuals who do not live in Maricopa County or submissions with insufficient responses answered. Responses were cleaned to address errors in the digital survey platform, discrepancies in data entry, and mistranslations. Cross-sectional frequencies were developed and ranked for various sub-categories following protocols for sufficient denominator size ($n \geq 50$) and numerator size ($n \geq 5$).

Survey Limitations

This assessment design and implementation included limitations. Because results were not based on a random sample, data should not be generalized to the full Maricopa County population. Rather, the data are best used to reflect the numerous community members who chose to express their thoughts during the time of data collection.

Limitations of convenience sampling include underrepresentation of groups and sampling bias. The effects of these limitations were mitigated by including outreach strategies that

focused on areas of underrepresentation by promoting at various locations such as health fairs, senior centers, and farmer's markets.

Lack of public knowledge on gender identity and sexual orientation related terms served as a barrier early in the data collection period, potentially resulting in non-response error due to incomprehension. To mitigate this issue, the MCDPH LGBTQ+ Community Health Specialist created a guide for staff to explain sexual orientation and gender identity terms to survey participants after one month of data collection.

2023 CHNA Focus Group Methods

Methodology: Focus Group Discussion Guide and Supplemental Survey Development

The focus group discussion guide was developed in partnership with the Maricopa County Department of Public Health (MCDPH) Community Health Needs Assessment (CHNA) team and Synapse Coalition. Southwest Interdisciplinary Research Center (SIRC) initiated the first version of focus group questions which stemmed from the 2015 and 2018 previous iterations of the CHNA and focus groups conducted by SIRC. These questions were modified for the 2023 CHNA to include team feedback yet were similar to previous versions in order to explore the data longitudinally. All processes and protocols were then reviewed and approved by the Arizona State University Institutional Review Board for research related projects involving human subjects. The review determined that the protocol was considered exempt.

The CHNA 2023 Supplemental Survey was modified from the 2023 CHNA Survey by SIRC to reformat the order of the demographic questions and explore additional areas of interest such as access to healthy food and physical activity. These questions were mainly close-ended questions to augment the focus group discussions. The survey was offered through the online platform Qualtrics in addition to a paper format. Taking the survey was optional and not a prerequisite for participating in the focus groups.

Methodology: Focus Group Recruitment

Purposive sampling via a screening questionnaire was used to recruit participants who lived in Maricopa County for at least six months of the year and met the criteria for one of the 17 priority populations identified by MCDPH and the Synapse Coalition healthcare partners: Asian, Black/African American, Disabled, Formerly Incarcerated, Hispanic, LGBTQ+, Low Income, Native American/American Indian, Native Hawaiian/Pacific Islander, Rural, Refugee/Immigrant/Migrant, Religious Minority, Youth (aged 12-17 years), Seniors (aged >65+ years) Unsheltered, and Veteran populations.

Marketing efforts included social media posts, English and Spanish flyers advertised in local businesses and community partner organizations, and word of mouth by SIRC evaluators and partners across Maricopa County. Focus groups were held on SIRC's Zoom platform and hosted in various regional locations across Maricopa County to ensure sufficient reach. These locations were volunteered by community partners.

All participants who attended the focus group sessions received a $45 Walmart gift card or Tango e-card as compensation for their time and were provided refreshments. Childcare arrangements were available upon request.

For participants with access to the internet, an anonymous Qualtrics survey lnk along with the focus group details (date, time, zoom link) was emailed by a SIRC Study Team member before the focus group. For participants where internet was not readily available, a paper copy of the survey along with the consent statement was administered on the day of the focus group prior to the start of the focus group. Those participating in person had the option to complete the survey either online or on paper.

Methodology: Qualitative and Quantitative Analysis

Both focus group and survey questions explored physical and mental health, connectedness, medical and mental health care, finances, health issues, discrimination, food, physical activity, and community. Focus groups were moderated by SIRC researchers and recordings were transcribed by a contracted third party. All names were redacted from transcripts to maintain anonymity. To ensure rigor and increased inter-coder agreement, three rounds of coding were conducted by experienced SIRC evaluators. Inductive analysis was primarily used to identify codes and themes as they emerged from the data. Deductive analysis was used to align with Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 themes and identify topics related to Health in Arizona Policy Initiative and Chronic Diseases.

After completion of the focus groups, the Qualtrics data file was downloaded into an Excel file. Paper surveys were entered into this file manually and the data was cleaned. After importing the data into SPSS software (version 27) for analysis, descriptive statistics based on survey responses were conducted in SPSS and Excel.

Focus Group Limitations

The focus group methodology is subject to a few limitations. First, the supplemental survey was self-reported and completed offsite, therefore no additional guidance could be provided if the respondent had clarifying questions. Additionally, there may have been respondents who took the supplemental survey but did not show up for the focus group.

2023 CHNA Key Informant Interviews Methods

Methodology: Data Collection

MCDPH contracted with OMNI Institute (OMNI) to carry out 24 key informant interviews. OMNI is a nonprofit social science consultancy that provides integrated research, evaluation, and capacity-building services to foster understanding, guide collaboration, and inform action to accelerate positive social change. The key informant interview design and implementation of the project proceeded through five phases: (1) development of the interview discussion guide and consent form; (2) outreach and recruitment for interviews and location securement; (3) data collection; (4) analysis and findings methods; and (5) report writing and presentation of findings.

Development of Interview Guide and Consent Form

To gather the needed context to inform the study design and tool development, OMNI obtained and reviewed pertinent documents from Maricopa County Department of Public Health (MCDPH), such as previous CHNA assessments and findings from the focus group component of the 2023 CHNA. This review informed the overall process and ensured that OMNI was building on, rather than duplicating, past work, making informed decisions, identifying gaps, and building on successes.

As described above, OMNI used the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework to develop the questions and approach for the key informant interviews. Part of the MAPP 2.0 framework is the Community Capacity Assessment (CCA) qualitative tool, which aims to gather insights, expertise, and perspectives from individuals and communities impacted by social systems to enhance the effectiveness and influence of those systems. Unlike approaches solely based on perceived community needs, the CCA delves deeper to uncover a community's strengths, resources, and cultural attributes. Recognizing the inherent vitality within all communities, the CCA underscores the importance of nurturing and bolstering community strengths in the pursuit of community betterment.

Drawing on the three areas of the CCA tool, OMNI designed an interview guide that addressed the following.

- Community strengths and assets: What strengths and resources are in communities that support health and well-being? How can community strengths and assets be used to address health inequities? Which organizations support community health and well-being?

- Built environment: What physical and cultural assets are in the built environment in communities? How may resources vary by neighborhood? How can the built environment promote and/or hinder community health and well-being?
- Forces of change: What are the current and historical forces of change locally, regionally, and globally that have shaped the political, economic, and social conditions of communities?

OMNI also developed a written Participant Informed Consent Form and protocols to support data collection. Both in the written consent form and verbally at the start of interviews, participants were made aware of their rights, risks, and how their information would be used in reporting. Participants then affirmed their desire to be interviewed.

Sample Population and Recruitment

Nomination Process

The MCDPH CHNA team facilitated a multiphase nomination process to identify community leaders to serve as key informants. A cross-sectional survey was sent to MCDPH staff, Synapse Coalition, Health Improvement Partnership of Maricopa County, and other community partners. The survey presented 15 business/health/community sectors and their definitions and requested respondents to nominate exemplary community leaders in their corresponding sectors. After this initial survey, the results were reviewed by a nomination committee composed of CHNA staff and MCDPH leadership. Primary and alternate key informants were selected in this process. The results were provided to OMNI for recruitment. When initial nominees were not available, OMNI shared this information with MCDPH, and their CHNA team made new selections for recruitment.

Recruitment

MCDPH and OMNI developed an outreach strategy for inviting key informants to participate in the assessment, whereby MCDPH CHNA staff sent an initial introductory email to potential participants. Once potential participants verified that they were interested in participating, OMNI followed up with a communication that further detailed the purpose of the assessment, participant rights, data privacy, and the option for an in-person or Zoom/phone call interview for a total of three outreach attempts. An alternate potential participant was provided to OMNI after three failed outreach attempts.

Sample

The 24 key informant interview participants were selected using purposive sampling, a non-probability sampling technique in which participants are selected because they have characteristics that are needed in a sample. MCDPH identified one to two participants in

key leadership or senior management roles to represent the 15 sectors of interest across geographic regions in the county. OMNI documented the geographic region served, populations served (e.g., adults with special health care needs, housing insecure community members, etc.) and ages served (e.g., children, adolescents, older adults, etc.) by the key informant.

Facilitation and Data Collection

For facilitator preparation, MCDPH and OMNI reviewed materials developed, including the interview guide, consent process, and approach to facilitation to ensure a consistent and standardized data gathering process that remained agile and responsive to the needs of each participant. OMNI and MCDPH agreed to a semi-structured neutral facilitation approach and the questions to prioritize if time was constrained. OMNI and MCDPH collaborated to ensure a culturally responsive interview approach that incorporated empathetic listening skills and navigation of difficult conversations founded within best practices for qualitative research and equitable evaluation principles.

Data collection took place from early February 6 - March 27, 2024. OMNI created and maintained an internal interview completion tracker to monitor communications, indicate when interviews were scheduled and completed, and document any barriers. The tool not only facilitated a systematic approach to scheduling interviews but also offered a real-time overview of completed interviews, allowing for quick and informed decision-making.

To build context ahead of each interview, organizational websites were reviewed and Maricopa County issues inventoried from professional and lived experiences. Interview questions were also shared with participants beforehand, though they were made aware that no prior preparation was required. Interviews were made available for in-person or via Zoom/phone call, and all but one participant selected a Zoom/phone interview. Additionally, per request, one of the interviews was conducted in Spanish.

Interviews ranged from 45 to 90 minutes, were attended by a second staff member for notetaking in addition to the facilitator, were audio recorded, and transcribed for analysis. Due to participants being leaders and representatives of county organizations (rather than community members), monetary incentives were not provided.

Methodology: Data Analysis

Validity and Reliability

To carry out the thematic analysis, OMNI employed an analytical framework that used MAPP 2.0 apriori codes and inductive codes. Because the questions for this assessment centered the MAPP 2.0 CCA tool, OMNI began by developing a deductive coding scheme around the three CCA domains of community strengths and assets, the built environment,

and forces of change. To anticipate that some codes could emerge inductively, each parent code had a "miscellaneous" child code that coders could use. This provided flexibility for coders to incorporate new insights, while ensuring the apriori coding scheme was not altered between initial coders. The analysis team then reviewed codes that were put under "miscellaneous" and determined if codes fell within existing themes or merited a new, inductive child code.

For additional rigor, OMNI included multiple coders for inter-rater reliability. Two interview facilitators, each code 12 transcript files. The Lead analyst served as the third data coder to provide the second round of coding for inter-rater reliability. To carry out the coding and thematic analysis, OMNI used Dedoose, a qualitative analysis software program that supports the systematic analysis of textual data. An apriori coding scheme was created to ensure consistency between reviewers. The team then came together after each initial coder had coded two transcript files to ensure alignment, answer any questions, and decide together if any inductive codes needed to be added to the coding scheme. The team of coders then proceeded to code the remaining data and assess for inter-rater reliability. By integrating multiple coders and employing both deductive and inductive approaches to the data, the team was able to employ a comprehensive analytical framework. This approach ensured that the subsequent analysis would be comprehensive, insightful, and reflective of the diverse range of perspectives captured through interviews.

Thematic Analysis

Data were analyzed in April of 2024, and the analysis team consisted of three writers (two of whom facilitated interviews) who reviewed codes and further organized them to determine what commonalities, patterns, and themes were evident from the data. To determine saliency or what constituted a major theme, OMNI noted the frequency of the coding when analyzing the data (i.e., how many times a coding category came up by the number of participants). However, frequency may not be the only criteria to use when determining what constitutes a major theme, as a finding may still be important, even if only surfaced a few times. Additionally, OMNI also paid attention to differing or outlying responses for contrast. In the report, themes or findings are organized in hierarchical order from most indicated responses to least to denote how prevalent a theme was in analysis.

Report Writing and Presentation of Findings

During April - May 2024, an OMNI team of five carried out the writing and formatting of the report in consultation with MCDPH.

Methodology: Data Considerations and Limitations

There were a few limitations to the study that are important to highlight:

1. **Community Issues Over Sector Focus:** While participants represented different sectors, many spoke about various community issues that were not always related to their specific sector. Therefore, themes emerged from interviews rather than being tied to specific sectors.

2. **Geographic Representation:** The nomination process focused on exemplary community leaders, which did not ensure even geographic representation. The Southwest and Northeast regions were not represented, and over half of the participants (54%) represented the entire state rather than specific regions.

3. **Participation Follow-Through:** Some nominees did not participate in the assessment for unknown reasons. Nominees came from diverse backgrounds and political ideologies, and some may have declined due to busy schedules or other factors such as the sociopolitical climate.

These limitations are crucial to consider when interpreting the study's findings and their implications.

Appendix D: Vizient High Vulnerability Zip Codes

Economic	85007	85009	85034
	85256	85301	85309
	85320	85321	85333
Education	85009	85017	85031
	85033	85035	85309
	85322		
Healthcare Access	85009	85017	85019
	85031	85040	85041
	85042	85043	85051
	85256	85264	85301
	85303	85305	85307
	85309	85320	85322
	85326	85333	85337
	85353	85354	85361
	85390		
Neighborhood Resources	85007	85034	85256
	85264	85321	85337
	85343		
Housing	85003	85004	85006
	85007	85008	85009
	85013	85014	85015
	85016	85017	85019
	85021	85026	85029
	85031	85033	85034
	85035	85040	85051
	85201	85202	85203
	85204	85210	85281
	85282	85301	85302
	85323	85337	85363
Clean Environment	85003	85004	85006
	85007	85008	85009
	85012	85013	85014
	85015	85016	85017
	85018	85019	85020
	85021	85022	85023
	85024	85026	85027
	85028	85029	85031

	85032	85033	85034
	85035	85037	85040
	85041	85042	85043
	85044	85048	85051
	85053	85201	85202
	85203	85204	85205
	85206	85208	85209
	85210	85212	85213
	85215	85224	85225
	85226	85233	85234
	85248	85250	85251
	85253	85254	85256
	85257	85258	85260
	85281	85282	85283
	85284	85286	85295
	85296	85301	85302
	85303	85304	85305
	85306	85307	85308
	85309	85323	85338
	85340	85345	85351
	85353	85363	85381
	85382	85392	85395
Social Environment	85003	85004	85006
	85007	85008	85009
	85015	85017	85019
	85026	85031	85033
	85034	85035	85037
	85040	85041	85042
	85120	85139	85210
	85256	85264	85281
	85301	85303	85309
	85320	85321	85323
	85335	85339	85342
	85343	85354	85363
	85390		
Transportation	85004	85007	85015
	85021	85034	85040
	85281	85301	85321
Public Safety	85003	85004	85006
	85007	85008	85009
	85012	85013	85014

	85015	85016	85017
	85018	85019	85020
	85021	85022	85023
	85024	85026	85027
	85028	85029	85031
	85032	85033	85034
	85035	85037	85040
	85041	85042	85043
	85044	85045	85048
	85050	85051	85053
	85054	85083	85085
	85086	85087	85201
	85202	85203	85204
	85208	85209	85210
	85212	85213	85254
	85256	85281	85282
	85283	85284	85301
	85302	85303	85304
	85305	85306	85307
	85308	85310	85331
	85339	85353	85363

Appendix E: Top 10 Leading Causes of Death in Maricopa County (2018-2022)

Leading Causes of Death in Maricopa County (2018-2022)					
	2018	2019	2020	2021	2022
1	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	Chronic Obstructive Pulmonary Disease	Alzheimer's	COVID	COVID	COVID
4	Alzheimer's	Chronic Obstructive Pulmonary Disease	Alzheimer's	Stroke	Stroke
5	Stroke	Stroke	Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary Disease	Chronic Obstructive Pulmonary Disease
6	Diabetes	All Drug Overdose	Stroke	All Drug Overdose	Alzheimer's
7	All Drug Overdose	Diabetes	All Drug Overdose	Alzheimer's	All Drug Overdose
8	All Mental Health	All Mental Health	Diabetes	Diabetes	Diabetes
9	Unintentional Injury	Unintentional Injury	All Mental Health	Unintentional Injury	Unintentional Injury
10	Fall Related Injury	Suicide	Unintentional Injury	All Mental Health	All Mental Health

Appendix F: Rated Community Assets in Maricopa County - Race/Ethnicity & Special Population

From the 2023 community survey, participants were asked to rate a series of community assets around where they live. Respondents could choose from "Very Good", "Fair", "Poor", or "Not Applicable."

The following tables display results from this question with the top three ratings of community assets by race/ethnicity and special population, focusing on the groups with the highest proportions of "poor" (lowest-rated) and "very good" (highest-rated) responses. Color coding is used to highlight trends across different groups.

<table>
<tr><th colspan="4">Top 3 Lowest-Rated Community Assets by Race/Ethnicity</th></tr>
<tr><th>Race/Ethnicity</th><th>1st</th><th>2nd</th><th>3rd</th></tr>
<tr><td>American Indian or Alaska Native</td><td rowspan="6">Access to affordable housing</td><td rowspan="3">Ability to communicate with local leadership and feel my voice is heard</td><td rowspan="2">Access to quality and affordable childcare</td></tr>
<tr><td>Multiracial</td></tr>
<tr><td>Black or African American</td><td>Access to affordable education after high school</td></tr>
<tr><td>Middle Eastern or North African</td><td>Access to quality mental health care</td></tr>
<tr><td>Hispanic, Latinx</td><td>Access to quality and affordable childcare</td><td>Feeling safe in public spaces</td></tr>
<tr><td>Native Hawaiian or Other Pacific Islander</td><td>Access to programs and activities for seniors 65+</td><td>Access to substance use treatment services</td></tr>
<tr><td>Asian</td><td rowspan="2">Access to quality public transportation</td><td rowspan="2">Access to affordable housing</td><td>Ability to communicate with local leadership and feel my voice is heard</td></tr>
<tr><td>White</td><td>Access to quality and affordable childcare</td></tr>
</table>

Top 3 Lowest-Rated Community Assets by Special Population			
Special Population	1st	2nd	3rd
Lesbian, Gay, Bisexual, Transgender	Access to affordable housing	Access to affordable education after high school	Access to quality and affordable childcare
Foster Youth/Former Foster Youth		Ability to communicate with local leadership and feel my voice is heard	
Homebound		Access to quality public transportation	Access to programs and activities for seniors 65+
Senior living in a Group		Access to quality and affordable childcare	Access to quality public transportation
Person with Disability			Ability to communicate with local leadership and feel my voice is heard
Person Experiencing Homelessness		Access to programs and activities for seniors 65+	
Refugee, Immigrant, Migrant			
Elderly	Access to quality public transportation	Access to substance use treatment services	Access to affordable education after high school
Military Member/Veteran		Access to affordable housing	Ability to communicate with local leadership and feel my voice is heard
Caregiver	Access to quality and affordable childcare		Feeling safe while driving

Top 3 Highest-Rated Community Assets by Race/Ethnicity			
Race/Ethnicity	1st	2nd	3rd
American Indian or Alaska Native	Feeling safe in your home (not worrying about burglary, domestic violence)	Access to parks and green spaces	Access to public libraries, community centers, and educational events
Multiracial		Opportunity to participate in religious,	Access to parks and green spaces

Black or African American	Access to parks and green spaces	spiritual, or cultural events	Feeling safe in your home (not worrying about burglary, domestic violence)
Middle Eastern or North African	Access to public libraries, community centers, and educational events	Access to parks and green spaces	Access to safe walking or biking paths
Hispanic, Latinx	Feeling safe in your home (not worrying about burglary, domestic violence)		Access to public libraries, community centers, and educational events
Native Hawaiian or Other Pacific Islander		Opportunity to participate in religious, spiritual, or cultural events	Accepting of all people (different cultures, identities)
Asian		Access to parks and green spaces	Opportunity to participate in religious, spiritual, or cultural events
White	Opportunity to participate in religious, spiritual, or cultural events		Access to public libraries, community centers, and educational events

Top 3 Highest-Rated Community Assets by Special Population			
Special Population	1st	2nd	3rd
Lesbian, Gay, Bisexual, Transgender	Access to high-speed internet	Feeling safe in your home (not worrying about burglary, domestic violence)	Access to public libraries, community centers, and educational events
Foster Youth/Former Foster Youth	Feeling safe in your home (not worrying about burglary, domestic violence)	Opportunity to participate in religious, spiritual, or cultural events	

Homebound	Access to parks and green spaces	Feeling safe in your home (not worrying about burglary, domestic violence)	Accepting of all people (different cultures, identities)
Senior Living in a Group	Feeling safe in your home (not worrying about burglary, domestic violence)	Access to places to stay cool during hot months	Opportunity to participate in religious, spiritual, or cultural events
Person With Disability	Opportunity to participate in religious, spiritual, or cultural events	Feeling safe in your home (not worrying about burglary, domestic violence)	Access to parks and green spaces
Person Experiencing Homelessness	Accepting of all people (different cultures, identities)	Opportunity to participate in religious, spiritual, or cultural events	Feeling safe in your home (not worrying about burglary, domestic violence)
Refugee, Immigrant, Migrant	Access to parks and green spaces	Feeling safe in your home (not worrying about burglary, domestic violence)	Opportunity to participate in religious, spiritual, or cultural events
Elderly	Opportunity to participate in religious, spiritual, or cultural events	Access to public libraries, community centers, and educational events	Access to places to stay cool during hot months
Military Member/Veteran		Access to parks and green spaces	
Caregiver	Access to parks and green spaces	Access to safe walking or biking paths	Access to places to stay cool during hot months Access to public libraries, community centers, and educational events Feeling safe in your home (not worrying about burglary, domestic violence)

Appendix G: Data Indicator Matrix

Indicates the indicator's data source & geographic level it's available

Resource Responsibility **HDD** - Hospital Discharge Data **BRFSS** - Behavioral Risk Factor Surveillance Survey **ACS** - American Community Survey (Census) **YRBS** - Youth Risk Behavior Survey **AYS** - Arizona Youth Survey **H-CUP** - The Healthcare Coast & Utilization Project **IP** - linpatient hospitalization **ED** - Emergency Department Visits	**Source**	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	**Level**	Maricopa County	Regions	Zipcode	National	State
Population Demographics																	
Gender				■							■		■	■	■	■	■
Age Groups				■							■		■	■	■	■	■
Race/Ethnicity				■							■		■	■	■	■	■
Education				■							■		■	■	■	■	■
Income				■							■		■	■	■	■	■
Employment Status				■							■		■	■	■	■	■
Access to Health Care																	
Health Insurance Coverage				■									■	■	■		
Poverty				■									■	■	■		
Health Care Coverage (18-64)			■										■			■	■
Usual Source of Care			■										■			■	■
Routine Checkup (last year)			■										■			■	■
Primary Payer Type for ED/IP		■									■		■	■	■	■	■
Birth Related																	
IMR						■	■						■	■	■		
Low Birth Weight							■						■	■	■		
PreTerm Births							■						■	■	■		
Teen Birth							■						■	■	■		
Prenatal Care Began							■						■	■	■		
Top 5 leading casuse of death						■							■	■	■		
Youth top 5 leading casuse of death						■							■	■	■		
Top 5 leading emergency department and hospitalization reasons		■									■		■	■	■	■	■
Cancer Incidence & Prevention																	
Cancer (by type) Incidence								■					■				
Cancer (by type) Screening			■										■			■	■
Cancer (by type) Deaths						■							■	■	■		
Chronic Disease																	
Stroke		■									■		■	■	■	■	■
Stroke Deaths						■							■	■	■		
% Been told they have high blood pressure			■										■			■	■
Cardiovascular Disease		■									■		■	■	■	■	■
Cardiovascular Disease Deaths						■							■	■	■		
% Told they have high cholesterol			■										■			■	■
Diabetes		■									■		■	■	■	■	■
Diabetes Deaths						■							■	■	■		
Been told they have diabetes			■										■			■	■
Alzheimer's ED/IP		■									■		■	■	■	■	■
Alzheimer's Deaths						■							■	■	■		
% told they have Confusion/Memory Loss			■										■			■	■
COPD ED/IP		■									■		■	■	■	■	■
COPD Deaths						■							■	■	■		
Been told they have asthma			■										■			■	■
Asthma ED/IP		■									■		■	■	■	■	■
Asthma Deaths						■							■	■	■		
Been told they have asthma			■										■			■	■

Resource Responsibility

HDD - Hospital Discharge Data
BRFSS - Behavioral Risk Factor Surveillance Survey
ACS - American Community Survey (Census)
YRBS - Youth Risk Behavior Survey
AYS - Arizona Youth Survey
H-CUP - The Healthcare Coast & Utilization Project
IP - Iinpatient hospitalization
ED - Emergency Department Visits

Source	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	Level	Maricopa County	Regions	Zipcode	National	State
Mental/Behavioral Illness																
Mood and Depressive Disorders		■								■		■	■	■	■	■
Schizophrenic Disorders		■								■		■	■	■	■	■
Drug-Induced Mental and Behavioral Disorders		■								■		■	■	■	■	■
All Mental/Behavioral disorders		■								■		■	■	■	■	■
Behavioral Health Risk Factors																
Alcohol Related ED/IP		■								■		■	■	■	■	■
Alcohol Related Deaths						■						■	■	■		
Intentional Self-Harm/Suicide ED/IP		■								■		■	■	■	■	■
Intentional Self-Harm/Suicide Death						■						■	■	■		
Opioids - Unintentional overdose ED/IP		■								■		■	■	■	■	■
Opioids - Unintentional overdose Deaths						■						■	■	■		
Alcohol/Drug use			■									■			■	■
Youth Alcohol/drug use								■				■				
Smoking			■									■			■	■
Youth Smoking								■				■				
Nutrition/Diet			■									■			■	■
Youth Nutrition/Diet					■											■
Physical Activity			■									■			■	■
Youth Physical Activity					■											■
Obesity			■									■			■	■
Youth Obesity					■											■
Injury																
Motor Vehicle Crash related ED/IP		■								■		■	■	■	■	■
Motor Vehicle Crash related Deaths						■						■	■	■		
Fall Related ED/IP		■								■		■	■	■	■	■
Fall Related Deaths						■						■	■	■		
Violence-related ED/IP		■								■		■	■	■	■	■
Violence-related Deaths						■						■	■	■		
Social Determinants of Health																
Transportation; no vehicle households									■			■	■	■	■	■
Access to Food; Low Income Low Access									■			■	■	■	■	■
Housing; cost burdened									■			■	■	■	■	■

Appendix H: References

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