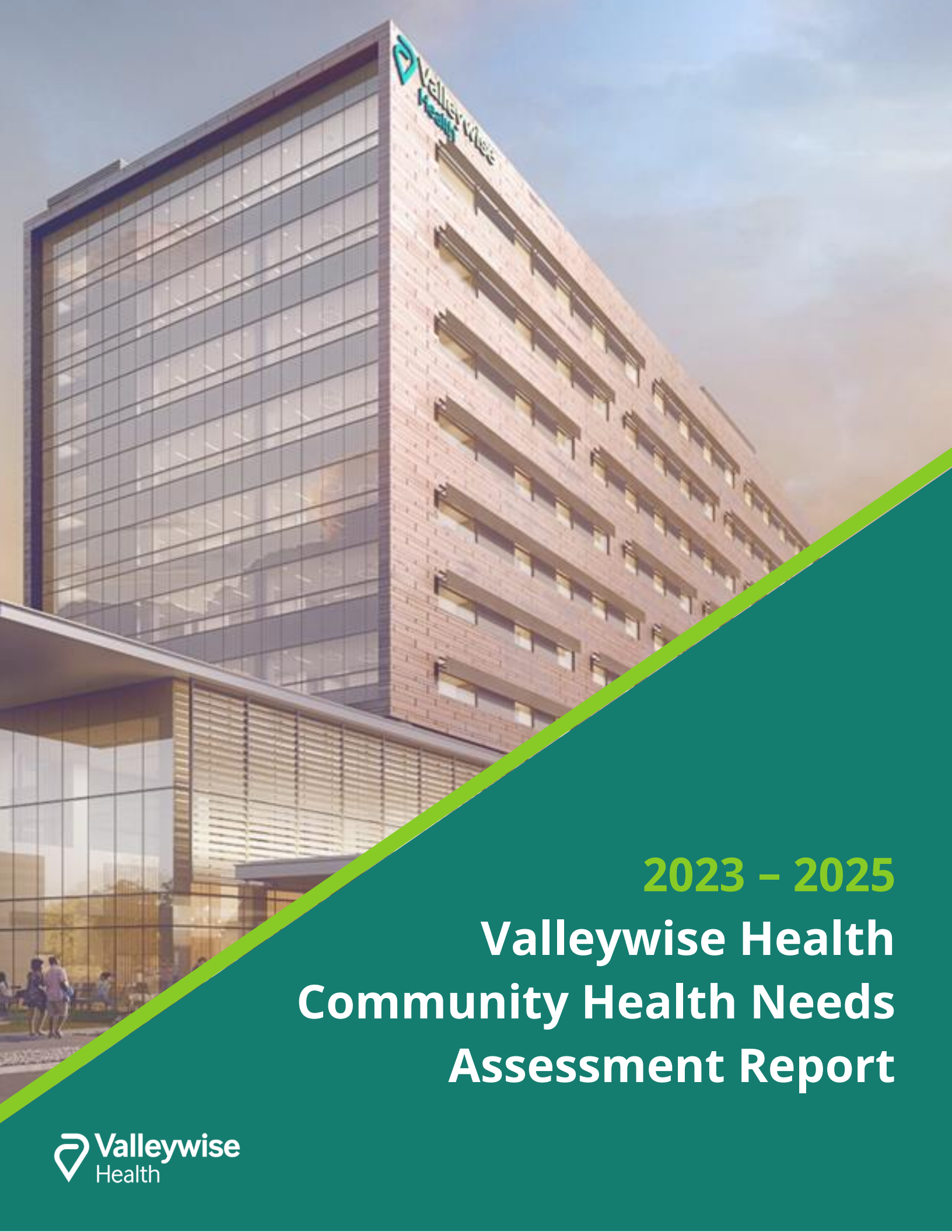

2023 – 2025

Valleywise Health Community Health Needs Assessment Report

Valleywise Health

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Executive Summary

CHNA Purpose Statement

This Community Health Needs Assessment (CHNA) aims to identify and prioritize significant health needs for the community served by Valleywise Health. The priorities identified in this report help to direct the healthcare system'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 serves as a guide to identify how Valleywise Health's existing efforts address the described needs of communities served. Additionally, this assessment will serve as an indicator to determine if the efforts to address perceived needs align with the needs of the communities served by Valleywise Health.

Community health centers, including Valleywise Health are required to complete or update a needs assessment of the current or proposed population at least once every 3 years, for the purposes of informing and improving the delivery of health center services. The needs assessment utilizes the most recently available data for the service area and special populations and addresses the following[i]:

Factors associated with access to care and health care utilization

such as geography, transportation, occupation, transience, unemployment, income level, educational attainment

The most significant causes of morbidity and mortality

such as diabetes, cardiovascular disease, cancer, low birth weight, behavioral health, as well as any associated health disparities

Any other unique health care needs or characteristics that impact health status or access to, and utilization of, primary care

such as social factors, the physical environment, cultural/ethnic factors, language needs, housing status

Valleywise Health Commitment and Mission Statement

The Valleywise Health mission is "to provide exceptional care, without exception, every patient, every time." Valleywise Health envisions being nationally recognized for transforming care to improve community health through accountability, compassion, excellence, and safety. With a 140-year history of providing care to a diverse population, regardless of a patient's ability to pay, Valleywise Health is a trusted name in healthcare for the entire community.

CHNA Collaborators

The Maricopa County Synapse Coalition includes member hospitals and healthcare entities who collaborate to conduct CHNAs. The following organizations are part of the Synapse Coalition:

- Adelante Healthcare
- Dignity Health
- Native Health
- Phoenix Children's
- Banner Health
- Mayo Clinic
- Neighborhood Outreach Access to Health
- Valleywise Health

In collaboration with Synapse and the Health Improvement Partnership of Maricopa County (HIPMC), Maricopa County Department of Public Health (MCDPH) spearheaded development of the CHNA survey used in this report and partnered with diverse community-based organizations to provide mini-grants for survey promotion and distribution. MCDPH contracted with Arizona State University Southwest Interdisciplinary Research Center (ASU SIRC) to conduct and analyze focus groups.

Assessment Process and Methods

Health needs for Valleywise Health were identified through the review of combined analysis including primary and secondary data sources.

Primary data sources include the 2019 and 2021 community surveys[ii,iii] and focus groups[iv,v]. The first round of community data collection occurred in the fall of 2019 and involved a community survey as well as a series of focus groups. In response to the severe changes in the community health landscape due to the COVID-19 pandemic, a supplemental survey and focus group cycle were conducted in the summer of 2021. In both rounds of data collection, focus groups prioritized

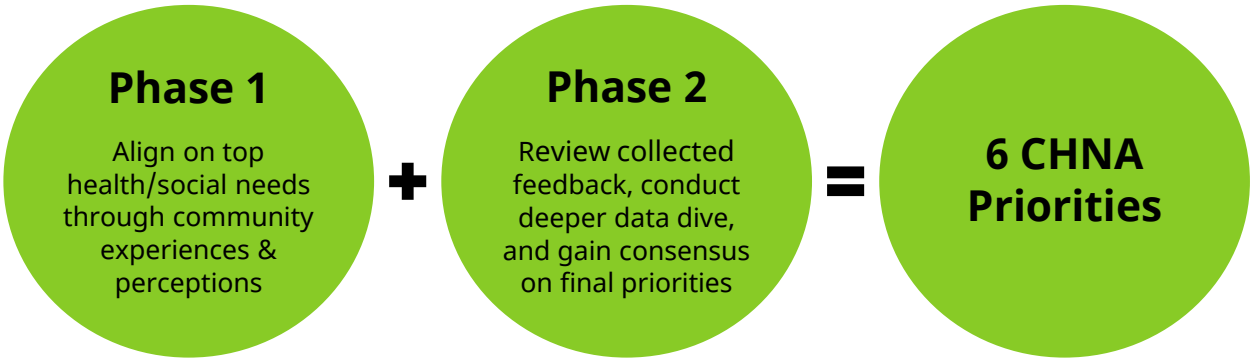
recruitment of underrepresented and underserved populations to identify community concerns and assets.

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

Process and Criteria to Identify and Prioritize Significant Health Needs

Valleywise Health's current cycle prioritization process to identify significant health needs included two phases. To better identify and categorize potential CHNA health indicators, Valleywise Health initially convened their Governing Council members and Dyad Management team to review and align on available primary and secondary data sources.

With the support from Valleywise Health, MCDPH facilitated interactive data presentation workshops with Valleywise Health's Governing Council members and Dyad Management team. The purpose of both presentations was to align on the CHNA background, decision-making criteria, present on health and social indicators, and prioritize significant health needs. Two meetings were conducted with each group – the first to present and align on initial data findings and the second to prioritize significant needs based on the input collected from the initial meetings. Through a structured feedback and engagement process facilitated by MCDPH and Valleywise Health, 6 priorities out of 16 priorities were identified and finalized for Valleywise Health to focus on in the next 3 years.



List of Prioritized Significant Health Needs

The following statements below summarize each of the priority areas for Valleywise Health and are based on data and information gathered through the CHNA. Valleywise Health recognizes that cancer disparities remain rooted in the communities that they serve as well as in the healthcare system. However, the final priorities selected focus on other areas that Valleywise Health can make the most significant impact on.

Diabetes: Diabetes is often associated with various co-morbidities which can lead to complications in disease management. As a result, this chronic condition can take a toll on quality of life, affecting physical, mental, and emotional well-being. According to the Maricopa County Community Survey, residents ranked diabetes as the 6th (2019) and 5th (2021) greatest community health condition.[ii,iii]

Heart Disease: Heart disease continues to be a growing burden in many communities. "Unhealthy eating habits, increased consumption of alcohol, lack of physical activity and the mental toll of quarantine isolation…all can adversely impact a person's cardiovascular risk."[vi] According to the Maricopa County Community Survey, residents ranked heart disease as the 7th greatest community health condition in 2019 and 2021.[ii,iii]

Hypertension: Hypertension is a main risk factor for development of other chronic conditions such as heart disease. Lifestyle modifications including changes in physical activity and diet can play a role in minimizing risks for hypertension. According to the Maricopa County Community Survey, residents ranked hypertension as the 4th greatest community health condition in 2019 and 2021.[ii,iii]

Mental Health: Mental health continues to be a growing crisis, especially after the onset of the COVID-19 pandemic. According to the Maricopa County Community Survey, residents ranked mental health as the 3rd (2019) and 1st (2021) greatest community health condition.[ii,iii]

Obesity/Overweight: Alongside of other chronic diseases, the COVID-19 pandemic has also exacerbated the obesity epidemic due to significant behavior changes including reductions in exercise and hours of sleep, along with increased alcohol use and smoking.[vii] According to the Maricopa County Community Survey, residents ranked obesity as the 2nd greatest community health condition in 2019 and 2021.[ii,iii]

Substance Use & Abuse: With the amplification of mental health conditions, substance use & abuse continues to be on the rise and disproportionally impact many communities. According to the Maricopa County Community Survey, residents ranked substance use & abuse as the 1st (2019) and 3rd (2021) greatest community health condition.[ii,iii]

Prioritized Health Needs: Disparities

There are many complexities to addressing health disparities and achieving health equity. Advancing health equity takes more than just ensuring that the community, partners, and leadership are invested to bridge the gap in resources and health outcomes. To start moving the needle, it's imperative that communities align on concepts of health disparity and health equity to promote effective collaborative work and future opportunities. Healthy People 2030 defines *health disparity* and *health equity* as the following[viii]:

Health Disparity:

"A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[viii]

Health Equity:

"The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[viii]

Valleywise Health prioritized significant health needs by utilizing a health equity lens to identify the most pressing health needs with the most extensive disparities in Valleywise Health's primary service area (PSA). An example of how this health equity lens was utilized is that all data indicators were stratified in analysis by race/ethnicity, age, and sex.

Table 1 displays a snapshot of identified health disparities among Valleywise Health's selected priorities. For each health indicator in Valleywise Health's PSA, disparities are highlighted by each data category of inpatient hospitalization (IP), emergency department (ED), and death.[ix]

Table 1. Health Indicator Disparities: Highest IP[1]/ED[2]/Death[3] rates by groups of residents living within Valleywise Health's PSA (2021)

Indicator	Race/Ethnicity	Age	Sex
Diabetes	American Indian[1, 3] Black/African American[2]	45-64[1, 2] 65+[3]	Male[1, 2, 3]
Heart Disease	Black/African American[1, 2, 3]	65+[1, 2, 3]	Male[1, 2, 3]
Hypertension	Hispanic[1] Black/African American[2, 3]	45-64[1, 2] 65+[3]	Female[1, 2] Male[3]
All Mental Health Disorders	Black/African American[1] American Indian[2]	25-44[1, 2]	Male[1, 2]
Obesity/Overweight	Black/African American[1, 3] White/Caucasian[2]	25-44[1, 2] 45-64[3]	Male[1, 2, 3]
Substance Use (All Drug Overdose)	Black/African American[1, 2] American Indian[3]	25-44[1, 2, 3]	Male[1, 3] Female[2]
Substance Use (Alcohol Related)	American Indian[1, 2, 3]	25-44[1, 2] 45-64[3]	Male[1, 2, 3]

Primary Care and Mental Health Professional Shortage Area Status

Health Professional Shortage Areas (HPSAs) play a role in health care utilization and overall health outcomes. Although HPSAs may be more prevalent in rural communities due to the lack of access to healthcare providers and facilities, they can also exist in urban communities due to factors such as poverty, public transportation, lack of insurance.[x] Pinpointing these HPSAs helps to identify underserved communities who need additional healthcare resources. According to PolicyMap, "All HPSAs are defined based on three criteria: the ratio of population to health providers, percent of population below the federal poverty level, and travel time to the nearest source of care outside the HPSA area.[xi]

Figure 1 below displays the Primary Care HPSA status in Valleywise Health's primary service in 2023. Primary Care HPSAs consider infant mortality rate and low birth weight rate.[xi] Valleywise Health locations are indicated by corresponding numbers on the map.

Figure 1. Primary Care HPSA Status in Valleywise Health's PSA (2023)

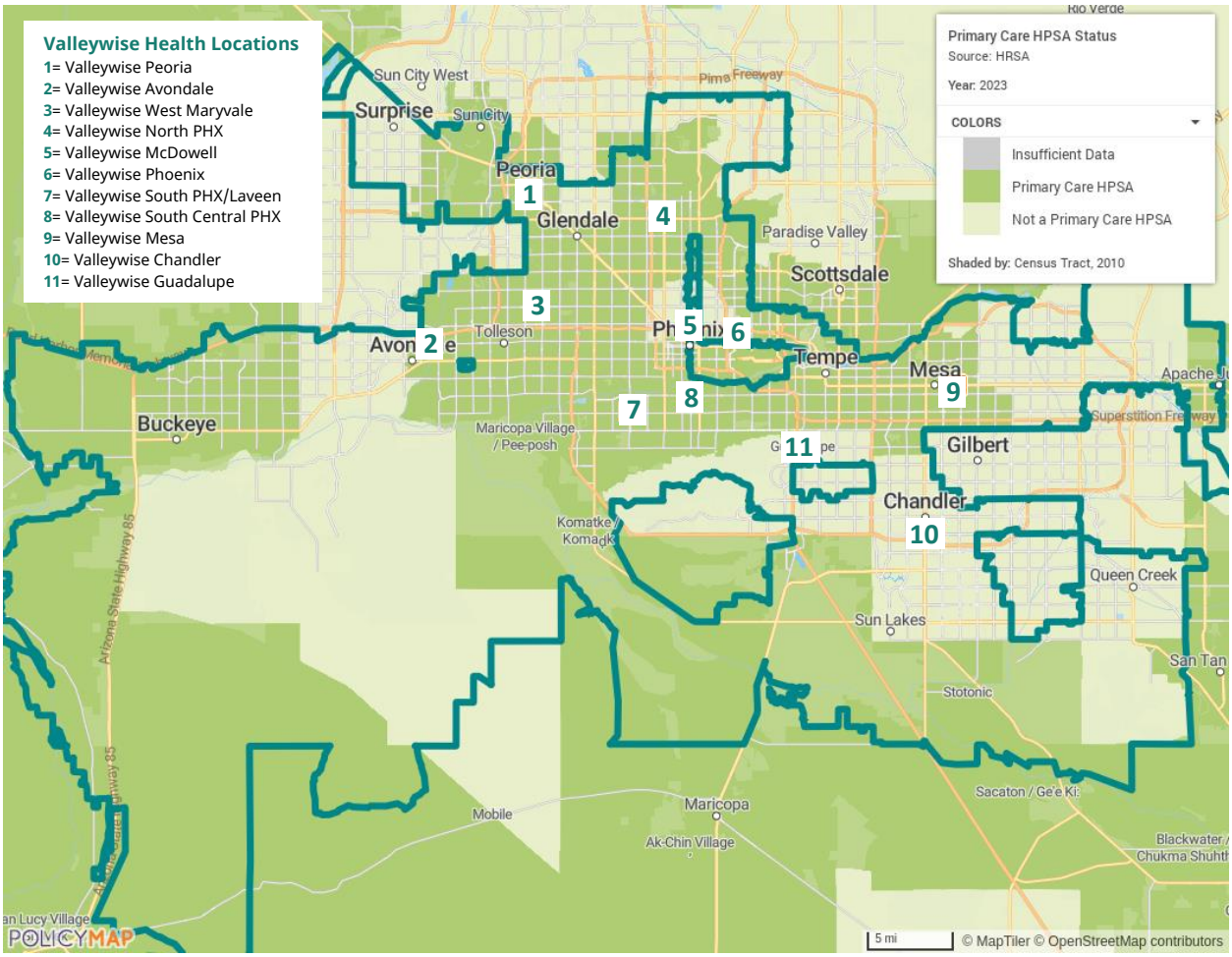
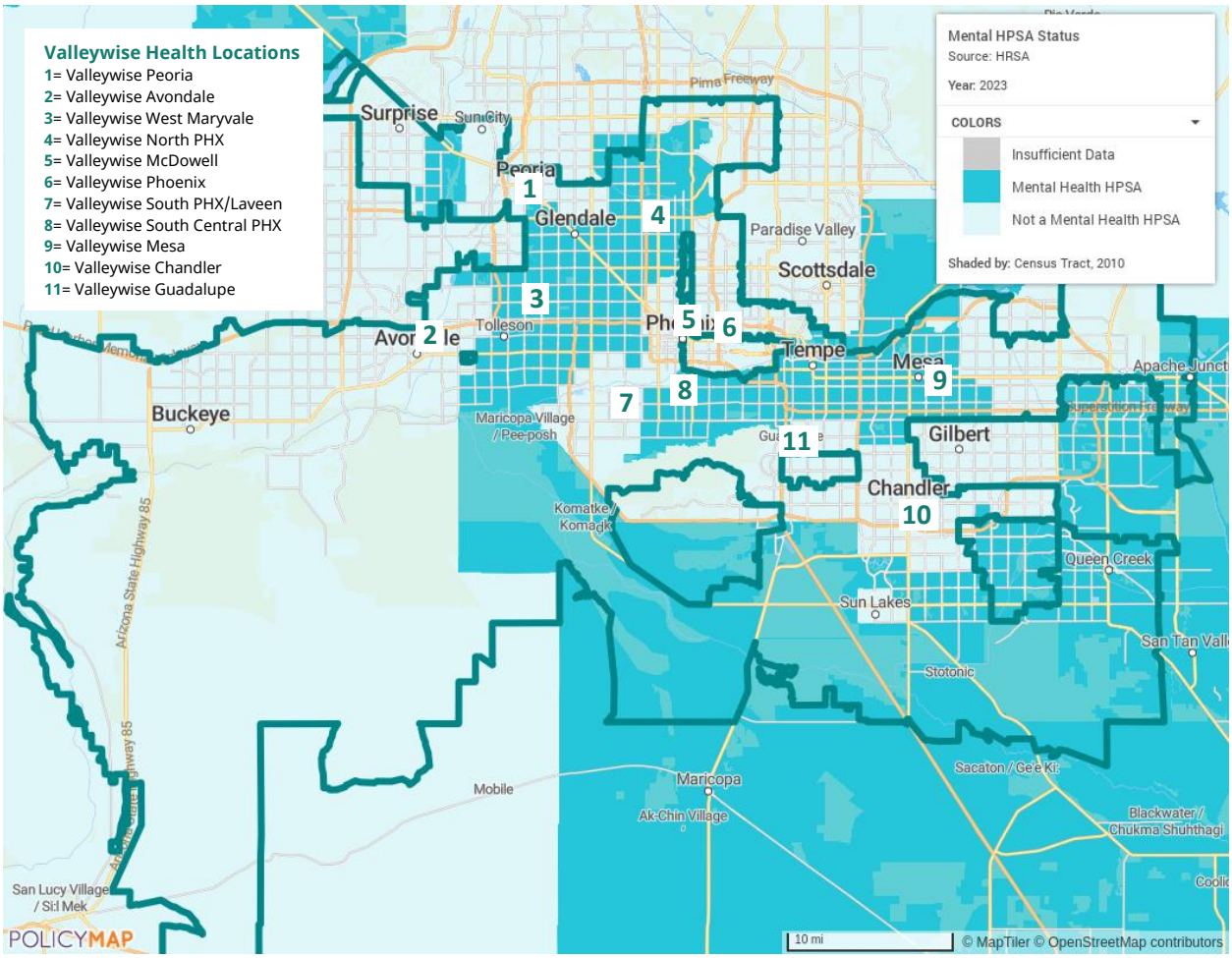


Figure 2 below displays the Mental HPSA status in Valleywise Health's PSA in 2023. Mental HPSAs consider substance and alcohol abuse prevalence, and percentage of the population over the age of 65 or under the age of 18.[xi]

Figure 2. Mental HPSA Status in Valleywise Health's PSA (2023)



Evaluating Primary Care and Mental HPSAs in Valleywise Health's PSA is fundamental to ensure appropriate community resource allocation and reduce redundant approaches. By utilizing this lens, Valleywise Health can address disparities in healthcare access efficiently to ensure adequate healthcare access for all people.

Resources Potentially Available

Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community-based organizations. Resources include access to over 40 hospitals for emergency and acute care services, over 10 different organizations with Federally Qualified Health Center (FQHC) designated community health centers, over 12 food banks, 8 homeless shelters, school-based health clinics, churches, transportation services, health enrollment navigators, free or low cost medical and dental care, behavioral health services, and prevention-based community education.

Valleywise Health also participates in the Health Improvement Partnership of Maricopa County – a collaborative effort between MCDPH and a diverse array of public and private organizations addressing healthy eating, active living, linkages to care and tobacco-free living. With more than 100 partner organizations, this is a valuable resource to help Valleywise Health connect to other community-based organizations that are targeting many of the same health priorities.

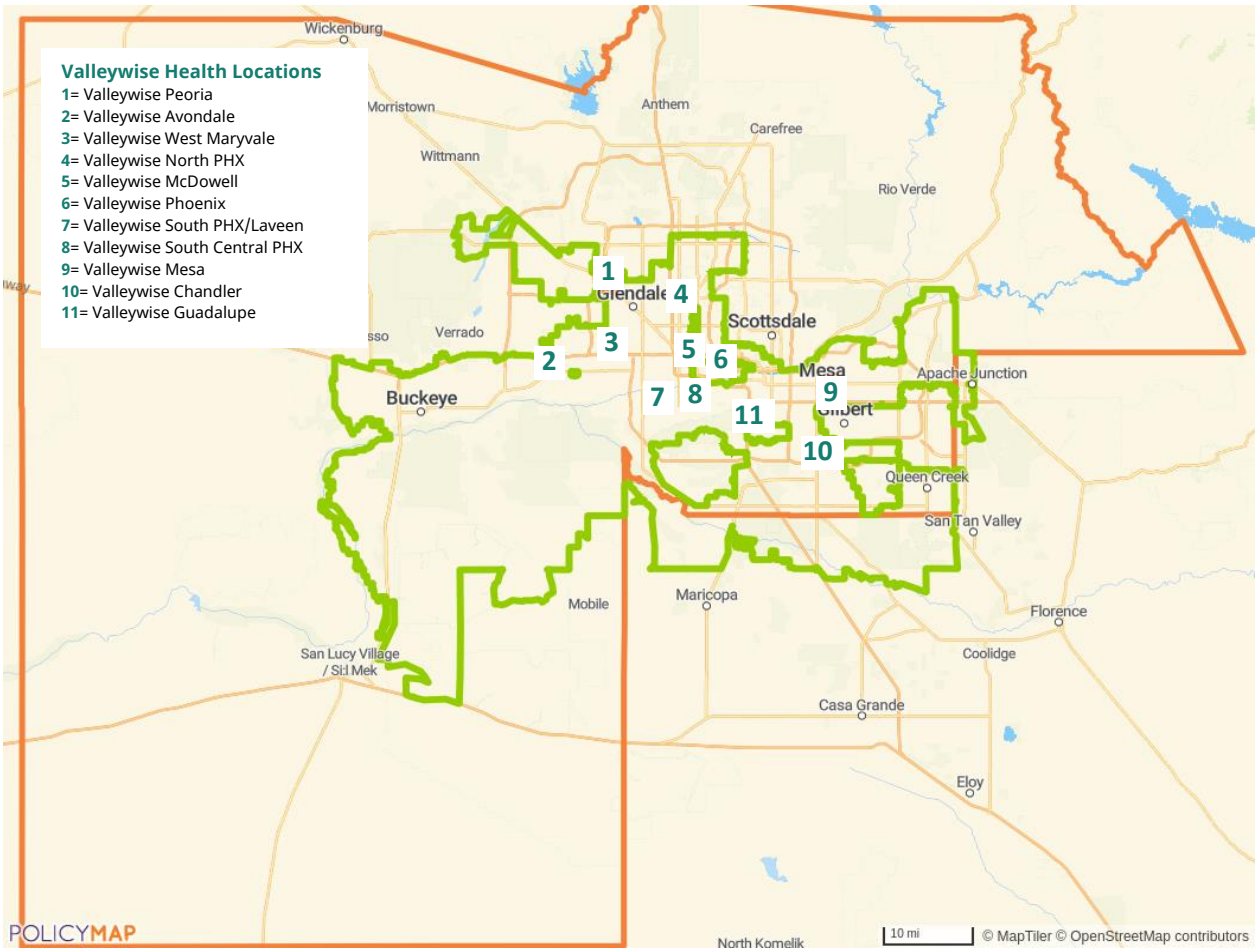
Report Adoption, Availability, and Comments

The Valleywise Health Governing Council adopted this report on November 1, 2023. This report is widely available to the public on the web site https://valleywisehealth.org/about/governing-council/ and a paper copy is available by request from Michelle Barker, Sr VP Ambulatory Services & CEO FQHC Clinics, at michelle.barker@valleywisehealth.org. Written comments on this report can be submitted to Michelle Barker, Valleywise Health 2609 East Roosevelt St, 6th Floor Exec Suite, Phoenix, AZ 85008, or by email at: michelle.barker@valleywisehealth.org.

Community Definition

Valleywise Health serves residents across Maricopa County with 14 FQHCs that span this region (**Figure 3**)[xi]. In this report, data will be provided for Valleywise Health's PSAs which represent the zip codes where more than 75% of Valleywise Health's patients reside.

Figure 3. Valleywise Health's Primary Service Areas in Maricopa County



Maricopa County is the fourth most populous county in the United States. Based on the 2021 American Community Survey, Maricopa County has an estimated population of over 4.3 million, which is home to well over half of Arizona's residents.[xii] Maricopa County encompasses 9,224 square miles, includes 24 cities and towns and several unincorporated communities, and 5% of Indigenous land from tribes including: Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation.[xiii]

Medically Underserved Areas

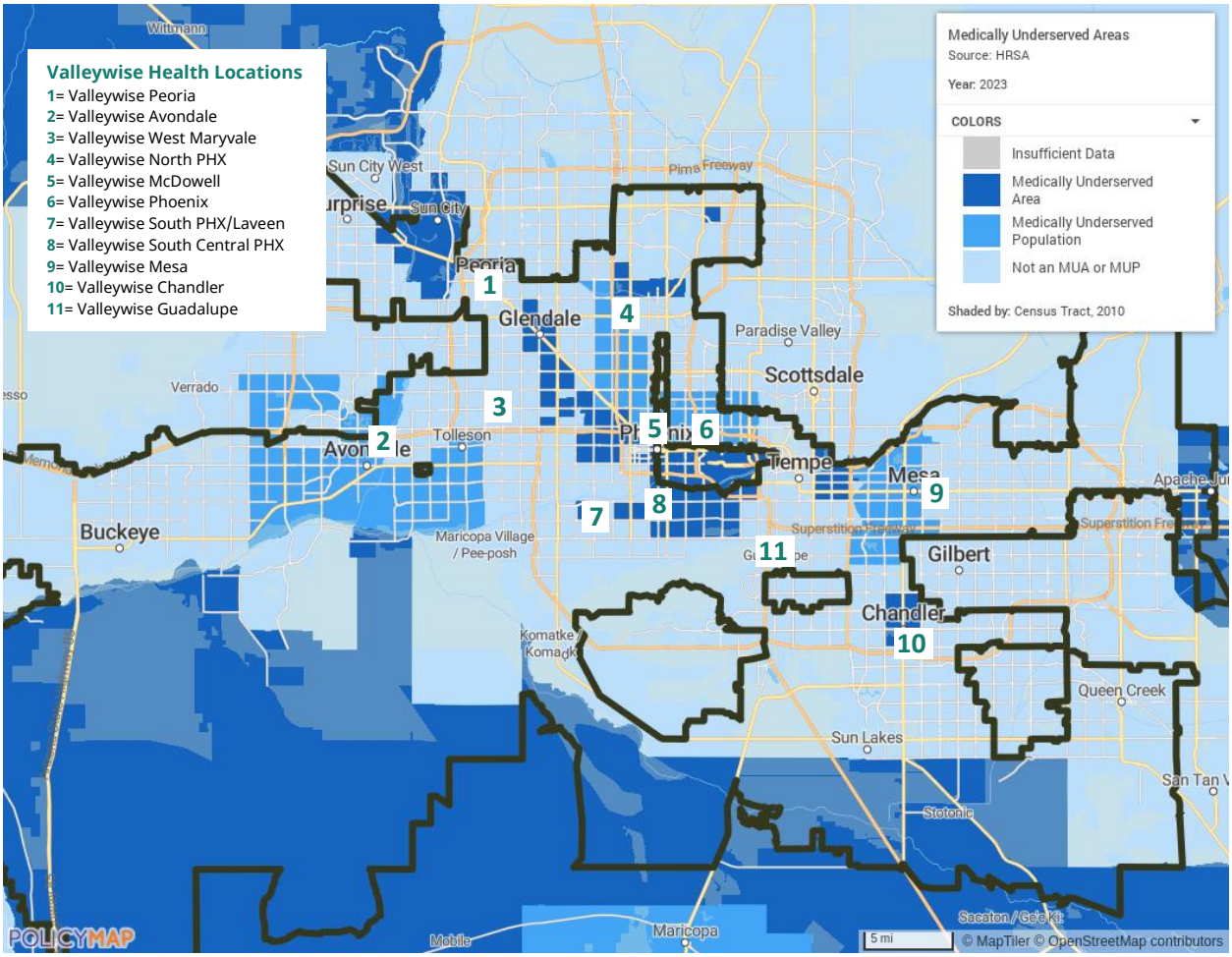
As a part of the CHNA process, health centers must define and annually review the boundaries of the catchment area to be served (service area), including the identification of the medically underserved population or populations within the catchment area.[i] The Arizona Medically Underserved Areas (AzMUA) report is prepared by the Arizona Department of Health Services (ADHS) to better understand medically underserved areas in Maricopa County. This report is also used for planning the delivery of primary care services.[xiv] **Table 2** displays primary care areas that were federally designated as medically underserved areas.[xiv]

Table 2. Medically Underserved Primary Care Areas in Maricopa County

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

According to PolicyMap, "Medically Underserved Areas are designated by the Health Resources & Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population. Medically Underserved Populations (MUP) are areas where a specific population group is underserved, including groups with economic, cultural, or linguistic barriers to primary medical care. If a population group does not meet the criteria for an MUP, but exceptional conditions exist which are a barrier to health services, they can be designated with a recommendation from the state's Governor".[xi] **Figure 4** displays medically underserved areas in Valleywise Health's PSA.

Figure 4. Medically Underserved Areas in Valleywise Health's PSA (2023)



Demographic and Socioeconomic Profile

Demographic and economic factors such as age and poverty level affect healthcare need and access.[i] **Table 3** describes the demographic and socio-economic profile of the population who reside in Valleywise Health's PSA, Maricopa County, and Arizona.[xii]

Table 3. Demographic/Socioeconomic Profile of Valleywise Health, MC & AZ (2021)

Total Population	**Valleywise Health** 2,779,945	**Maricopa County (MC)** 4,367,186	**Arizona (AZ)** 7,079,203
Population by Race/Ethnicity			
American Indian	2%	2%	4%
Asian	3%	4%	3%
Black	6%	5%	4%
Hispanic	55%	31%	32%
White	34%	54%	53%
Population by Sex			
Male	50%	50%	50%
Female	50%	50%	50%
Population by Age Group			
1-14	21%	20%	19%
15-24	15%	13%	13%
25-44	29%	28%	26%
45-64	23%	24%	24%
65+	13%	15%	18%
Population by Educational Attainment			
Less than 9th grade	7%	5%	5%
9th to 12th grade, no diploma	8%	6%	7%
High school graduate (includes equivalency)	25%	22%	24%
Some college, no degree	24%	24%	25%
Associate's degree	9%	9%	9%
Bachelor's degree	18%	22%	19%
Graduate or professional degree	10%	13%	12%
Income			
Household Income	Min: $40,717 Max: 130,938	Median: $72,944	Median: $65,913
Poverty			
Percent persons below poverty level	15%	12%	14%
Under age 18 in Poverty	22%	17%	19%
Employment Status			
Employed	94%	95%	94%
Unemployed	6%	5%	6%
Health Insurance Coverage			
Insured	86%	89%	89%
Uninsured	14%	11%	11%

Assessment, Process and Methods

Maricopa County health centers and hospitals play significant roles in the region's overall health and economy. In addition to providing high-quality medical care, these institutions work to improve regional health through programs that promote health in response to identified community needs. Health care partners often serve overlapping communities across Maricopa County. As a result, Adelante Healthcare, Banner Health, Dignity Health, Mayo Clinic, Native Health, Neighborhood Outreach Access to Health, Phoenix Children's, and Valleywise Health joined forces with MCDPH through the Synapse Coalition to identify the communities' strengths and greatest needs in a coordinated community health needs assessment.

Valleywise Health, as a member of Synapse, contracted with MCDPH starting in 2020 to conduct the 2023 CHNA process. The CHNA utilizes a mixed-methods approach that includes the collection of primary sources like community input data from focus groups, surveys, and meetings with community stakeholders and secondary sources like hospital discharge and death data. The process incorporated both primary and secondary data to iteratively inform each other, leading to high quality data through the cross-references of many sources.

Primary Data

The first round of community data collection occurred in the fall of 2019 and involved a community survey as well as a series of focus groups. MCDPH contracted with ASU SIRC to conduct the focus group analysis. In response to the severe changes in the community health landscape due to the COVID-19 pandemic, a supplemental survey and focus group cycle was conducted in the summer of 2021. Both data sources are included in this assessment to provide a robust evaluation of community needs, both before and during the pandemic.

2019 Community Health Needs Assessment Focus Groups[iv] (Appendix B)

A total of 52 focus groups were conducted between August 2018 and December 2019 with medically underserved populations across Maricopa County including youth in the third and final cycle. The groups consisted of specific ethnic groups: (1) African Americans, (2) Native American, (3) Congolese, (4) Hispanic, and (5) Filipino. Other groups represented were: (6) homeless populations, (7) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) persons including veterans, and migrant seasonal farmworkers, (8) people who've been incarcerated, (9) people in rural communities, (10) new parents, and (11) parents of children with special health care needs. Six groups were conducted in Spanish, one in Mandarin, one in Swahili and the remainder in English.

The focus group design and execution proceeded through 5 phases: (1) initial review of literature; (2) focus group discussion guide development; (3) focus group recruitment; (4) focus group data collection; and (5) report writing and presentation of findings. Focus group participants were asked to complete a survey that assessed a variety of factors that could have an important impact on individual and community health and quality of life. These were mainly closed-ended questions to augment the focus group discussions. The focus group data were analyzed and organized thematically to highlight prevalent ideas across the groups as well as surprising/unique responses from particular focus groups.

2021 COVID-19 Impact Community Health Needs Assessment Focus Groups[v] (Appendix B)

Between February and June 2021, a series of 33 focus groups were conducted which included 186 participants across various community regions, service providers and individual residents to better understand the impact of COVID-19 on Maricopa County residents. Focus groups helped to identify and address health needs, resource allocation, and long-term services needed for COVID-19 response efforts. Members of the community representing subgroups, defined as groups with unique attributes (race/ethnicity and ethnicity, age, sex, culture, lifestyle, or residents of a particular area of Maricopa County), were recruited to participate in focus groups. A standard protocol was used for all focus groups (Appendix B) to understand the experiences of these community members as they relate to the impact of COVID-19 on Maricopa County residents. In all, a total of 33 focus groups were conducted with 186 community members from 5 geographic Maricopa County locations based on the following groups: (1) older adults; specific ethnic groups (2) African American; (3) Hispanics/Latino; (4) Native American; (5) Asian American; (6) ethnic minority young adults; (7) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) persons; (8) veterans; (9) new parents; (10) parents of young children, and (11) refugees.

The focus groups explored the topics of COVID-19 impact, barriers, concerns, messaging, trust in public health, vaccine intent, vaccine choices, and vaccine hesitancy. Participants also spent a great deal of time discussing health care, obstacles to care, access to food, financial well-being, and quality of life. To complement the focus groups, 158 respondents (most but not all of whom participated in the focus groups) completed an online anonymous questionnaire that asked about COVID-19 concerns, social determinants of health, medical trust, and mental and physical health. Participants discussed declines in mental health and physical health and barriers to the vaccine as well as vaccine hesitancy and confusion. Suggestions were offered for messages and for who would influence their vaccine decisions, noting that one size does not fit all. The focus group data were analyzed and organized thematically to highlight prevalent ideas across the groups as well as surprising/unique responses from particular focus groups.

2019 Maricopa County Community Survey[ii] (Appendix B)

Between February and June 2019, MCDPH collected community surveys from residents and professionals within Maricopa County. This survey is part of the Coordinated Maricopa County Community Health Needs Assessment (CCHNA) designed to identify priority health issues, resources, and barriers to care within Maricopa County through a community-driven process known as Mobilizing for Action through Planning and Partnerships (MAPP). A total of 22 survey questions were included, organized by the following sections: Physical and Mental Health, Health Care and Living Expenses, Barriers and Strengths of the Community, and Health and Wellness of the Community.

The survey questionnaire was originally developed by the National Association of County and City Health Officials (NACCHO). The survey was modified from its original version by members of the Synapse Coalition, a group of non-profit hospitals and federally qualified health care providers, the HIPMC, and MCDPH staff. Response options were expanded from the original format to include additional health issues and social determinants of health. The questionnaire was provided on a digital platform using Qualtrics® in addition to a paper format. All surveys were provided in English and Spanish. There was minimal request for additional language translations, so MCDPH worked with partners who were able to assist individuals as translators to complete the survey.

The goal for the community survey was 15,000 responses, however once all data was cleaned to ensure usability, a total of 11,893 surveys were collected from community residents ages 14 and above. The digital survey was sent out via extensive community partner networks throughout Maricopa County including internal programs, hospital/healthcare systems, municipalities, school districts, and social media, allowing us to maximize resources. The survey was widely publicized with community and healthcare partners prior to March 1, 2019 to secure presence at community events and provide online advertisement to redirect individuals to the survey.

2021 Maricopa County COVID-19 Community Impact Survey[iii] (Appendix B)

COVID-19 was declared a global pandemic in March of 2020, and this set off a series of drastic changes to everyday life for residents of Maricopa County. From May - July 2021, MCDPH mobilized data collection resources and community partnerships to explore how COVID-19 had impacted residents. This COVID-focused survey is part of the CCHNA designed to identify priority health issues, resources, and barriers to care. Survey questions were grouped into the following sections: Demographics, Physical and Mental Health, Health Care and Living Expenses, COVID-19 Impact on Employment, Barriers, Strengths, Health Conditions, Community Issues, Survey Usability, and Other Noteworthy COVID-19 Experiences. The questionnaire was primarily provided on a digital platform using

Alchemer© and was provided in over 12 languages (Arabic, Burmese, Chinese, English, French, Kinyarwanda, Korean, Lao, Spanish, Swahili, Tagalog, Thai, and Vietnamese).

The 2021 survey was based off NACCHO's Example Community Health Survey.[xv] The survey was modified from its original version by members of the Synapse Coalition, the HIPMC, and MCDPH staff. Additional questions and response options were added and modified from the original format to assess the impact of COVID-19 on Maricopa County residents and explore additional health issues and social determinants of health. Free response questions were analyzed through a thematic analysis. A codebook was developed inductively based on the response data, and key themes were identified with the consensus of the MCDPH community impact team and epidemiology team. At least 50% of the collected responses from each region in Maricopa County were analyzed and coded with key themes, totaling 2,186 responses analyzed. Key themes were ranked by frequency.

The goal for the community survey was 15,000 responses, however a total of 14,380 surveys were completed by residents of Maricopa County. MCDPH partnered with an extensive network of community-based organizations and healthcare partners to collect community surveys from residents and professionals within Maricopa County. The MCDPH team wanted to ensure diverse community representation and that the survey provided insight from all regions (Northeast, Northwest, Central, Southeast, and Southwest) of the county. MCDPH collaborated with several community-based organizations to provide stipends from $2,000 - $5,000 to support survey translation, distribution & completion, social media outreach via networks, purchase of incentives for survey completion, and administrative expenses.

2023 Maricopa County Community Survey

Beginning in spring 2022, MCDPH began preparations for the 2023 CHNA data collection cycle with guidance from Synapse. Along with other Synapse members, Valleywise Health contributed to the development of survey and focus group questions. From March to June 2023, MCDPH spearheaded data collection. Valleywise Health promoted the surveys among staff, clients, and community members – contributing many surveys to the total. As of October 2023, MCDPH is conducting a thorough data validation and analysis process, with results expected in spring 2024. MCDPH is using the recently released MAPP 2.0 framework for analysis and reporting to continue the cycle of timely and relevant community feedback.

Secondary Data

Many of the challenging health problems facing the United States in the 21st century require understanding the health of communities – not just individuals. The challenge of maintaining and improving community health has led to the development of a "population health" perspective. Population health is defined by the Institute for Healthcare Improvement as "the health outcomes of a group of individuals, including the distribution

of such outcomes within the group."[xvi] A focus on population health implies a concern for the determinants of health for both individuals and communities. The health of a population grows directly out of the community's social and economic conditions as well as the quality of its medical care. As a result, the CHNA utilizes a population health framework for this report to develop criteria for indicators used to measure health needs.

Quantitative data used in this report are high quality, population-based data sources and were analyzed by the MCDPH Office of Epidemiology. Secondary data was collected from local, state, and national sources from MCDPH, ADHS, U.S. Census Bureau (American Census Survey), Centers for Disease Control and Prevention (CDC), Healthy People 2030, and PolicyMap. Secondary data includes Maricopa County Hospital Discharge Data (HDD - inpatient hospitalization, emergency department, death), Maricopa County birth data, demographic data, heath equity definitions, and maps related to medically underserved areas, and primary and mental HPSA status.

Hospital Discharge Data, Death Data, and Birth Data

MCDPH receives HDD bi-annually from ADHS.[ix] HDD consists of inpatient (IP) and emergency department (ED) discharge data for most Maricopa County hospitals. Data is collected based on the discharge date of the patient. Since 2015, diagnoses are coded using ICD-10. Since these diagnostic codes are recorded by healthcare providers and don't provide information regarding treatment, this limits MCDPH's ability to identify and analyze health indicator data by controlled or uncontrolled cases. HDD includes anyone who was hospitalized or visited the emergency department regardless if they are categorized as controlled or uncontrolled.

MCDPH receives vital records death data annually from ADHS for the previous year. This data includes deaths in Maricopa County regardless of residency status. The finalized and cleaned vital data consists of death data for residents of Maricopa County. Data is collected based on the event date of the patient, i.e., date of death. The death database is coded using ICD-10. MCDPH receives vital Birth data annually from ADHS. This data includes births in Maricopa County regardless of residency status. Data is collected based on the event date of the patient, e.g., birth date. HDD, Birth, and Death data are obtained from ADHS and cleaned by MCDPH to use for analyses. These datasets are used along with population estimates from the American Census Survey to analyze health indicators for Maricopa County residents. All health indicator rates are age adjusted using the 2000 Standard Population. Age-adjustment methods allow for fairer comparisons between population groups even if the size of the groups is different. The National Center for Health Statistics recommends using the 2000 Standard Population when calculating age-adjusted rates. In this report, the 2000 Standard Population is used to standardize HDD and vitals data. Health indicators that were analyzed include fatal and nonfatal chronic conditions, fatal cancer indicators, fatal and non-fatal injuries, mental and behavioral health indicators, and infant

birth indicators. Each indicator is analyzed as an overall rate for Maricopa County, and then further analyzed by age, race/ethnicity, and sex to highlight disparities.

The American Census Survey by the U.S. Census Bureau measures the social and economic characteristics of U.S. populations. For this assessment, 2021 data was used to analyze demographic data in Valleywise Health's PSA, Maricopa County, and Arizona. Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 was used in this assessment to define health disparity and health equity and how they are intertwined with the CHNA process. PolicyMap provides geographic data that maps demographic, social, and health indicators across the United States. PolicyMap is used in this assessment to evaluate social indicators and visualize measures such as medically underserved areas and HPSAs within Valleywise Health's PSAs in 2023.

Initial Round of Health and Social Indicators

Tables 4 and **5** display the list of 11 health indicators and 5 social indicators that Valleywise Health selected for initial evaluation. For the health indicators, HDD was utilized for analysis. For the social indicators, PolicyMap was utilized for analysis. CHNA survey and focus group data from both 2019 and 2021 provided community context and examples of lived experience for both health and social indicators.

Cardiovascular Disease	Chronic Obstructive Pulmonary Disease
Diabetes	Cervical Cancer
Mood & Depressive Disorders	Colorectal Cancer
Hypertension	Breast Cancer
Body Mass Index	Stroke
All Mental Disorders	

Table 4. Initial Round Health Indicators

Housing Stability/Homelessness	Food Insecurity
Transportation	Domestic Intimate Partner Violence
Utilities	

Table 5. Initial Round Social Indicators

Input from the Valleywise Health Team and Community

The Valleywise Community Health Centers Governing Council is organized, as designated by HRSA, to provide governance and oversight of the FQHCs at Valleywise Health. The Governing Council maintains sole approval authority for the CHNA. The Dyad Management team represents the leadership teams for each FQHC including the clinic managers and clinic medical directors. The Dyad Management team also includes the Chief Medical Officer, Quality Officers (physicians), and leaders from the Integrated Behavioral Health team.

Valleywise Health engaged their Governing Council members and Dyad Management team to gather input and consensus on prioritized health needs. This process involved iterations of data presentations with interactive workshops co-led by MCDPH and Valleywise Health. The first rounds of data presentations were facilitated on July 5 and July 20, 2023, while the second rounds of presentations were facilitated on August 15 and September 6, 2023.

Assessment Data and Findings

This section includes overall data and findings from the community surveys, focus groups, and social/health indicator analyses. These combined assessments provide a comprehensive picture of the top issues and concerns facing the community. Whenever possible, the measures of interest are evaluated through a health equity lens to identify any disparities based on race/ethnicity, age, sex, and geography.

In this Section:

- Indicator data for top social and health needs (Tables 6-9)
- Quantitative data from 2019 and 2021 community surveys
    - Top health and social community issues from 2021 COVID-19 Impact Survey (Figure 5)
    - Comparison of top issue rankings from 2019 and 2021 survey results (Table 10)
    - Top health and social issue rankings analyzed by race/ethnicity and priority populations (Tables 11-12)
- Qualitative data themes from 2019 and 2021 focus groups and open-ended survey questions (Table 13)

Top Health Needs

Table 6 below displays indicators from the initial round of health needs that Valleywise Health reviewed prior to the prioritization process. Each number within the table represents the ranking of each health indicator based on overall age-adjusted rates per 100,000 population for inpatient hospitalization (IP), emergency department (ED), and deaths.[ix] The color gradients are used to help visualize the different rankings among the indicators.

Table 6. Top Health Issue Indicators in Valleywise Health's Combined PSA (2021)

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

Indicator	IP	ED	Death
All Mental Disorders	1	3	*
Diabetes	7	7	11
Body Mass Index (Obesity/Overweight)	12	20	19
Chronic Obstructive Pulmonary Disease	10	10	4
Hypertension	20	8	18
Heart Disease	2	2	1
Mood & Depressive Disorders	3	12	*
Colorectal Cancer	*	*	12
Breast Cancer	*	*	13
Stroke	5	15	3
Domestic/Intimate Partner Violence	13	6	14

**Indicates that no data is available*

Table 7 identifies the top causes of death for the combined Valleywise Health PSA from 2017 to 2021.[ix] Heart disease, cancer, and chronic obstructive pulmonary disease (COPD) all maintain the same place in the top 3 in most years.

Table 7. Top Causes of Death in Valleywise Health Combined PSA (2017-2021)

	2017	2018	2019	2020	2021
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	COVID
3	COPD	COPD	COPD	COVID	Cancer
4	Alzheimer's	Alzheimer's	Alzheimer's	Drug Overdose	Drug Overdose
5	Stroke	Stroke	Drug Overdose	COPD	Stroke
6	Diabetes	Drug Overdose	Stroke	Alzheimer's	COPD
7	Drug Overdose	Diabetes	Diabetes	Stroke	Diabetes
8	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Diabetes	Alzheimer's
9	All Mental Health	All Mental Health	All Mental Health	Unintentional Injuries	Unintentional Injuries
10	Liver Disease	Liver Disease	Suicide	All Mental Health	All Mental Health

Health Equity

Identifying differences in health outcomes based on factors including race/ethnicity, sex, age, and socio-economic status is essential to achieving equitable health access and outcomes for all people. **Table 8** displays health indicators analyzed through a health equity lens by highlighting disparities by race/ethnicity, age, sex in Valleywise Health's combined PSA.[ix]

Comparing rates of hospitalization and death between population groups, Black/African American and American Indian individuals experienced disproportionately high rates across the board. Individuals aged 65+ had the highest rates of hospitalization and/or death across half the indicators analyzed. Those 25-44 had the highest hospitalization and/or death rates of mental health and substance abuse, compared to those 45-64 who had the highest rates of diabetes, obesity/overweight, hypertension, and COPD. When looking at disparities by geography, communities in the South Central Phoenix PSA held the highest rates of hospitalization or death for every indicator except overweight/obesity, hypertension, and cancers.

Table 8. Health Indicator Disparities: Highest IP[1]/ED[2]/Death[3] rates by groups of residents living within Valleywise Health's combined PSA (2021).

Glendale and El Mirage were included in the current-cycle analysis but will be removed in the next CHNA cycle.

	Race/Ethnicity	Age	Sex	Top 10 Ranking	Community Ranking	Compared to MC	Top PSAs
All Mental Health Disorders	Black/African American[1] American Indian[2]	25-44[1,2]	Male[1,2]	#1 IP #3 ED	#1 Health Condition (2021)	Did Not Exceed MC	South Central Phoenix[1,2]
Mood & Depressive Disorders	Black/African American[1,2]	25-44[1,2]	Male[1] Female[2]	#3 IP	No Ranking Available		South Central Phoenix[1] Mesa[2]
Diabetes	American Indian[1,3] Black/African American[2]	45-64[1,2] 65+[3]	Male[1,2,3]	#7 IP #6 ED	#5 Health Condition (2021)	⇧[1,2,3]	*Glendale[1] South Central Phoenix[2,3]
Obesity/ Overweight	Black/African American[1,3] White/Caucasian[2]	25-44[1,2] 45-64[3]	Male[1,2,3]	Did Not Rank Top 10	#2 Health Condition (2021)	⇧[2,3]	Avondale[1] North Phoenix[2] West Maryvale[3]

Chronic Obstructive Pulmonary Disease	Black/African American[1,2] White/Caucasian[3]	45-64[2] 65+[1,3]	Female[1] Male[3]	#10 IP #9 ED #4 Death	#10 Health Condition (2021)	 [1,2,3]	South Central Phoenix[1] Glendale[2] North Phoenix[3]
Hypertension	Hispanic[1] Black/African American[2,3]	45-64[1,2] 65+[3]	Female[1,2] Male[3]	#7 ED	#4 Health Condition (2021)	 [3]	Avondale[1] South Phoenix[2] West Maryvale[3]
Heart Disease	Black/African American[1,2,3]	65+[1,2,3]	Male[1,2,3]	#2 IP, ED #1 Death	#7 Health Condition (2021)- CVD and Stroke	 [3]	South Central Phoenix[1] South Phoenix[2] Phoenix[3]
Substance Use (all drug overdose)	Black/African American[1,2] American Indian[3]	25-44[1,2,3]	Male[1,3] Female[2]	#9 IP, #8 ED, #2 Death	#3 Health Condition (2021)	 [3]	South Central Phoenix[1,2] McDowell[3]
Substance Use (alcohol related)	American Indian[1,2,3]	25-44[1,2] 45-64[3]	Male[1,2,3]	#5 Death		 [3]	McDowell[1,3] South Central Phoenix[2]
Stroke	Black/African American[1,2,3]	65+[1,2,3]	Male[1,3] Female[2]	#5 IP #3 Death	#7 Health Condition (2021)- CVD and Stroke	 [3]	South Central Phoenix[1] Peoria[2] Phoenix[3]
Colorectal Cancer	Black/African American[3]	65+[3]	Male[3]	Did Not Rank Top 10	#8 Health Condition- All Cancers	Did Not Exceed MC	West Maryvale[3]
Breast Cancer	Black/African American[3]	65+[3]	Female[3]				Guadalupe[3]
Cervical Cancer	Black/African American[3]	45-64[3]	Female[3]			 [3]	*El Mirage[3]
Interpersonal Violence	Black/African American[1,2,3]	25-44[1,2,3]	Male[1,2,3]	#6 ED	#9 Community Issue- Domestic Violence/Sexual Assault	 [1,2,3]	McDowell[1] South Central Phoenix[2] *Glendale[3]

Top Social Needs

Social determinants of health (SDOH) are environmental and societal conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can contribute to wide health disparities and inequities. **Table 9** displays the top social issues identified in Maricopa County and Arizona.

Table 9. Top Social Issues Identified in Maricopa County (MC) and Arizona (2021 and 2022)

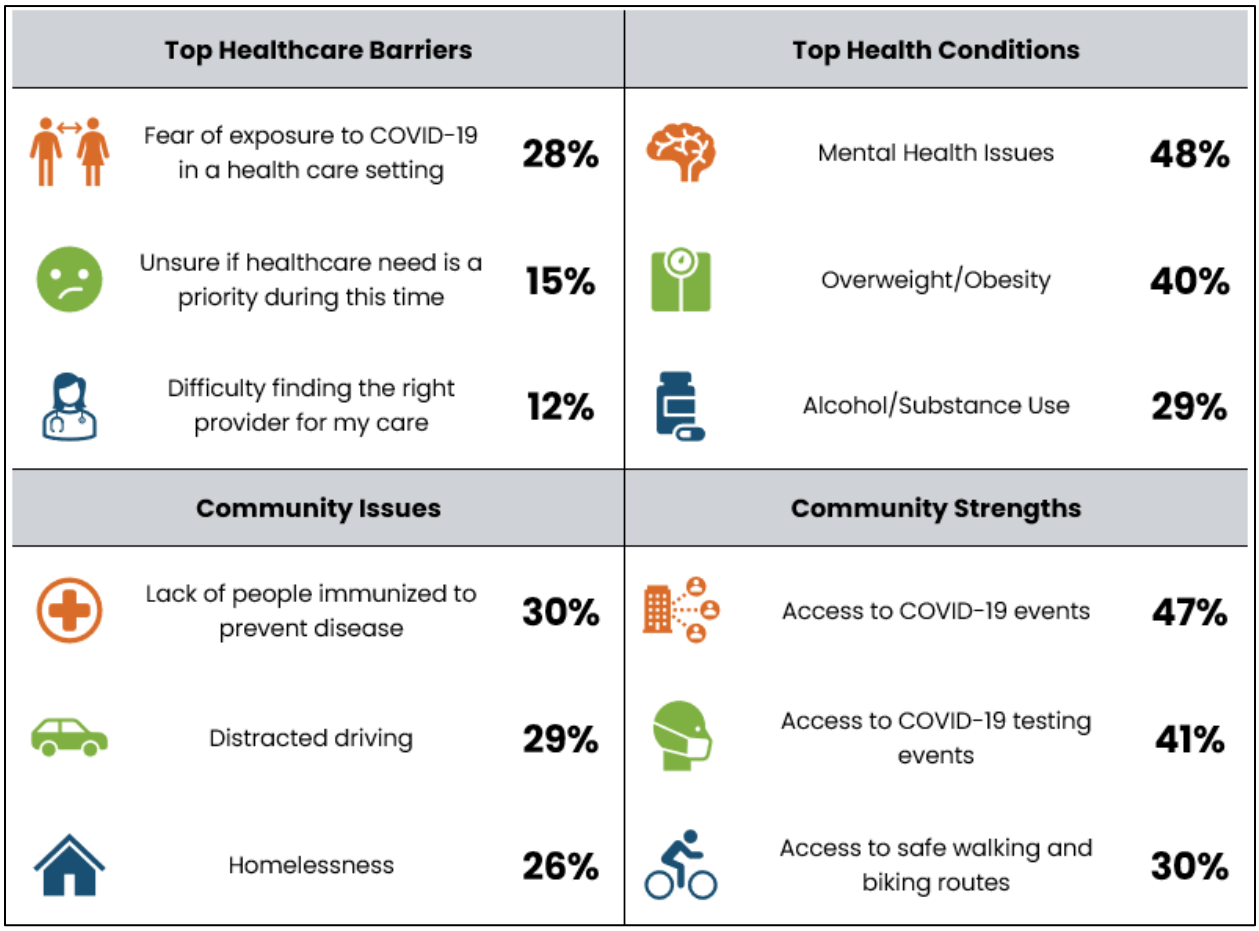
	Maricopa County (MC)	Arizona (AZ)
Housing Stability (2021)	 ○ 22% of MC renters were severely cost-burdened.[xi] ○ 9% of MC homeowners were severely cost-burdened.[xi]	 ○ 21% of AZ renters were severely cost-burdened.[xi] ○ 9% of AZ homeowners were severely cost-burdened.[xi]
Homelessness (2022)	 Of MC residents experiencing homelessness: ○ 44% were sheltered.[xvii] ○ 56% were unsheltered.[xvii]	 Of AZ residents experiencing homelessness: ○ 41% were sheltered.[xviii] ○ 59% were unsheltered.[xviii]
Food Insecurity (2021)	 ○ 9% of MC residents were food insecure. [xi]	 ○ 10% of AZ residents were food insecure. [xi]
Transportation (2021)	 ○ 5.3% of MC residents had no vehicles available in an occupied housing unit. [xi]	 ○ 5.6% of AZ residents had no vehicles available in an occupied housing unit. [xi]
Utilities (2021)	 ○ 27.3% of MC residents used utility gas to heat their home. [xi]	 ○ 33.2% of AZ residents used utility gas to heat their home.[xi]
Domestic Intimate Partner Violence (2022)	 ○ 65 victims were killed due to domestic violence.[xix]	 ○ 101 victims were killed due to domestic violence.[xix]

SDOH Definitions: (1) **Severely cost-burdened**: gross rent >50% of household income. (2) **Sheltered**: emergency shelter, transitional housing, or safe haven programs. (3) **Unsheltered**: on the streets or other place not meant for human habitation. (4) **Food insecure**: lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate food

Maricopa County Overall COVID-19 Impact Survey Results

Figure 5 below displays data from the 2021 CHNA survey reflecting top healthcare barriers, health conditions, community issues, and community strengths experienced by Maricopa County participants.[iii]

Figure 5. Top Health and Social Community Issues (2021)



Comparison of 2019 & 2021 Maricopa County Community Survey Results

Some health priorities changed due to COVID-19, while others were merely exacerbated. From 2019 to 2021, the top 3 community health issues remained the same, but *mental health* rose to the top. Community issues still included *distracted driving* and *homelessness*, with *lack of people immunized* as a leading issue. *Access to outdoor spaces and biking paths* remained a top community strength. *Fear of COVID-19 exposure* and *uncertainty if healthcare is a priority at this time* rose to the top for barriers to healthcare, but *difficulty finding the right provider* remained a top choice.[ii,iii]

Table 10. Ranked Community Survey Results – 2019 and 2021

Rank	2019	2021
Community Issues		
1	Distracted driving (46.1%)	Lack of people immunized to prevent disease (29.5%)
2	Homelessness (28.9%)	Distracted driving (28.5%)
3	Illegal drug use (24.1%)	Homelessness (25.8%)
Community Strengths		
1	Access to parks and recreation sites (55.9%)	*Access to COVID-19 vaccine events (46.7%)
2	Access to public libraries and community centers (50.3%)	*Access to COVID-19 testing events (41.1%)
3	Clean environments and streets (39.1%)	Access to safe walking and biking routes (29.7%)
Health Conditions		
1	Alcohol/substance abuse (48.3%)	Mental health issues (47.8%)
2	Overweight/obesity (38.4%)	Overweight/obesity (39.6%)
3	Mental health issues (37.5%)	Alcohol/substance abuse (28.6%)
Barriers to Accessing Healthcare		
1	Not enough health insurance coverage (32.9%)	*Fear of exposure to COVID-19 in a healthcare setting (28.2%)
2	Difficulty finding the right provider for my care (32.1%)	*Unsure if healthcare need is a priority during this time (14.7%)
3	Inconvenient office hours (25.4%)	Difficulty finding the right provider for my care (11.6%)

Response was not available in 2019 survey

In the 2021 COVID-19 Impact survey, participants were asked: "Since March of 2020, which of the following issues have had the greatest impact on your community's health and wellness?". **Table 11** and **Table 12** display the greatest community issues analyzed by race/ethnicity and special populations.[iii]

Table 11. Greatest Community Issues – Race/Ethnicity (2021)

	①	②	③
African American/Black	Racism/discrimination	Lack of affordable housing	Homelessness
American Indian/Native American	Homelessness	Distracted driving	Lack of affordable housing
Asian/Native Hawaiian/ Pacific Islander	Racism/discrimination	Lack of people immunized to prevent disease	
Caucasian/White	Lack of people immunized to prevent disease	Distracted driving	Homelessness
Hispanic/Latinx	Homelessness	Lack of affordable housing	Distracted driving
Two or more races		Racism/discrimination	Lack of affordable housing
Unknown/Not Given	Distracted driving	Homelessness	

Table 12. Greatest Community Issues – Special Populations (2021)

	①	②	③
Adult with Kids	Lack of people immunized to prevent disease	Distracted driving	Lack of affordable housing
Single Parent	Lack of affordable housing	Homelessness	Lack of people immunized to prevent disease
LGBTQI+	Racism/discrimination	Lack of affordable housing & Homelessness	
Person experiencing homelessness	Lack of affordable housing & Homelessness		Racism/discrimination
Person with disability	Lack of people immunized to prevent disease	Lack of affordable housing	Homelessness
Immigrant	Homelessness	Distracted driving & Racism/discrimination	
Refugee	Distracted driving	Racism/discrimination	Lack of people immunized to prevent disease
Veteran		Lack of people immunized to prevent disease	Homelessness

Qualitative Themes from Focus Groups

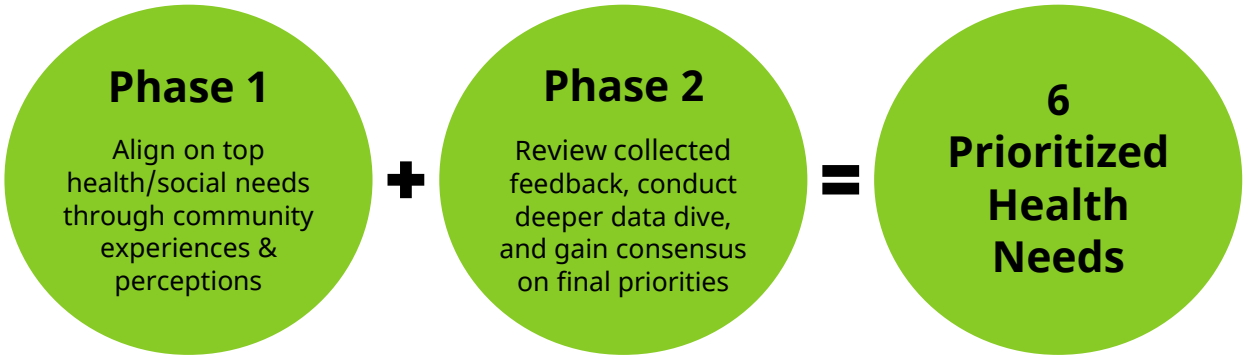
The following themes were identified from 2019 & 2021 focus group[iv,v] data and open-ended surveys responses from the 2021 COVID-19 impact survey.[iii] In focus groups, participants were asked questions about how they perceive their own health status, how COVID-19 affected their family, where they get information about health/COVID-19, barriers, and facilitators to accessing care, and how health/COVID-19 messaging could be improved.

Table 13. Qualitative Focus Group Themes (2019 and 2021)

Mental Health (2019)	Mental Health (2021)
○ Access to social connections and sense of community ○ Depression, suicide, and substance abuse increasingly important issues ○ Need for mental health services	○ Decline in mental health due to isolation, depression, and anxiety ○ Difficulty accessing mental health services ○ Importance of social gatherings and mental health
Healthcare (2019)	**Healthcare (2021)**
○ Inaccessible healthcare appointments with long wait times ○ Need more clinics, pharmacies, and specialists ○ Need greater insurance coverage	○ Perceived medical discrimination ○ Lack of trust in healthcare ○ Issues with accessing physical health and pharmaceutical services
Finances for Living Essentials (2019)	**Finances for Living Essentials (2021)**
○ High cost of medical care ○ Make too much to qualify for AHCCCS but still can't cover daily costs ○ Transportation, housing financially inaccessible	○ Financial burden on food, rent/mortgage utilities, clothing, childcare ○ Difficulty paying for medical expenses ○ Challenge accessing financial services
Information/Education (2019)	**Information/Education (2021)**
○ Lack of education regarding insurance ○ Need more information about health conditions, sex-ed, and nutrition ○ Indicate medical misinformation is a problem	○ COVID-19 vaccine misinformation/rumors ○ Merits/utility of doctors, primary health care providers, social media, and news as information sources ○ Frustrations with politicization of COVID-19 prevention and vaccination measures
Laws/Infrastructure (2019)	**Laws/Infrastructure (2021)**
○ Access to public libraries, spaces, and events is important ○ Suggest laws to improve nutrition	○ Adherence/ambivalence toward COVID-19 prevention measures (face masks, physical distancing, hand washing, testing)

Prioritized Significant Community Health Needs

The top health and social needs were assessed and identified based on available data from Maricopa County Hospital Discharge and Death Data, supplemental data sources, and community feedback. A total of 16 health and social indicators were established in collaboration with Valleywise Health. These indicators were selected based on highlighted disparities analyzed by race/ethnicity, sex, and age in Valleywise Health's combined PSA. Of the indicators that were analyzed, a top 10 ranking chart in addition to more in-depth data for IP, ED, and death were presented to the Dyad Management group and Governing Council members. Valleywise Health and MCDPH co-designed and implemented a prioritization process with 2 phases.



Phase 1

The Governing Council members and Dyad Management group provided feedback based on their personal and professional experiences. All data was presented to these groups in 2 phases. During Phase 1, MCDPH facilitated virtual presentations to share current health data, seek feedback from the Governing Council members and Dyad Management group and determine next steps in the prioritization process. Both groups participated in an interactive activity to align on top health and social needs based on their community perceptions. An online poll was utilized, and participants were invited to participate and provide feedback for the following questions and statements:

- What is the top health issue affecting your community?
- These health issues accurately reflect what I see in my community.
- What is the top social issue affecting your community?
- These social issues accurately reflect what I see in my community.
- Are there any health and social issues that have not been addressed?

All responses received from the Governing Council and Dyad Management meetings were compiled and evaluated through a health equity lens. Health equity is an underlying factor for many health and social needs. MCDPH and Valleywise Health utilized a health equity lens to analyze health disparities based on race/ethnicity, sex, age. Prior to the prioritization process, the Governing Council members proposed to add 4 indicators for additional review: financial security, housing stability, mood and depressive disorders, and interpersonal violence. Of the 20 total health and social indicators that were presented, 9 indicators were selected to be reviewed in Phase 2 of the prioritization process.

Phase 2

During Phase 2, MCDPH facilitated a virtual presentation to the Dyad Management group and an in-person presentation to the Governing Council members to review collected feedback, take a deeper data dive into identified priorities, and gain consensus on priorities through an interactive prioritization activity. The purpose of this meeting was to narrow down from 9 to 6 prioritized health needs to steer Valleywise Health's action plan for the next 3 years of their CHNA cycle.

The prioritization activity began with Valleywise Health and MCDPH establishing a criteria matrix of "need" and "feasibility" for which the health needs would be prioritized (**Figure 6**). The "need" criteria was defined as problem impact *(e.g., number of people affected)*, morbidity/mortality *(e.g., high risk associated with illness/death)*, and health disparity/health equity *(e.g., problem disproportionally impacts underserved/uninsured population)*. The "feasibility" criteria was defined as ability to mobilize action *(e.g., practicality of implementing immediate interventions)*, available resources *(e.g., staffing and leadership capacity)* and organizational readiness *(e.g., alignment with policies, compliance, and agency initiatives)*.

Figure 6. Matrix Criteria

Low Need/High Feasibility -/+ Often politically important and difficult to eliminate, these items may need to be re-designed to reduce investment while maintaining impact.	**High Need/High Feasibility +/+** With high demand and high return on investment, these are the highest priority items and should be given sufficient resources to maintain and continuously improve.
Low Need/Low Feasibility -/- With minimal return on investment, these are the lowest priority items and should be phased out allowing for resources to be reallocated to higher priority items.	**High Need/Low Feasibility +/-** These are long term projects which have a great deal of potential but will require significant investment. Focusing on too many of these items can overwhelm an agency.

For each health and social need, MCDPH invited the Dyad Management group and Governing Council members to participate in an online poll and an in-person facilitation exercise. During these exercises, members of both groups indicated where each health indicator belonged on the matrix (**Figure 7**) based on the established criteria through the lens of Valleywise Health.

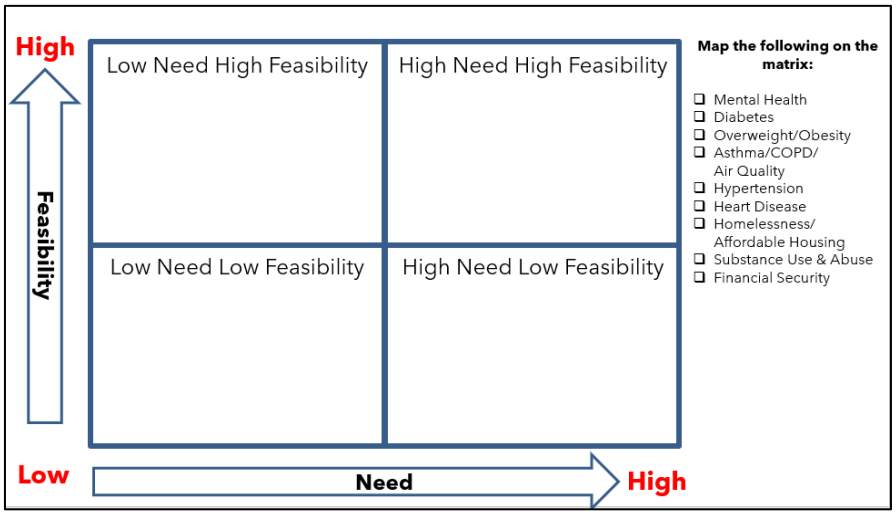


Figure 7. Example of Prioritization Decision-Making Matrix

The placement of each indicator on the matrix was dependent on group consensus. As a result, the following indicators were placed in the matrix under "high need high feasibility", "low need low feasibility", and "high need low feasibility" based on consensus established by members of both groups (**Table 14**).

Dyad Management		Governing Council	
Low Need High Feasibility	**High Need High Feasibility**	**Low Need High Feasibility**	**High Need High Feasibility**
	• Mental Health • Diabetes • Heart Disease • Hypertension • Overweight/obesity • Substance Use and Abuse		• Heart Disease • Substance Use & Abuse • Mental Health • Hypertension • Overweight/Obesity • Diabetes
Low Need Low Feasibility	**High Need Low Feasibility**	**Low Need Low Feasibility**	**High Need Low Feasibility**
• Asthma/COPD/Air Quality	• Homelessness/ Affordable Housing • Financial Security		• Homelessness • Asthma/COPD

Table 14. Prioritization Matrix Activity Results

Based on the consensus received from both the Governing Council members and Dyad Management group, the following CHNA priorities were finalized for incorporation in this CHNA and in subsequent action plan:

Diabetes	Heart Disease
Substance Use & Abuse	Obesity/Overweight
Hypertension	Mental Health

2023 - 2025

Valleywise Health CHNA Executive Summaries

The following executive summaries provide a snapshot of identified health disparities among Valleywise Health's selected CHNA priorities:

- **Diabetes**
- **Substance Use & Abuse**
- **Hypertension**
- **Heart Disease**
- **Obesity/Overweight**
- **Mental Health**

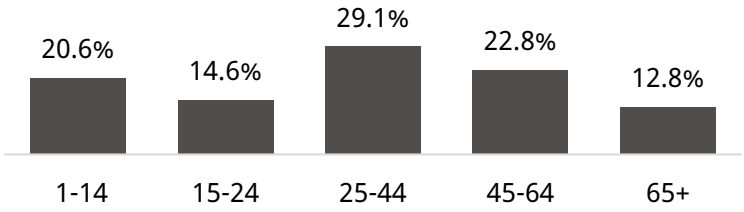
Data provided for the health disparities are 2021 age-adjusted rates per 100,000 and are based on the Maricopa County population who reside in Valleywise Health's primary service area (PSA). Since Valleywise Health's PSA is a subset of the Maricopa County dataset, direct comparison between both rates are estimates.

Valleywise Health

Demographic Profile: Maricopa Residents in Valleywise Health PSA

Valleywise Health provides a wide array of primary medical care for adults and children through community health centers. Services include family and internal medicine, women's services such as gynecological and obstetric care, pediatric services, such as screenings, immunizations, sports physicals, and well child visits. Most locations offer dental, nutrition, pharmacy, x-ray, laboratory, immunizations, and family resource centers that support education, wellness, and assistance with other community services.

Age[1]

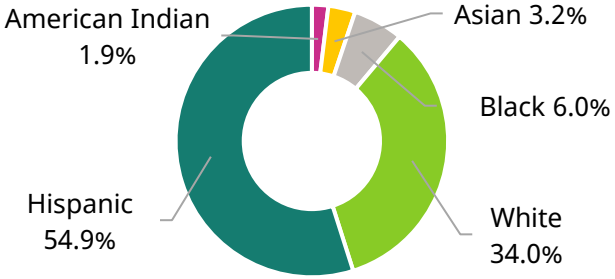


Sex[1]

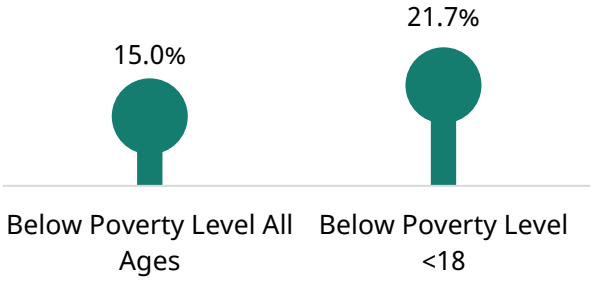
50% Female **50% Male**

2021 Census did not ask for gender identity data – unable to assess if or where transgender and gender-expansive individuals are represented

Race/Ethnicity[1]



Population Living in Poverty[1]



Household Income[1]

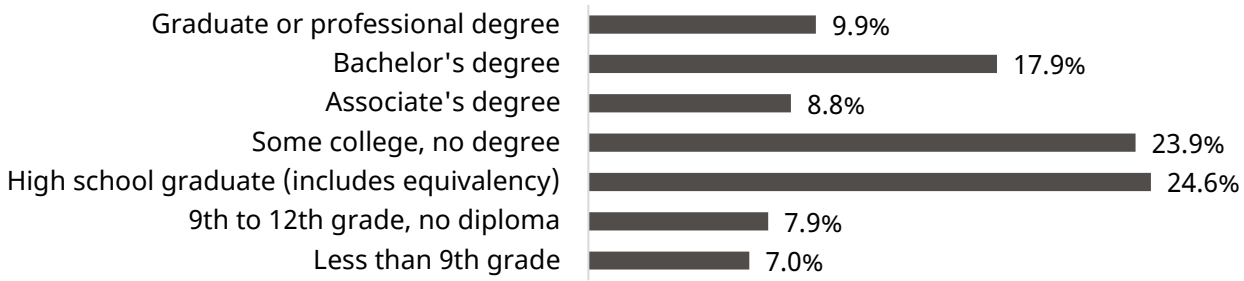
Minimum **$40,717**

Maximum **$130,938**

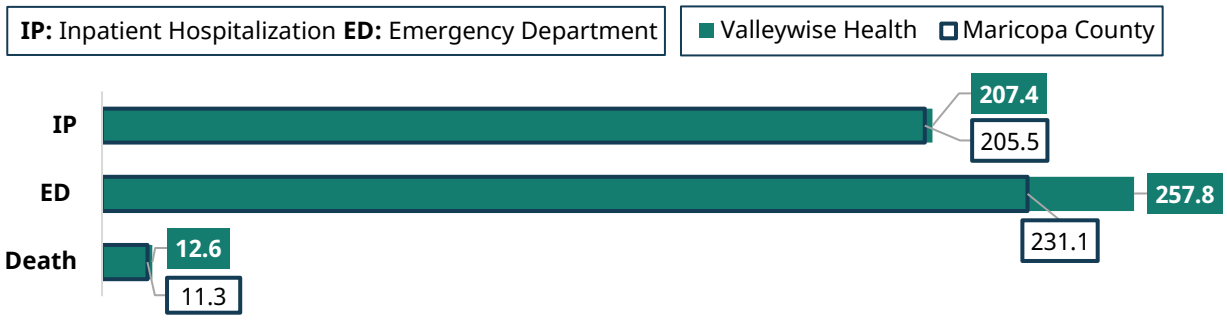
Health Insurance[1]

14% of the population in the Valleywise Health PSA are **uninsured**

Education[1]

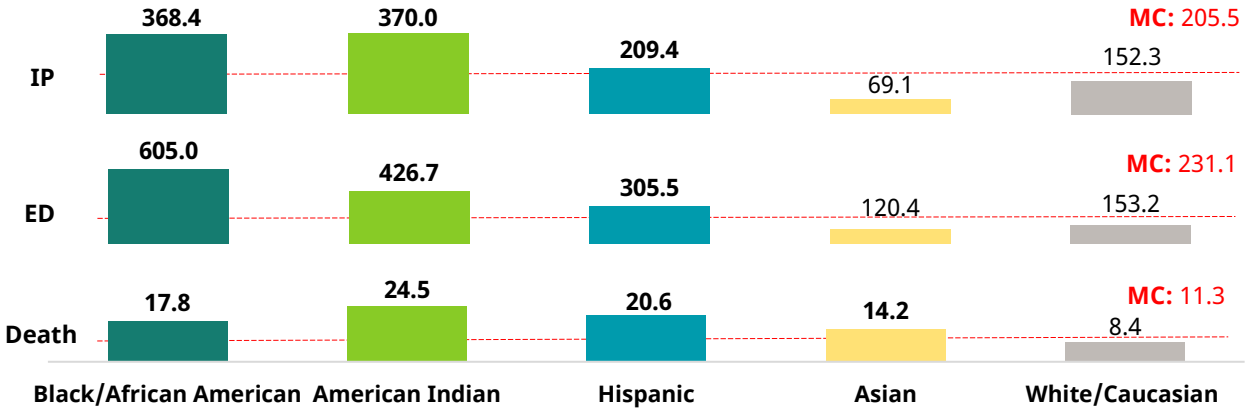


Disparities by Overall Rates[2]

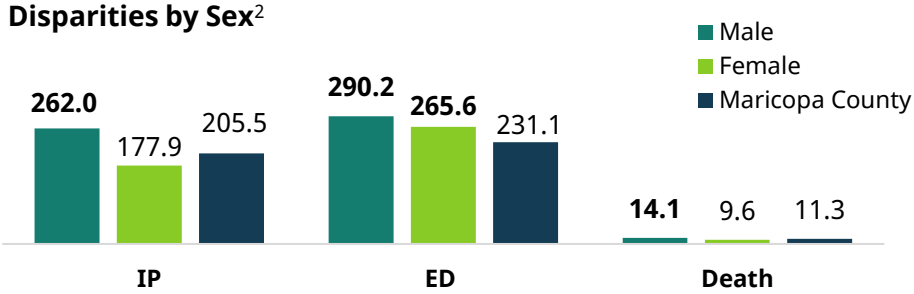


Disparities by Race/Ethnicity[2]

Maricopa County (MC)



Disparities by Sex[2]



Disparities by Age[2]

No age groups in Valleywise Health's primary service area exceeded Maricopa County's rates.

Valleywise Health Patient Health Outcomes[3]

12,600

VWH patients diagnosed with diabetes

34,322

Visits with a diabetes diagnosis

Top Community Health Condition[4]

Diabetes was ranked as the **6th** (2019) and **5th** (2021) greatest community health

From a Community Member (2021)[4]

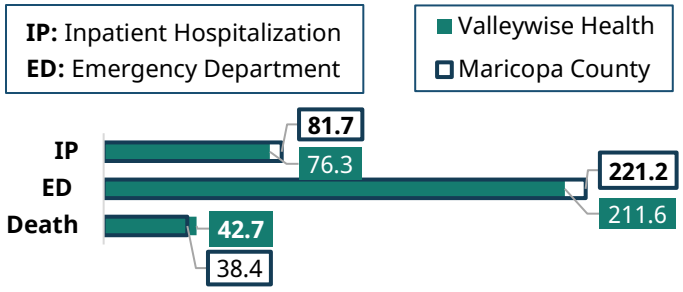
"I think people have moved on [from COVID-19]. It is hot in Arizona, we need to focus on reinforcing healthy eating/lifestyles to prevent a repeat. Arizona has too much obesity and diabetes prone citizens. We must be healthy to ward off illness...."

Sources: *(1) 2021 American Community Survey; Census, (2) 2021 Hospital Discharge Data, obtained from ADHS & analyzed by MCDPH (3) Valleywise Health 2022 Uniform Data System Report, (4) 2019 & 2021 MCDPH Community Survey*

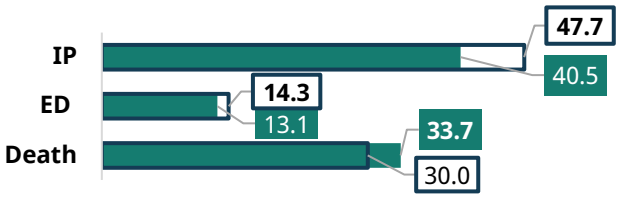
Substance Use and Abuse

Disparities by Overall Rates (All Drug Overdose)[2]

IP: Inpatient Hospitalization
ED: Emergency Department



Disparities by Overall Rates (Alcohol Related)[2]

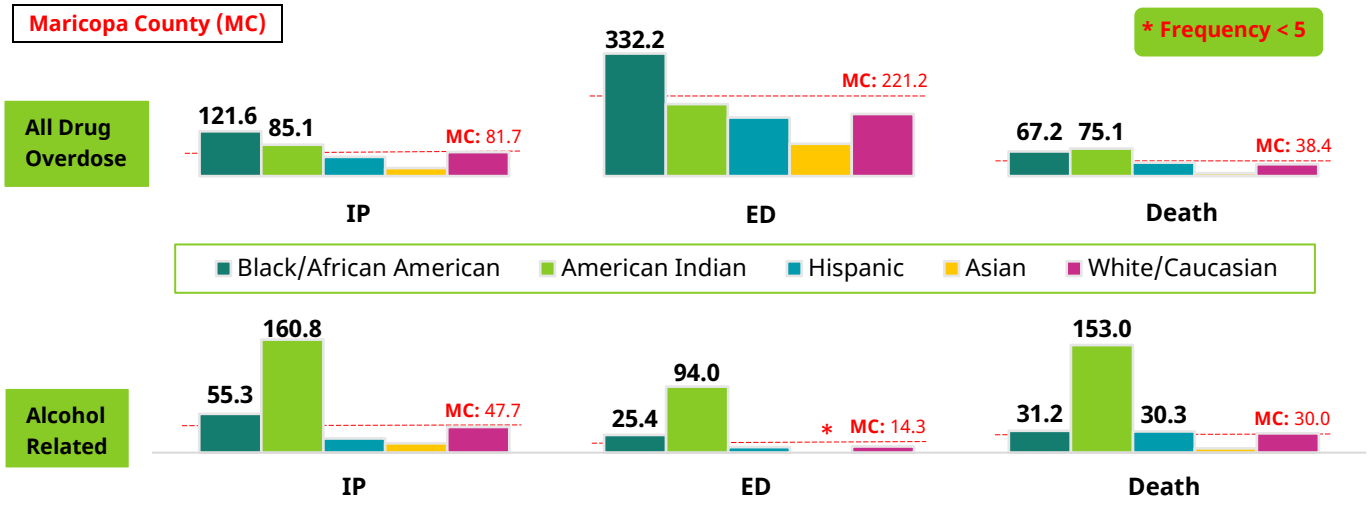


Disparities by Race/Ethnicity[2]

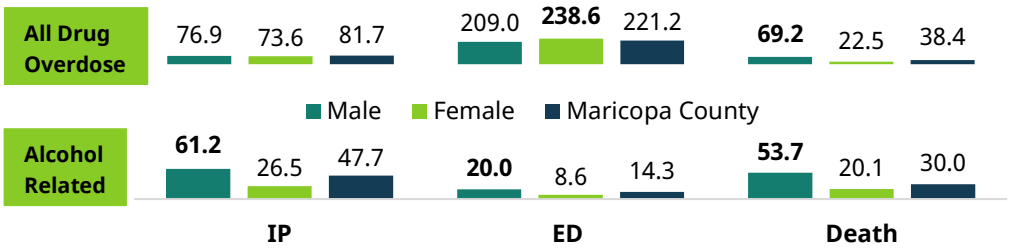
Maricopa County (MC)

Only Valleywise Health rate > MC rate have data

* Frequency < 5



Disparities by Sex[2]



Disparities by Age[2]

No age groups in Valleywise Health's primary service area exceeded Maricopa County's rates.

Valleywise Health Patient Health Outcomes[3]

1,272

VWH patients diagnosed with a substance-related disorder (excluding tobacco)

2,477

Visits with a substance-related disorder diagnosis (excluding tobacco)

Top Community Health Condition[4]

Alcohol/Substance Abuse was ranked as the **1st** (2019) and **3rd** (2021) greatest community health condition.

From a Community Member (2021)[4]

"Many younger adults in this community need help with substance abuse issues, depression, etc...but do not know where to go to get the help or don't have much faith in helping "programs" to follow through with the help their promising."

Sources: *(1) 2021 American Community Survey; Census, (2) 2021 Hospital Discharge Data, obtained from ADHS & analyzed by MCDPH (3) Valleywise Health 2022 Uniform Data System Report, (4) 2019 & 2021 MCDPH Community Survey*

Hypertension

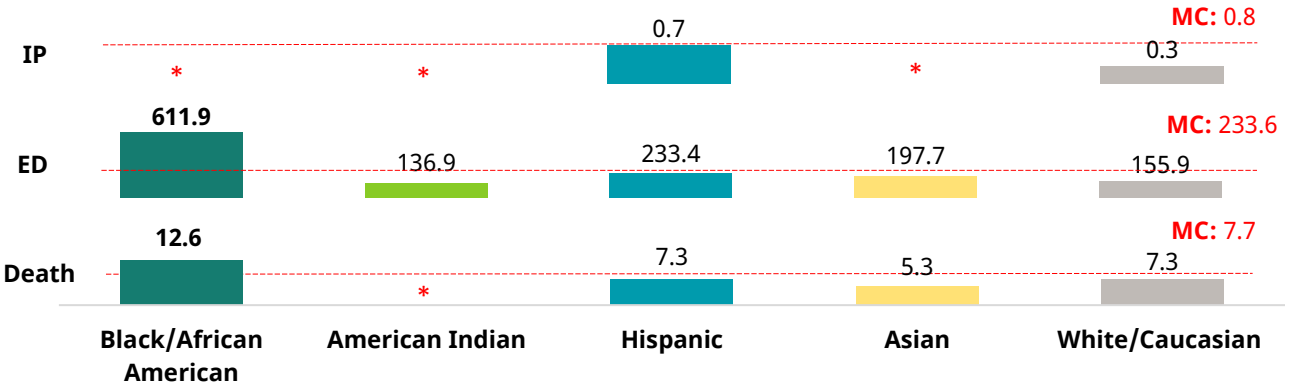
Disparities by Overall Rates[2]

IP: Inpatient Hospitalization **ED:** Emergency Department

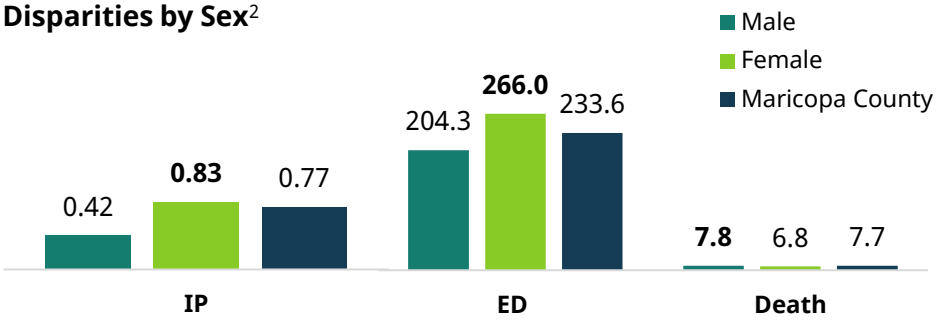
Disparities by Race/Ethnicity[2]

Maricopa County (MC)

* Frequency < 5



Disparities by Sex[2]



Disparities by Age[2]

No age groups in Valleywise Health's primary service area exceeded Maricopa County's rates.

Valleywise Health Patient Health Outcomes[3]

17,461

VWH patients diagnosed with hypertension

37,216

Visits with a hypertension diagnosis

Top Community Health Condition[4]

Hypertension was ranked as the **4th** (2019 & 2021) greatest community health condition.

From a Community Member (2021)[4]

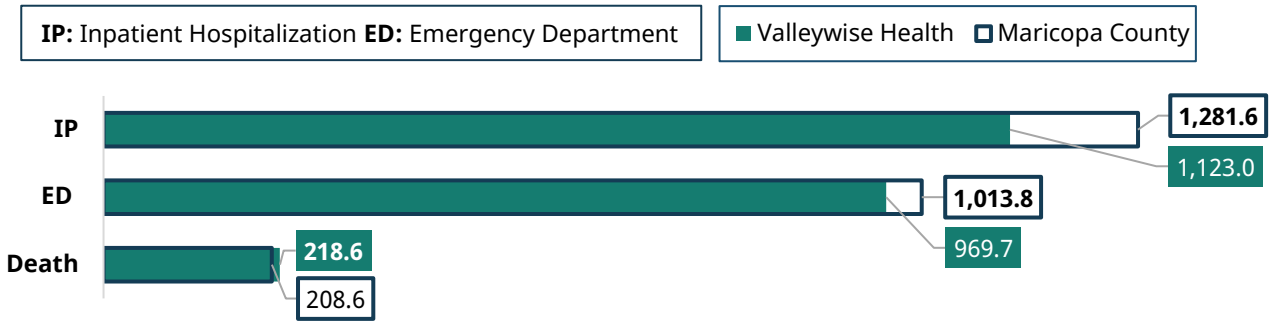
"People with disabilities fell through the cracks [during COVID-19]. I was struggling to work and got laid off because of my health risks not allowing me to travel as required. Couldn't get unemployment because I couldn't work...I couldn't afford my asthma medications and blood pressure meds; therefore my health continued to decline and now I'm in crisis and cannot access social services, mental health services etc..."

Sources: *(1) 2021 American Community Survey; Census, (2) 2021 Hospital Discharge Data, obtained from ADHS & analyzed by MCDPH (3) Valleywise Health 2022 Uniform Data System Report, (4) 2019 & 2021 MCDPH Community Survey*

Heart Disease

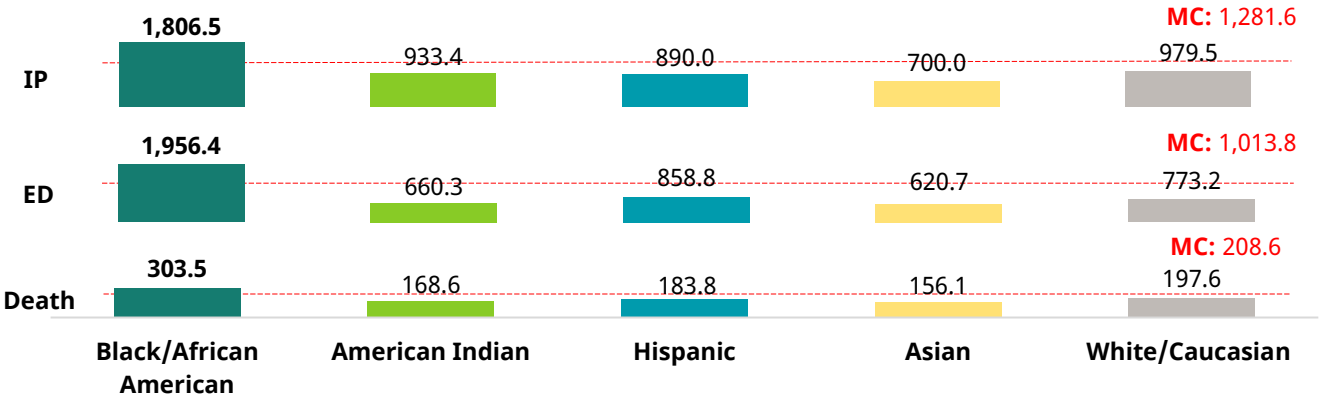
Disparities by Overall Rates[2]

IP: Inpatient Hospitalization **ED:** Emergency Department

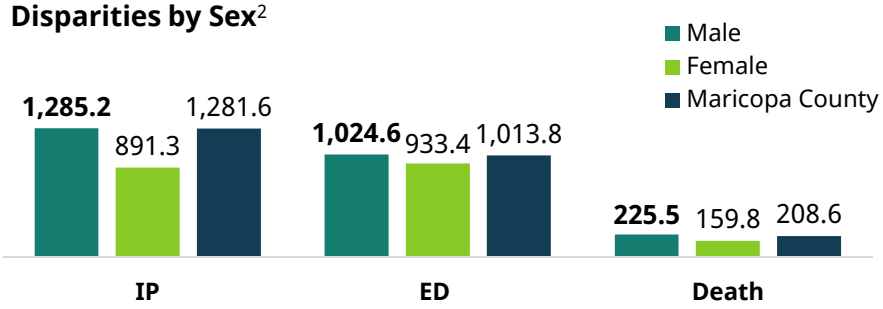


Disparities by Race/Ethnicity[2]

Maricopa County (MC)



Disparities by Sex[2]



Disparities by Age[2]

No age groups in Valleywise Health's primary service area exceeded Maricopa County's rates.

Valleywise Health Patient Health Outcomes[3]

3,053

VWH patients diagnosed with heart disease

5,623

Visits with a heart disease diagnosis

Top Community Health Condition[4]

Heart Disease was ranked as the **7th** (2019 & 2021) greatest community health condition.

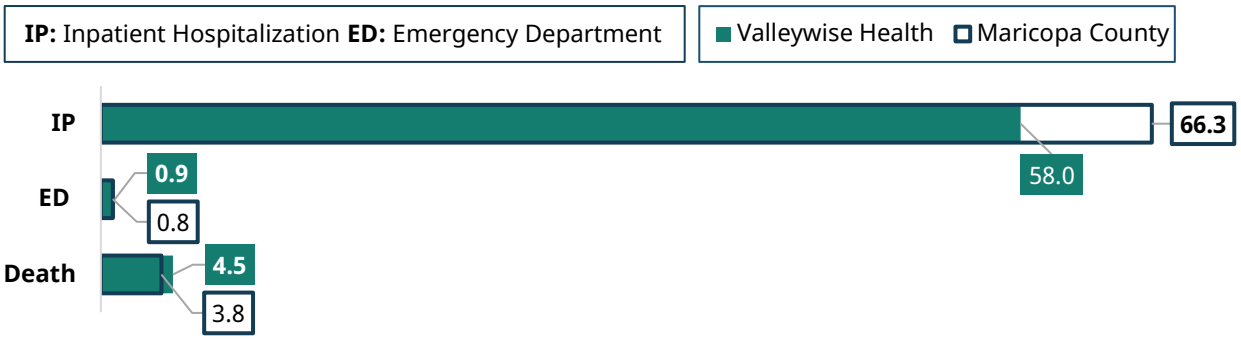
From a Community Member (2021)[4]

"I wish you had focused on the needs of elderly homebound people during the pandemic. It's been really hard. I survived Covid, 2 heart attacks, pneumonia, and a broken hip mainly due to access to good healthcare and the fact that my daughter moved here from another state and worked remotely in order to care for me the entire year."

Sources: *(1) 2021 American Community Survey; Census, (2) 2021 Hospital Discharge Data, obtained from ADHS & analyzed by MCDP (3) Valleywise Health 2022 Uniform Data System Report, (4) 2019 & 2021 MCDPH Community Survey*

Obesity/Overweight

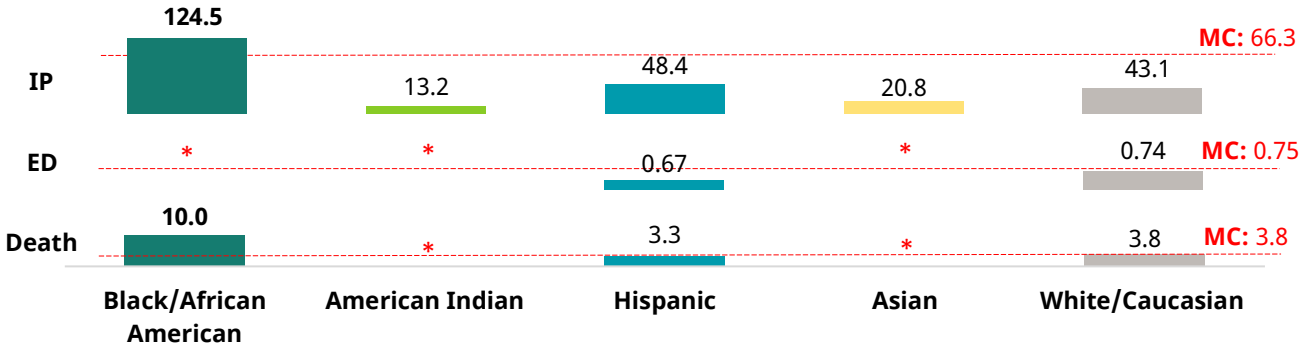
Disparities by Overall Rates[2]



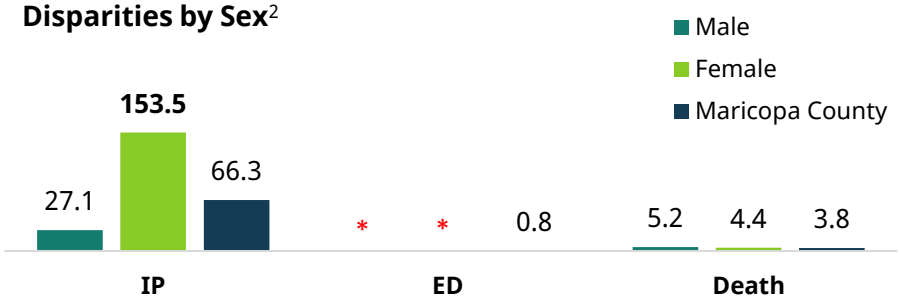
Disparities by Race/Ethnicity[2]

Maricopa County (MC)

* Frequency < 5



Disparities by Sex[2]



Disparities by Age[2]

No age groups in Valleywise Health's primary service area exceeded Maricopa County's rates.

Valleywise Health Patient Health Outcomes[3]

10,669

VWH patients diagnosed with an overweight or obesity medical condition

13,896

Visits with an overweight or obesity related diagnosis

Top Community Health Condition[4]

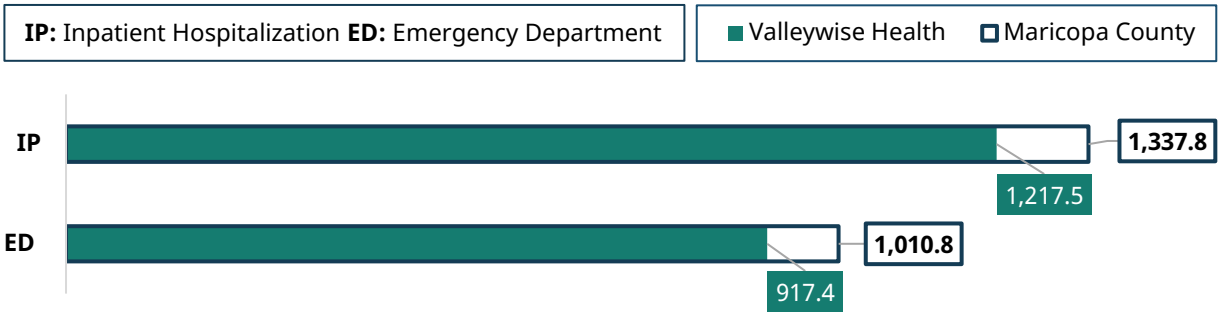
Obesity/Overweight was ranked as the **2nd** (2019 & 2021) greatest community health condition.

From a Community Member (2021)[4]

"I think people have moved on [from COVID-19]. It is hot in Arizona, we need to focus on reinforcing healthy eating/lifestyles to prevent a repeat. Arizona has too much obesity and diabetes prone citizens. We must be healthy to ward off illness. Not get limbs cut off due to overeating, etc..."

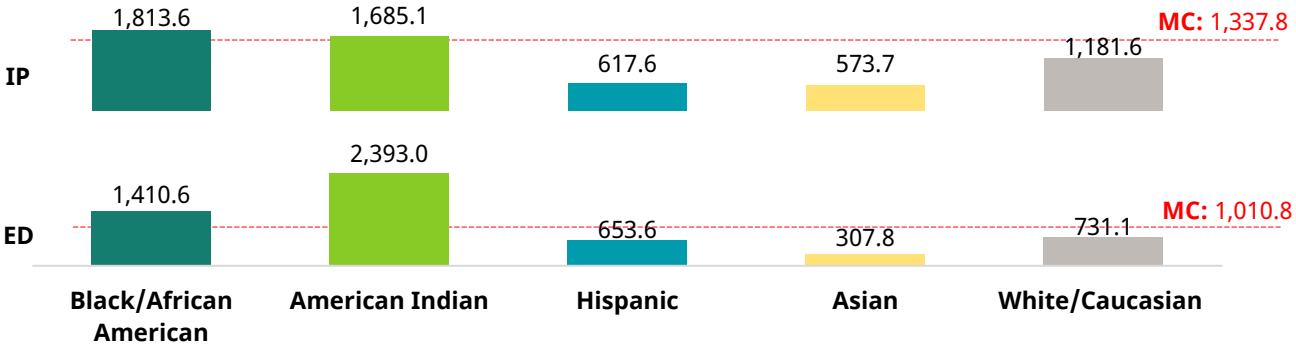
Sources: *(1) 2021 American Community Survey; Census, (2) 2021 Hospital Discharge Data (overweight data only available), obtained from ADHS & analyzed by MCDPH (3) Valleywise Health 2022 Uniform Data System Report, (4) 2019 & 2021 MCDPH Community Survey*

Disparities by Overall Rates[2]

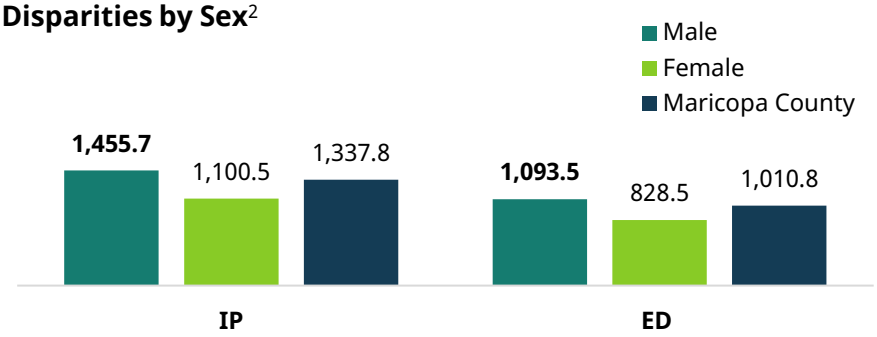


Disparities by Race/Ethnicity[2]

Maricopa County (MC)



Disparities by Sex[2]



Disparities by Age[2]

No age groups in Valleywise Health's primary service area exceeded Maricopa County's rates.

Valleywise Health Patient Health Outcomes[3]

6,130

VWH patients diagnosed with depression and other mood disorders

20,584

Visits with a depression or other mood disorder diagnosis

Top Community Health Condition[4]

Mental Health Issues was ranked as the **3rd** (2019) and **1st** (2021) greatest community health condition.

From a Community Member (2021)[4]

"I wish we had more mental health access for everyone. It's difficult to find a person and also like to see mental health covered by insurance. Its really sad that this one area of health is always getting over looked. I have many mental health issues and I have given up on the search because I can't afford one. And I refuse to see a county medical professional."

Sources: *(1) 2021 American Community Survey; Census, (2) 2021 Hospital Discharge Data (nonfatal rates only available), obtained from ADHS & analyzed by MCDPH (3) Valleywise Health 2022 Uniform Data System Report, (4) 2019 & 2021 MCDPH Community Survey*

Resources Potentially Available to Address Needs

Resources potentially available to address identified needs include services and programs available through hospital, government agencies, and community-based organizations. Resources include access to hospital emergency and acute services, FQHCs, food banks, homeless shelter, faith communities, transportation services, health navigators, and prevention-based community education. **Table 15** identifies organizations who may have resources to address the identified priorities.

Table 15. Community Resources Potentially Available to Address Health Needs

Health Need	Resources Potentially Available
Heart Disease, Hypertension, and Obesity/Overweight	• American Heart Association: 602-414-5353 • Gellert Health: 480-710-0195 • Home Assist Health: 602-795-7620 • U.S. Department of Agriculture
Diabetes	• American Diabetes Association: 602-861-4731 • St. Mary's Food Bank: 602-352-3640 • Diabetes Empowerment Education Program: 602-305-4742
Mental Health	• National Suicide & Crisis Lifeline: 988 • Solari Crisis Line: 844-534-4673 or 800-327-9254 (TTY/TDD) • Warm Line (Peer-to-Peer): 602-347-1100 • Connections Urgent Psychiatric Center: 602-416-7600 • Community Bridges Inc. Community Psychiatric Emergency Center: 877-931-9142 • Mercy Care ACC Regional Behavioral Health Authority – Member Services: 1-800-624-3879 • Arizona Health and Human Services: 2-1-1 or 877-211-8661 • Jewish Family & Children's Services: 602-353-0703 • Southwest Behavioral Health: 602-265-8338 • Open Hearts: 602-285-5550
Substance Abuse	• Community Bridges Inc.: 602-273-9999 • Terros Health: 602-285-6800 • Valle Del Sol: 602-258-6797

Appendices

The appendix includes the following documents:

Appendix A
2019 & 2021 Focus Group Discussion Schedules

Appendix B
Primary Data Collection Tools

Appendix C
2019 & 2021 Community Survey Demographics

Appendix D
Valleywise Health's PSA Zip Codes (Top 10)

Appendix E
Top 10 Valleywise Health IP, ED, and Death Rankings by Overall Rates

Appendix F
Data Indicator Matrix

Appendix G
References

Appendix A – 2019 & 2021 Focus Group Discussion Schedules

2019 Focus Group Schedule

Cycle 1

Date	Time	Population	Location
4/8 (Mon.)	6:00pm – 8:00pm	Native American Adult Males [n = 8]	**Native American Fatherhood & Families Association** (460 N. Mesa Dr, Suite 115, Mesa, AZ)
4/16 (Tues.)	10:00am – 12:00pm	Homeless Males over 60 [n = 10]	**St. Vincent de Paul** (420 W. Watkins Rd., Phoenix, AZ)
4/17 (Wed.) & 5/16 (Thurs.)	6:00pm -8:00pm & 5:30pm–7:30pm	Native American Adults [n = 17]	**Mesa Public Schools** (1025 N. Country Club, Mesa, AZ) & **Native Health (East Valley)** (777 W. Southern Ave., Building C, Mesa, AZ)
4/18 (Thurs.)	10:30am - 12:30pm	Homeless Women with Children [n = 15]	**UMOM** (3333 E. Van Buren St., Phoenix, AZ)
4/18 (Tues.)	5:30pm - 7:30pm	African American Males [n = 7]	**Hatton Hall** (34 E. 7th St., Tempe, AZ)
4/23 (Tues.)	4:30pm - 6:30pm	LGBTQI Adults [n = 7]	**Southwest Center for HIV/AIDS (Parson's Center)** (1101 N. Central Ave, Phoenix, AZ)
4/24 (Wed.)	6:00pm – 8:00pm	Homeless Youth (14-21) [n = 7]	**Native American Connections/HomeBase** (931 E. Devonshire, Phoenix, AZ)
4/25 (Thurs.)	12:30pm- 2:30pm	Adults over 60 (New Retirees) [n = 13]	**Ahwatukee Foothills Family YMCA** (1030 E. Liberty Lane, Phoenix, AZ)
4/26 (Fri.)	10:30am- 12:30pm	New Parents [n = 7]	**Adelante Healthcare – WIC Office** (1705 W. Main St., Mesa, AZ)
4/27 (Sat.)	10:30am- 12:30pm	Homeless Veterans [n = 15]	**MANA House** (2422 W. Holly St., Phoenix, AZ)
4/29 (Mon.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [n = 9]	**Ignacio Conchos Elementary School** (1718 W. Vineyard Rd., Phoenix, AZ)
4/30 (Tues.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [SPANISH; n = 7]	**Ignacio Conchos Elementary School** (1718 W. Vineyard Rd., Phoenix, AZ)
5/4 (Sat.)	10:30am – 12:30pm	Filipino Adults [n = 8]	**Chandler Community Center** (125 E. Commonwealth Ave., Chandler, AZ)
5/14 (Tues.)	5:30pm - 7:30pm	Veterans [n = 7]	**Tanner Community Development Corporation** (700 E. Jefferson St., Phoenix, AZ)
5/16 (Wed.)	8:30am- 10:30am	New Parents [SPANISH; n = 11]	**Moon Mountain Elementary School** (13425 N. 19th Ave, Phoenix, AZ)

Cycle 2

Date	Time	Population	Location
4/8 (Mon.)	6:00pm – 8:00pm	Native American Adult Males [n = 8]	**Native American Fatherhood & Families Association** (460 N. Mesa Dr, Suite 115, Mesa)
4/16 (Tues.)	10:00am – 12:00pm	Homeless Males over 60 [n = 10]	**St. Vincent de Paul** (420 W. Watkins Rd., Phoenix)
4/17 (Wed.) & 5/16 (Thurs.)	6:00pm -8:00pm & 5:30pm–7:30pm	Native American Adults [n = 17]	**Mesa Public Schools** (1025 N. Country Club, Mesa, AZ) & **Native Health (East Valley)** (777 W. Southern Ave., Mesa)
4/18 (Thurs.)	10:30am - 12:30pm	Homeless Women with Children [n = 15]	**UMOM** (3333 E. Van Buren St., Phoenix)
4/18 (Tues.)	5:30pm - 7:30pm	African American Males [n = 7]	**Hatton Hall** (34 E. 7th St., Tempe)
4/23 (Tues.)	4:30pm - 6:30pm	LGBTQI Adults [n = 7]	**Southwest Center for HIV/AIDS (Parson's Center)** (1101 N. Central Ave, Phoenix)
4/24 (Wed.)	6:00pm – 8:00pm	Homeless Youth (14-21) [n = 7]	**Native American Connections/HomeBase** (931 E. Devonshire, Phoenix, AZ)
4/25 (Thurs.)	12:30pm- 2:30pm	Adults over 60 (New Retirees) [n = 13]	**Ahwatukee Foothills Family YMCA** (1030 E. Liberty Lane, Phoenix)
4/26 (Fri.)	10:30am- 12:30pm	New Parents [n = 7]	**Adelante Healthcare – WIC Office** (1705 W. Main St., Mesa)
4/27 (Sat.)	10:30am- 12:30pm	Homeless Veterans [n = 15]	**MANA House** (2422 W. Holly St., Phoenix, AZ)
4/29 (Mon.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [n = 9]	**Ignacio Conchos Elementary School** (1718 W. Vineyard Rd., Phoenix, AZ)
4/30 (Tues.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [SPANISH; n = 7]	**Ignacio Conchos Elementary School** (1718 W. Vineyard Rd., Phoenix, AZ)
5/4 (Sat.)	10:30am – 12:30pm	Filipino Adults [n = 8]	**Chandler Community Center** (125 E. Commonwealth Ave., Chandler, AZ)
5/14 (Tues.)	5:30pm - 7:30pm	Veterans [n = 7]	**Tanner Community Development Corporation** (700 E. Jefferson St., Phoenix, AZ)
5/16 (Wed.)	8:30am- 10:30am	New Parents [SPANISH; n = 11]	**Moon Mountain Elementary School** (13425 N. 19th Ave, Phoenix, AZ)

Cycle 3

Date	Time	Population	Location
10/16 (Wed.)	1:00 pm – 3:00 pm	Native Americans - Young adults (19-24)	**ASU Discovery Hall** 250 E Lemon St. Tempe 85281
10/17 (Thurs.)	10:00 am – 12:00 pm	Immigrants/Refugee/Asylum Seekers - Congolese	**IRC** 4425 W Olive #400 Glendale 85302
10/17 (Thurs.)	1:30 pm – 3:30 pm	Asian Americans - South and southeast Asia [n = 29]	**Asian Pacific Community in Action-IACRF Hall** 2809 W Maryland Phoenix 85017
10/22 (Tues)	4:00 pm – 6:00 pm	LGBTQ - Young adults (19-24)	**One.n.ten** 931 #202 Phoenix 85004
10/28 (Mon.)	11:00 am – 1:00 pm	Homeless - Young adults (19-24)	**Homebase** 931 E Devonshire Phoenix 85014
11/1 (Sat.)	1:00 pm – 3:00 pm	Youth Focus Groups (14 - 18) - African Americans 1	**Ironwood Library** 4333 E Chandler Phoenix 85048
11/5 (Tues.)	10:00 am – 12:00 pm	Adults over 65 - Hispanic/Latino [n = 6]	**Gila Bend Family Resource Center** 303 E Pima St, Gila Bend, AZ 85337
11/6 (Wed.)	5:30 pm – 7:30 pm	People Living with Special Healthcare Needs - Parents/caregivers	**Sunset Library** 4930 W Ray, Chandler
11/7 (Thurs.)	12:00 pm – 2:00 pm	Adults over 65 - African Americans [n = 12]	**Muriel Smith Center** 2230 W Roeser Rd, Phoenix 85041
11/7 (Thurs.)	5:00 pm – 7:00 pm	African Americans- Young adults (19-24) [n = 4]	**Muriel Smith Center** 2230 W Roeser Rd, Phoenix 85041
11/12 (Wed.)	5:00 pm – 7:00 pm	Youth Focus Groups (14-18) - Homeless	**UMOM** 2344 E Earll Drive
11/13 (Wed.)	8:30 am – 10:30 am	Youth Focus Groups (14 - 18) - Hispanic	**Natalie's room North High School** 1101 E Thomas Phoenix 85014
11/13 (Wed.)	4:00 pm – 6:00 pm	People who have been previously incarcerated – combined	**Black Canyon building** 2445 W Indianola
11/13 (Wed.)	5:00 pm – 7:00 pm	Youth Focus Groups (14 - 18) - Native American	**Seewa Tomteme Community Center** 8066 S Avenida del Yaqui Guadalupe 85283

2021 Focus Group Schedule

FG#	Date	Region	Group (Location/provider)	Number
1	2/16/2021	SE	I-HELP Chandler	8
2	2/17/2021	Central	Native Health- Phoenix	8
3	2/18/2021	NE	Paiute - South Scottsdale	4
4	2/18/2021	SE	Native Health - Mesa	5
5	2/25/2021	NW	Sun Health - NW Valley	5
6	3/02/2021	NW	Sun Health - NW Valley	5
7	3/10/2021	South Central	South Mountain	6
8	3/12/2021	NW	Family Resource Center –English	6
9	3/19/2021	NW	Family Resource Center-Spanish	5
10	3/24/2021	SW	Gila Bend - English	8
11	3/26/2021	SW	Gila Bend - Spanish	6
12	3/29/2021	NE	Paiute, S. Scottsdale – Spanish - 9am	8
13	3/29/2021	NE	Paiute, S. Scottsdale – Spanish -11:30	6
14	3/30/2021	South Central	South Phoenix (AA/Black)	6
15	4/07/2021	SE	Gilbert - AZCEND Moms Club Gilbert	6
16	4/26/2021	South Central	S Phoenix Young Parents	5
17	5/10/2021	SE	African American/Black Women 85048	5
18	5/12/2021	South Central	Parents w/minors living home 85041	4
19	5/14/2021	*	Asian Americans 65+	8
20	5/16/2021	NW	Parents of Young Children 85086	4
21	5/17/2021	*	Hispanic/Latino Men	6
22	5/17/2021	*	Asian Americans	7
23	5/20/2021	*	Racial/Ethnic Minority Young Adults	7
24	5/27/2021	*	Guadalupe	6
25	6/01/2021	*	LGBTQIA+ Community Members	3
26	6/02/2021	*	Veterans	5
27	6/04/2021	*	Parents with Young Children	8
28	6/07/2021	*	Expectant Mothers & Parents of Young Children	5
29	6/08/2021	*	Young Adults	5
30	6/09/2021	*	Seniors & Veterans	2
31	6/11/2021	*	Central Phoenix residents	10
32	6/14/2021	*	Immigrants - Spanish	4
33	6/14/2021	*	Refugees - Advocates	4
Total Participants				186

* Community members participated from various regions of Maricopa County

Appendix B – Primary Data Collection Tools

2019 Coordinated Community Health Needs Assessment Focus Group Questions

For the purposes of this discussion, "community" is defined as where you live, work, and play.

Opening Question (5 minutes)

To begin, why don't we go around the table and say your name (or whatever you would like us to call you) and what community event brings everybody out? (such as: festival, school play, sporting event, parade; what brings all the people together for fun)

General Community Questions (15 minutes)

I want to begin our discussion today with a few questions about health and quality of life in your community.

1. What does quality of life mean to you?
2. What makes a community healthy?
3. When thinking about health, what are the greatest strengths in your community?
4. What makes people in the community healthy?
    a. Why are these people healthier than those who have (or experience) poor health?

Community Health Concerns (15 minutes)

Next, let's discuss any health issues you have in your community.

5. What do you believe are the 2-3 most important issues that should be addressed to improve health in your community?

    [Prompt – ask this if it does not come up naturally]

    i. What are the biggest health problems/conditions in your community?
    ii. Do other communities in this area have the same health problems?

6. A) What makes it hard to access healthcare for people in your community?

    [Prompt – ask this if it does not come up naturally]

i. Are there any cost issues that keep you from caring for your health? (such as copays or high-deductible insurance plans)
ii. If you are uninsured, do you experience any barriers to becoming insured?
iii. If you do not regularly seek care, are there provider concerns that keep you from caring for your health? (prompt – ask if there are concerns about providers not identifying with them)

B) How do these barriers affect the health of your community? Your family? Children? You?

7. For this question, think about the last year. Was there a time when you or someone in your family needed to see a doctor but could not? Did anything keep you from going?

Community Health Recommendations (15 minutes)

As the experts in your community, I would like to spend this final part of the focus group discussion talking about your ideas to improve community health.

8. What are some ideas you have to help your community get or stay healthy? To improve the health and quality of life?

9. A) What else do you (your family, your children) need to maintain or improve your health?

   [Prompt – ask this if it does not come up naturally]

   i. Services, support or information to manage a chronic condition or change health behaviors such as smoking, eating habits, physical activity, or substance use
   ii. Preventative services such as flu shots, screenings or immunizations
   iii. Specialty healthcare services or providers (such as heart doctors or dermatologists)

   B) What health services do you or your family need that aren't in your community?

10. What resources does your community have/use to improve your health?

    [Prompt – ask this if it does not come up naturally]

    i. Why do you use these particular services or supports?

Ending Question (5 minutes)

11. Is there anything else related to the topics we discussed today that you think I should know that I didn't ask or that you have not yet shared?

Facilitator Summary & Closing Comments (5-10 minutes)

Let's take a few minutes to reflect on responses you provided today. We will review the notes we took and the themes we observed. This is your opportunity to clarify your thoughts or to provide alternative responses. [Co-facilitator provides a brief summary of responses for each of the questions or asks clarifying questions if she thinks she may have missed something.]

Thank you for your participation in this focus group meeting. You have all raised a number of great issues for us to consider. We will look at what you have told us and use this information to make recommendations to area hospitals and the Maricopa County Department of Public Health

2021 COVID-19 Focus Group Questions

A. Information about COVID-19
Let's start our conversation about how COVID-19 has affected you and your family.

1. How has COVID-19 affected you and your family?
2. What do people close to you (e.g., your family/friends) say about the COVID-19 vaccine?
    a. What about your neighbors? Faith/religious leaders or faith community?
    b. PROBE: And what about schools (if applicable)? Colleagues? Employers? Medical professionals? How has COVID-19 affected you differently because of your race/ethnicity or ethnicity?
3. Where have you seen information about the COVID-19 vaccine?
    a. PROBE: Word of mouth? TV? Radio? Social media (e.g., Facebook, Twitter, text message sources)? Online sources?
    b. Where are some places you've noticed health messages in general?
        i. PROBE: Grocery store? Shopping stores (e.g., Walmart, Costco, Walgreens, CVS)? Doctor's office? Health clinic? Community/faith-based organization? Other?
    c. What kind of messaging are you seeing? What do you think of these messages? Do you think they reach Arizona's communities?

4. Who do you trust and/or rely on information or updates about the COVID-19 vaccine?
    a. PROBE: Why do you trust this person/s?
    b. PROBE: Who don't you trust? Why?
5. Is there anything about COVID-19 or vaccine that you want to know more about?
    a. PROBE: Why would you like to know this information?
    b. PROBE: How would you like to receive this information?
    c. PROBE: Language preference? Radio? TV? Pamphlets?
6. Where do you usually go to get health care or for your health needs?
    a. PROBE: Urgent care? Hospital/ER? Clinic? Telehealth?
7. What thoughts do you have on preventing COVID-19?
    a. Where did you get that information?

B. Intent to get vaccinated against COVID-19

The following questions are about your intentions to get vaccinated against COVID-19 when a vaccine becomes available to the general public.

1. What do you think about a COVID-19 (Pfizer vaccine? Moderna? Johnson & Johnson)?
    a. PROBE: What are some reasons you think that (about each)?
2. What are some reasons why you and/or your family did/ would get vaccinated for COVID-19?
    a. PROBE: Where would you go?
3. What concerns do you have about getting vaccinated for COVID-19?
    a. **NOTE: List concerns and probe – ex. "I don't know what is in the vaccine?" ASK: What do you think is in it? What have you heard?
    b. PROBE: What concerns do you have about elders getting vaccinated for COVID19? Children?
4. In your opinion, what barriers do you think there may be to get vaccinated against COVID-19 (e.g., cost)?
   PROBE: perhaps you've already had the vaccine?
5. What challenges do you, your family, and/or your community have in getting the COVID19 vaccine?

C. Communication and Messaging

Now let's discuss communication about COVID-19 and messaging.

1. What information would your reluctant family/friends need before getting the vaccine?
2. What are some ways we can communicate updates on "COVID-19 vaccines and research information" specifically to [BLACK, INDIGENOUS, HISPANIC/LATINO] communities?
    a. PROBE: What are some things that may work?
3. What ways could community leaders build and maintain trust with your community [or BLACK, INDIGENOUS, HISPANIC/LATINO] communities?
4. What kind of messaging would you or your community need to know the vaccine is safe?
5. Do you think COVID has affected different groups of people differently? (Why do you think this is and how do you think we could we improve this situation?)

D. FINAL WRAP UP QUESTION

1. At this time, what do you and your family need to maintain or improve your health?
2. Is there anything else related to the topics we discussed today that you think I should know that I didn't ask or that you have not yet shared?

2019 Maricopa County Community Health Needs Assessment Survey

The purpose of this brief survey is to get your opinion about issues related to community health and quality of life here in Maricopa County. Information collected in this survey will be kept confidential and used only in combination with others participating in the survey. No personal identifying information will be collected. Your feedback will be used to help guide future community health improvement planning efforts. Thank you for supporting your community. This survey should take about 10 minutes. If you have questions about the survey or need it provided in an alternative format, please visit http://www.MaricopaHealthMatters.org.

In this survey, "community" is defined as the areas where you work, live, learn and/or play.

1. **In general, how would you rate your physical health?**

   Poor Fair Good Very Good Excellent

2. **How would you rate your mental health, including your mood, stress level, and your ability to think?**

   Poor Fair Good Very Good Excellent

3. **How often are you able to get the services you need to maintain your mental health?**

   Never Sometimes Always

4. **On a monthly basis, do you have enough money to pay for essentials such as food, clothing and housing?**

   Never Sometimes Always

5. **In your community, do people trust one another and look out for one another?**

   Never Sometimes Always

6. **On a monthly basis, do you have enough money to pay for health care expenses (e.g. doctor bills, medications, etc.)?**

   Never Sometimes Always

7. **How do you pay for your health care (including medications, dental and health treatments)? (Check all that apply.)**

☐ Health insurance purchased on my own or by family member	☐ Health insurance purchased/provided through employer	☐ I do not use health care services	☐ Indian Health Services
☐ Medicaid/AHCCCS	☐ Medicare	☐ Travel to a different country to afford health care	☐ Use free clinics
☐ Use my own money (out of pocket)	☐ Veterans Administration	☐ Other: _____	

8. **What are the biggest barriers to accessing healthcare in your community? (Check up to 3.)**

☐ Childcare	☐ Difficulty finding the right provider for my care	☐ Distance to provider	☐ Inconvenient office hours
☐ No health insurance coverage	☐ Not enough health insurance coverage	☐ Transportation to appointments	☐ Understanding of language, culture, or sexual orientation differences
☐ Other: _____			

9. **What are the greatest strengths of your community? (Check all that apply.)**

☐ Ability to communicate with city/town leadership and feel that	☐ Accepting of diverse residents and cultures	☐ Access to affordable after school activities	☐ Access to affordable childcare

my voice is heard			
□ Access to affordable healthy foods	□ Access to affordable housing	□ Access to community classes and trainings	□ Access to cultural events
□ Access to fitness programs	□ Access to good schools	□ Access to jobs & healthy economy	□ Access to medical care
□ Access to mental health services	□ Access to parks and recreation sites	□ Access to public libraries and community centers	□ Access to public transportation
□ Access to religious or spiritual events	□ Access to safe walking and biking routes	□ Access to services for seniors	□ Access to social services for residents in need or crisis
□ Access to substsance abuse treatment services	□ Access to support networks such as neighbors, friends, and family	□ Clean environment and streets	□ Good place to raise children
□ Low crime/safe neighborhoods	□ Other: _____		

10. **Which health conditions have the greatest impact on your community's overall health and wellness? (Check up to 5.)**

□ Alcohol/Substance abuse	□ Anorexia/bulimia and other eating disorders	□ Arthritis	□ Autism
□ Cancers	□ Chronic stress	□ Chronic pain	□ Dementia/Alzheimer's
□ Dental problems (oral health)	□ Diabetes	□ Food allergies/anaphylaxis	□ Heart disease and stroke

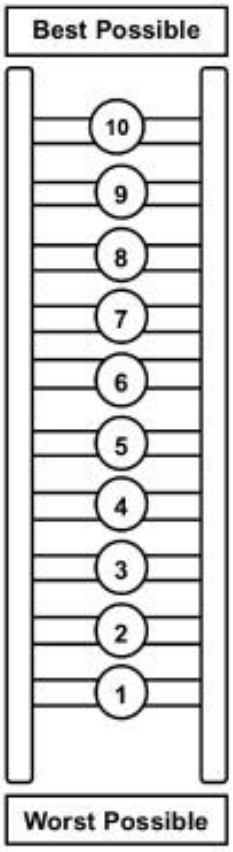
□ High blood pressure or cholesterol	□ HIV/AIDS	□ Lung disease (asthma, COPD, emphysema)	□ Vaccine preventable diseases such as flu, measles, and pertussis (whooping cough)
□ Mental health issues (depression, anxiety, bipolar, etc.)	□ Overweight/obesy	□ Sexually transmitted diseases	□ Suicide
□ Tobacco use including vaping	□ Other: _____	□	□

11. **Which <u>issues</u> have the greatest impact on your community's health and wellness? (Check up to 5.)**

□ Bullying/peer pressure	□ Child abuse/neglect	□ Distracted driving (such as cell phone use, texting while driving)	□ Domestic violence
□ Dropping out of school	□ Elder abuse/neglect	□ Gang-related violence	□ Gun-related injuries
□ Homelessness	□ Homicide (murder)	□ Illegal drug use	□ Limited access to healthcare
□ Lack of affordable healthy food options	□ Lack of affordable housing	□ Lack of child car seats and seat belts use	□ Lack of good jobs
□ Lack of good schools	□ Lack of people immunized to prevent disease	□ Lack of public transportation	□ Lack of quality and affordable childcare
□ Lack of safe spaces to exercise and be physically active	□ Lack of support networks such as neighbors, friends and family	□ Limited places to buy groceries	□ Motor vehicle & motorcycle crash injuries

☐ Racism/discrimination	☐ Rape/sexual assault	☐ Smoking/electronic cigarette use or caping	☐ Suicide
☐ Teen pregnancy	☐ Unsafe working conditions	☐ Other: _____	

For the next four questions, please imagine a ladder with steps numbered from one at the bottom to ten at the top. The top of the ladder represents the <u>best possible life</u> and the bottom of the ladder represents the <u>worst possible life.</u>



12. **Which step represents the health of your community?**

1 2 3 4 5 6 7 8 9 10
Worst Possible Best Possible

13. **Indicate where on the ladder you feel you personally stand right now.**

1 2 3 4 5 6 7 8 9 10
Worst Possible Best Possible

14. **On which step do you think you will stand about five years from now?**

1 2 3 4 5 6 7 8 9 10
Worst Possible Best Possible

15. **Now imagine the top of the ladder represents the <u>best possible *financial situation* for you</u>, and the bottom of the ladder represents the <u>worst possible *financial situation* for you</u>. Please indicate where on the ladder you stand right now.**

1 2 3 4 5 6 7 8 9 10
Worst Possible Best Possible

The following information is used for demographic purposes and does NOT identify you; all responses are confidential.

16. **What is your ZIP code? _____**

17. **What is your gender?**

□ Male	□ Female	□ Transgender	□ Other

18. **What is your age?**

□ 12-17	□ 18-24	□ 25-34	□ 35-44
□ 45-54	□ 55-64	□ 65-74	□ 75+

19. **Which racial or ethnic group do you identify with? (Check only 1.)**

□ White	□ Asian	□ American Indian: Tribal Affiliation _____	□ Hispanic or Latino
□ Black of African American	□ Native Hawaiian or Other Pacific Islander	□ Alaskan Native	□ Multi-racial
□ Other			

20. **Which group(s) do you most identify with? (Check all that apply.)**

□ Adult with children	□ Adult with no children	□ Caregiver	□ LGBTQI
□ Person experiencing homelessness	□ Person with a disability	□ Refugee/Asylum Seeker	□ Single parent
□ Veteran	□ Person living with HIV/AIDS	□ Other: _____	□ None

21. **What range is your household income?**

□ Less than $20,000	□ $20,000 - $29,000	□ $30,000 - $49,000
□ 50,000 - $74,000	□ $75,000 - $99,999	□ Over $100,000

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

□ Less than a high school graduate	□ High school diploma or GED	□ Associate's Degree	□ Currently enrolled at vocational school or college
□ College degree or higher	□ Other		

2021 COVID-19 Impact Community Health Survey

The purpose of this brief survey is to get your opinion about COVID-19's impact on community health and quality of life in Maricopa County since March of 2020. Information collected in this survey will be kept confidential and used only in combination with others participating in the survey. No personal identifying information will be collected. Your feedback will be used to help guide future community health improvement planning and funding efforts. This survey should take about 15 minutes. If you have questions about the survey or need it provided in an alternative language or format, please email Tiffany.Tu@maricopa.gov and we will do our best to accommodate.

The following information is used for demographic purposes and does NOT identify you; all responses are confidential. To learn more about why CHNAs are important, please visit https://www.cdc.gov/publichealthgateway/cha/plan.html.

1. **What is the ZIP code that you currently reside in? _____**
2. **What is your gender?**

☐ Female	☐ Male	☐ Transgender	☐ Prefer to self-describe	☐ Prefer not to answer

3. **What is your age range?**

☐ 12-17	☐ 18-24	☐ 25-34	☐ 35-44
☐ 45-54	☐ 55-64	☐ 65-74	☐ 75+

4. **Which racial and/or ethnic group do you identify with? (Check no more than two)**

☐ African American/Black	☐ American Indian/Native American	☐ Asian	☐ Hispanic/Latinx
☐ Native Hawaiian or other Pacific Islander	☐ Caucasian/White	☐ Other: _____	☐ Prefer not to answer

5. **Which group(s) do you most identify with? (Check all that apply)**

□ Adult with children under age 18 or living in the same home	□ Single parent	□ LGBTQI	□ Person experiencing homelessness
□ Person living with a disability	□ Immigrant	□ Refugee	□ Veteran
□ Person living with HIV/AIDS	□ Other	□ Prefer not to answer	□ None

6. **What range is your household income?**

□ Less than $20,000	□ $20,000 - $29,000	□ $30,000 - $49,000
□ 50,000 - $74,000	□ $75,000 - $99,999	□ Over $100,000
□ Prefer not to answer		

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

□ Less than a high school graduate	□ High school diploma or GED	□ Some College or Associate degree (2yr)	□ Graduate of vocational/trade school
□ Currently enrolled in college	□ Bachelor's Degree (4yr)	□ Postgraduate Degree	□ Other
□ Prefer not to answer			

In this survey, "community is defined as the areas where you work, live, learn and/or play.

8. **Since March of 2020 (the start of the COVID-19 pandemic), how would you rate your physical health?**

Excellent	Very Good	Good	Fair	Poor

9. **Would you rate your current physical health as Better, Similar, or Worse compared to your physical health prior to March of 2020?**

Better	Similar	Worse

10. **Since March of 2020 (the start of the COVID-19 pandemic), how would you rate your mental health, including your mood, stress level, and your ability to think?**

Excellent	Very Good	Good	Fair	Poor

11. **Would you rate your current mental health as Better, Similar, or Worse compared to your mental health prior to March 2020?**

Better	Similar	Worse

12. **Since March of 2020 (the start of the COVID-19 pandemic), if you sought services to address your mental health, including your mood, stress level and/or your ability to think, how often have you been able to get the services you need?**

Always	Sometimes	Never	Not Applicable

13. **What services would have improved overall mental and physical health of your family in the last year? (Check all that apply)**

☐ Childcare services	☐ In-person school	☐ Technology and internet service	☐ Assistance with finding employment
☐ Assistance with paying utilities	☐ Assistance with paying rent	☐ Assistance with finding healthcare	☐ Assistance with finding substance use treatment
☐ Assistance with mental health issues	☐ Assistance with finding COVID-19 vaccine	☐ Other _____	

14. **Since March of 2020, have you had enough money to pay for essentials such as:**

Food	Always	Sometimes	Never	N/A
Housing: Rent/Mortgage	Always	Sometimes	Never	N/A
Utilities	Always	Sometimes	Never	N/A
Car/Transportation	Always	Sometimes	Never	N/A
Insurance	Always	Sometimes	Never	N/A
Clothing/Hygiene Products	Always	Sometimes	Never	N/A
Medication/Treatments	Always	Sometimes	Never	N/A

Childcare	Always	Sometimes	Never	N/A
Tuition or Student Loans	Always	Sometimes	Never	N/A

15. **Since March of 2020, have you applied for any of the following financial assistance due to the impact of the COVID-19 pandemic to assist with the essential cost of living expenses listed above?**

COVID-19 Relief Funding for You/Family	Yes	No
COVID-19 Relief Funding for your business	Yes	No
Unemployment due to loss of job (laid off)	Yes	No
Unemployment due to staying home to care for children, elderly parents, or ill family members	Yes	No
Unemployment due to COVID-19 illness (self)	Yes	No
WIC (Women, Infant, and Children)	Yes	No
SNAP Food Stamps	Yes	No
Medicaid Insurance	Yes	No

16. **Since March of 2020, how often did you seek financial assistance to help pay for healthcare expenses (e.g. doctor bills, medications, medical treatments, doctor co-pay, etc.)**

Always	Sometimes	Never	N/A

17. **If you received a stimulus check in the fall of 2020 and spring of 2021, what impact did this have on alleviating your essential living expenses and access to healthcare?**

Strong Impact	Moderate Impact	Weak Impact	No Impact/No difference	Did Not Receive

18. **Since March of 2020, was your employment impacted due to the COVID 19 pandemic? (Check all that apply)**

□ No, continued working the same number of hours	□ No, required to continue working onsite	□ Yes, work hours were reduced	□ Yes, required to telework

☐ Yes, furloughed (temporary job loss, able to return to work once management contacts you)	☐ Yes, laid off	☐ Yes, quit to care for children due to school closure	☐ Yes, quit to care for ill family members
☐ Yes, quit due to COVID-19 illness (self)	☐ Yes, unable to return to work due to COVID-19 illness (long-term effects)	☐ Yes, started a new job	☐ Other: _____

19. **Since March of 2020, how do you currently pay for your healthcare including medications, dental, and health treatments? (Check all that apply)**

☐ Health insurance purchased on my own or by family member	☐ Health insurance provided through employer	☐ Indian Health Services	☐ Medicaid/AHCCCS
☐ Medicare	☐ Use free clinics	☐ Use my own money (out of pocket)	☐ Veterans administration
☐ Did not seek healthcare since March of 2020	☐ Other: _____		

20. **Since March of 2020, what have been the primary barriers to seeking or accessing healthcare in your community? (Check all that apply)**

☐ Lack of childcare	☐ Difficulty finding the right provider for my care	☐ Fear of exposure of COVID-19 in a healthcare setting	☐ Unsure if healthcare need is a priority during this time
☐ Distance to provider	☐ Inconvenient office hours	☐ No health insurance coverage	☐ Not enough health insurance coverage
☐ Transportation to appointments	☐ Understanding of language, culture, or sexual	☐ I have not experienced any barriers	☐ Other: _____

	orientation differences		

21. **Since March of 2020, what have been the greatest strengths of your community? (Check all that apply)**

□ Ability to communicate with city/town leadership and feel that my voice is heard	□ Accepting of diverse residents and cultures	□ Access to schools or school alternatives	□ Access to affordable childcare
□ Access to affordable healthy foods	□ Access to COVID-19 testing events	□ Access to cultural & educational events	□ Access to medical care
□ Access to affordable housing	□ Access to COVID-19 vaccine events	□ Access to quality online school options	□ Access to mental health services
□ Access to community programming such as classes & trainings	□ Access to Flu vaccine events	□ Access to jobs & healthy economy	□ Access to parks and recreation sites
□ Access to public libraries and community centers	□ Access to safe walking and biking routes	□ Access to substance abuse treatment services	□ Access to low crime / safe neighborhoods
□ Access to public transportation	□ Access to services for seniors	□ Access to support networks such as neighbors, friends, and family	
□ Access to religious or spiritual events	□ Access to social services for residents	□ Access to clean environments and streets	□ Other: _____

	in need or crisis		

22. **Since March of 2020, in addition to COVID-19, which health conditions have had the greatest impact on your community's overall health and wellness? (Check all that apply)**

☐ Alcohol/Substance abuse	☐ Cancers	☐ Dementia/Alzheimer's	☐ Diabetes
☐ Heart disease and stroke	☐ High blood pressure or cholesterol	☐ HIV/AIDS	☐ Lung disease (asthma, COPD, emphysema)
☐ Vaccine preventable disease such as flu, measles, and pertussis (whooping cough)	☐ Mental health issues (depression, anxiety, bipolar, etc)	☐ Overweight/ obesity	☐ Sexually transmitted disease
☐ Tobacco use including vaping	☐ Other: _____		

23. **Since March of 2020, which of the following issues have had the greatest impact on your community's health and wellness? (Check all that apply)**

☐ Child abuse/elder abuse & neglect	☐ Distracted driving (such as cell phone use, texting while driving)	☐ Domestic violence / sexual assault	☐ Gang-related violence
☐ Gun-related injuries	☐ Limited/lack of access to COVID19 testing	☐ Lack of affordable healthy food options	☐ Lack of people immunized to prevent disease
☐ Homelessness	☐ Limited access to healthcare	☐ Lack of affordable housing	☐ Lack of public transportation
☐ Drug/substance abuse (illegal & prescribed)	☐ Limited access to mental/behavioral health services	☐ Lack of jobs	☐ Lack of quality and affordable childcare

☐ Lack of COVID-19 vaccine access	☐ Limited access to educational and supportive programing for children and adolescents	☐ Lack of alternative educational opportunities	☐ Lack of safe spaces to exercise and be physically active
☐ Lack of support networks such as neighbors, friends, and family	☐ Motor vehicle & motorcycle crash injuries	☐ Racism/ discrimination	☐ Suicide
☐ Teen Pregnancy	☐ Other: _____		

24. **Overall, how easy was it to navigate this electronic survey?**

☐ Very easy to use	☐ Easy to use	☐ Neither easy nor difficult to use	☐ Difficult to use	☐ Very difficult to use

25. **Based on the given survey questions above, the information provided was easy to understand.**

☐ Strongly agree	☐ Agree	☐ Neutral	☐ Disagree	☐ Strongly disagree

26. **What else would you like to share with us regarding your experience with COVID-19 that we didn't ask?**

27. **Want to tell us more? We want to share community members' stories. Let us know you're interested by indicating your type of experience along with sharing your email address/phone so we can contact you.**

    ☐ I experienced COVID-19. _____
    ☐ A loved one experienced COVID-19. _____
    ☐ My work was impacted by COVID-19. _____
    ☐ Other: _____

Thank you for completing MCDPH's COVID-19 Impact Community Health Assessment Survey.

Appendix C – 2019 & 2021 Community Survey Demographics

2019	
Total # of participants	**11,893**
Race/ethnicity/Ethnicity	
African American/Black	3.0%
American Indian/ Native American	2.0%
Asian	25.0%
Caucasian/White	61.0%
Hispanic/Latinx	4.0%
Other	6.0%
Age	
12-24	8.0%
25-44	32.0%
45-64	39.0%
65+	21.0%
Gender	
Female	73.0%
Male	25.0%
Other	1.0%

2021	
Total # of participants	**14,380**
Race/ethnicity/Ethnicity	
African American/Black	4.1%
American Indian/ Native American	1.4%
Asian	4.5%
Caucasian/White	64.5%
Hispanic/Latinx	18.3%
Native Hawaiian/ Other Pacific Islander	1.2%
Two or more race/ethnicities	1.2%
Unknown/Not given	4.9%
Age	
12-24	6.4%
25-44	30.9%
45-64	43.0%
65+	20.0%
Gender	
Female	68.9%
Male	29.1%
Additional Genders	0.6%
Unknown/Not Given	1.4%

Appendix D – Valleywise Health's PSA Zip Codes (Top 10)

At the time the 2021 PSAs areas were submitted to MCDPH, Valleywise Health's Glendale and El Mirage locations were included in the analysis. Therefore, both PSAs are part of Valleywise Health's combined PSA results.

Valleywise Community Health Center Avondale				
85003	85035	85037	85043	85301
85323	85326	85338	85353	85392

Valleywise Community Health Center Chandler				
85120	85142	85204	85224	85225
85226	85248	85249	85286	85295

Valleywise Community Health Center Maryvale				
85009	85017	85019	85031	85033
85035	85037	85043	85301	85303

Valleywise Community Health Center West Maryvale				
85009	85017	85019	85033	85035
85037	85043	85301	85031	85303

Valleywise Community Health Center McDowell				
85008	85009	85013	85014	85015
85016	85017	85021	85041	85301

Valleywise Community Health Center North Phoenix				
85015	85017	85020	85021	85022
85023	85029	85032	85051	85301

Valleywise Community Health Center South Central Phoenix				
85003	85006	85007	85008	85009
85015	85035	85040	85041	85042

Valleywise Comprehensive Health Center Phoenix				
85006	85008	85009	85017	85033
85035	85040	85041	85042	85301

Valleywise Community Health Center South Phoenix/Laveen				
85007	85008	85009	85031	85035
85040	85041	85042	85043	85339

Valleywise Comprehensive Health Center Peoria				
85019	85031	85033	85035	85037
85301	85302	85303	85335	85345

Valleywise Community Health Center Mesa				
85201	85202	85203	85204	85205
85206	85207	85210	85213	85225

Valleywise Community Health Center Guadalupe				
85008	85040	85042	85044	85201
85205	85210	85281	85282	85283

Valleywise Community Health Center El Mirage				
85031	85033	85301	85323	85335
85345	85351	85363	85374	85379

Valleywise Community Health Center Glendale				
85009	85017	85019	85031	85033
85035	85051	85301	85301	85303

Appendix E –Top 10 Valleywise Health IP, ED, and Death Rankings by Overall Rates

Rank	Inpatient Hospitalization	Emergency Department	Death
1	All Mental Disorders	Falls Related Injuries	CVD
2	CVD	CVD	All Drug Overdose
3	Mood and Depressive Disorders	All Mental Disorders	Stroke
4	Schizophrenic	Motor Vehicle Traffic Related	COPD
5	Stroke	Asthma	Alcohol Related
6	Falls Related Injuries	Interpersonal Violence	Opioid Overdose
7	Diabetes	Diabetes	Alzheimer's
8	Motor Vehicle Traffic Related	Hypertension	Falls Related Injuries
9	All Drug Overdose	All Drug Overdose	Lung Cancer
10	COPD	COPD	Suicide

Appendix F – Data Indicator Matrix

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 - 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
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 G - References

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