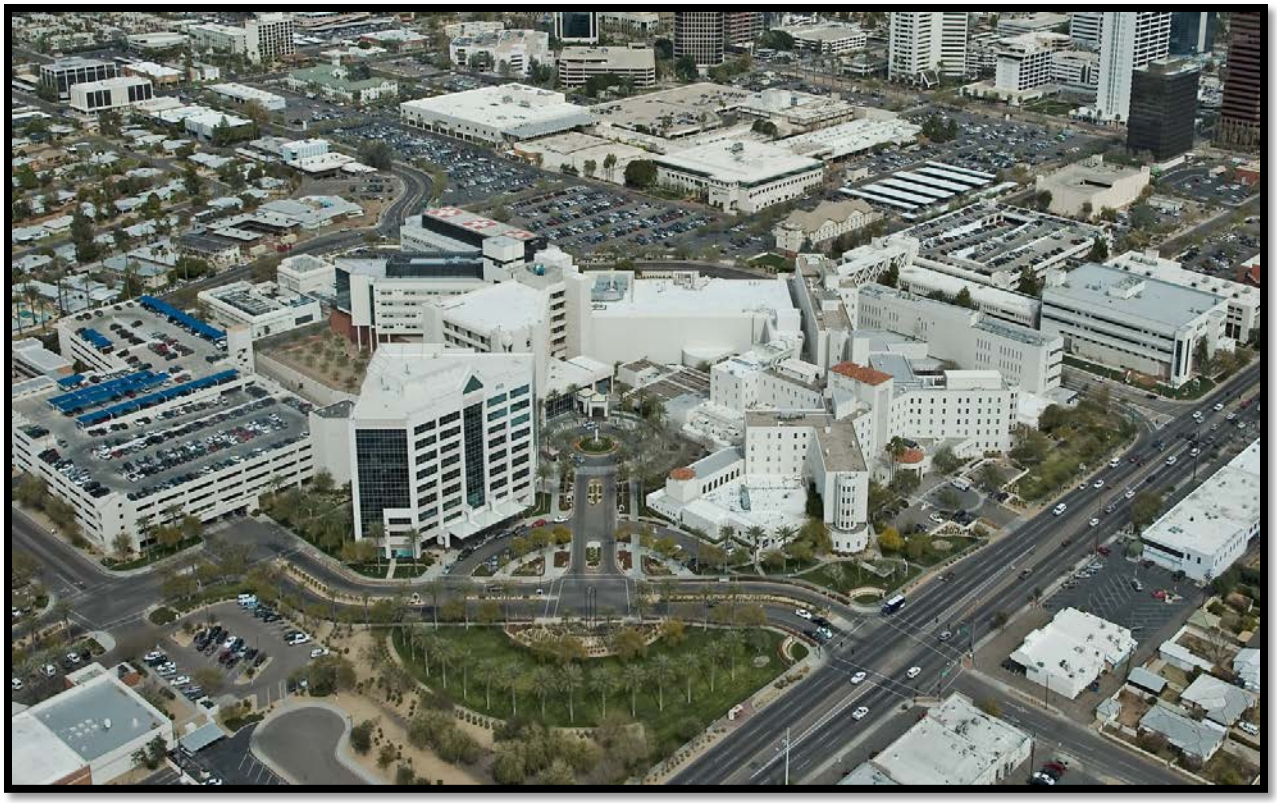
Dignity Health™
St. Joseph's Hospital and Medical Center



St. Joseph's Hospital and Medical Center

Community Health Needs Assessment 2019

Maricopa County Coordinated Community Health Needs Assessment

Dignity Health
St. Joseph's Hospital and Medical Center
Phoenix, AZ

This community health needs assessment report is a customized version of the coordinated community health needs assessment that the Maricopa County Department of Public Health (MCDPH) conducted in partnership with Adelante Healthcare, Banner Health, Dignity Health, Mayo Hospital, Native Health, and Phoenix Children's Hospital.

December 20, 2019

SYNAPSE

Maricopa County Public Health
WeArePublicHealth.org

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Executive Summary

Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (ACA) added new requirements which nonprofit hospitals must satisfy in order to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to meet the identified needs of the community at least once every three years. As part of the CHNA, each hospital is required to collect input from individuals in the community, including public health experts as well as residents, representatives or leaders of low-income, minority, and medically underserved populations.

Synapse is a coalition of non-profit and federally-qualified health care partners who collaborate to conduct a coordinated community health assessment to identify needs for both individual hospitals, health care centers, and the county overall. Beginning in early 2015, St. Joseph's Hospital and Medical Center (SJHMC), in partnership with Synapse worked collaboratively and conducted an assessment of the health needs of residents of Maricopa County as well as those in their Primary Service Area. The CHNA process undertaken and described in this report was conducted in compliance with federal requirements.

Purpose Statement

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

Community Definition

The geographic area for this CHNA is Maricopa County, the common community for all partners participating in the Synapse collaborative. Maricopa County is the fourth most populous county in the United States. With an estimated population of 4 million and growing, Maricopa County is home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations. Maricopa County is ethnically and culturally diverse, home to more than 1.2 million Hispanics (30% of all residents), 216,000 African Americans, 157,000 Asian Americans, and 77,000 American Indians. According to the U.S. Census Bureau, 14% percent of the population does not have a high school diploma, 17% are living below the federal poverty level, and over 600,000 are uninsured[i].

Dignity Health defines the community served by a hospital as those individuals residing within its primary and secondary service areas. For this report the focus will be on the primary service area of SJHMC. The primary service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. Located in the heart of Phoenix, Arizona, SJHMC draws populations from Maricopa County, outside Maricopa County but within Arizona, and from outside the state. SJHMC's primary service area is within the urban inner city areas, and it also serves the suburban and rural

communities for high-risk services. According to the Community Need Index (CNI), a proprietary tool developed by Dignity Health, the primary service area includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85003, 85004, 85006, 85007, 85008, 85009, 85015, 85017, 85019, 85031, 85033, 85040, and 85301.[ii]

Assessment, Process and Methods

The ACA requirements are mirrored in the Public Health Accreditation Board's (PHAB) standard mandating that health departments participate in or conduct a community health assessment every three to five years. Federally funded community health centers must also ensure their target communities are of high need. The similar requirements from IRS, PHAB, and the federally funded health center requirements put forth by the United States Department of Health and Human Services provide an opportunity to catalyze stronger collaboration and better shared measurement systems among hospitals, health centers, and health departments. Additionally, limited resources for comprehensive health assessments and the move toward new population health models have created the need for an organized, collaborative, public-private approach for conducting assessments. As a result, Adelante Healthcare, Banner Health, Dignity Health, Mayo Hospital, Native Health, and Phoenix Children's Hospital have joined forces with Maricopa County Department of Public Health (MCDPH) to identify the communities' strengths and greatest needs in a coordinated community health needs assessment.

The process of conducting this assessment began with a review of approximately 100 indicators to measure health outcomes and associated health factors of Maricopa County residents. The indicators included demographic data, social and economic factors, health behaviors, physical environment, health care, and health outcomes. Health needs were identified through the combined analysis of secondary data and community input. Based on the review of the secondary data, a consultant team developed a primary data collection guide used in focus groups which were made up of representatives of minority and underserved populations who identified community concerns and assets. Surveys were collected from key informants to help determine community needs and priorities. Additionally, meetings were held with stakeholders from the Community Health Integration Network (CHIN) and Arizona's Communities of Care Network (ACCN) to assist with the analysis and interpretation of data findings.

Summary of Prioritization Process

To be considered a health need, a health outcome or a health factor had to meet two criteria; first, existing data had to demonstrate that the primary service area had a health outcome or factor rate worse than the average Maricopa County rate, demonstrate a worsening trend when compared to Maricopa County data in recent years, or indicate an apparent health disparity; second, the health outcome or factor had to be mentioned in a substantial way in at least two primary data collection sources which were focus groups, surveys, or stakeholder meetings.

The process for prioritization included engagement with both internal Dignity Health stakeholders and community partners. The first step of the process was a comprehensive presentation by MCDPH that included an overview of the CHNA findings and key emerging health needs. The second step in the process involved review and prioritization of the key emerging health needs outlined in the MCDPH presentation by the CHIN and ACCN. Participants discussed each health need, consideration was given to the size of the problem,

disparity and equity, known effective interventions, resource feasibility and sustainability, and community salience. Through a voting process, participants made final recommendations to SJHMC for priority health needs.

Summary of Prioritized Needs

The following statements summarize each of the areas of priority for SJHMC, and are based on data and information gathered through the CHNA.

1. Access to Care

Community members and key informants overwhelmingly felt that access to care is an important issue for the community. When SJHMC 2015 community survey respondents were asked, what was the most important "Health Problem" impacting their community, access to care was number one top concern. Within SJHMC's primary service area, 20.1% of the population is unemployed and uninsured with 20.7% employed making under $25,000[iii]. Additionally, there are disparities experienced across members of certain racial/ethnic backgrounds, with Hispanics and American Indians being least likely to have insurance[iv].

2. Mental/Behavioral Health

Mental and behavioral health is term often used interchangeably to refer to a spectrum of health conditions which are each distinct yet often co-occurring and overlapping. Behavioral health includes not only ways of promoting well-being by preventing or intervening in mental illness such as anxiety or depression, but also has an aim preventing or intervening in substance abuse and suicide.

Mental health was ranked as the most important health problem impacting the community by key informants. This was echoed by participants in the focus groups who believe mental health is one of top health issues impacting community residents.

Substance abuse was one of the top concerns for both focus group participants and key informants. Key informants listed alcohol and drug abuse as two of the riskiest health behaviors community members are engaging in. In 2017, the United States Health and Human Services Department declared a public health emergency and announced a plan to combat the opioid crisis. In 2016, 790 Arizonians died from opioid overdoses and trends show an increase of a startling 74% over the past four years.[v]

Suicide was the eighth leading cause of death for Maricopa County residents and SJHMC's primary service area in 2016. Suicide rates across Maricopa County have slightly increased from 2012-2016, with male rates 3 times higher than female suicide rates. In Maricopa County, rates of suicide are highest among age groups 45-54 and 75+, which could indicate a potential health disparity in identification, referral or treatment of suicidal ideation.

Maternal Health is an important part of mothers, infants, and child's overall health and wellbeing. It determines the health of the next generation and can help predict health challenges for families, communities, and the medical care system. Moreover, healthy birth outcomes and early detection and treatment of health conditions among infants can prevent death[vi]. Maricopa County's infant mortality rates from 2012-2016 range from 5.3 to 6.3 infant deaths per 1,000 births. The SJHMC Primary Service Area infant mortality rate is higher than Maricopa County[vii].

Alzheimer's is a type of dementia that causes problems with memory, thinking, and behavior[viii] In Arizona, 2,943 deaths occurred in 2015 due to Alzheimer's and it is the fifth leading cause of death, which is a 182% increase since 2000[ix]. In Maricopa County and SJHMC primary service area, Alzheimer's is the fourth leading cause of death[x].

3. Overweight/Obesity

Arizona has the 30th highest adult obesity rate in the nation, and the 32rd highest obesity rate for youth ages 10-17[xi]. In Maricopa County, males have higher rates of being overweight, and Hispanics have higher rates of obesity when compared to non-Hispanic whites[xii]. Key informants felt that being overweight, poor eating habits and lack of exercise were among the top five risky health behaviors community members were engaging in.

4. Cancer

While advancements continue to be made in the fight against cancer, it remains the leading cause of death in Maricopa County and the SJHMC's primary service area and was identified as one of the top five areas of concerns from key informants. Colorectal cancer death rates in Maricopa County and SJHMC primary service area has fluctuated over the last five years[xiii]. In SJHMC primary service area, colorectal rates are just below Maricopa County rate[xiv]. Some lung, breast, and cervical cancer rates will be highlighted in this report.

5. Trauma/Injury Prevention

Injuries are not accidents, they are predictable and preventable. Unintentional injuries, including traffic-related, injuries, falls, burns, poisonings, and drowning were responsible for lost lives in the SJHMC primary service area[xv]. Unintentional injury is the fifth leading cause of death in Maricopa County and SJHMC's primary service area. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females[xvi].

6. Social Determinant of Health

Social determinants of health are conditions in the environments in which 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[xvii]. Dignity Health SJHMC is dedicated to making a positive impact on the social determinants of health, particularly on the health of those economically-disadvantaged communities. Resources that enhance quality of life can have a significant influence on population health outcomes. SJHMC will focus on addressing homelessness, food insecurity, transportation, and problems related to psychosocial circumstances.

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 Federally Qualified Health Centers (FQHC), 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, and prevention-based community education.

The Health Improvement Partnership of Maricopa County (HIPMC) is 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 to resource to help SJHMC connect to other community based organizations that are targeting many of the same health priorities[xviii].

This CHNA report was adopted by the SJHMC community board in January 23, 2019.

This report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at St. Joseph's Hospital and Medical Center's Department of Community Health Integration.

Written comments on this report can be submitted to the St. Joseph's Hospital and Medical Center's Department of Community Health Integration, by e-mail to CommunityHealth-SHJMC@DignityHealth.org or by phone to 602-406-2288.

Assessment Purpose and Organizational Commitment

Community Health Needs Assessment (CHNA) Background

St. Joseph's Hospital and Medical Center (SJHMC) is dedicated to enhancing the health of the communities it serves. The findings from this Community Health Needs Assessment (CHNA) report will serve as a foundation for understanding the health needs found in the community and will inform the implementation strategies selected. This report complies with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a CHNA at least once every three years. With regard to the CHNA, the ACA specifically requires nonprofit hospitals to: (1) collect and take into account input from public health experts as well as community leaders and representatives of high need populations—this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions; (2) identify and prioritize community health needs; (3) document a separate CHNA for each individual hospital; (4) and make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an Implementation Strategy that describes how the hospital will address the identified significant community health needs.

Purpose Statement

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

Organizational Commitment

Since 1895, SJHMC has delivered high-quality, affordable, health care services in a compassionate environment that meets each patient's physical, mental and spiritual needs. Upholding the core values of dignity, justice, stewardship, collaboration, and excellence, our healing philosophy serves not just our patients, but our staff, our communities, and our planet.

Rooted in Dignity Health's mission, vision and values, SJHMC is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Health Integration Network (CHIN). The board and its committee on community health and benefit issues are composed of community members who provide stewardship and direction for the hospital as a community resource.

The Community Board and its chairperson, Richard Horn, Patty White, the hospital's President and CEO,
The Executive Management Team and the community are involved in the CHNA process, Community Benefit planning process, and the prioritization of the identified unmet health-related needs to inform the development of the programs for each year and how they link to the hospital's strategic plan. This commitment is reflected in the hospital's Community Health Integration and Community Benefit programs, which are a demonstration of the hospital's commitment to improving the lives of the communities within Arizona. The Community Board, leadership and CHIN hold the planning of the community needs, oversee the

CHNA and its adoption through setting the priority for the Community Benefit Plan and approving the strategies for implementing the programs that will work with the community. They will continue to monitor the outcomes of the programs and ensure the appropriate resources are made available to sustain a healthier Arizona.

The key staff positions dedicated to planning and carrying out the community benefit programs include, but are not limited to the following:

- Director of Community Health Integration and Community Benefit provides the leadership, oversight, evaluation, and effectiveness of the community benefit programming for the hospitals and its affiliates.
- Directors of Hospital Service Lines provide oversight of the programs within their departments that are providing community benefit programming to meet the needs within the community.
- Community Benefit Specialists and Program Coordinators provide program coordination, outreach efforts, and community integration. These program coordinators are integrated within the hospital departments delivering the programs.
- Community Benefit Analyst provides oversight of the evaluation and outcomes of the programs to meet the needs within the community.

SJHMC's community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our CHNA.

In addition, we are investing in community capacity to improve health – including by addressing the social determinants of health – through Dignity Health's Community Investment Program. In Arizona, $14,900,000 has been invested through Dignity Health Community Investments. The following are the investments made to date:

Name	Amount
Arizona Community Foundation	$5,000,000
Local Initiatives Support Corporation (LISC)/WESCAP Investments, Inc.	$2,400,000
Chicanos por la Causa (Prestamos)	$4,000,000
Trellis	$500,000
Foundation for Senior Living	$2,500,000
Brighter Way Institute (BWI)	$500,000
	$ 14,900,000

These investments were made to improve the community through social impact funding with the Arizona Community Foundation; improve a local food bank who also provides social supports to the Chandler Community; provide low-interest loans to small, start-up business to minority groups; improve early childhood learning; provide low-interest rates to individuals who are unable to secure loans for homes; and transitional housing for adolescents. All these projects and investments continue to create healthier, safe, communities in Arizona.

Community Definition

Definition of Community

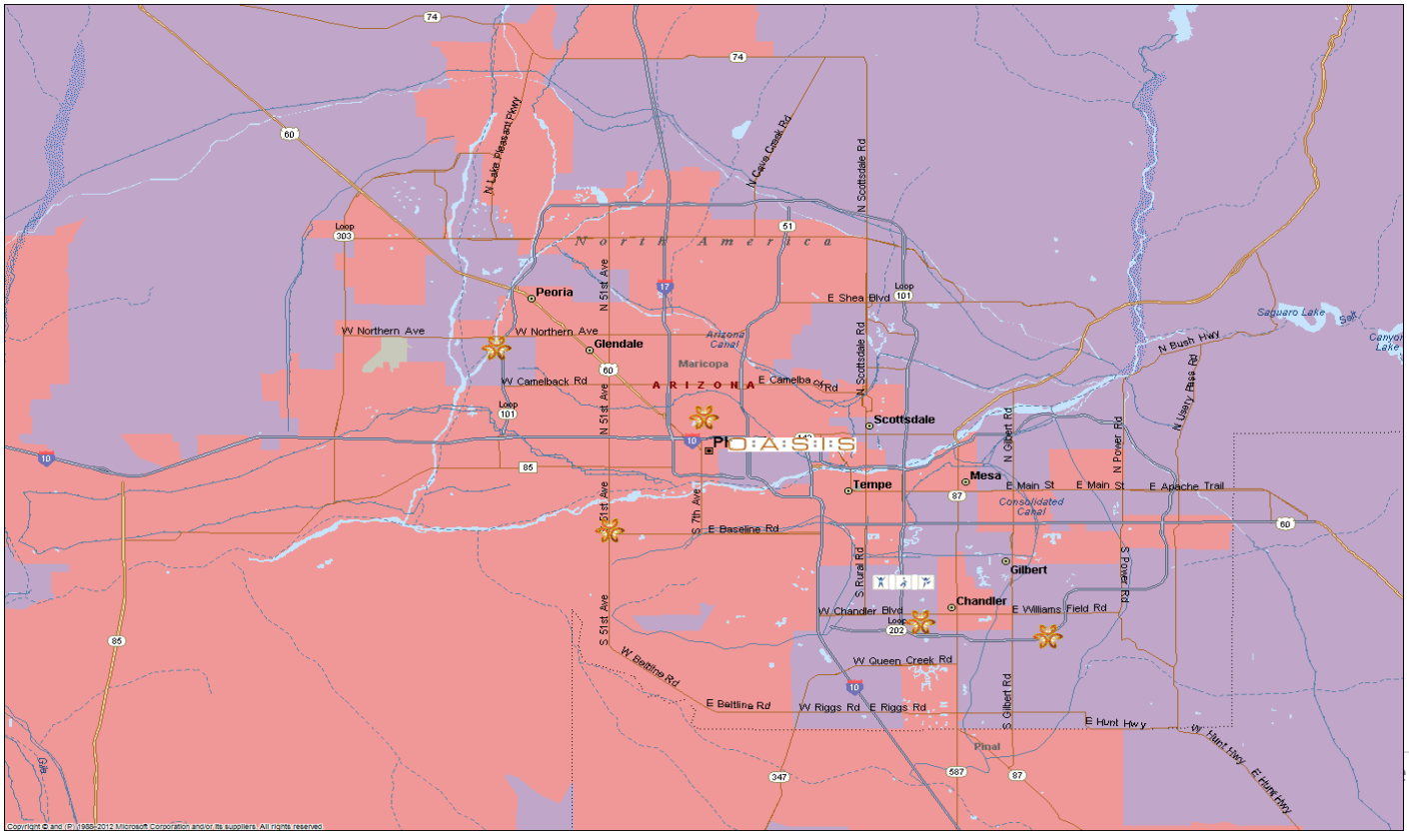
The geographic area for this CHNA is Maricopa County, the common community for all partners participating in the SYNASPE Partnership. However, SJHMC's primary service area specific information will also be provided when available.

Maricopa County is the fourth most populous county in the United States. With an estimated population of four million and growing, Maricopa County is home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations.

Dignity Health defines the community served by a hospital as those individuals residing within its primary and secondary service areas. For this report the focus will be on the primary service area of SJHMC. The primary service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. The primary service area for SJHMC includes the zip codes making up the top 75% of the total patient cases.

The city of Phoenix is primarily served by SJHMC for acute care and trauma services. Phoenix is the 5th largest city in the United States by population, making it the most populous state capital. Its population in 2017 was 1,626,078 with a median age of 33.3[xix]. Surrounding communities include Tempe, Scottsdale, Glendale, Peoria, Tolleson, Avondale, Buckeye, Goodyear, Surprise, and Gila Bend.

St. Joseph's Hospital and Medical Center Primary and Secondary Service Areas



Demographic and Socioeconomic Profile

Primary Care Area (PCA) Statistical Profiles are revised annually and provide detailed information on the demographics, health resources, hospital utilization, and health status indicators in defined geographic areas throughout Arizona. According to the Arizona Department of Health Services (ADHS), the Avondale, Buckeye, Camelback East, Central City Village, Chandler Central, Estrella Village, Glendale Central and North, Laveen, Maryvale Village, Peoria North, Surprise and Tempe North PCAs have been federally designated as a Medically Underserved Areas[xx]. More than half of the population of SJHMC's primary service area is adults between 20-64 years of age. Nearly 17.2% of residents do not have a high school diploma, and approximately 16.3% are without health insurance. These data show that the population as a whole is majority White, and with a median income below Maricopa County and the state of Arizona. Table 1 provides the specific age, sex, and race/ethnicity distribution and data on key socio-economic drivers of health status of the population in SJHMC's primary service area compared to Maricopa County and the state of Arizona.

Table 1. Demographic information for the St. Joseph Hospital and Medical Center primary service area.

	SJHMC PSA	Maricopa County	Arizona
Population: estimated 2016	2,902,805	4,088,549	6,728,577
Gender			
• **Male**	49.8%	49.5%	49.7%
• **Female**	50.2%	50.5%	50.3%
Age			
• **0 to 9 years**	14.5%	13.8%	13.3%
• **10 to 19 years**	14.2%	13.8%	13.6%
• **20 to 34 years**	23.1%	21.2%	20.5%
• **35 to 64 years**	36.0%	37.3%	36.7%
• **65 to 84 years**	10.8%	8.0%	9.2%
• **85 years and over**	1.4%	5.9%	6.7%
Race			
• **White**	47.4%	56.9%	77.8%
• **Asian/Pacific Islander**	3.6%	4.0%	3.2%
• **Black or African American**	6.0%	5.0%	4.3%
• **American Indian/Alaska Native**	1.7%	1.5%	4.4%
• **Other/Unknown**	2.3%	2.3%	7.0%
Ethnicity			
• **Hispanic**	39.0%	30.3%	30.5%
Median Income	$48,600	$53,694	$51,340
Uninsured	16.3%	13.9%	13.6%
Unemployment	4.8%	4.4%	5.4%
No HS Diploma	17.2%	14.0%	13.8%
***% of Population 5+ non-English speaking**	7.6%	9.2%	8.9%
***Renters**	44.4%	39.0%	36.9%
CNI Score	4.0	3.4	
Medically Underserved Area	Yes		

*Source: U.S. Census American Community Survey, 5 year estimates 2013-2017

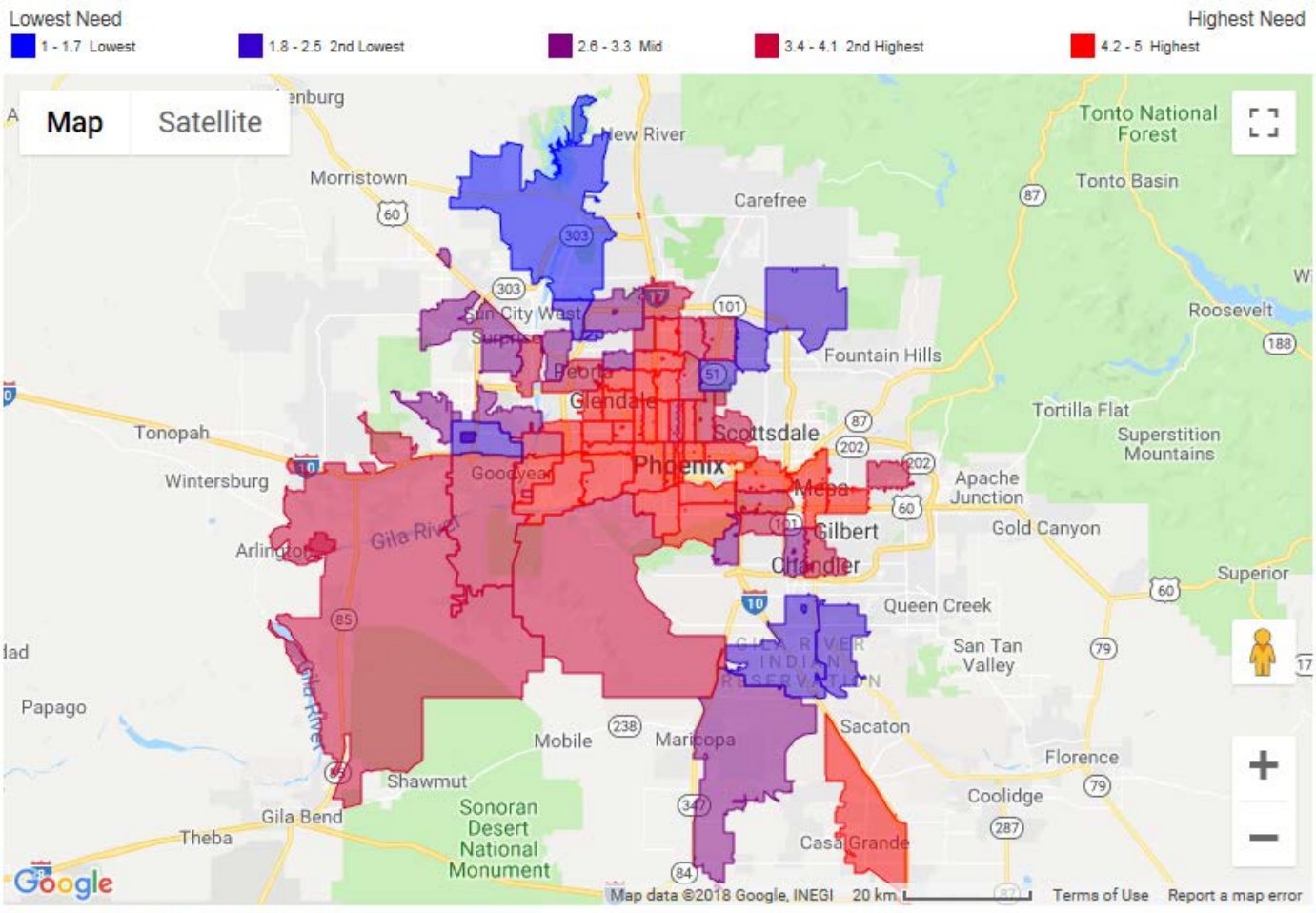
SJHMC is one of the few hospitals along the "light rail line" which provides the opportunity for the community to access the health services and community resources offered by the hospital. The community is in the center

of Phoenix, but, with the rail service, it provides ready access to services for individuals who have complex health needs. Within Maricopa County, there is a concentration of the minority populations in close proximity to the hospital. Access to affordable health care continues to challenge individuals who do not qualify for Medicaid and Marketplace insurance. Many of these individuals seek care within the Emergency Department and local free clinics.

Community Need Index

Dignity Health has developed the nation's first standardized Community Need Index (CNI) in partnership with Truven Health Analytics. The CNI identifies the severity of health disparity for every zip code in the United States based on specific barriers to healthcare access. The CNI considers multiple factors that are known to limit health care access such as income, language, educational, insurance and housing barriers. The ability to pinpoint neighborhoods with significant barriers to health care access is an important new advancement for public health advocates and care providers. According to the CNI illustrated below, the primary service area has a mean CNI score of 4 and includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85003, 85004, 85006, 85007, 85007, 85009, 85014, 85015, 85017, 85019, 85021, 85023, 85029, 85031, 85033, 85035, 85037, 85040, 85041, 85042, 85043, 85051, 85122, 85201, 85204, 85210, 85281, 85301, 85302, 85303, 85323, 85353, and 85364[xxi].

Primary Service Area Map



Primary Service Area CNI Scores

Zip Code	CNI Score	Population	City	County	State
85003	5	9893	Phoenix	Maricopa	Arizona
85004	5	6030	Phoenix	Maricopa	Arizona
85006	5	26837	Phoenix	Maricopa	Arizona
85007	5	15497	Phoenix	Maricopa	Arizona
85008	5	61987	Phoenix	Maricopa	Arizona
85009	5	56314	Phoenix	Maricopa	Arizona
85012	3.4	6940	Phoenix	Maricopa	Arizona
85013	3.8	20775	Phoenix	Maricopa	Arizona
85014	4.2	26840	Phoenix	Maricopa	Arizona
85015	5	41033	Phoenix	Maricopa	Arizona
85016	4	37069	Phoenix	Maricopa	Arizona
85017	5	40872	Phoenix	Maricopa	Arizona
85018	3.6	36245	Phoenix	Maricopa	Arizona
85019	5	26643	Phoenix	Maricopa	Arizona
85020	4	34775	Phoenix	Maricopa	Arizona
85021	4.8	39811	Phoenix	Maricopa	Arizona
85022	3.8	49918	Phoenix	Maricopa	Arizona
85023	4.2	35832	Phoenix	Maricopa	Arizona
85027	3.4	39589	Phoenix	Maricopa	Arizona
85028	2.4	20239	Phoenix	Maricopa	Arizona
85029	4.4	45812	Phoenix	Maricopa	Arizona
85031	5	31959	Phoenix	Maricopa	Arizona
85032	4	69226	Phoenix	Maricopa	Arizona
85033	5	56391	Phoenix	Maricopa	Arizona
85035	5	49036	Phoenix	Maricopa	Arizona
85037	4.2	49579	Phoenix	Maricopa	Arizona
85040	5	32400	Phoenix	Maricopa	Arizona
85041	4.2	65874	Phoenix	Maricopa	Arizona
85042	4.2	46098	Phoenix	Maricopa	Arizona
85043	4.6	42051	Phoenix	Maricopa	Arizona
85044	2.6	40284	Phoenix	Maricopa	Arizona
85051	5	42644	Phoenix	Maricopa	Arizona
85053	3.4	29961	Phoenix	Maricopa	Arizona
85122	4.2	57888	Casa Grande	Pinal	Arizona
85138	2.6	43214	Maricopa	Pinal	Arizona
85201	4.6	50779	Mesa	Maricopa	Arizona
85204	4.4	66676	Mesa	Maricopa	Arizona
85205	3.4	43398	Mesa	Maricopa	Arizona
85210	4.6	39243	Mesa	Maricopa	Arizona

85224	3	46593	Chandler	Maricopa	Arizona
85225	4	75370	Chandler	Maricopa	Arizona
85248	2.2	36325	Chandler	Maricopa	Arizona
85249	2	48083	Chandler	Maricopa	Arizona
85254	2.2	47753	Scottsdale	Maricopa	Arizona
85255	2	47040	Scottsdale	Maricopa	Arizona
85281	4.8	64075	Tempe	Maricopa	Arizona
85282	3.6	52175	Tempe	Maricopa	Arizona
85283	3.4	47190	Tempe	Maricopa	Arizona
85301	5	64419	Glendale	Maricopa	Arizona
85302	4.2	38875	Glendale	Maricopa	Arizona
85303	4.6	35890	Glendale	Maricopa	Arizona
85304	3	27847	Glendale	Maricopa	Arizona
85308	2.8	67460	Glendale	Maricopa	Arizona
85323	4.6	47815	Avondale	Maricopa	Arizona
85326	4	66221	Buckeye	Maricopa	Arizona
85335	3.6	38657	El Mirage	Maricopa	Arizona
85338	3.4	54696	Goodyear	Maricopa	Arizona
85339	3.6	46318	Laveen	Maricopa	Arizona
85340	2.8	33787	Litchfield Park	Maricopa	Arizona
85345	3.8	63930	Peoria	Maricopa	Arizona
85351	2.6	29594	Sun City	Maricopa	Arizona
85353	4.2	40153	Tolleson	Maricopa	Arizona
85364	4.6	72928	Yuma	Yuma	Arizona
85365	4	52385	Yuma	Yuma	Arizona
85374	2.6	46444	Surprise	Maricopa	Arizona
85379	2.6	50793	Surprise	Maricopa	Arizona
85382	2.4	46052	Peoria	Maricopa	Arizona
85383	1.6	50970	Peoria	Maricopa	Arizona
85392	3.4	42612	Avondale	Maricopa	Arizona
85395	2.2	34771	Goodyear	Maricopa	Arizona
86314	4	37060	Prescott Valley	Yavapai	Arizona

Assessment Process and Methods

Process and Methods

The ACA requirements are mirrored in the Public Health Accreditation Board's (PHAB) standard mandating that health departments participate in or conduct a community health assessment every three to five years. Other PHAB standards require health departments to conduct a comprehensive planning process resulting in a community health improvement plan, and implement strategies to improve access to health care. Federally funded community health centers must ensure their target communities are of high need, and address the shortage of health services that are occurring within these communities. The similar requirements from IRS, PHAB, and the Federally funded health center requirements put forth by the United States Department of Health and Human Services provides an opportunity to catalyze stronger collaboration and better shared measurement systems among hospitals, health centers, and health departments. Additionally, limited resources for comprehensive health assessments and the move toward new population health models have created the need for an organized, collaborative public-private approach for conducting assessments.

Maricopa County hospitals and health centers play significant roles in the region's overall economy and health. In addition to providing safe and high-quality medical care, these institutions work to improve regional health through programs that promote health in response to identified community needs. Additionally, health care partners are often serving the same or portions of the same communities across Maricopa County. As a result, Adelante Healthcare, Banner Health, Dignity Health, Mayo Hospital, Native Health, and Phoenix Children's Hospital have joined forces with Maricopa County Department of Public Health (MCDPH) to identify the communities' strengths and greatest needs in a coordinated community health needs assessment.

The CHNA utilized a mixed-methods approach that included the collection of secondary or quantitative data from existing data sources and community input or qualitative data from focus groups, surveys, and meetings with community stakeholders. The process was reiterative as both the secondary and primary data were used to help inform each other. The advantage of using this approach is that it validates data by cross-verifying from a multitude of sources.

Secondary Data

Many of the challenging health problems facing the United States in the 21st century require an understanding of the health not just of individuals but also of communities. The challenge of maintaining and improving community health has led to the development of a "population health" perspective[xxii]. Population health can be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group ." 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 utilized a community health framework for this report to develop criteria for indicators used to measure health needs.

SYNAPSE partners selected approximately 100 data indicators to help examine the health needs of the community (Appendix A). These indicators were based on the Center for Disease Control and Prevention's (CDC) Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics report[xxiv]. While this report does not identify the specific indicators that should be utilized, it does specify the categories of information that should be considered.

The following five data categories describe the type of health factor and health outcome indicators utilized in the CHNA (See Table 2):

- ***Health Outcomes*** include: morbidity, which refers to how healthy people are by measuring disease burden and quality of life (e.g. obesity rates, asthma incidence, and low birth weight babies, etc.); and mortality, which measures causes of death by density rates (e.g. cancer mortality, motor vehicle deaths, etc.);
- ***Health Care*** includes access, which refers to factors that impact people's access to timely, affordable clinical care (e.g. primary care physicians, number of federally qualified health centers, etc.); and health insurance coverage;
- ***Health Behavior*** refers to the personal behaviors that influence an individual's health either positively or negatively (e.g. breastfeeding, physical activity, eating fruits and vegetables, etc.). This also includes delivery, which measures clinical care being delivered to the community (e.g. rate of preventive screenings, ambulatory care sensitive discharges, etc.);
- ***Demographics and Social Environment*** describe the population of interest by measuring its characteristics (e.g. total population, age breakdowns, limited English proficiency, etc.). Unlike other categories, demographic indicators are purely descriptive and not generally compared to benchmarks or viewed as positive or negative. This category also includes measures of social status, educational attainment, and income, all of which have a significant impact on an individual's health and;
- ***Physical Environment*** measures characteristics of the built environment of a community that can impact the health of that community either positively or negatively (e.g. parks, grocery stores, walkability, etc.)

Table 2. Health Factor and Health Outcome Indicators

Health Outcome Metrics		**Health Determinants and Correlated Metrics**			
Mortality	***Morbidity***	***Access to Healthcare***	***Health Behaviors***	***Demographics & Social Environment***	***Physical Environment***
Leading Causes of Death	Hospitalization Rates	Health Insurance Coverage	Tobacco Use/Smoking	Age	Air Quality
Infant Mortality	Obesity	Provider Rates	Physical Activity	Sex	Water Quality
Injury-related Mortality	Low Birth Rates	Quality of Care	Nutrition	Race/Ethnicity	Housing
Motor Vehicle Mortality	Cancer Rates		Unsafe Sex	Income	
Suicide	Motor Vehicle Injury		Alcohol Use	Poverty Level	
Homicide	Overall Health Status		Seatbelt Use	Educational Attainment	
	STDs		Immunizations & Screenings	Employment Status	
	Communicable Diseases			Language Spoken at Home	

Source CDC's Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics

Quantitative data used in this report are high quality, population-based data sources and were analyzed by MCDPH, Office of Epidemiology. Data came from local, state, and national sources such as the Maricopa County Department of Public Health, Arizona Department of Health Services, Arizona Criminal Justice Commission, U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System survey, and Youth Risk Behavior survey.

Primary Data

The broad interests of the community were incorporated through three means. First, data was collected through focus groups engaging members of underserved populations and communities. Second, surveys were conducted with key informants who serve the primary service area. Finally, a series of meetings were held with key stakeholders from SJHMC's primary service area. Members of the CHIN and Arizona's Community of Care Network (ACCN) provided input on the selection of data indicators, provided feedback on data collected, and aided in the selection of final priorities. Membership of the above mentioned committees and collaborations intentionally represent vulnerable and disenfranchised populations including the homeless, uninsured/underinsured, Medicaid, Medicare, immigrant, disabled, mentally ill, and elderly.

Focus Groups

A series of 36 focus groups with medically underserved populations across Maricopa County were conducted between September 2015 and June 2016. Focus groups helped 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 Partnership (MAPP) [xxv1].The focus group process moved through five phases: (1) initial review of literature; (2) focus group discussion guide development; (3) focus group recruitment and securement; (4) focus group collection; and (5) report writing and presentation findings.

Members of the community representing subgroups, defined as groups with unique attributes (race 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 (See Appendix B) to understand the experiences of these community members as they relate to accessing health care, health disparities and chronic disease. In all, a total of twelve focus groups were conducted with 127 community members from the following groups: (1) older adults (50-64, 65-74, 75+ years of age); (2) adults without children; (3) adults with children; (4) American Indian adults; (5) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) adults; (6) African American adults; (7) Hispanic/Latino adults (English); (8) adults with children (Spanish); (9) low socio-economic status adults (Spanish), and (10) young adults (18-30 years of age), (11) adult males (Spanish), (12) adult females (Spanish), (13) Caregivers, and (14) Asian American adults.

Content analysis was performed on focus group interview transcripts to identify key themes and salient health issues affecting the community residents. The most common problem identified was access to care. Specific barriers discussed includes lack of transportation, high cost of doctor visits, high deductibles, unexpected or complicated bills from insurance, and a perceived lack of cultural competency and respect from providers. Participants also identified mental health, substance abuse, and community safety as important issues. Additionally, American Indian and African American participants felt diabetes was a significant health concern for their community.

Recommended prevention strategies for health improvement discussed amongst the participants included:

- More educational resources and opportunities, especially for children.
- Improved access to physical fitness facilities and activities.
- Access to healthy food, nutrition information.
- Access to healthcare for special populations (e.g. the elderly, disabled, Native Americans, LGBTQ, and children), shortened wait times for medical appointments, affordable medical transportation services, and additional ADA accessible buildings.
- Cultural Competency, being mindful of cultural issues especially in Spanish speaking communities.
- More trained healthcare system community workers, navigators, advocates, and aides.
- Improved affordability services, lower the cost of insurance, copays, and specialists, sliding scale fees.

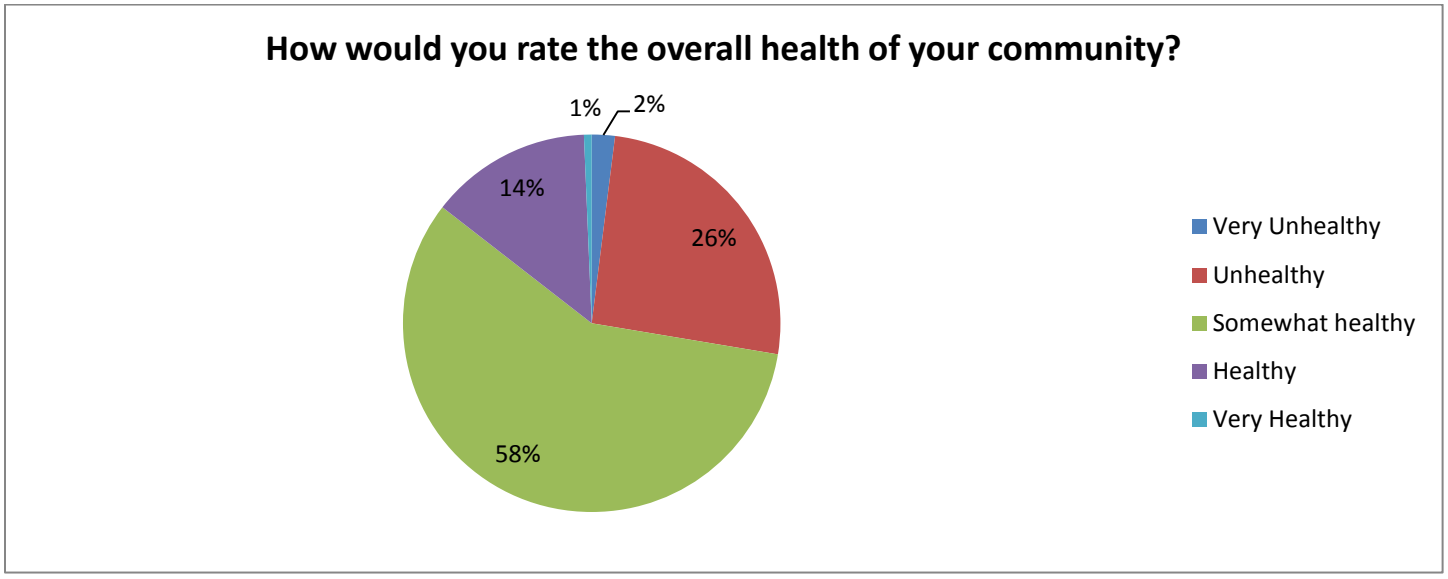
Key Informant Surveys

In order to identify and understand community health needs, a community health survey was administered to key informants. Key informants were identified as health or community experts familiar with target populations and geographic areas within SJHMC's primary service area. The survey instrument was created by MCDPH based on recommendations from the National Association of County and City Health Officials, Centers for Disease Control and Prevention, and Dignity Health leadership.

The survey was administered to 152 key informants who provide services throughout SJHMC's primary service area. The survey asked respondents about factors that would improve "quality of life," most important "health problems," in the community, "risky behaviors" of concern, and their overall rating of the health of the community (Appendix B).

When surveyed about the overall health of the community, an alarming 28% felt the community was either "very unhealthy" or "unhealthy" (Graph 1).

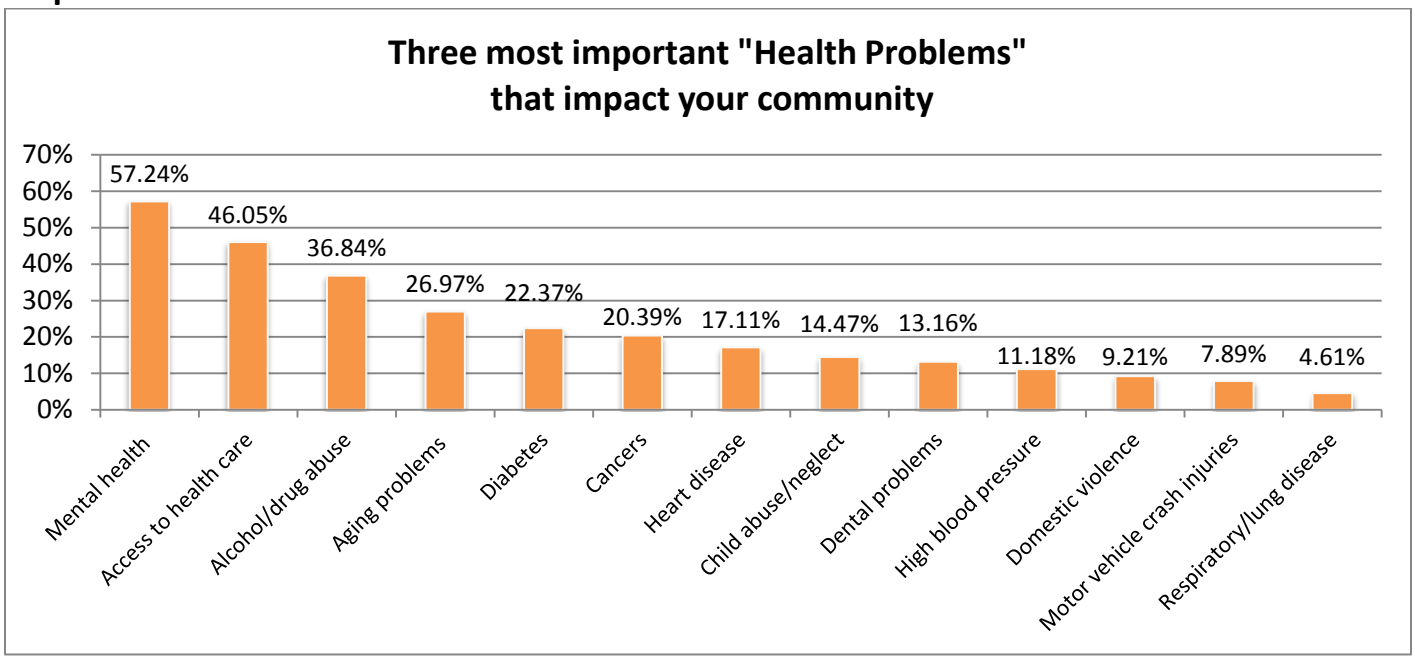
Graph 1



Source Key Informant Survey

Key informants felt the most important health problems impacting their community are mental health, access to health care, alcohol/drug abuse, aging problems, and diabetes (Graph 2).

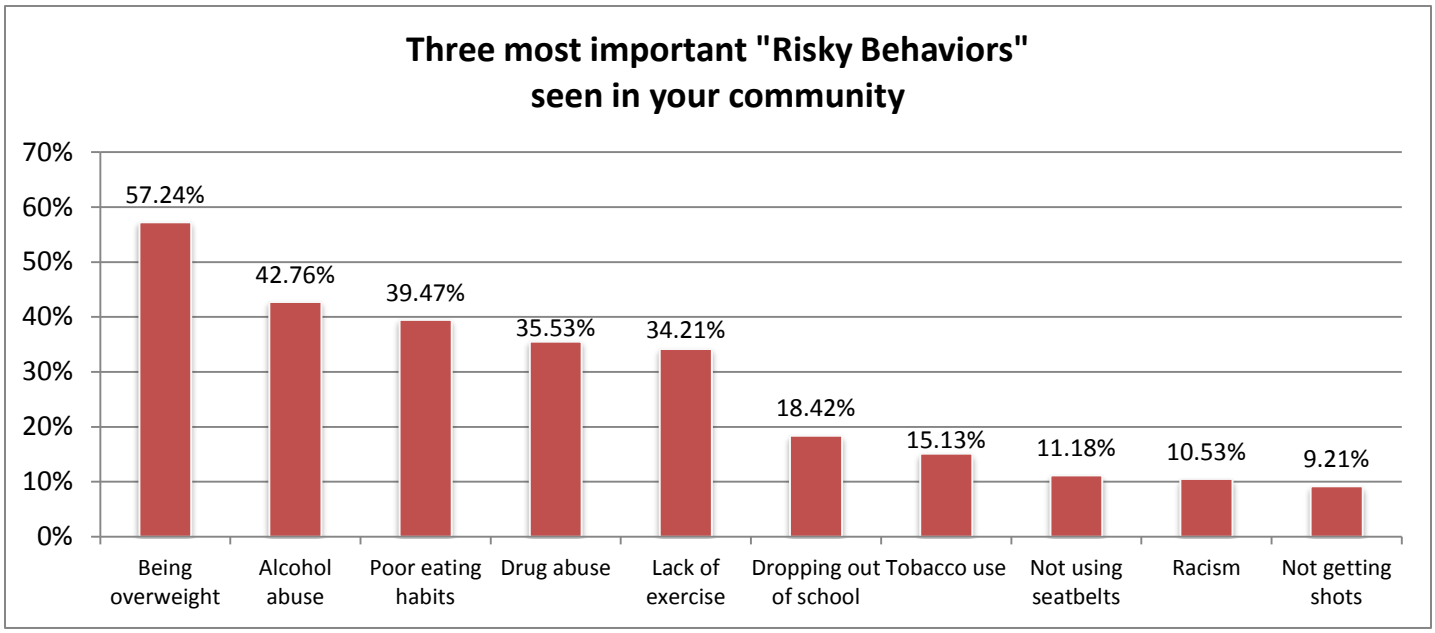
Graph 2



Source Key Informant Survey

When asked to rank the three most important risky behaviors seen in the community, the top five answers selected by respondents included being overweight, alcohol abuse, poor eating habits, drug abuse, and lack of exercise (Graph 3). Though the responses reflect distinct behaviors, there appears to be some overlap with primary concerns of key informants centering on the areas of substance use, healthy eating, and active living.

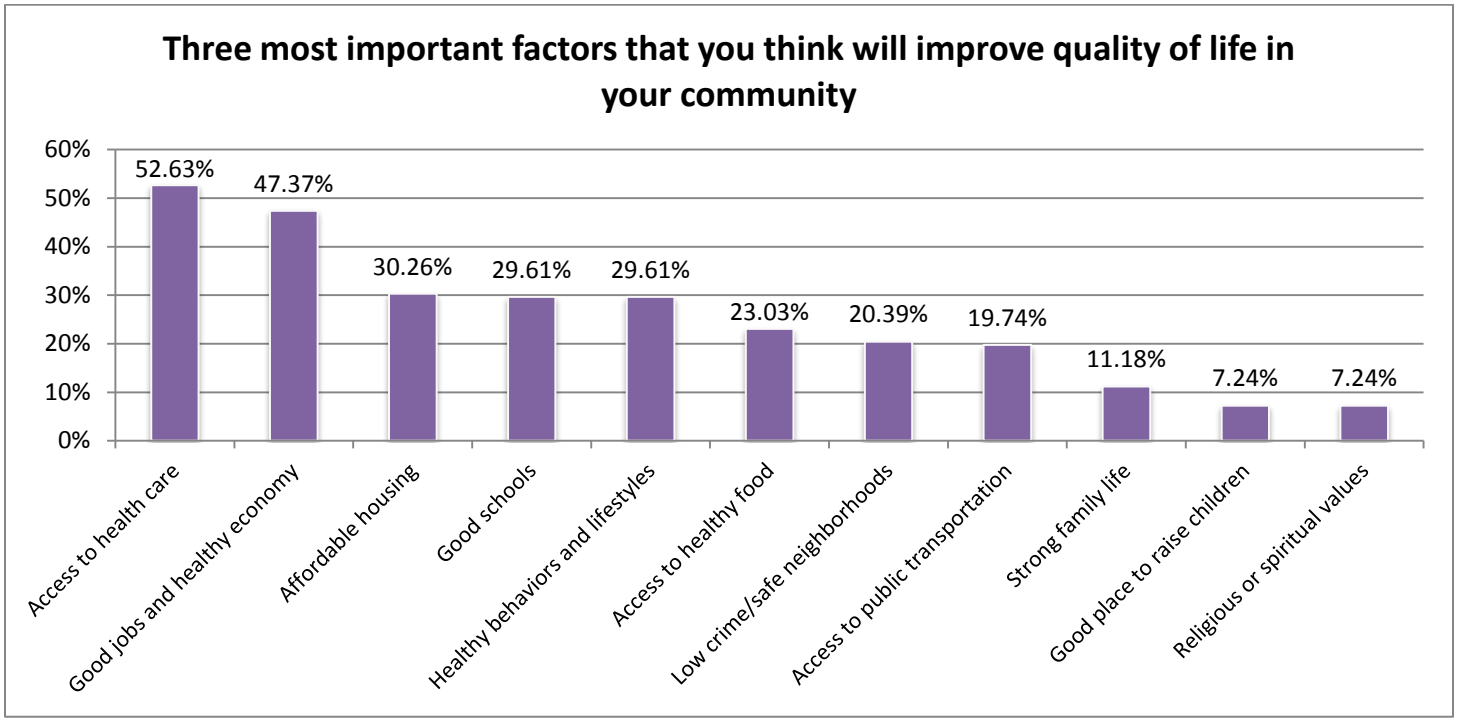
Graph 3



Source Key Informant Survey

Lastly, the most important factors key informants felt would improve the quality of life within their community included access to healthcare, good jobs and healthy economy, affordable housing, good schools, and healthy behaviors and lifestyles (Graph 4).

Graph 4



Source Key Informant Survey

Community Input/Engagement

Community input for the CHNA included engagement from the following Dignity Health sponsored stakeholder groups:

St. Joseph's Hospital and Medical Center Community Health Integration Network (CHIN)

Each Dignity Health Hospital and Joint Venture Hospital participated and gave input at the Community Health Integration Network (CHIN) that is facilitated by the St. Joseph's Hospital and Medical Center Board of Directors and representatives from the community and experts within the hospitals that are working collaboratively to meet the needs within the communities' they serve. A key function of the Community Health Integration Network (CHIN), comprised of Dignity Health, community agencies, and community members, is to participate in the process of establishing program priorities based on the community needs and assets and to review, advice, and make recommendations to Dignity Health –St. Joseph's Hospital and Medical Center's Board's Community Benefit Committee.

St. Joseph's Hospital and Medical Center's Arizona Community of Care Network (ACCN)

Arizona Community of Care Network (ACCN) is a collaborative among diverse hospital, community organizations, government agencies, and community members. Through the collective impact model, the ACCN shares common agenda's, shared measurement systems, mutually reinforcing activities and continuous communication to solve complex issues and improve the health of Arizona residents.

The information from the key informant survey along with the key findings from the MCDPH assessment data report was presented on October 2, 2018 to the Executive Leadership Team, Community Board, and CHIN. Attendees were surveyed on the information provided in this presentation in order to further narrow down the list of significant health needs. Following the survey feedback, MCDPH provided additional presentations incorporating focus group findings and gathered final recommendations from the CHIN and ACCN, in order to solidify the recommended priorities.

Data limitations and Gaps

The data used in this report are from various reliable sources, but there are limitations to the data that need to be considered. When reviewing birth and death records some of the fields in these records are filled in based on recall. Example, a mother is asked when she began prenatal care and may have an estimate but typically not the exact date. With death records a family member assists when filling in information on the death certificate. If the individual doesn't know about an individual's personal habits (like smoking) it may not get recorded on the death certificate. With Hospital Discharge Data (HDD) for Inpatient (IP) discharges and Emergency Department (ED) visits the data is from all licensed facilities, but does not include Federal, military, and the Department of Veteran Affairs. When reviewing this data we have to consider the fact that these are those individuals that are seeking care. There are various reasons why and individual does not go to a hospital for care (like lack of money to pay) or individuals may use the ED for routine care that they could receive if they had a primary care physician. The year we evaluated for HDD used the ICD-9 code, which is different from the death certificate coding which utilizes ICD-10.

The survey data used from our state and national partners also have limitations since they are self-reported surveys. The Behavioral Risk Factor Surveillance System survey (BRFS) is a survey of adults within Maricopa County. This data could not be drilled down to each hospitals primary service area. The survey questions can be personal in nature and individuals have the option of not responding, or they may answer what they feel the best answer is, causing issues with the data. The Youth Risk Behavior survey (YRBS) is a survey of students

in 8th, 10th, and 12th grades of school. The survey is done every other year and cannot be drilled down to the county level. All data from the YRBS is for the entire state. The Arizona Youth survey (AYS) is done every other year, opposite of the YRBS, and is of 8th, 10th, and 12th grade students in Arizona schools. This data can be evaluated at the county level, but not at the hospital service area.

Prioritized Descriptions of Significant Community Health Needs

Identifying Community Health Needs

To be a considered a health need, a health outcome or a health factor had to meet two criteria; first, existing data had to demonstrate that the primary service area had a health outcome or factor rate worse than the average Maricopa County rate, demonstrate a worsening trend when compared to Maricopa County data in recent years, or indicate an apparent health disparity; second, the health outcome or factor had to be mentioned in a substantial way in at least two primary data collection sources which were focus groups, surveys, or stakeholder meetings.

Process and Criteria for Prioritization

The process for prioritization included engagement with both internal Dignity Health stakeholders and community partners from the CHIN and ACCN (See Appendix A for list of participating organizations). The first step of the process was a comprehensive presentation by MCDPH that included an overview of the CHNA findings and key emerging health needs. Throughout the presentation, stakeholders in attendance responded to survey questions that would later be used during strategy sessions to identify health priorities. After completion of the presentation, stakeholders were given the opportunity to provide additional feedback and recommendations. The second step in the process involved review and prioritization of the key emerging health needs outlined in the MCDPH presentation. Participants discussed each health need, consideration was given to the size of the problem, disparity and equity, known effective interventions, resource feasibility and sustainability, and community salience. Through a voting process consensus, participants made final recommendations to SJHMC for priority health needs.

Description of Prioritized Community Health Needs

The following statements summarize each of the areas of priority for SJHMC, and are based on data and information gathered through the CHNA.

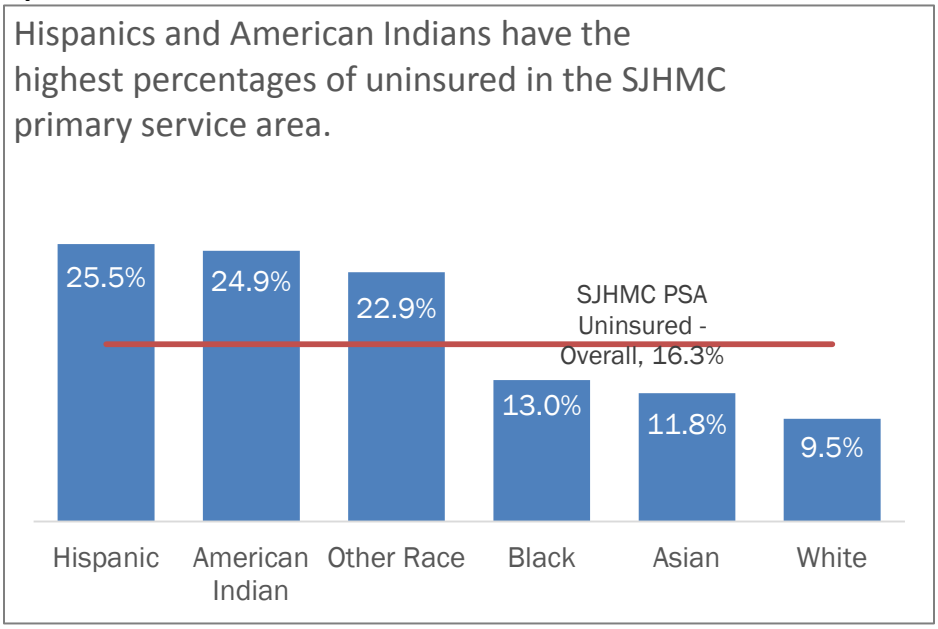
<u>Access to Care</u>

Overall, the percentage of people without health care insurance in Maricopa County has declined noticeably in the years since the implementation of the Affordable Care Act. In 2016, the percentage of Maricopa County's population without health insurance was 13.9%. More recently, respondents to the community survey conducted in 2016 reported that 15.1% had no health insurance, possibly suggesting that uninsured rates are still declining. Maricopa County has also seen a decrease in the percent of adults who could not afford needed healthcare, falling from 20.8% in 2012 to 14.6% in 2016. However, many adults may still face difficulty accessing care -- 45.9% of respondents to our 2016 community survey indicated that sometimes they did not have enough money to pay for health care expenses on a monthly basis[xxvi].

Graph 5

According to the 2012-2016 American Community Survey, 16.3% of St. Joseph's Hospital and Medical Center's primary service area was uninsured. This percentage is higher than Maricopa County's uninsured percentage of 13.9%.

Males are more likely to be uninsured than females in this PSA, 18.2% versus 14.4%, respectively.



Source: American Community Survey, 5 year estimates 2012-2016

When focus group respondents were asked about choices, needs, and barriers to healthcare, responses included:
When community participants were asked about healthcare needs, responses included:

- *Most get their healthcare information online.*
- *Attend health fairs, workshops, free clinics, urgent cares, emergency rooms, and some go out of state or even out of country.*
- *The healthcare system is disjointed and they want better communication and greater coordination across providers.*
- *System is hard to navigate and was seen to require a significant amount of personal effort and persistence.*
- *Eligibility restrictions, insurance issues, and a lack of low cost options for care.*

Access to care is a critical component to the health and well-being of the community members in the primary service area. Often individuals without insurance, and even those who are underinsured, experience greater difficulty readily accessing health care services, particularly preventive and maintenance health care. This can be very costly, both to the individuals and the health care system. The most frequently identified barriers to health care discussed amongst focus group participants included cost, complication of navigating the system, lack of cultural competency, and respect among healthcare providers. Focus group participants also discussed the need to educate the community and increase awareness of available resources, such as free or low cost clinics, financial aid for medical bills, and other community programs.

Mental/Behavioral Health

Mental and behavioral health are terms often used interchangeably to refer to a spectrum of health conditions which are each distinct yet often co-occurring and overlapping. Behavioral health includes not only ways of promoting well-being by preventing or intervening in mental illness such as anxiety or depression, but also has an aim preventing or intervening in substance abuse and suicide. Mental health was ranked as the most important health problem impacting the community by key informants. This was echoed by participants in the focus groups who felt it was among their top concerns.

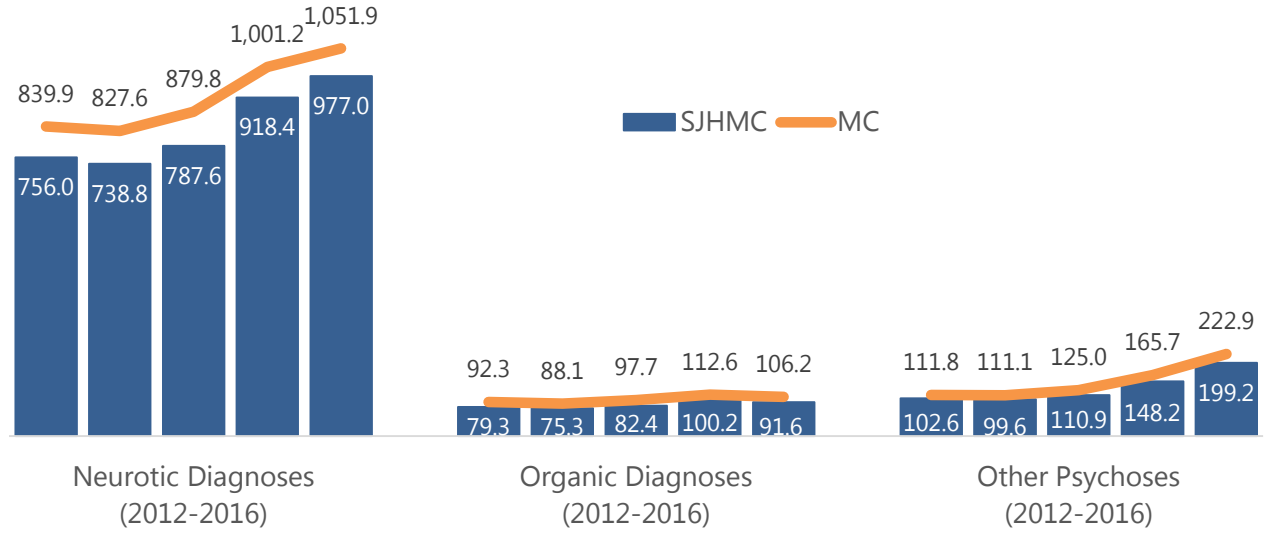
> *"It's hard to care about being physically healthy when you're not happy, or you just feel like there's an invisible ceiling, there's a road block everywhere. I think it starts with the mental health."*
> *-Focus Group Participant*

Emergency department visits related to mental and behavioral health have increased over the last 5 years in Maricopa County and in the SJHMC primary service area (graphs 6 and 7). The 6 mental and behavioral categories analyzed were considered Neurotic, Organic Psychotic, Other Psychoses, Suicide, Alcohol Related and Drug Overdoses. The following are some examples of conditions included in each mental/behavioral category analyzed, but note that this list is not exhaustive:

Neurotic Diagnoses:	personality disorders, depressive disorders, anxiety disorders, OCD, phobias, eating disorders, stress and adjustment disorders and sleep disorders
Organic Psychotic Diagnoses:	dementias, alcohol induced mental disorders, drug-induced mental disorders, transient mental disorders, and persistent mental disorders
Other Psychoses Diagnoses:	schizophrenic disorders, episodic mood disorders, other nonorganic psychoses, pervasive developmental disorders
Suicide:	Intentional self-harm (gun discharge, jumping from a high place, crashing, etc.), poisoning by medicaments and biological substances, toxic effects of non-medicinal substances, asphyxiation
Alcohol Related Diagnoses:	alcohol abuse or dependence, toxic effects from alcohol, alcoholic myopathy, and alcohol-induced chronic pancreatitis
Drug Overdose Diagnoses:	drug abuse or dependence, overdose on all drugs (including opioids), and injuries related to be under the influence of a drug

Graph 6

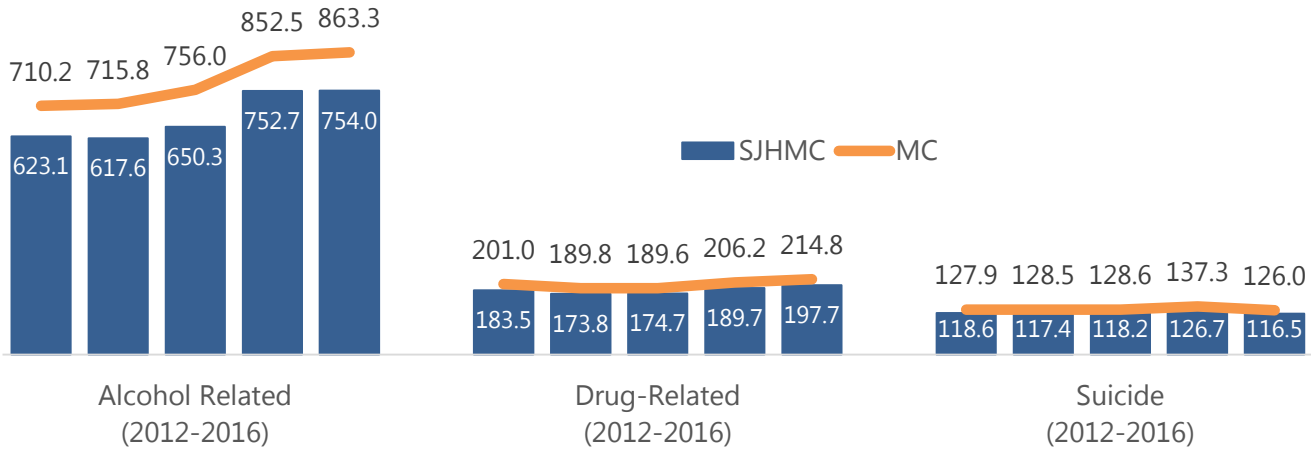
In the SJHMC PSA, Neurotic, Organic Psychotic and Other Psychoses Diagnoses seen in the ED have been increasing every year since 2013, but the rates per 100,000 are consistently lower than Maricopa County.



Source: Hospital discharge data from ADHS, analyzed by MCDPH

Graph 7

Alcohol and Drug related ED visits in the SJHMC PSA have been increasing every year since 2013 and the rates are typically higher than Maricopa County as a whole. Suicide rates for the ED have been increasing overall although there was a slight dip in 20



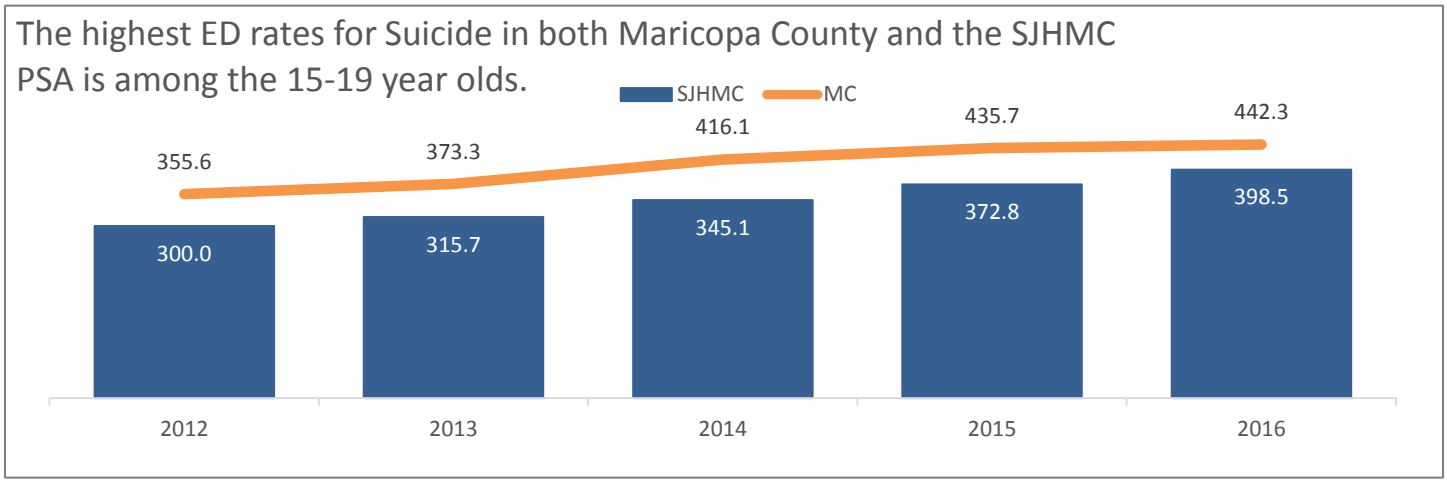
Source: Hospital discharge data from ADHS, analyzed by MCDPH

Suicide is a major public health problem and a leading cause of death in the United States[xxvii]. In Arizona, the latest data shows 1,310 Arizonans died by suicide in 2016

-19 year olds. Graph 8 below

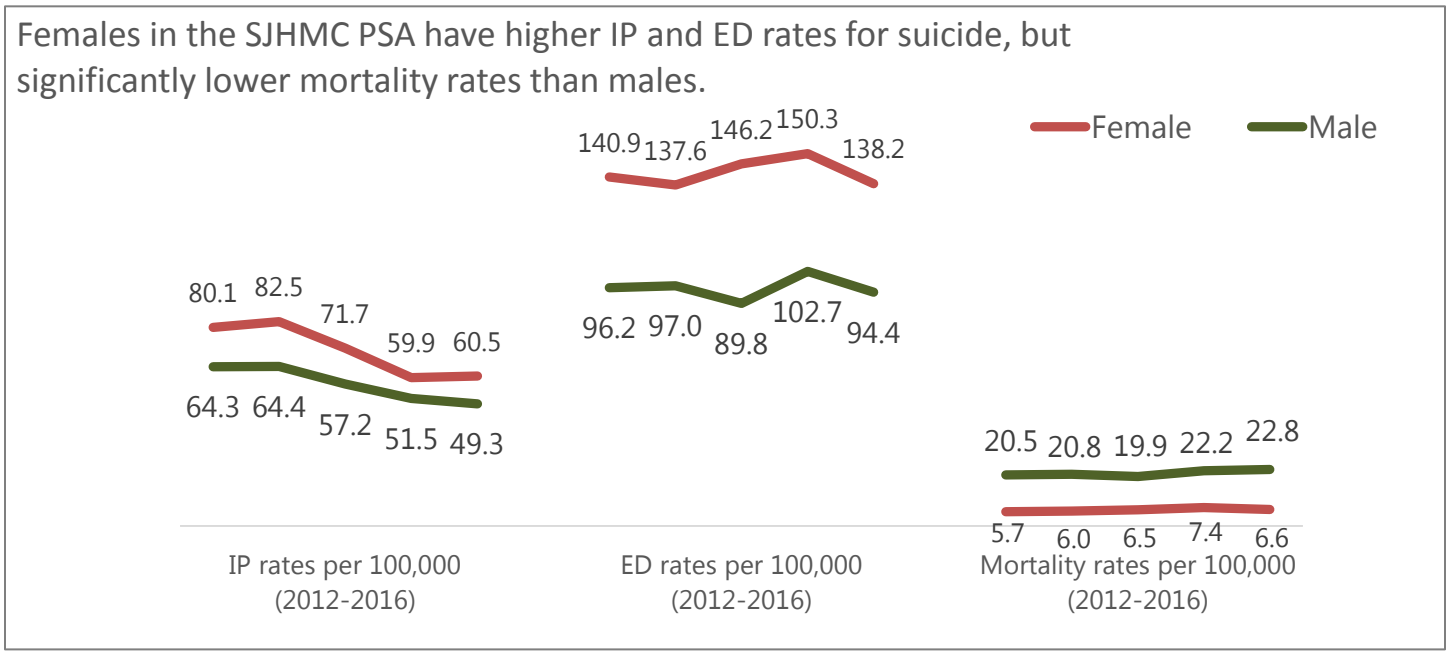
shows ED rates among this young age group. It is also interesting to note that women have higher IP and ED rates due to suicide, but significantly lower mortality rates than men as shown in Graph 9.

Graph 8



Source: Hospital discharge data and mortality data from ADHS, analyzed by MCDPH

According to the death data analyzed by MCDPH, the age group with the highest mortality rate due to suicide was among the 45-64 followed by 75+. The suicide rates in these age categories for St. Joseph's Hospital and Medical Center's primary service area was never higher than Maricopa County's. In 2016, the overall rate for the SJHMC PSA was slightly higher than Maricopa County's, but in the specific categories, the rates were lower than Maricopa County.



Graph 9

Source: Hospital discharge data from ADHS, analyzed by MCDPH

The races with the highest suicide mortality rates are Whites followed by American Indians. This trend holds true for both Maricopa County as a whole and also the SJHMC primary service area.

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs[xxix]. According to the Centers for Disease Control and Prevention, substance abuse cost our nation $700 billion dollars annually in costs related to crime, lost productivity, and health care.[xxx] According to the Substance Abuse and Mental Health Service Administration's (SAMHSA's) National Survey on Drug Use and Health, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009. Of these, only 2.6 million—11.2% of those who needed treatment—received it at a specialty facility.[xxxi]

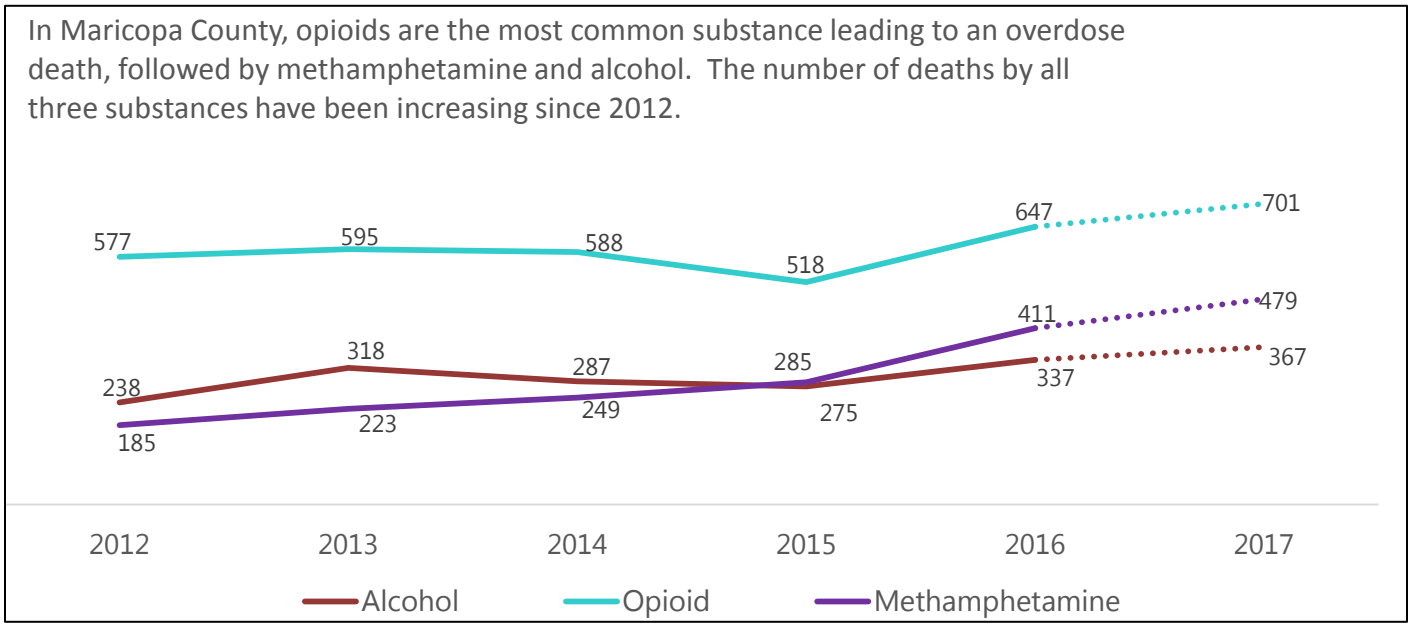
Key informants listed alcohol and drug abuse as two of the top risky health behaviors community members are engaging in. The substances most frequently cited in the survey as being of concern included methamphetamines, prescription drugs, heroin, marijuana, cocaine and alcohol. Additionally, substance abuse was frequently mentioned as a concern amongst focus group participants.

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues. Examples are morphine and heroin[xxxii]. In 2016 there were 790 deaths attributed to opioids in Arizona. This represents a

Opioid-related mortality rates have risen over the past 5 years and match the trend nationally. In June of 2017 Arizona Governor Doug Ducey declared a public health emergency to address this epidemic.

In Maricopa County, opioids are found more often than alcohol and methamphetamine when examined by the Maricopa County Office of the Medical Examiner (OME). All three of these drugs are showing an upward trend with our preliminary 2017 data (Graph 10).

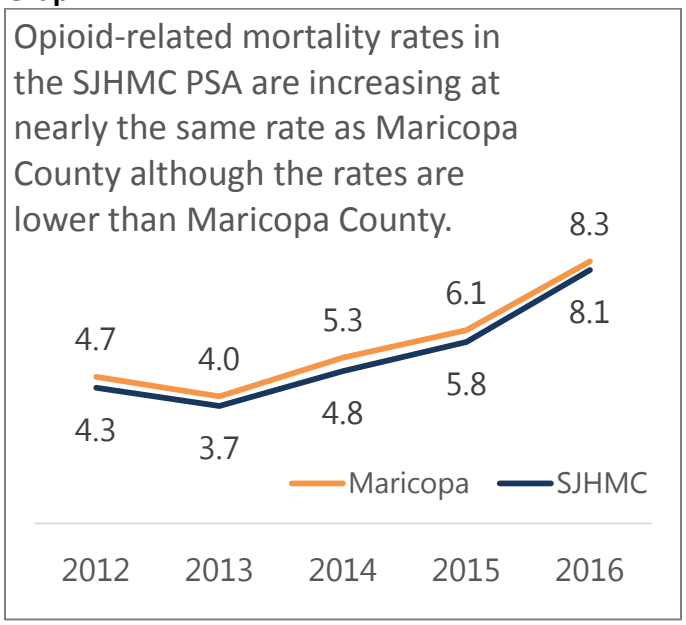
Graph 10



Note: Deaths for the year 2017 are still being finalized as of December 2018. To compare the SJHMC primary service area with Maricopa County as a whole, the rates for opioid-related deaths were calculated and plotted

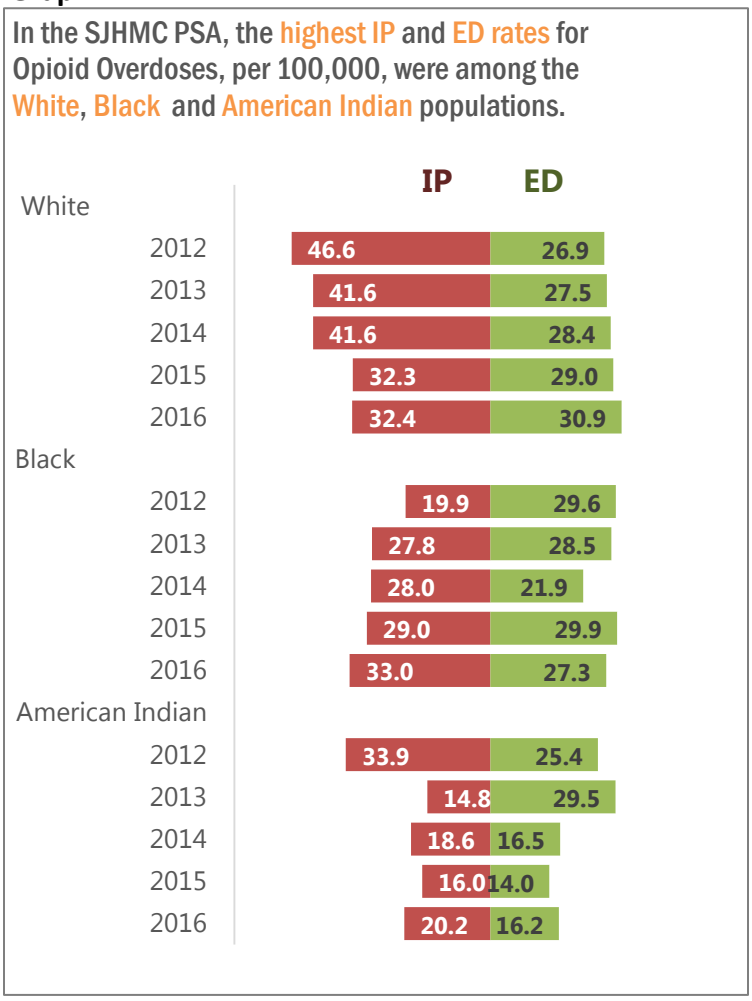
in Graph 11. The SJHMC primary service area's opioid mortality rates are lower than Maricopa County as a whole, but are definitely following the same increasing trend of deaths as Maricopa County.

Graph 11



The mortality rates in the SJHMC PSA for opioid-related overdoses is highest among White, Black and American Indians as well, just as they are for the IP and ED rates (graph 12). The mortality rates are also highest among the age categories of 25-64.

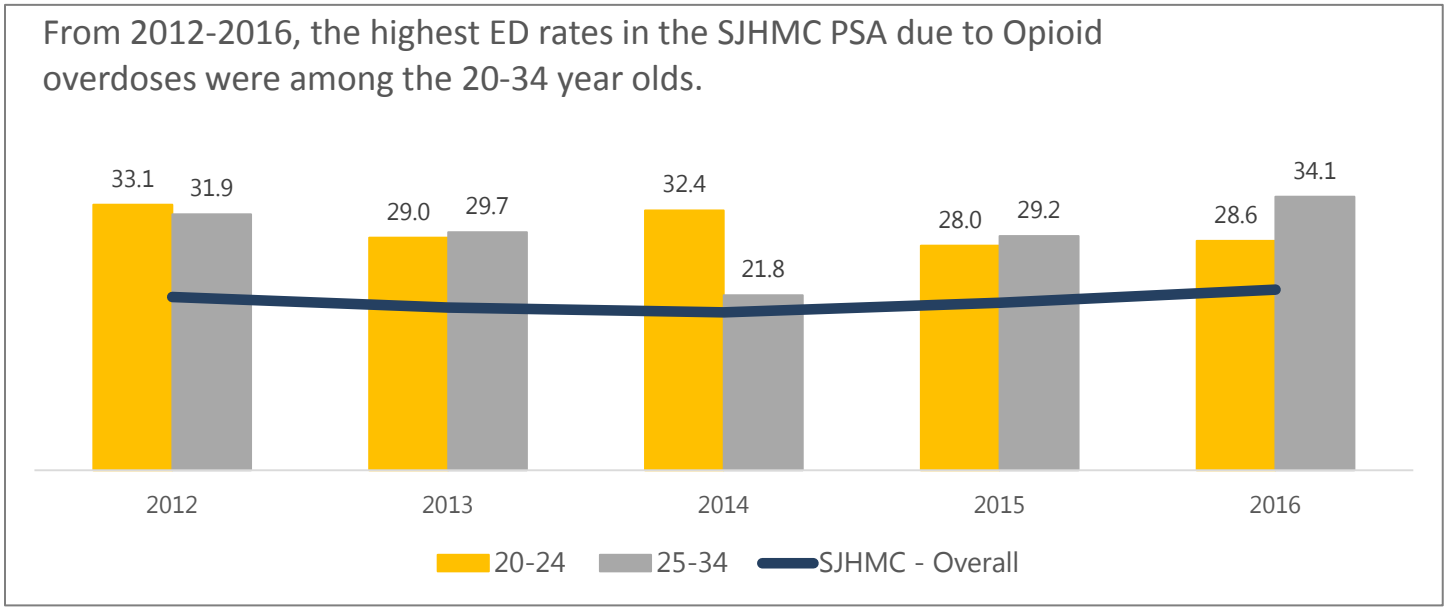
Graph 12



From 2012-2016, the inpatient hospitalization rates from opioid-related overdoses were consistently highest among the age groups 45-54, 55-64, and 65-74. In those 5 years, the rates were nearly the same as Maricopa County's overall for those particular age groups.

Opioid-related overdose rates for the emergency department has been increasing every year for Maricopa County as a whole. When looking at just the SJHMC primary service area, the 20-24, 35-34, 35-44 and 45-54 year olds almost always had the highest rates of visits to the emergency department due to Opioid overdoses, and since 2012, they're always higher than SJHMC's PSA as a whole. The highest rates are among the 20-34 years of age (graph 13).

Graph 13



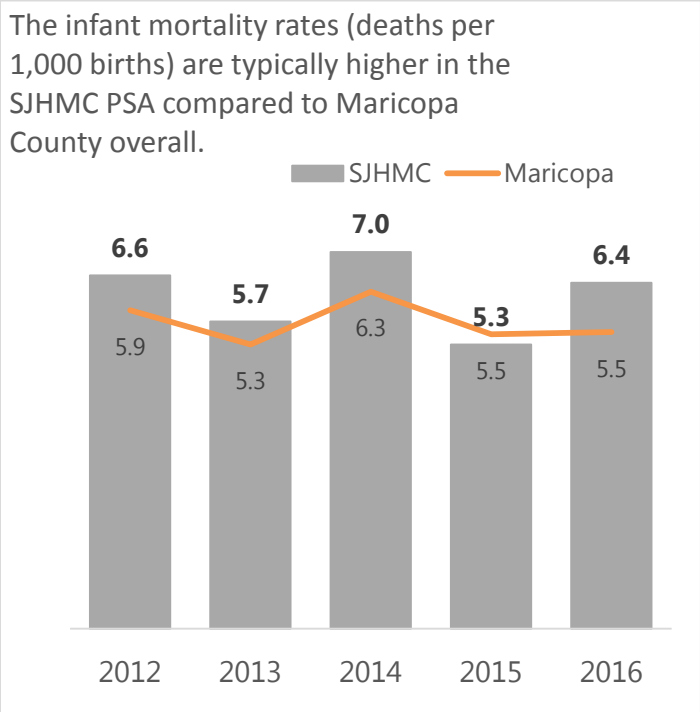
Source: Hospital discharge data from ADHS, analyzed by MCDPH

Opioid-related overdose rates for inpatient hospitalizations have fluctuated up and down in the years 2012-2016, but the highest rates per 100,000 are fairly consistently seen in the age groups 45-54, 55-64, 65-74 and 75+. These rates are very close to Maricopa County's inpatient hospitalization rates among these same age groups.

Maternal Health

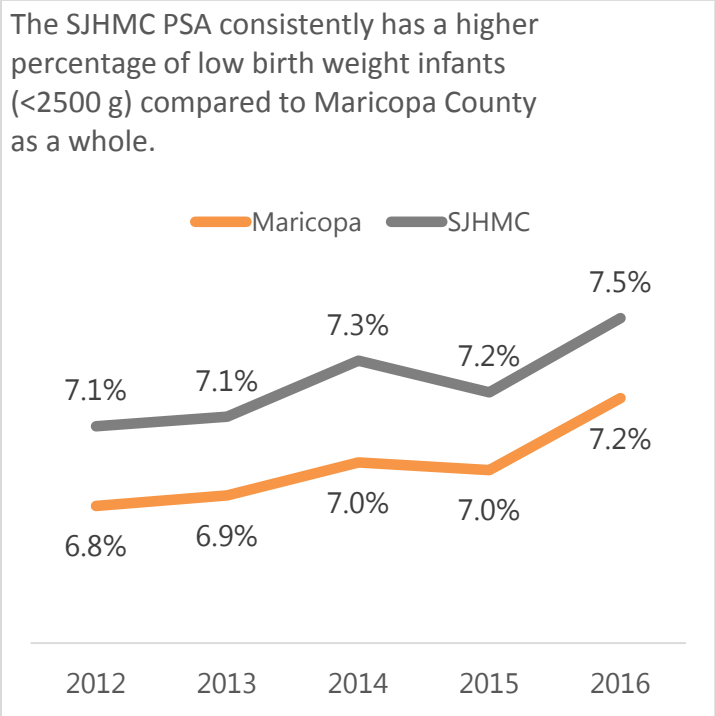
Maternal Health is an important part of a mothers, infants, and child's overall health and wellbeing. It determines the health of the next generation and can help predict health challenges for families, communities, and the medical care system[xxxiv]. The SJHMC Primary Service Area's infant mortality rates are higher than Maricopa County for all years from 2012-2016 except for 2014 (Graph 14)[xxxv]. A higher percentage of babies are born considered low birth weight (less than 2,500 grams) in the SJHMC PSA compared to Maricopa County overall (Graph 15).

Graph 14



Source: Death data from ADHS, analyzed by MCDPH

Graph 15



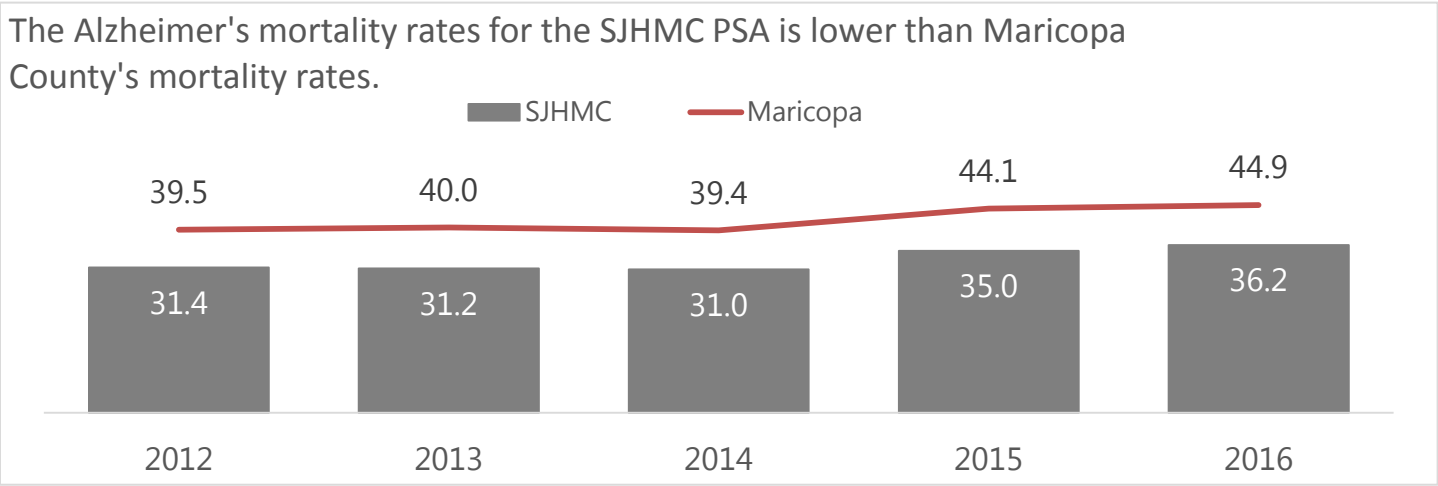
Source: Live birth data from ADHS, analyzed by MCDPH

Alzheimer's disease

Alzheimer's is a type of dementia that causes problems with memory, thinking, and behavior[xxxvi] In Arizona, 2,943 deaths occurred in 2015 due to Alzheimer's and it is the fifth leading cause of death, which is a 182% increase since 2000

. In graph 16, we can see that the mortality rates for Alzheimer's in the SJHMC PSA are consistently lower than Maricopa County's overall.

Graph 16



Source: Death data from ADHS, analyzed by MCDPH

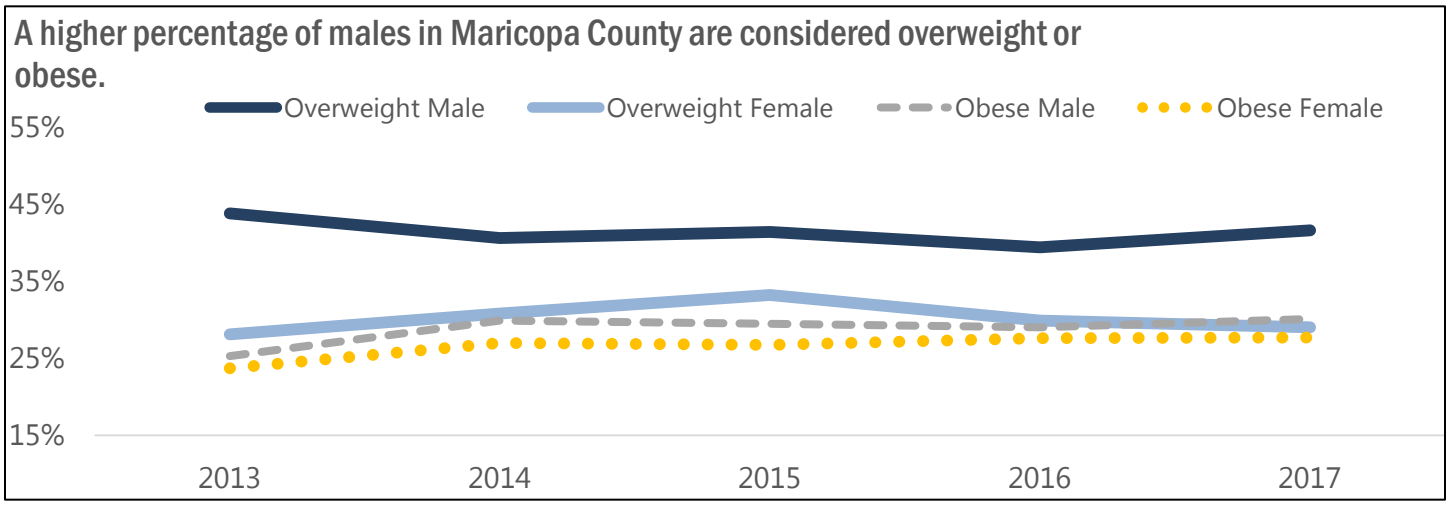
Women have a higher mortality rate due to Alzheimer's Disease compared to men, and that trend holds true for both Maricopa County overall and the SJHMC PSA.

Whites have the highest mortality rates due to Alzheimer's disease followed by Blacks.

Source: Death data from AHDS, analyzed by MCDPH

Overweight/Obesity

According to the World Health Organization (WHO), in 2016, more than 1.9 billion adults, 18 and older, were overweight. Of these over 650 million were obese[xxxix].The prevalence of obesity was 39.8% and affected by 93.3 million US adults in 2015-2016. Obesity related conditions include heart disease, stroke, type 2 diabetes, and certain types of cancers[xl]. In 2017, the Arizona adult obesity rate was 29.5%[xli]. In Maricopa County, males have higher overweight rates than females (Graph 17) and Hispanic obesity rates are higher than non-Hispanic whites[xlii].Key informants felt that being overweight, poor eating habits and lack of exercise were among the top five risky health behaviors community members were engaging in.



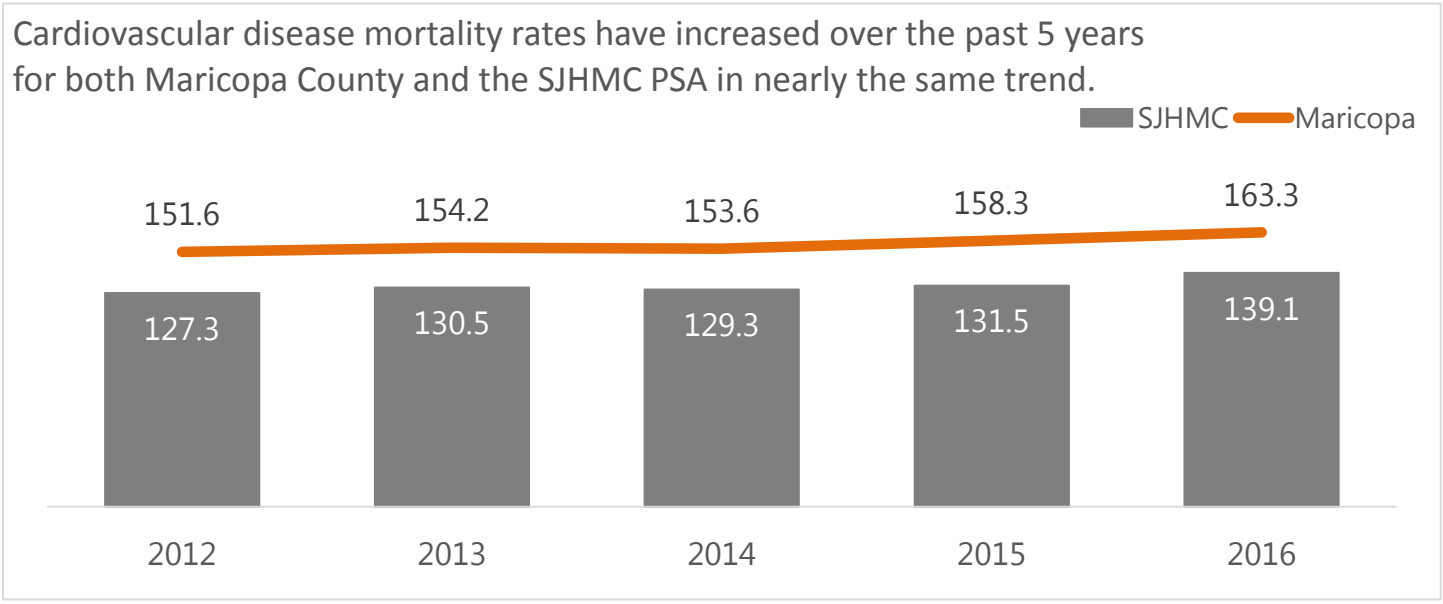
Graph 17

Source: Behavioral Risk Factor Surveillance Survey, 2013-2017

Cardiovascular disease is the second leading cause of death for Maricopa County and SJHMC's primary service area. The primary risk factors include diabetes, overweight/obesity, poor diet, physical inactivity and excessive alcohol use. Many of these are the same risky behaviors key informants reported being concerned about for the primary service area.

Overall, the number of deaths related to cardiovascular disease in the SJHMC PSA as well as Maricopa County overall are increasing (graph 18). According to the hospital discharge data and death data for Maricopa County, adults age 75 and older have the highest rates of cardiovascular disease-related inpatient discharges, emergency department visits and mortality.

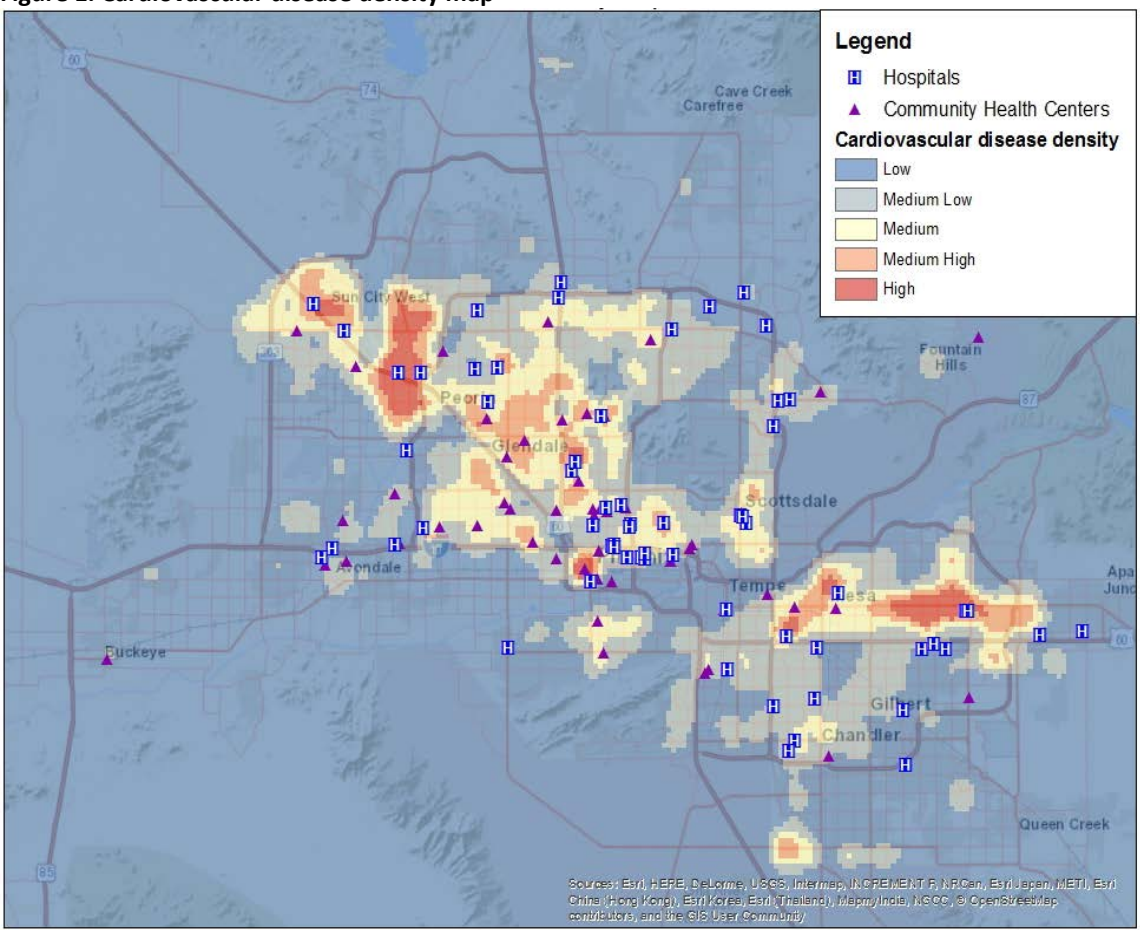
Graph 18



Source: Death data from ADHS, analyzed by MCDPH

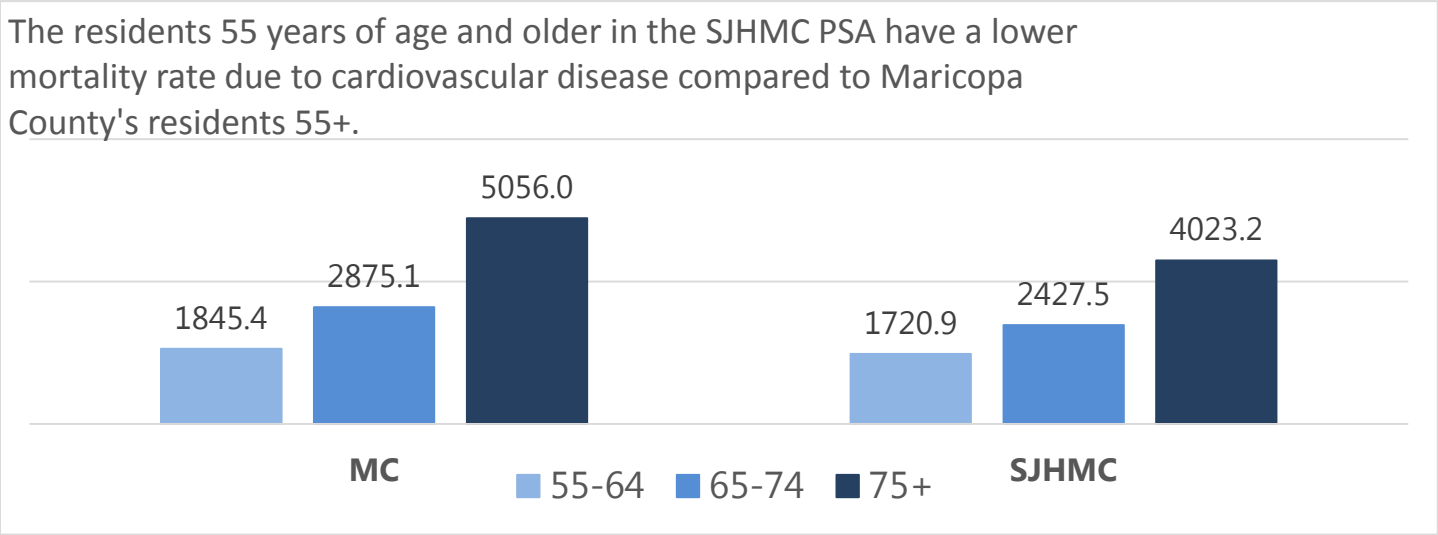
A cardiovasular disease density map (figure 1 below) highlights in red where the death rates due to cardiovascular rates are highest in Maricopa County.

Figure 1. Cardiovascular disease density map



Cardiovasular disease emergency room rates are highest among those 55. Graph 19 below shows that the SJHMC PSA's ED rates for cardiovascular disease are not higher than Maricopa County's.

Graph 19



Source: 2016 death data from ADHS, analyzed by MCDPH.

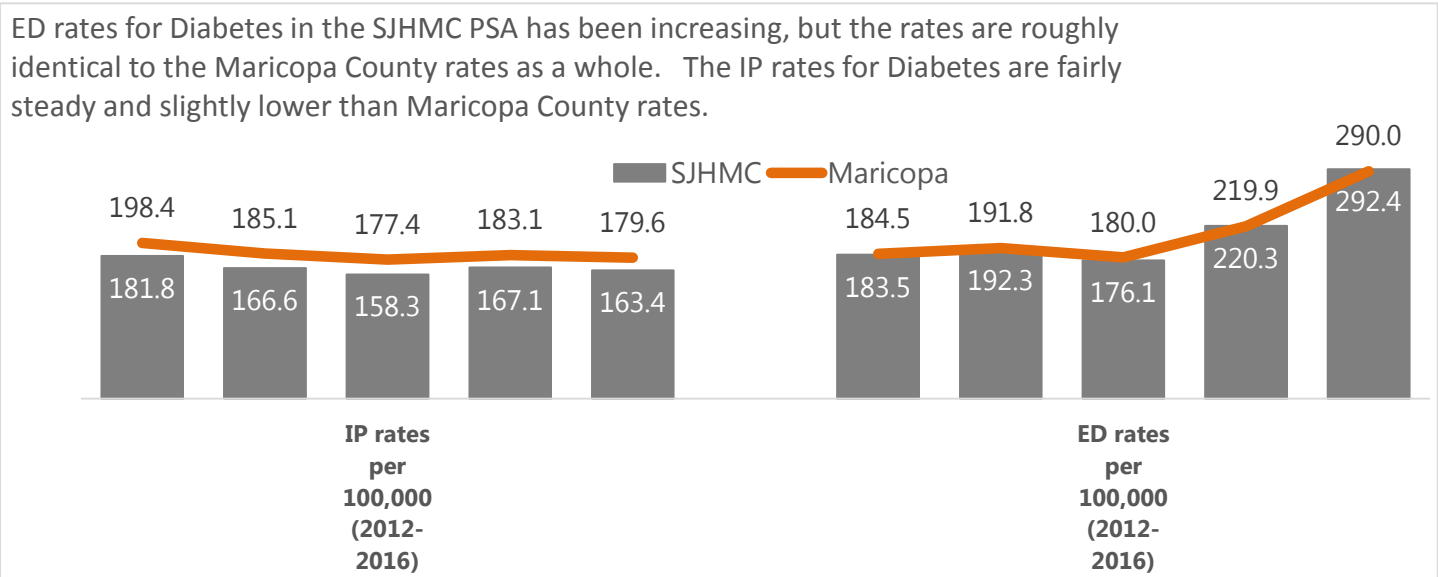
Diabetes

More than one million U.S. adults are now living with diabetes or pre-diabetes, according to a new report released by the Centers for Disease Control and Prevention[xliii]. Diabetes is the sixth leading cause of death in

years 2012 to 2016 with a low of 23.2 per 100,000 and a high of 26.4 per 100,000. Overall, there has been a slight increase in deaths due to Diabetes in both Maricopa County and the SJHMC primary service area. These mortality rates are very close to those of Maricopa County as a whole. According to the behavioral risk factor surveillance survey, the number of people reporting they have been told they have diabetes is also increasing.

The ED rates per 100,000 for Diabetes in the SJHMC primary service area has been increasing overall since 2012 but the IP rates have held fairly steady. The rates for both IP and ED are very similar to Maricopa County's rates for ED and IP due to Diabetes (Graph 20).

Graph 20



Source: hospital discharge data from ADHS, analyzed by MCDPH

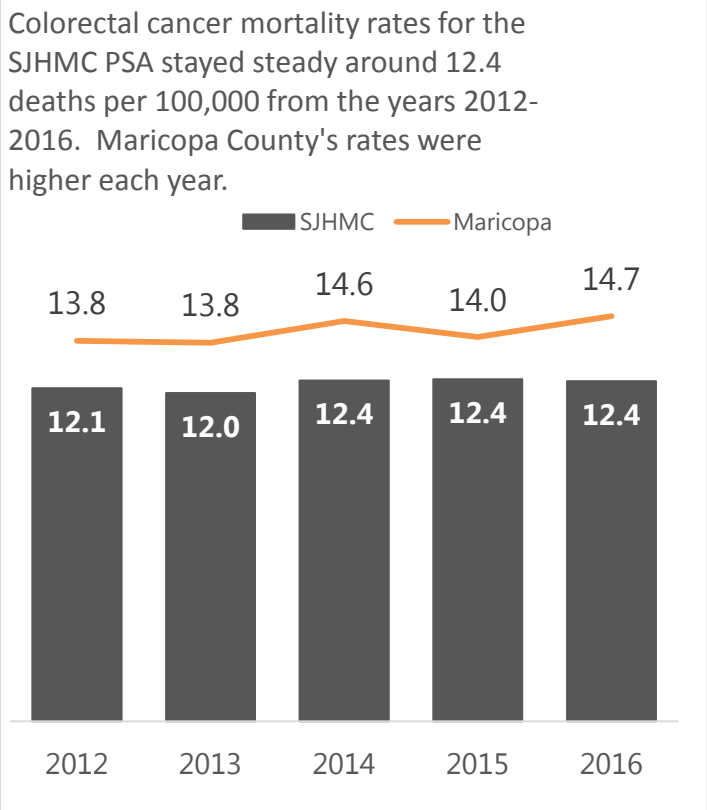
Cancer

While advancements continue to be made in the fight against cancer, it remains the leading cause of death in Maricopa County and the SJHMC's primary service area and was identified as one of the top five areas of concerns from key informants.

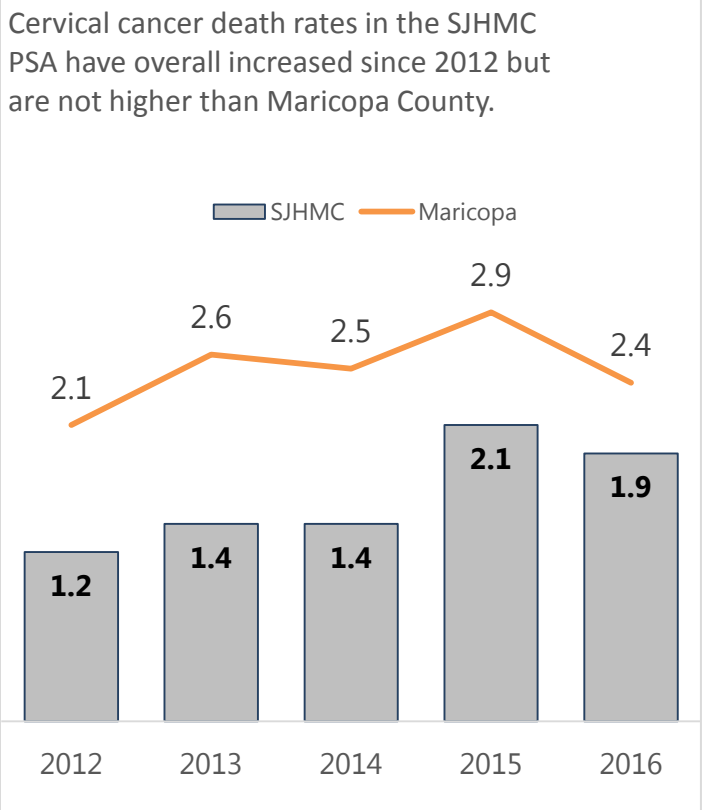
Colorectal cancer death rates in Maricopa County have fluctuated over the last five years but SJHMC's primary service area rates have remained very steady at 12.4 deaths per 100,000 since 2014 (graph 21). Also seen in graph 17 is that the Maricopa County rates for colorectal cancer mortality are consistently higher than the rates for the SJHMC PSA.

In Maricopa County, cervical cancer incidence rates have also fluctuated slightly since 2012, and the death rates due to cervical cancer in the SJHMC PSA are consistently lower than Maricopa County's rates (graph 22). According to the Behavioral Risk Factor Surveillance Survey for Maricopa County, the percentage of women that have had a pap test has been declining slightly since 2012.

Graph **21**



Graph 22



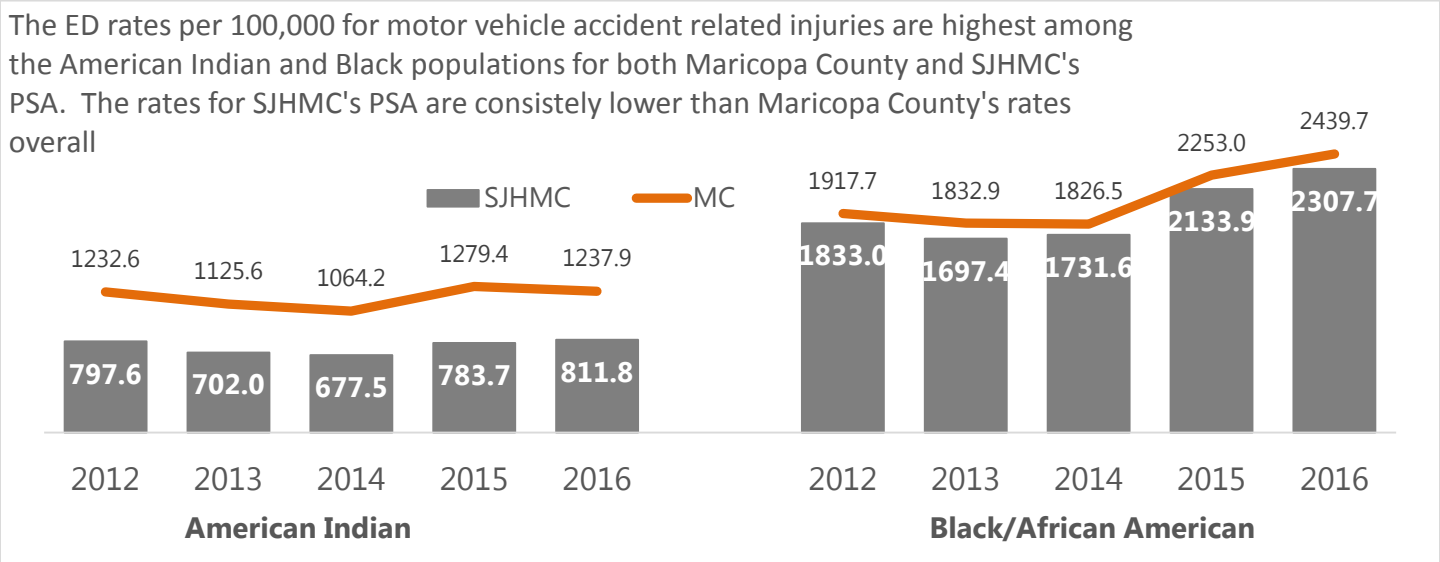
Source: Death data from ADHS, analyzed by MCDPH (graphs 21 and 22)

Trauma/Injury Prevention

In the United States, deaths from unintentional injuries is the seventh leading cause of death among older adults, and falls account for the largest percentage of those deaths[xliv]. In 2016 unintentional injuries was the fifth leading cause of deaths in Maricopa County and SJHMC's primary service area and falls were ninth

leading cause of death (Appendix A). Unintentional injuries are preventable and largely due to lifestyle choices. Nationally, nearly one-third of these deaths are due to car crashes and nearly another one-third is due to accidental poisonings[xlv]. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females[xlvi].

From the years 2012-2016, the inpatient discharge and emergency department rates per 100,000 for motor vehicle accidents in the SJHMC PSA were consistently lower than the rates for Maricopa County as a whole. See graph 23. The death rates per 100,000 for the SJHMC primary service area were not higher than Maricopa County's rates as well. In 2016, the death rate for the SJHMC PSA was 12.6 deaths per 100,000 which is almost to the goal of Healthy people 2020 with a goal of 12.4 deaths per 100,000 individuals. As also seen in Graph 23, the races with the highest ED visits due to a motor vehicle accident were American Indians and Blacks. Even looking at the ED rates by race, Maricopa County's rates were still higher for those same populations.

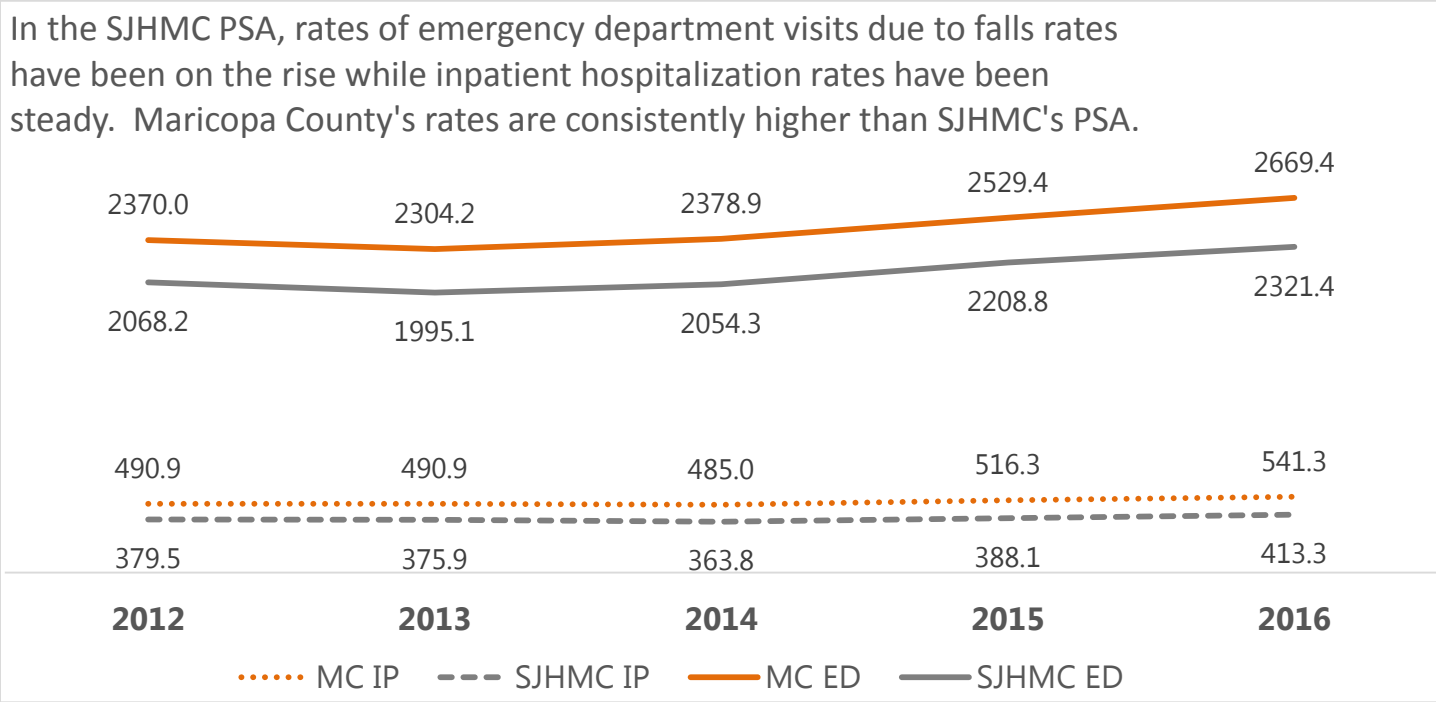


Graph 23

Source: Hospital discharge data from ADHS, analyzed by MCDPH

Falls

Falls are a great concern, particularly among the aging population. Looking at both the inpatient hospitalization rates and emergency department rates for the SJHMC PSA, it can be seem that the rates follow almost the same exact trend as Maricopa County overall, but the rates are consistently lower than Maricopa County's (graph 24).



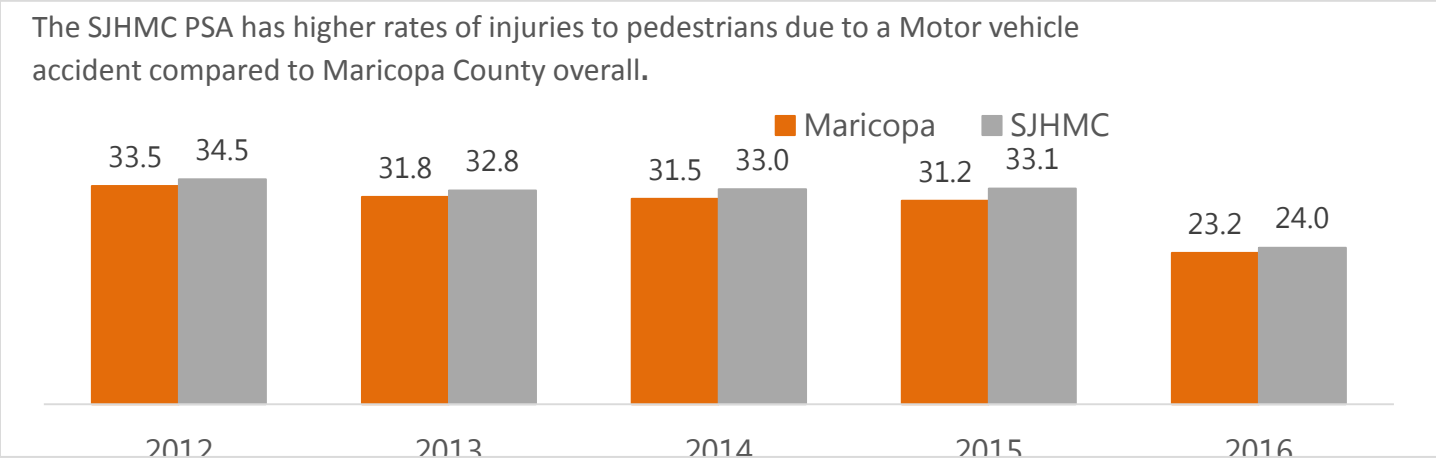
Graph 24

Source: Hospital discharge data from ADHS, analyzed by MCDPH

Pedestrian Injuries

A pedestrian related injury is any injury to a pedestrian due to a motor vehicle accident. The SJHMC's primary service area has higher emergency department visit rates per 100,000 compared to Maricopa County's rates. See graph 25. It is also noteworthy that the inpatient hospitalization rates are lower than the emergency department visit rates.

Graph 25

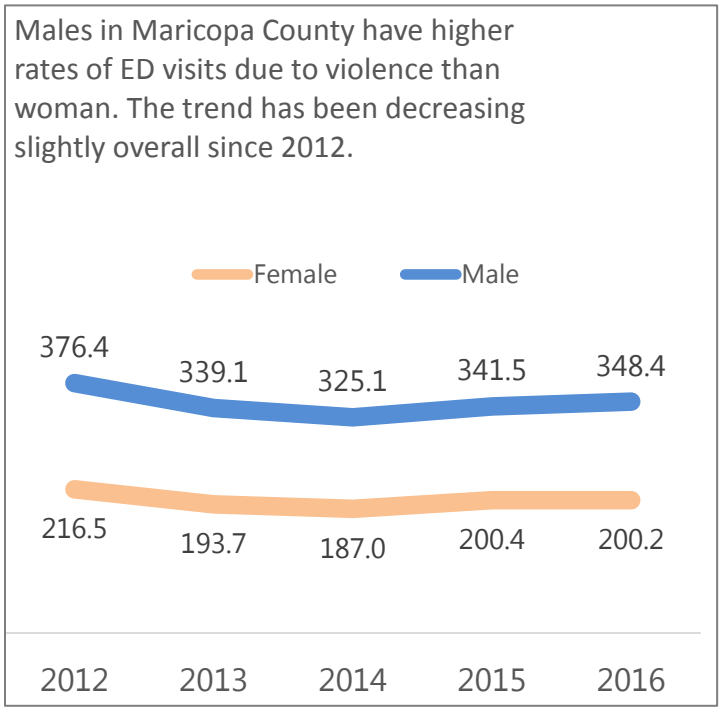


Source: Hospital discharge data from ADHS, analyzed by MCDPH

Violence

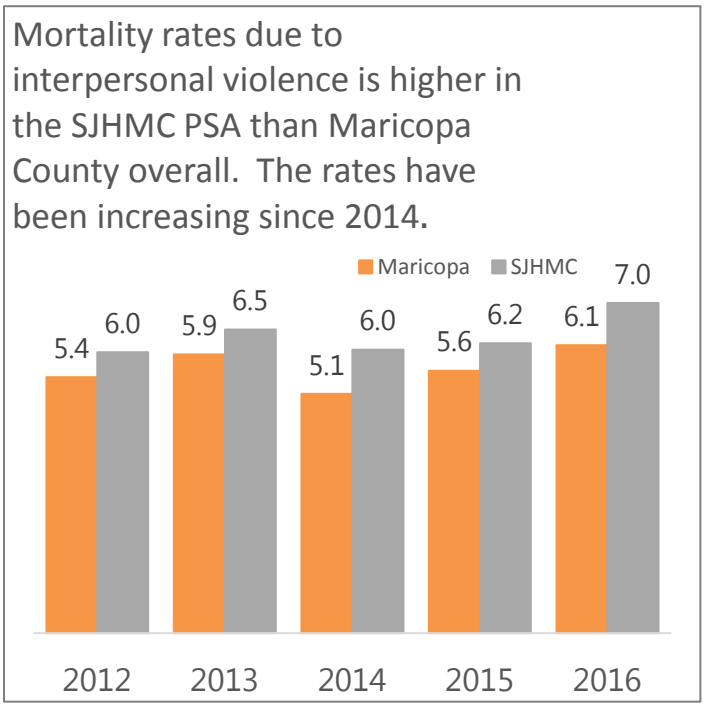
In Maricopa County, males enter the emergency room due to violence at a much higher rate than females, graph 26. It was also found that deaths due to interpersonal violence are more likely in the SJHMC primary service area than in Maricopa County overall. See graph 27.

Graph 26



Source: Hospital discharge data from ADHS, analyzed by MCDPH

Graph 27



Source: Hospital discharge data from ADHS, analyzed by MCDPH

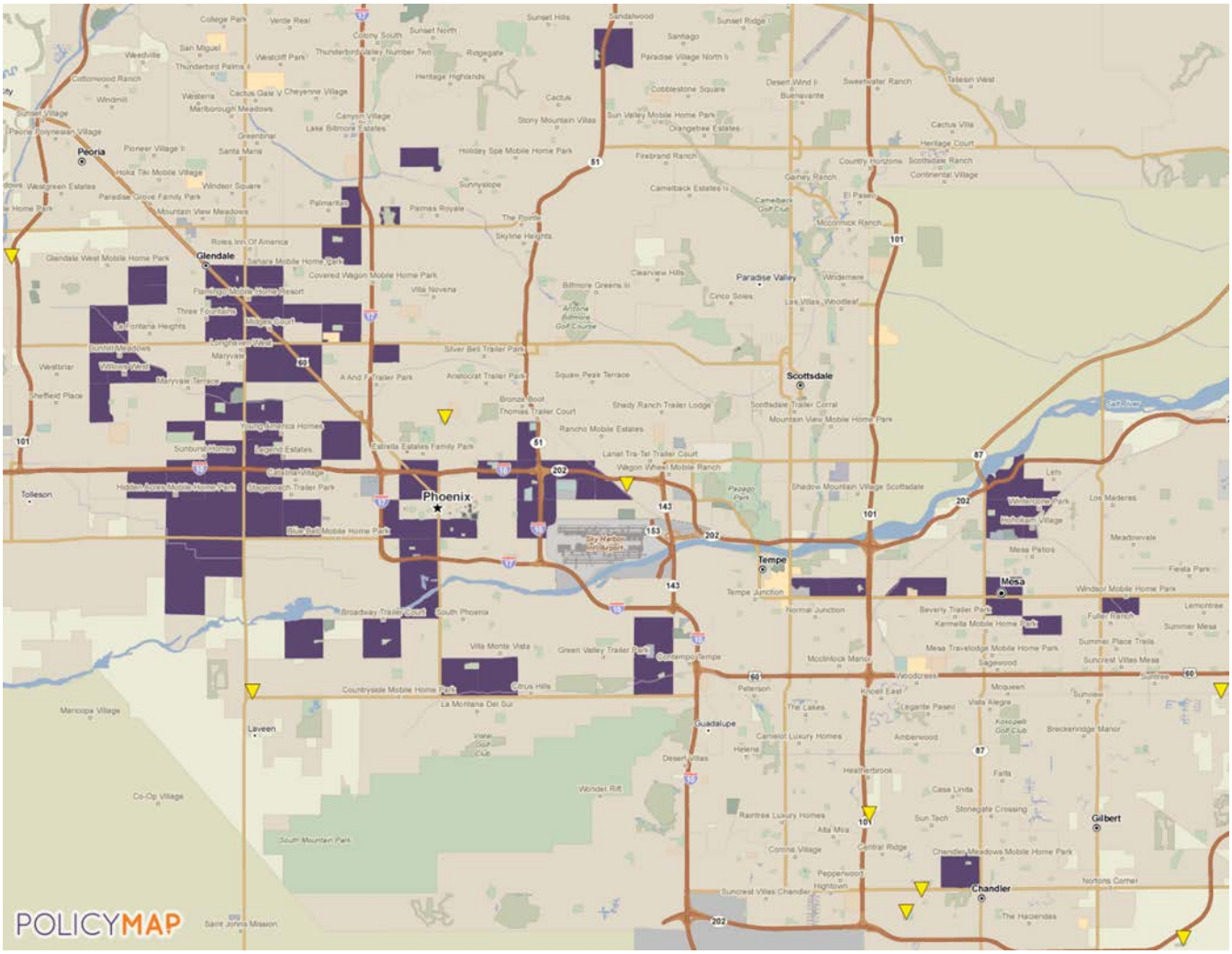
Social Determinants of Health

According to Health People 2020, a social determinants of health is a condition in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and qualify-of-life outcomes and risks[xlvii]. For the SJHMC primary service area, transportation, access to food, and housing were mapped to better understand those social determinants of health for this primary service area.

Homelessness/Housing

A household is considered cost burdened if they are paying 30% or more (for homeowners) and 50% or more (for renters) of their gross income towards housing, which includes rent or mortgage, utilities, etc. If a household is cost burdened then it can make it more difficult to afford the other necessities such as transportation, health care, food, child care, clothing, etc. To greater understand the population considered cost burdened by home ownership or renting, a map was created. The purple areas on the map meet the following criteria as of 2012-2016:

- At least an estimated 20% of all people are considered living in poverty
- At least an estimated 25% of all homeowners are considered cost burdened
- At least an estimated 46% of all renters are considered cost burdened

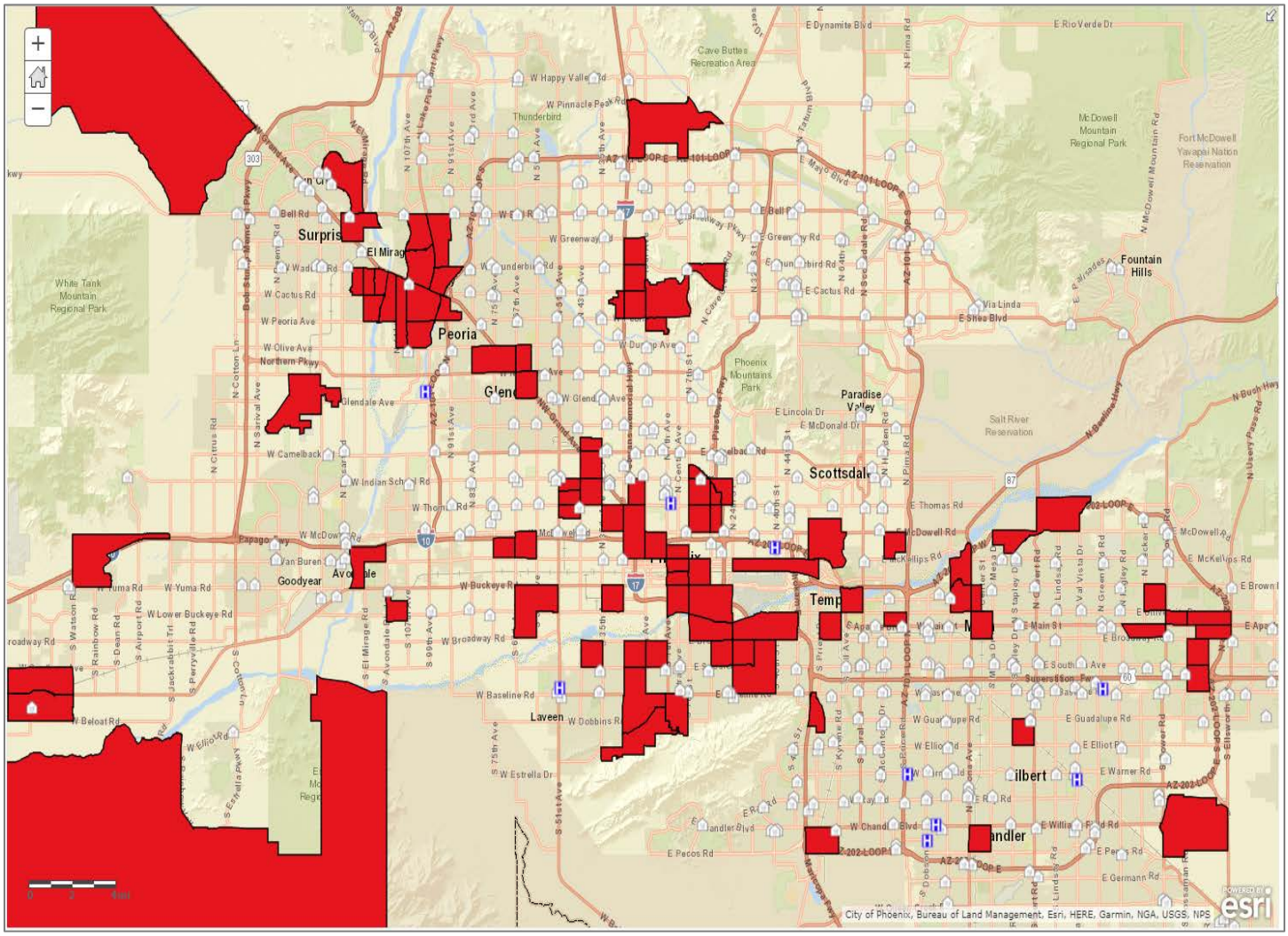


Source: PolicyMap

Access to Food – Low-Income and Low-Access to Grocery Stores

Every individual needs access to healthy food to live and sustain health. Without the ability to access, afford and consume healthy food, a person is at an incredible risk of developing a chronic disease, such as cardiovascular disease and diabetes, and the chance of living a long and healthy live is very small. Census tracts were visually analyzed in the SJHMC's primary service area to see which census tracts had lower access to healthy food. These census tracts are considered low-income and low-access.

The USDA defines a low-income neighborhood as a census tract with a poverty rate that is 20 percent or greater, a family with a household income that is 80 percent or less than the State-wide median family income or a census tract that is 80 percent or less than the metro area's median family income. The USDA defines a low-access neighborhood is a census tract that is considered to be far from a supermarket, supercenter or large grocery store. It is calculated as low-access if it has at least 33% (or at least 500) people farther than ½ mile from the nearest supermarket, supercenter or large grocery store for an urban area or more than 10 miles for a rural area. A census tract is considered low-income and low-access if it fits both criteria. The following maps highlight in red those census tracts considered low-income and low-access.



Resources Potentially Available to Address Needs

Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community based organizations. Resources include access to hospital emergency and acute care services, Federally Qualified Health Centers (FQHC), food banks, homeless shelters, school-based health clinics, churches, transportation services, health enrollment navigators, free or low cost medical and dental care, and prevention-based community education. Below is a listing of some potential resources to address prioritized community health needs:

Hospitals and Hospital Systems providing emergency care, acute care, outpatient services, and community programs:

- Arizona Heart Hospital
- Banner Health
- Dignity Health
- Honor Health
- Maricopa County Integrated Health System
- Phoenix Children's Hospital

- Valley Hospital
- OASIS Hospital
- Arizona Orthopedic Surgical Hospital

Community-Based Agencies:

Organization Name	Services Provided
Ability 360	Social and health supports for individuals with disabilities
Area on Aging	Programs and support for aging population
Arizona's Children's Association	Resources to protect children, empower youth, and strengthen families.
Arizona's First Health Navigation & Transportation System for the Homeless	Improve continuity of care for homeless individuals.
Arizona Living Well Institute	Chronic Disease Self-Management Education
Arizona Spinal Cord Injury Association	Enhances the lives of individuals with spinal cord injuries
AZ Housing Coalition	Leads in the efforts to end homelessness and advocate for safe, affordable homes for ALL Arizonans.
Cancer Support Community, AZ	Provides support throughout cancer journey
Catholic Charities Community Services	Provides social services, including behavioural health to veterans and their families, sex-trafficked survivors, victims of domestic abuse, refugees and those experiencing homelessness and the broader community
Circle the City	Medical care and respite for homeless
Clinica Adelante	Primary medical care for uninsured/underserved
Combating Cardiac Arrest Inequities in South Phoenix	*I*ncrease communities understanding of cardiac arrest, risk factors and prevention strategies.
Community Bridges	Supportive services for homeless
Coordinated Hospital Discharge	Seamless and coordinated emergency department discharge process
Community Medical Services	Substance abuse treatment and assistance programs
Corporate for Supporting Housing	Housing
Developmental Snapshot to School Readiness Success	empower families through knowledge of their child's developmental milestones
Dignity Health Medical Group	Primary Care services – General, Internal Medicine, Specialty Care and women's health services
DUET: Partners in Health and Aging	Elderly and care giver support services, parish nurse programs
Faith Community/Churches	Parish Nurse programs
Family Involvement Center	provides assistance and support to parents and caregivers raising children with emotional, physical and/or behavioral health challenges

Feeding Matters	Support for parents of infants and children who struggle with eating and the physicians who treat them
Foundation for Senior Living	Adult Health Services
Healthy Kiddos, Healthy Communities	Therapeutic interventions for youth
Gila River Healthcare	Mental health and substance abuse treatment services.
Keogh Health Connection	Heath insurance enrollment and navigation
International Rescue Committee	Refugee and Immigrant Services
Healthcare for the Homeless and Dental Clinic	Health and dental care for the homeless population
Hospice of the Valley	Palliative and Hospice Care
Lodestar Day Resource Center	Resource Center
Mercy Housing	Provides affordable housing & supportive services for low income families, seniors, and people w/ special needs.
Mercy Maricopa	Behavioral health services.
Mission of Mercy	Primary medical care for uninsured/underserved
Mountain Park Health Center	Primary medical care for uninsured/underserved
Native American Connections	Housing, behavioral health, adolescent, homeless, and native services
Native American Health Center	Medical, Dental Behavioral health for urban Native Americans
Neighborhood Christian Clinic	Free and reduced health services
NOAH	Provide accessible and affordable healthcare while improving health outcomes
Parson's Family Health Center	Homeless Healthcare and Federally Qualified Health Center
Phoenix Indian Center	Support to American Indians for education and employment
Refugee Health Partnership	Identify and respond to barriers that newly arrived refuges face.
Smooth Way Home	Improve the social, developmental, and medical outcomes of very fragile infants and their families.
Social Determinants of Drug Use	address unmet health-related social needs of people who use drugs
Southwest Behavioral Health	Services in the areas of housing, residential care, prevention services, outpatient services to children, incarcerated persons and dually diagnosed adults (SMI/SA).
Southwest Human Development	Services for children and families
St. Mary's Food Bank	Food bank
Strengthening Homeless Pregnant and Parenting Women	Family support services
Strong Families Healthy Communities	improve access to community based mental health treatment and resources
Terros Health Center	Primary medical care for uninsured/underserved
The Society of St. Vincent De Paul	Medical, dental, food, clothing, housing for underserved
Touchstone Behavioral Health	Mental Health/Behavioral Health services
United Food Bank	Food bank
Valle dal Sol	Primary healthcare services are offered for children and adults, in addition to behavioral health services.

Vitalyst Health Foundation	Improve well-being in Arizona by addressing root causes and broader issues that affect health.
Youth Violence Intervention & Prevention Project (Y-VIPP)	addresses the untreated risk factors associated with interpersonal violence perpetration among youth

The Health Improvement Partnership of Maricopa County (HIPMC) is 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. The HIPMC provides a forum to share ideas and resources as well as a data-driven process to identify gaps and barriers to health improvement, especially among vulnerable populations. With more than 100 partner organizations, this is a valuable to resource to help St. Joseph's Hospital and Medical Center connect to other community based organizations that are targeting many of the same health priorities[xlviii].

Impact of Actions Taken Since Preceding CHNA

From fiscal year 2016 through fiscal year 2018, Dignity Health – St. Joseph's Hospital and Medical Center provided $614,977,700 in patient financial assistance, unreimbursed cost of Medicaid, community health improvement services, and other benefits. The hospital also incurred $340, 388,753 in unreimbursed costs of caring for patients covered by Medicaid.

In addition, the number of persons served through financial assistance and community health improvement services between fiscal year 2016-2018 further demonstrates the impact of Dignity Health actions taken through community benefit services. 3,208 people received financial assistance and 429,886 people were served through community health services. Below is a listing of key community benefit services:

- Mohammed Ali Parkinson Center
- Maternity Outreach Mobile
- Keogh Health connections
- Barrows Neurological Institute's Fall Prevention Program
- Barrows Neurological Institute's Stroke Program

- Healthier Living Chronic Disease Self-Management
- ACTIVATE – ACTIVATE Prime Transitional Care Program
- Refugee Health Partnership
- Smooth Way Home
- Native American Collaborative
- HOMeVP: Health and Home of Medically Vulnerable People

Input Received on Most Recent CHNA and Implementation Strategy

A formal mechanisms is being worked on to receive and track written comments regarding the Community Benefit Report and Plan. St. Joseph's Hospital Westgate is working to track or record written comments for the most recently conducted CHNA and adopted Implementation Strategy. Positive feedback on the value and benefit of the CHNA report has been received verbally by many internal and external stakeholders. In addition, many individuals and agencies have requested the CHNA report to use for grant applications, assessments, and planning. Although there have not been formal mechanisms in place to receive and track written comments in the past, a process will be in place for newly conducted CHNA's, including this report, to comply with the regulatory requirement to solicit and take into account input received from written comments.

This report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at St. Joseph's Hospital and Medical Center's Department of Community Health Integration.

Written comments on this report can be submitted to the St. Joseph's Hospital and Medical Center's Department of Community Health Integration, by e-mail to CommunityHealth-SHJMC@DignityHealth.org or by phone to 602-406-2288.

Appendix A - List of Data Sources

Data Sources

- Vital statistics (birth, death) – obtained from the Arizona Department of Health Services (ADHS). Data analysis completed by MCDPH Office of Epidemiology staff.
- Hospital Discharge Data (inpatient and emergency department) - obtained from the Arizona Department of Health Services. Data analysis completed by MCDPH Office of Epidemiology staff.
- Behavioral Risk Factor Surveillance Survey (BRFSS)
- Arizona Youth Survey (AYS)
- Youth Risk Behavioral Surveillance Survey (YRBSS)
- Centers for Disease Control (CDC) Environmental Public Health Tracking (EPHT) –
- ADHS EPHT Explorer
- US Census, American FactFinder

Data Indicators

1. **Population Demographics**
   - Gender
   - Age groups
   - Race/Ethnicity
   - Education
   - Income
   - Employment Status

2. **Access to Health Care**

   Health Insurance Coverage by:
   - Age groups
   - Gender
   - Race/Ethnicity
   - Nativity/Citizenship
   - Education
   - Income
   - Employment status
   - Poverty level

   Health Care Coverage (18-64)
   - Usual Source of Care
   - Routine Checkup (last year)
   - Couldn't Afford Needed Care
   - AHCCS enrollment broken down as much as possible
   - Primary Payer Type for ED/IP

3. **Birth Related**
   - IMR
   - Low Birth Weight
   - Preterm Births
   - Teen Birth

4. **Cancer Incidence & Prevention**
   - Breast Cancer Incidence
   - Breast Cancer Screening
   - Breast Cancer
   - Cervical Cancer Incidence
   - Cervical Cancer Screening
   - Cervical Cancer
   - Colorectal Cancer Incidence
   - Colorectal Cancer Screening
   - Colorectal Cancer
   - Prostate Cancer Incidence
   - Prostate Cancer Screening
   - Prostate Cancer
   - Lung Cancer Incidence
   - Lung Cancer

5. **Environmental Health**
    - Asthma rates
    - Air Quality
    - Blood Lead Levels in children
    - Carbon Monoxide Poisonings
    - Extreme Heat Days
    - Heat Related Illness
    - Flood Vulnerability

6. **Chronic Disease**
    - Stroke
    - Been told they had a stroke
    - Been told they have high blood pressure
    - Cardiovascular Disease
    - Cholesterol checked in last 5 yrs.
    - Told they have high cholesterol
    - Congestive Heart Failure
    - Told they have coronary heart disease
    - Told they have had heart attack
    - Diabetes
    - Arthritis
    - Alzheimer's
    - Confusion/Memory Loss
    - COPD
    - Been told they have COPD
    - Asthma
    - Been told they have asthma
    - Diabetes
    - Been told they have diabetes

7. **Mental/Behavioral Illness**
    - Organic Psychotic Conditions
    - Other Psychoses
    - Neurotic, Personality & Other Non-Psychotic Disorders
    - Suicide
    - All Mental/Behavioral Ranked
    - Screenings for all forms depression (include maternal child health)
    - Alcohol Related
    - All Drug Related Intentional
    - All Drug Related Unintentional
    - Opioid prescribing over recommended amount and/or days
    - Opioids - Intentional
    - Opioids - Intentional
    - Opioids - Unintentional
    - Opioids - Unintentional

8. **Behavioral Health Risk Factors**
    - Alcohol/Drug use
    - Smoking
    - Nutrition/Diet
    - Physical Activity
    - Obesity

9. **Injury**
    - Motor Vehicle Related
    - Motor Cycle Related
    - Bicycle Related
    - Pedestrian Related
    - Fall Related
    - Violence

10. **Prevention Quality Indicators** (PQI's)

11. **Social Determinants of Health**
    - Transportation
    - Access to Food
    - Housing
    - Utilities
    - CNI Map
    - Z Codes

12. Top 5 leading causes of death
13. Youth Top 5 leading causes of death
14. Preventable ED's
15. Community Surveys
16. Focus Groups

Top 10 Leading Causes of Death

Rank	Maricopa County	St. Joseph's Hospital and Medical Center
1	Cancer	Cancer
2	Cardiovascular Disease	Cardiovascular Disease
3	Chronic Lower Respiratory	Chronic Lower Respiratory
4	Alzheimer's	Alzheimer's
5	Unintentional Injury	Unintentional Injury
6	Stroke	Stroke
7	Diabetes	Diabetes
8	Suicide	Suicide
9	Falls	Falls
10	Liver Disease	Liver Disease

Key Informant Survey

Total Number of Participants	152
Characteristic	Percentage of Participants
Male	22%
Female	78%
0-17	0%
18-24	1%
25-39	16%
40-54	39%
55-64	29%
65 or older	15%
American Indian/Alaskan Native	1%
Asian/Pacific Islander	1%
African American	7%
Hispanic	15%
White	76%

Focus Groups

Total Number of Participants = 127

Date	Time	Population	Location
9/25 (Fri.)	9:30-11:30am	Older adults (65-74) [n=10]	Sun City Branch Library (16828 N 99th Ave, Sun City, AZ 85351)
9/28 (Mon.)	5:30-7:30pm	Native American adults (x2) [n=24]	Phoenix Indian Center (4520 N Central Ave #250, Phoenix, AZ 85012)
9/29 (Tues.)	5:30-7:30pm	Adults without children [n=10]	Mesa Main Library (64 E. 1st St., Mesa, AZ 85201)
9/30 (Wed.)	6:00-8:00pm	Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) adults [n=6]	Phoenix Pride LGBT Center (801 N 2nd Ave, Phoenix, AZ 85003)
10/2 (Fri.)	9:00-11:00am	Adults with children under age 18 [Spanish; n=15]	Maryvale Community Center (4420 N. 51st Avenue, Phoenix, AZ, 85031)
10/2 (Fri.)	6:00-8:00pm	Low-income Adults [Spanish; n=15]	Sojourner Center (2330 E Fillmore St, Phoenix, AZ 85006)
10/4 (Sun.)	2:00-4:00pm	Hispanic/Latino adults [English; n=8]	Cesar Chavez Library (3635 W Baseline Rd, Laveen Village, AZ 85339)
10/5 (Mon.)	5:30-7:30pm	Adults with children under age 18 [n=10]	Embry Riddle Aeronautical University, Phoenix Mesa Campus (5930 S. Sossaman Rd., Ste. #102, Mesa, AZ 85212)
10/6 (Tues.)	5:30-7:30pm	Young adults (18-30) [n=10]	Pendergast Community Center (10550 W. Mariposa St., Phoenix, AZ 85037)
10/7 (Wed.)	6:00-8:00pm	African American adults [n=10]	Southwest Behavioral Health Services (4420 S. 32nd St., Phoenix, AZ 85040)
10/8 (Thurs.)	11:30-1:30pm	LGBTQ adults [n=9]	ASU/SIRC (502 E. Monroe St., Phoenix, AZ 85004)

Stakeholder Meetings

Organization	Number of representatives	Date Attended
CHNA Presentation		
Dignity Health	27	Attended CHNA presentation 10.2.18
Ability 360	1	Attended CHNA presentation 10.2.18
POM Consulting	1	Attended CHNA presentation 10.2.18
Southwest Human Development	2	Attended CHNA presentation 10.2.18
Premier Risk Management	1	Attended CHNA presentation 10.2.18
Cancer Support Community Arizona	1	Attended CHNA presentation 10.2.18
Mountain Park Health Center	1	Attended CHNA presentation 10.2.18
Foundations for Senior Living	1	Attended CHNA presentation 10.2.18
Maricopa Community College	1	Attended CHNA presentation 10.2.18
Arizona State University	8	Attended CHNA presentation 10.2.18
Sacks-Tierney Law Firm	1	Attended CHNA presentation 10.2.18
PV Health Solutions	1	Attended CHNA presentation 10.2.18
Arizona Healthy Communities	1	Attended CHNA presentation 10.2.18
AzCCN Meeting		
City of Phoenix	3	Attended AzCCN meeting 12.6.18
Mercy Housing	2	Attended AzCCN meeting 12.6.18
Valley of the Sun United Way	3	Attended AzCCN meeting 12.6.18
Arizona Spinal Cord Injury Association	1	Attended AzCCN meeting 12.6.18
Southwest Human Development	2	Attended AzCCN meeting 12.6.18
Foundation for Senior Living	4	Attended AzCCN meeting 12.6.18
Maggie's Place	2	Attended AzCCN meeting 12.6.18
Ability 360	2	Attended AzCCN meeting 12.6.18
St. Joseph's Hospital and Medical Center	2	Attended AzCCN meeting 12.6.18
Touchstone Health Services	1	Attended AzCCN meeting 12.6.18
Keogh Health Connections	1	Attended AzCCN meeting 12.6.18
International Rescue Committee	3	Attended AzCCN meeting 12.6.18
Accel	1	Attended AzCCN meeting 12.6.18
Family Involvement Center	1	Attended AzCCN meeting 12.6.18
Tanner Community Development Corporation	1	Attended AzCCN meeting 12.6.18
Special Olympics AZ	1	Attended AzCCN meeting 12.6.18
Therapeutic Harp Foundation	1	Attended AzCCN meeting 12.6.18
Arizona Care Network	1	Attended AzCCN Meeting 12.6.18
Franciscan Renewal Center	1	Attended AzCCN meeting 12.6.18
Nami Valley of the Sun	1	Attended AzCCN meeting 12.6.18
CHIN Meeting		

St. Joseph's Westgate Medical Center	1	Attended CHIN meeting 11.29.18
PV Health Solutions	1	Attended CHIN meeting 11.29.18
Arizona Dept. of Health Services	1	Attended CHIN meeting 11.29.18
Sacks Tierney P.A.	1	Attended CHIN meeting 11.29.18
Dignity Health	1	Attended CHIN meeting 11.29.18
Adelante Healthcare	1	Attended CHIN meeting 11.29.18
Arizona State University	1	Attended CHIN meeting 11.29.18
Foundation for Senior Living	1	Attended CHIN meeting 11.29.18
Catholic Charities Community Services	1	Attended CHIN meeting 11.29.18
Chicanos Por La Causa	1	Attended CHIN meeting 11.29.18
St. Joseph's Hospital and Medical Center	4	Attended CHIN meeting 11.29.18
Maricopa County Dept. of Public Health	1	Attended CHIN meeting 11.29.18
Mercy Care Plan	1	Attended CHIN meeting 11.29.18

Appendix B – Primary Data Collection Tools

CHNA Focus Group Questions

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

Opening Question (5 minutes)

1. To begin, why don't we go around the table and introduce ourselves. State your name (or whatever you would like us to call you) and what makes you most proud of your community.

General Community Questions (20 minutes)

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

2. What does quality of life mean to you?

3. What makes a community healthy?

4. Who are the healthy people in your community?

    a. What makes them healthy?

    b. Why are these people healthier than those who have (or experience) poor health?

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

    a. What are the biggest health problems/conditions in your community?

Family Questions (20 minutes)

Now we are going to transition a bit and focus a bit more on your family and experiences.

6. What types of services or support do you (your family, your children) use to maintain your health?

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

7. Where do you get the information you need related to your (your family's, your children's) health?

8. What keeps you (your family, your children) from going to the doctor or from caring for your health?

    a. Are there any cost issues that keep you from caring for your health? (such as co-pays or high-deductible insurance plans)

    b. If you are uninsured, do you experience any barriers to becoming insured?

Improvement Questions (20 minutes)

Next I'd like to ask a few questions about ways to improve community health.

9. What are some ideas you have to help your community get or stay healthy?

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

[Prompts]

a. Services, support or information to manage a chronic condition or change health behaviors such as smoking, eating habits, physical activity, or substance use?
b. Preventive services such as flu shots or immunizations?
c. Specialty healthcare services or providers?

CHNA Focus Group Questions Cont'd

11. What resources does your community have that can be used to improve community health?

Ending Question (5 minutes)

12. 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.

Community Health Survey

Please take a minute to complete the survey below. The purpose of this instrument is to get your opinions about community health issues. In collaboration with our public health partners we plan to compile this information and use it as input for the development of Dignity Health healthcare's community health improvement plan.

Thank you for your time and interest in helping us to identify our most pressing problems and issues.

In this survey, "community" refers to the major area where you provide services. Please check one from the following list:

__ Northeast (Scottsdale, Carefree, Fountain Hills, Cave Creek)
__ Northwest (Peoria, Surprise, El Mirage, Sun City)
__ Central (Phoenix, Paradise Valley)
__ Central west (Glendale, Avondale, Litchfield Park)
__ Central East (Tempe, Mesa)
__ Southeast (Chandler, Ahwatukee, Gilbert)
__ Southwest (Tolleson, Buckeye, Goodyear)

Part I: Community Health

1. Please check the **three most important factors that you think will improve the quality of life in your community?"**

Check only three:

___ Good place to raise children	___ Excellent race/ethnic relations
___ Low crime / safe neighborhoods	___ Good jobs and healthy economy
___ Low level of child abuse	___ Strong family life
___ Good schools	___ Healthy behaviors and lifestyles
___ Access to health care (e.g., family doctor)	___ Low adult death and disease rates
___ Safe Parks and recreation	___ Low infant deaths
___ Clean environment	___ Religious or spiritual values
___ Affordable housing	___ Emergency preparedness
___ Arts and cultural events	___ Access to public transportation
___ Access to Healthy Food	___ Other_____

2. In your opinion, what are **the three most important "health problems"** that impact your community?

Check only three:

___Access to Health care	___ Heart disease and stroke	___ Rape / sexual assault
___Aging problems (e.g., arthritis, hearing/vision loss, etc.)	___ High blood pressure	___ Respiratory / lung disease
	___ HIV / AIDS	___ Sexually Transmitted Diseases (STDs)
___ Cancers	___ Homicide	
___ Child abuse / neglect	___ Infant Death	___ Suicide
___ Drug and Alcohol abuse	___ Infectious Diseases (e.g., hepatitis, TB, etc.)	___ Teenage pregnancy___ Other _____
___ Dental problems		
___ Diabetes	___ Mental health problems	
___ Domestic Violence	___ Motor vehicle crash injuries	
___ Firearm-related injuries		

3. In the following list, what do you think are **the three most important "risky behaviors"** seen in your community?

Check only three:

___ Alcohol abuse	___ Racism
___ Being overweight	___ Tobacco use
___ Dropping out of school	___ Not using birth control
___ Drug abuse	___ Not using seat belts / child safety seats/bike helmets
___ Lack of exercise	___ Unsafe sex
___ Lack of maternity care	___ Unsecured firearms
___ Poor eating habits	___ Other_____
___ Not getting "shots" to prevent disease	

4. If you selected drug abuse in question 3 please specify substances of use here:

_____

5. How would you rate the overall health of your community?

___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

Part II: Demographics

Please answer questions #5-8 so we can see how different types of people feel about local health issues**.**

6. Zip code where you work: _____

7. Age:

___ 0-17
___ 18-25
___ 26-39
___40-54
___ 55-64
___ 65 or over

8. Sex: ____Male ____Female

9. Ethnic group you most identify with:

___ African American	____ Asian/Pacific Islander	___ Hispanic/Latino
___ Native American	____ White/Caucasian	___ Other: _____

Appendix C –References

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