Dignity Health.
A member of CommonSpirit

MARICOPA COUNTY
PUBLIC HEALTH

2025 Community Health Needs Assessment

Arizona General Hospital – Laveen

Adopted May 2025

TABLE OF CONTENTS

Executive Summary 3
Introduction 10
Community Definition 11
Demographic and Socioeconomic Profile 12
Medically Underserved Areas 13
Primary Care and Mental Health Professional Shortage Area (HPSA) Status 15
Assessment, Process, and Methods 18
Primary Data 18
Secondary Data 20
Assessment Data and Findings 25
Population Indicator Data for Initial Round of Health Needs 25
Community Input 29
Social Vulnerability Index 33
Vizient Vulnerability Index 34
Climate and Health 35
Equity Lens 39
Process to Prioritize Significant Community Health Needs 40
Prioritized Community Health Needs 46
Mental Health 46
Chronic Conditions 49
Social Determinants of Health 51
Access to Care 54
Violence and Injury Prevention 57
Cancer 61
Resources Potentially Available to Address Needs 63
Impact of Actions Taken Since the Preceding CHNA 66
Conclusion 71
Appendix A: Participating Organizations in the Prioritization Meetings 73
Appendix B: Leading Causes of Death in AGHL's Primary Service Area (2018-2022) 75
Appendix C: Rated Community Assets in Maricopa County - Race/Ethnicity & Special Population 76
Appendix D: CHNA Assessment Tools and Reports 80
Appendix E: Data Indicator Matrix 90
Appendix F: References 92

Executive Summary

Community Health Needs Assessment (CHNA) Purpose Statement

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

CommonSpirit Commitment and Mission Statement

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

CHNA Collaborators

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

SYNAPSE
A Platform for Community Health Partnership

MARICOPA COUNTY
PUBLIC HEALTH

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

Community Definition

AGHL defines its community as individuals residing within its primary service area (PSA), which accounts for the top 75% of AGHL's inpatient and outpatient discharges. This PSA is defined by zip codes and encompasses all populations, including low-income and underserved groups.

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

Assessment Process and Methods

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

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

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

Process and Criteria to Identify and Prioritize Significant Health Needs

Phase One

Indicator Review and Simplification

The Community Health Team at AGHL reviewed a list of common health indicators, streamlining it from 73 to 30 indicators to identify key areas of focus. These areas were chosen based on local leadership priorities and indicators that reflected the greatest disparities within AGHL's PSA.

Phase Two

CHNA Prioritization Workshops

In collaboration with Maricopa County Department of Public Health, AGHL facilitated one in-person and one hybrid (virtual/in-person) prioritization workshop. These workshops engaged both internal stakeholders (executive leadership, hospital community board members, Community Health Committee, Community Grants Committee) and external stakeholders (community-based organizations: local town, faith community and governance, and community members). The goal was to align on and prioritize significant health needs. Structured feedback from these workshops helped AGHL finalize its prioritized health needs.

Phase Three

Final Consensus of CHNA Priorities

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

List of Prioritized Significant Health Needs

The following statements summarize the priority areas identified by AGHL, based on data and insights gathered from both primary and secondary sources. While recognizing the health disparities present in the communities they serve, AGHL focused on areas where they could make the most significant impact. For areas with sub-priorities, it's important to note that these represent just one aspect of the broader priority and are not the sole focus, but part of a comprehensive approach to addressing the need.

The priorities were identified through a health, social, and racial equity lens. This approach focuses on identifying disparities in historically marginalized communities and recognizing that achieving equity requires targeted efforts to address the root causes of these disparities. AGHL applied this lens to better understand the factors driving inequities and to identify barriers faced by specific populations. By using this lens, AGHL can develop and implement tailored interventions that promote optimal health and well-being for everyone in the community.

Mental Health (Including All Mental and Behavioral Disorders)

According to 2022 age-adjusted overall rates, all mental and behavioral disorders ranked #2 for inpatient hospitalization (IP) and #3 for emergency department (ED) visits in the PSA.[viii] The 2023 CHNA survey highlighted anxiety (38.5%) and depression (33.5%) as the top two health issues that had the most impact on respondents and/or those they lived with or cared for.[v]

Chronic Conditions (Including Cardiovascular Disease, Diabetes, Obesity)

According to 2022 age-adjusted overall rates, cardiovascular disease ranked #1 for IP, #2 for ED, and #1 for death. Diabetes ranked #6 for IP, while overweight ranked #10 for IP in the PSA.[viii] The 2023 CHNA survey revealed that over 1 in 8 (12.6%) respondents indicated heart disease and over 1 in 4 (25.6%) indicated diabetes as health issues that had the most impact on respondents and/or those they lived with or cared for.[v]

Social Determinants of Health (Including Housing and Homelessness, Access to Food)

The 2022 Maricopa Association of Governments Point in Time Count revealed that the East Valley experienced the second-highest growth rate for unsheltered homelessness, increasing by 109% from 2018 to 2022.[ix] Additionally, the 2023 CHNA survey found that

almost 3 in 4 (71.9%) respondents rated *access to affordable housing* and over 1 in 2 (56.3%) rated *access to affordable healthy foods* as "Fair" or "Poor" where they live.[v]

Access to Care (Including Dental Health)

Underserved populations face significant barriers to healthcare access, leading to delayed care and poor health outcomes. In AGHL's PSA, about 17% percent of the population were uninsured.[x] According to the 2022 Behavioral Risk Factor Surveillance System, 39.3% of Arizona residents *did not visit the dentist or dental clinic* within the past year for any reason. Additionally, in 2022 41.3% of Arizona adults had their *permanent teeth extracted*.[xi]

Violence and Injury Prevention

According to 2022 age-adjusted overall rates, fall-related injuries ranked #7 for IP and #1 for ED while assault-related injuries visits ranked #8 for IP, #7 for ED, and #3 for death in the AGHL PSA.[viii] The 2023 CHNA survey identified *intentional injuries* (2.8%) and *unintentional/accidental injuries* (5.5%) as health issues that had the most impact on respondents and/or those they lived with or cared for.[v] Additionally, the 2022 Human Trafficking Hotline reported 207 identified cases of *human trafficking* in Arizona, most of which were sex trafficking, involving 350 victims.[xii] At AGHL, there were 12,838 total screenings for abuse, neglect, and violence.[xiii] According to the Maricopa County Youth Survey, 19.4% of students from grades eight, 10, and twelve harassed or made fun of another person online or through text in 2022.[xiv]

Cancer (Including Breast Cancer)

According to 2022 age-adjusted overall rates, all cancers ranked #2 for deaths in the PSA.[viii] The 2023 CHNA survey highlighted *cancer* (13.4%) as one of the top 10 health issues that had the most impact on respondents and/or those they lived with or cared for.[v] Additionally, the 2022 Behavioral Risk Factor Surveillance System reported that 32.9% of women aged 40 and older in Arizona *had not received a mammogram* within the past two years.[xi]

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

Significant Health Needs by Disproportionately Affected Populations			
Indicator	**Race/Ethnicity**	**Age (years)**	**Sex**
Mental Health (AGHL PSA data, Source: 2022 HDD[viii], only hospitalization data were reported)			
All Mental and Behavioral Disorders	American Indian/Alaska Native [1,2]	25-44 [1,2]	Male [1,2]
Chronic Conditions (AGHL PSA data, Sources: 2022 HDD[viii] and 2022 Death Data)			
Cardiovascular Disease	Black/African American [1,2,3]	65+ [1,2,3]	Male [1,2,3]
Diabetes	Black/African American [1,2] American Indian/Alaska Native [3]	45-64 [2] 65+ [1,3]	Male [1,2,3]
Obesity	Black/African American [1,3] White [2]	25-44 [1] 45-64 [2] 65+ [3]	Female [1,2] Male [3]
Social Determinants of Health (Maricopa County data, Sources: 2022 Maricopa Association of Governments Point-in-Time Count[ix], Feeding America[xv])			
Housing and Homelessness	White	25+	Male
Access to Food	Black/African American	<18	*Not Available*
Access to Care (Combined Dignity East Valley and Arizona data, Source: 2022 Census[x], Behavioral Risk Factor Surveillance System[xi])			
Without Health Insurance	Hispanic/Latino	19-64	Male
Dental Health *(did not visit the dentist or dental clinic within past year for any reason)*	Black/African American	25-34	Male
Violence and Injury Prevention (AGHL PSA data, Sources: 2022 HDD[viii] and 2022 Death Data)			
Fall-related Injuries	White [1,3] Black/African American [2]	65+ [1,2,3]	Female [1,2,3]

Assault-related Injuries	Black/African American [1,2] American Indian/Alaska Native [3]	15-24 [2] 45-64 [3] 65+ [1]	Female [1,2] Male [3]
Cancer (AGHL PSA data, Source: 2022 Death Data, only death data were reported)			
Breast Cancer	Black/African American [3]	65+ [3]	Female [3]

Table 1. Health Indicator Disparities by subgroups of residents living in AGHL's PSA

Disparities related to *social determinants of health* and *access to care* are presented as **proportions**, with the subgroups showing the highest proportions highlighted. Data for *mental health*, *chronic conditions*, *violence and injury prevention*, and *cancer* are presented as **rates per 100,000 people** from hospital discharge data (HDD).

Resources Potentially Available

AGHL evaluated current programs, partnerships, and resources related to each of the selected health priorities. These resources include community organizations, facilities, and programs, as well as hospital-provided services, that could help address the identified health needs.[xvi] Resources potentially available to support these priorities span various sectors like healthcare, non-profit, government, and/or public entities. A full list of resources can be found on page 63.

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

Report Adoption, Availability, and Comments

This CHNA report was adopted by AGHL's community board in May 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at AGHL's Community Health Office. Written comments on this report can be submitted to the AGHL's Community Health Department at 1750 E. Northrop Blvd., Chandler, AZ 85286 or by e-mail to chandler-chna@commonspirit.org.

End of Executive Summary

Introduction

Dignity Health originated as a single hospital founded by the Sisters of Mercy, dedicated to providing care for all. Established in 1854 as St. Mary's Hospital in San Francisco, it became the city's oldest continuously operating hospital. Over time, the organization expanded, emphasizing human dignity in healthcare. In 1986, the Sisters combined their hospitals into Catholic Healthcare West, later renamed Dignity Health in 2012.

Arizona General Hospital Laveen (AGHL) is one of eight acute care Dignity Health hospitals in the Arizona market. Dignity Health is a member of CommonSpirit Health, one of the largest health care systems in the nation. AGHL spans 39,000 square feet featuring 16 inpatient rooms, two state-of- the-art operating rooms for inpatient and outpatient surgical procedures, an emergency department, high complexity laboratory and a full radiology suite. It also operates four hospital satellite emergency departments throughout the west valley. AGHL provides 24/7 access to emergency medical care plus on-site digital X-ray, CT and ultrasound imaging technology. As of fiscal year 2024, AGHL had 311 employees and 463 physicians representing all major specialties.

Community Health Needs Assessment

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

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

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

Community Definition

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

AGHL's community is defined as individuals residing within the primary service area (PSA) of AGHL. The PSA is defined by the top 75% of AGHL's inpatient and outpatient discharges and is outlined by zip codes that encompass all populations, including low-income and underserved populations. AGHL's PSA is unique in that it overlaps with the Gila River Indian Community (GRIC).During fiscal year 2023, the top 75% of patient encounters at AGHL came from the following zip codes: 85339, 85041, 85043, 85302, 85042, 85033, 85301, 85037, 85040, 85338, 85051, 85035, 85353, 85323, 85009, 85395, 85029, 85015, 85303. **Figure 1** displays a map of AGHL's community.

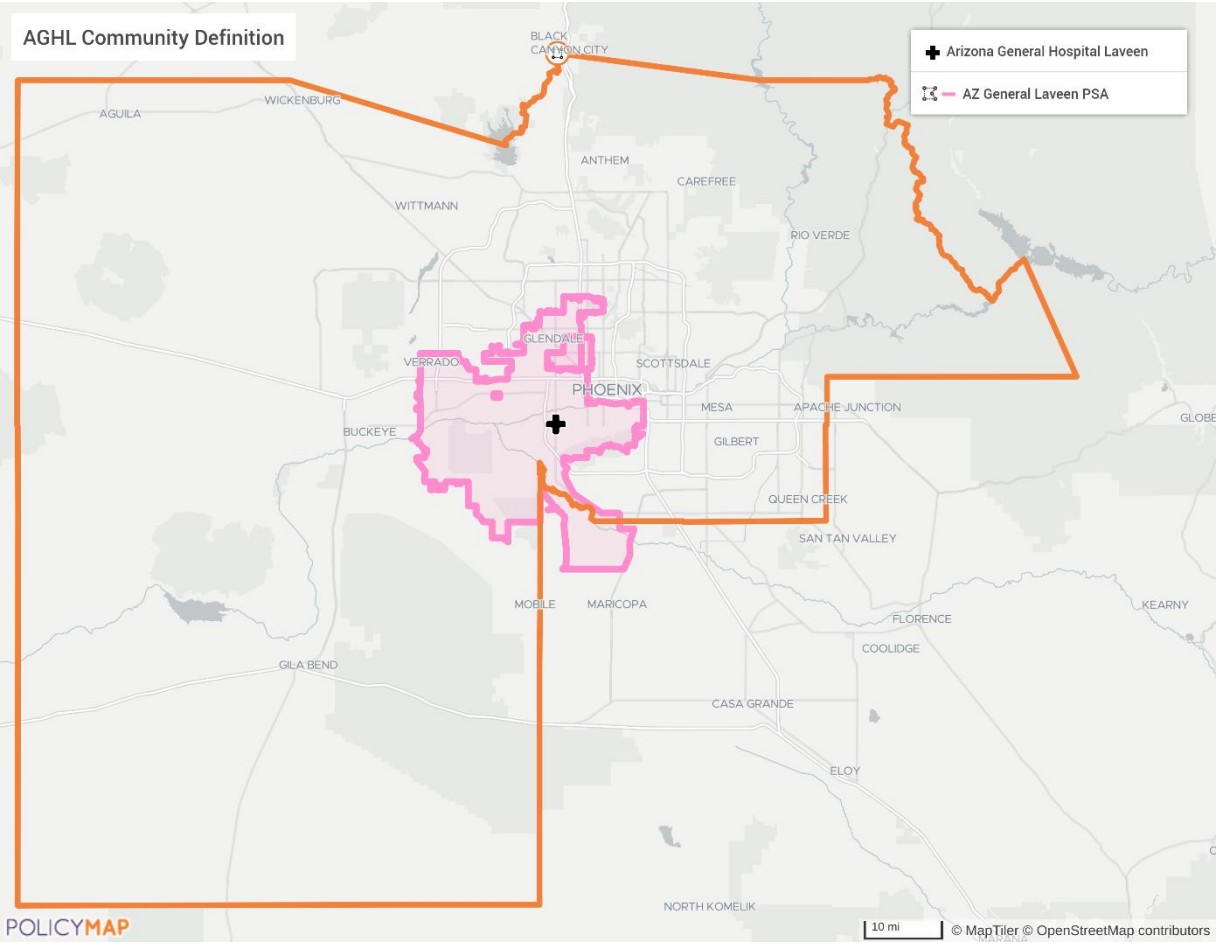


Figure 1. AGHL's Community Definition

Demographic and Socioeconomic Profile

Table 2 describes the 2022 demographic and socioeconomic profile of residents in AGHL's PSA, Maricopa County, and Arizona.[x] For data related to health insurance type, only the PSA has Medicaid coverage specific to inpatient hospitalization (IP) and emergency department (ED).[viii] AGHL's PSA is predominantly a rural community, while Maricopa County and Arizona are both urban and rural.

	AGHL's PSA	Maricopa County	Arizona
Total Population Size	919,201	4,430,871	7,172,282
Population by Race/Ethnicity			
American Indian/Alaska Native (non-Hispanic)	2%	1%	4%
Asian and Native Hawaiian/Pacific Islander (non-Hispanic)	3%	4%	3%
Black/African American (non-Hispanic)	10%	5%	4%
White (non-Hispanic)	24%	53%	53%
Hispanic/Latino	59%	32%	32%
Population by Sex			
Male	50%	50%	50%
Female	50%	50%	50%
Population by Age Group			
0-14 years	23%	19%	18%
15-24 years	16%	14%	14%
25-44 years	30%	28%	26%
45-64 years	21%	24%	24%
65+ years	10%	16%	18%
Languages, among those 5 years and over			
Non-English Languages Spoken at Home	47%	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over			
Less than 9th grade	11%	5%	5%
9th – 12th grade, no diploma	11%	6%	6%
Employment Status			
Unemployed	6%	5%	5%
Median Household Income			
Income	$70,254	$80,675	$72,581
Poverty (based on income thresholds & family size)			
Below poverty level all ages	17%	12%	13%
Below poverty level all ages under 18 years	7%	16%	18%
Health Insurance Coverage			
Uninsured	17%	11%	11%

Health Insurance Type			
Medicaid	IP: 50%, ED: 58%	18%	21%
Health Professional Shortage Area	Yes	Yes	Yes
Medically Underserved Area	No	Yes	Yes
Medically Underserved, Low Income, Minority Populations	Not available	Medically Underserved, Low Income	
Number of Other Hospitals Serving the Community - 2023	8	66	138

Table 2. AGHL's PSA, Maricopa County, and Arizona Demographic and Socioeconomic Profile – 2022 ACS Census, HRSA MUA Finder, PolicyMap

Medically Underserved Areas

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

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

Table 3. Medically Underserved Areas in Maricopa County

This section uses PolicyMap to show medically underserved areas within AGHL's PSA, using data from the Health Resources and Services Administration. These areas are designated based on criteria such as a shortage of primary care providers, high infant mortality, high poverty rates, and/or a high elderly population. Medically underserved populations are designated when specific groups face a shortage of primary care health services and encounter barriers, including economic, cultural, or language challenges. **Figure 2** displays medically underserved areas in AGHL's PSA. The PSA has medically underserved areas in *Glendale*, *Phoenix*, *Goodyear*, and *Avondale*.[xvii]

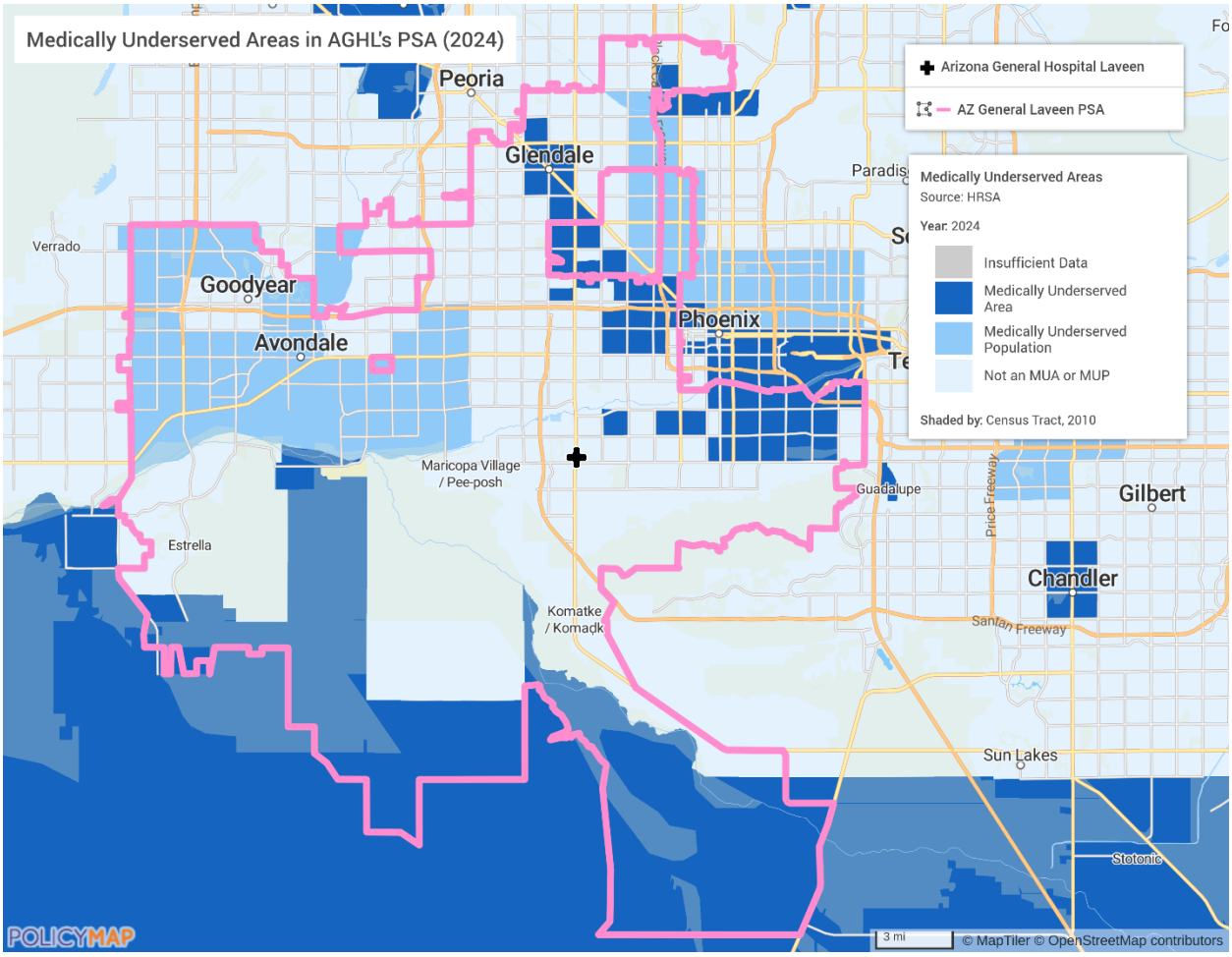


Figure 2. Medically Underserved Area/Population in AGHL's PSA

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

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

Figure 3 displays the primary care health professional shortage areas status in AGHL's PSA in 2023. Primary care health professional shortage areas also consider infant mortality rate and low birth weight rate.[xvii] The PSA has primary care health professional shortage areas in *Phoenix*, *Avondale*, *Laveen,* and in the GRIC (*Maricopa Village* and *Komatke*).[xvii]

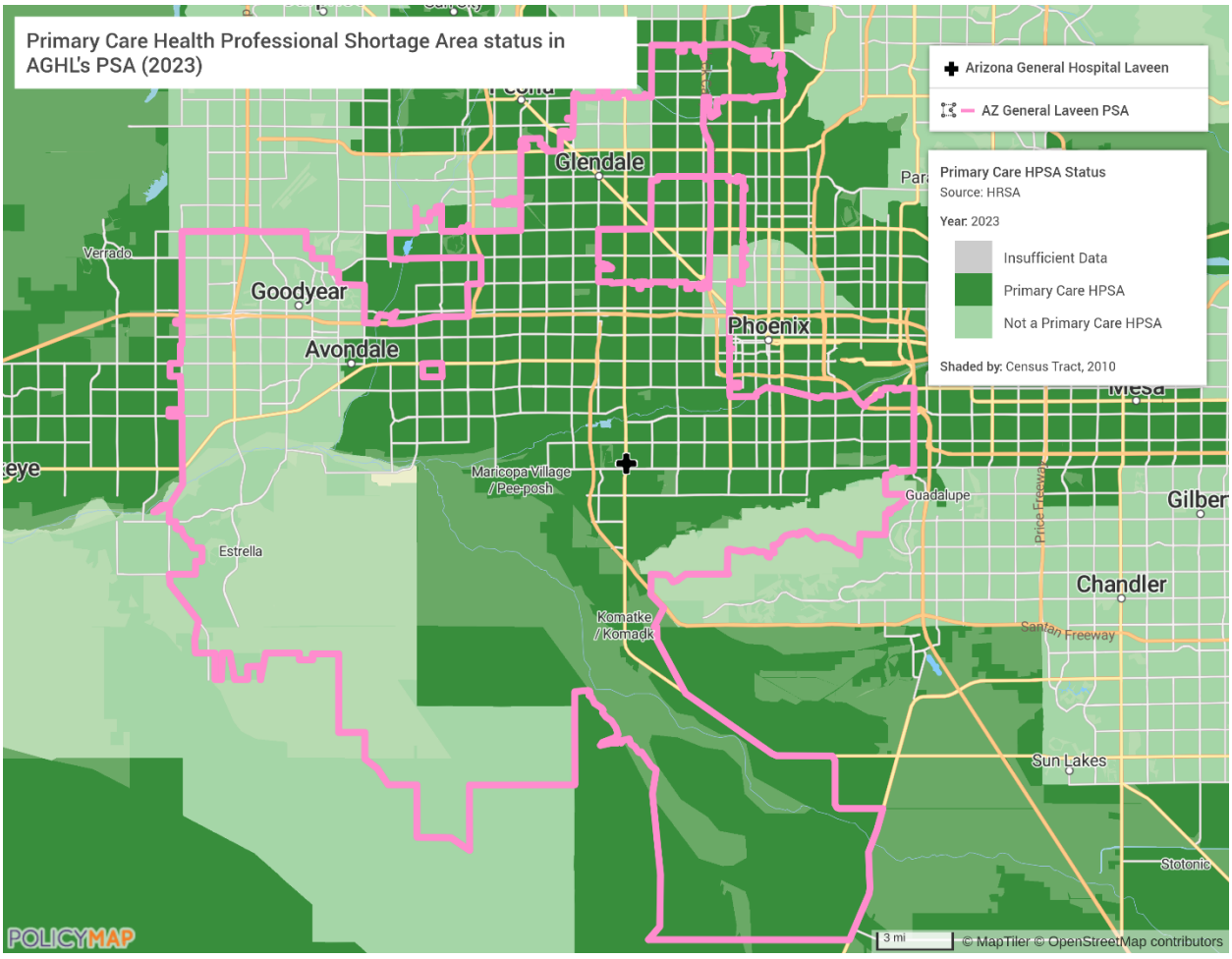


Figure 3. Primary Care Health Professional Shortage Areas Status in AGHL's PSA

Figure 4 displays the mental health professional shortage areas status in AGHL's PSA in 2023. Mental health professional shortage areas consider substance and alcohol abuse prevalence, and proportion of the population over age 65 years or under age 18 years.[xvii] The PSA has mental health professional shortage areas in *Glendale*, *Phoenix*, and in the GRIC (*Maricopa Village* and *Komatke*).[xvii]

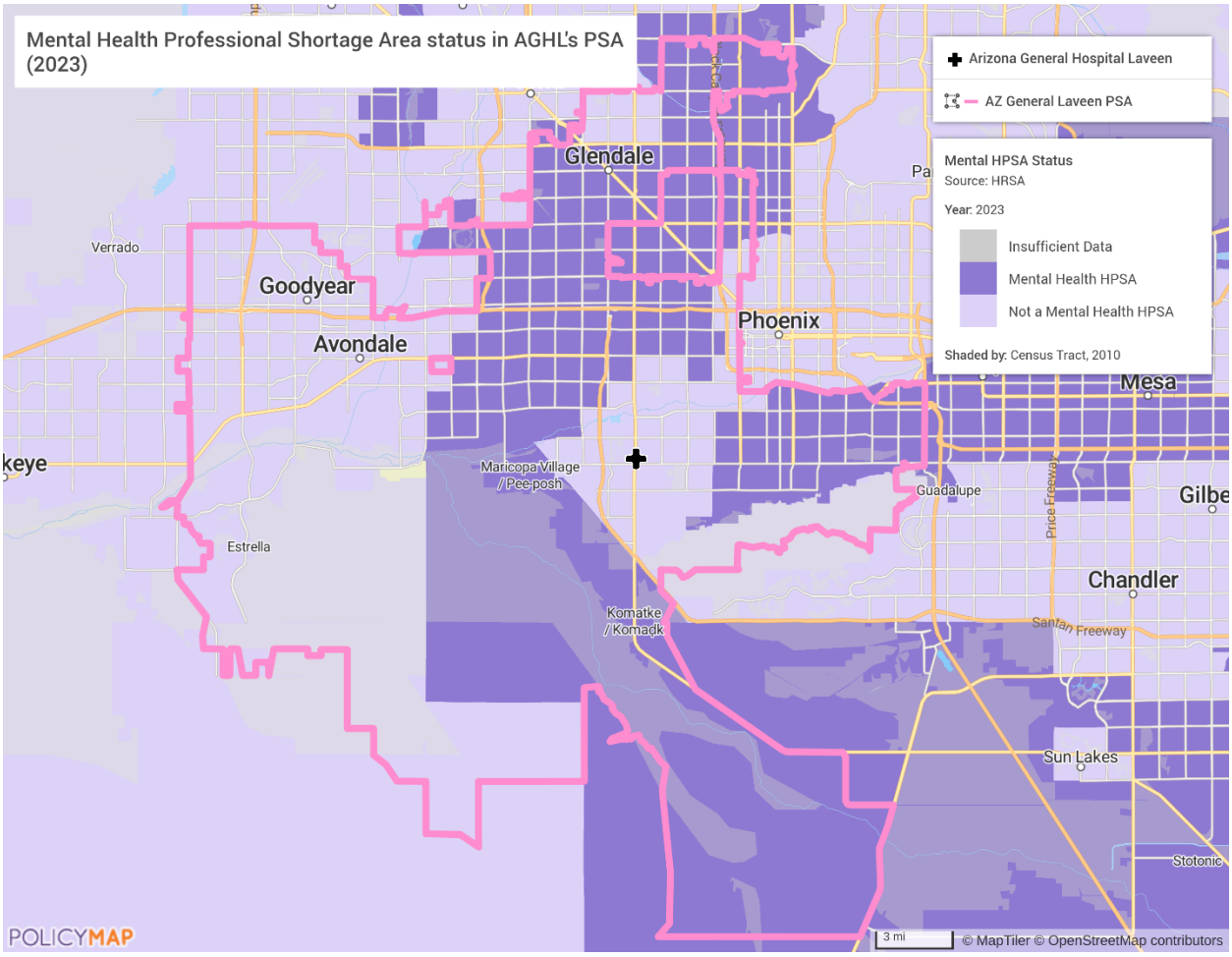


Figure 4. Mental Health Professional Shortage Areas Status in AGHL's PSA

Figure 5 displays the dental health professional shortage areas status in AGHL's PSA in 2023. Dental health professional shortage areas also consider an area's water fluoridation status.[xvii] The PSA has dental health professional shortage areas in *Glendale*, *Phoenix*, and in the GRIC (*Maricopa Village* and *Komatke*).[xvii]

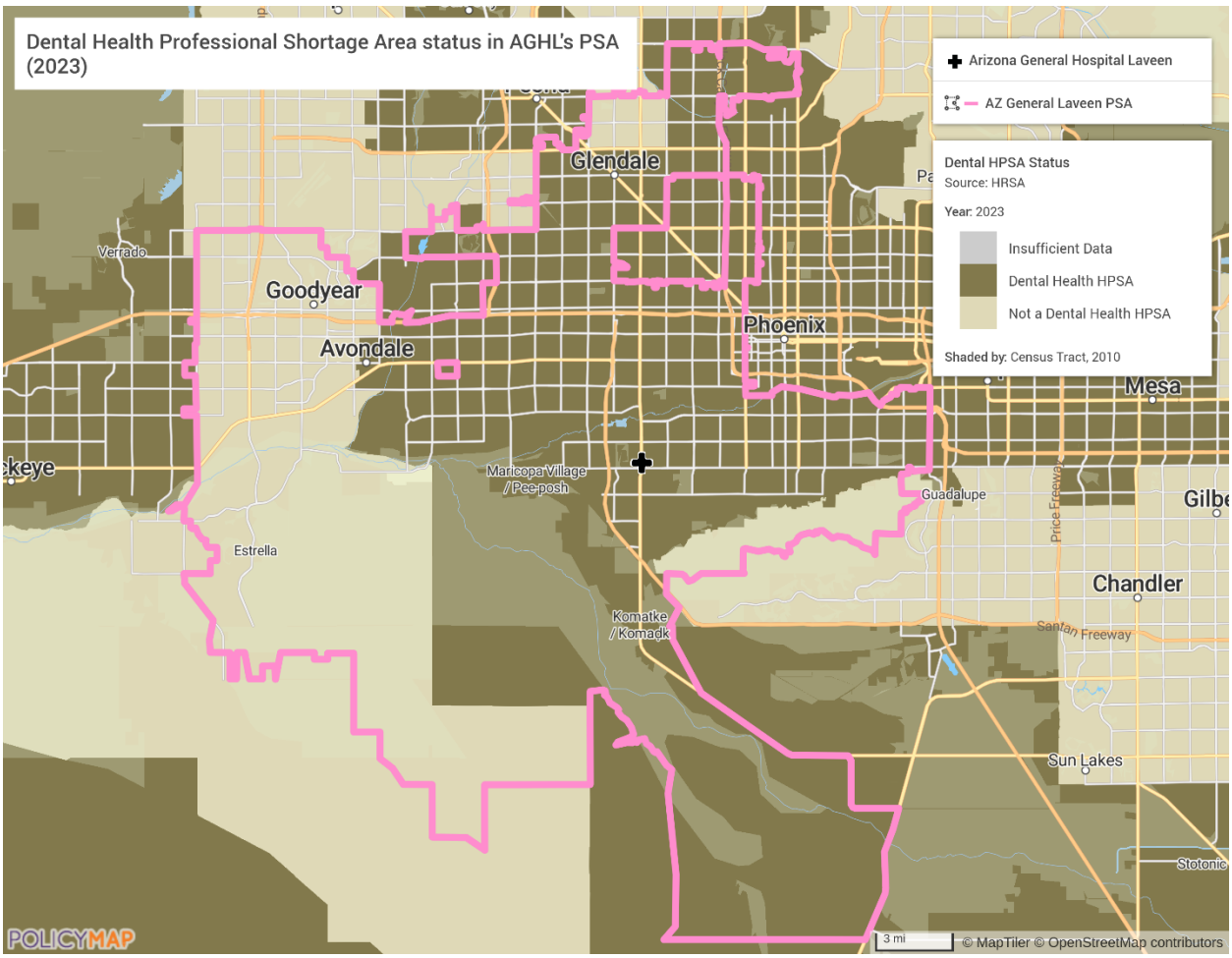


Figure 5. Dental Health Professional Shortage Areas Status in AGHL's PSA

Evaluating primary care, mental, and dental health professional shortage areas in AGHL's PSA is crucial for effectively allocating resources and minimizing overlapping efforts to address the identified health needs. This targeted approach supports AGHL in strengthening its commitment to addressing health disparities, ensuring that everyone in the community has the opportunity to receive the care they need.

Assessment, Process, and Methods

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

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

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

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

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

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

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

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

2023/2024 CHNA Focus Groups Overview[vi] (Appendix D)

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

From September to December 2024, Maricopa County Department of Public Health collaborated with AGHL to conduct a supplemental focus group with six participants at the Queen Creek Chamber of Commerce. The purpose of this focus group was to identify additional community needs, strengths, and challenges in AGHL's PSA. This focus group entailed four stages: planning and recruitment, data collection, analysis, and reporting. The findings are used throughout the report to support the identified CHNA priorities.

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

During January—May 2024, Maricopa County Department of Public Health contracted with the OMNI Institute to carry out 24 key informant interviews for the CHNA. The 24 participants who were identified for key informant interviews were selected using purposive sampling. Participants were chosen across geographical regions around the county, and they were in key leadership and senior management roles and could speak to their organization's work in communities (e.g., Executive Director, Deputy Director,

Community Outreach and Engagement Supervisor, etc.). Findings from this assessment were grouped into three main categories: community strengths and assets, built environment, and forces of change.

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

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

Population Health Framework

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

Hospital Discharge Data (HDD)

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

Vital Records Data

Maricopa County Department of Public Health receives annual vital records for birth and death data from Arizona Department of Health Services for the previous year. The data in this report pertain to deaths of Maricopa County residents only, including those who passed away within Maricopa County and those who passed away elsewhere. However, some out-of-state deaths of Maricopa County residents may not be captured due to data sharing between states. Data are reported based on the date of death. Causes of death are defined by using ICD-10 codes.

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

Population Data

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

Calculating Rates

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

Initial Round of Health Indicators

Primary and secondary data were used to assess the current needs of the community they serve. AGHL's Community Health team engaged internal leadership to gather input on the initial health indicators. **Table 4** displays the list of 30 health indicators that AGHL selected for initial evaluation, which doesn't reflect any ranking. For the health indicators, hospital discharge and PolicyMap data were used for analysis.[viii, xvii]

Population Demographics	• Education, Income/Poverty, Employment Status
Access to Health Care	• Health Insurance Coverage, Primary Payer Type (IP/ED)
Birth	• Low Birth Weight, Preterm Births • Infant Mortality Rate
Cancer	• Breast • Cervical • Colorectal • Lung • Prostate
Chronic Disease	• Chronic Obstructive Pulmonary Disease • Asthma • High Blood Pressure • Diabetes • Alzheimer's • Obesity • Stroke • Cardiovascular Disease • Congestive Heart Failure
Mental Health	• All Mental/Behavioral Disorders
Behavioral Health Risk Factors	• Alcohol-related • All Drug Overdoses • Opioids – Unintentional Overdose • Youth Alcohol/Drug Use/Vaping
Injury	• Intentional Self-Harm/Suicide • Motor Vehicle Crash • Fall-related Injury • Violence-related, Teen Against Teen Violence/Bullying
Social Determinants of Health	• Nutrition/Diet, Access to Food: Low Income Low Access (food insecurity for families experiencing poverty) • Transportation: No Vehicle Households • Housing: Cost Burdened (housing for families experiencing poverty, homeless population)

Table 4. AGHL's Initial Round of Health Indicators

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

Input Solicitation

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

The Community Health Committee (CHC) plays a key role in ensuring that the hospital Community Board is actively involved in establishing and monitoring priorities, plans, and programs aimed at improving the health status of the communities served. Representing a broad range of stakeholders, the committee meets regularly to contribute to the hospital's CHNA focused on addressing health needs. It also provides a voice for those who may benefit from the Dignity Health Community Investment and Community Health Improvement programs. For this CHNA prioritization process, AGHL organized two meetings with members of Dignity Health's CHC and Community Grants Committee, community-based organizations, and Dignity Health leadership to leverage their expertise and community insights. The full prioritization process is shared in the section "Prioritized Description of Significant Community Health Needs."

CHNA Prioritization Meetings

August 20, 2024 – CHC, Community Grants Committee, Community-Based Organizations, Community Members, Hospital Community Board, Dignity Health Leadership: During this meeting, participants engaged in a scoring activity to help narrow down 30 indicators to 15 indicators. Participants noted that the results aligned with their work and reflected the trends observed in the communities they serve. Following the workshop, participants received meeting notes, preliminary priority results, and a survey to offer one final opportunity for input on the health and social priorities.

September 17, 2024 – CHC: During this meeting, participants engaged in a similar scoring activity to select six final health priorities and their associated sub-priorities from the 15 data indicators identified at the August prioritization meeting. Following the workshop, AGHL's Community Health Team followed up with the CHC to gather additional feedback and confirm alignment on the proposed priorities.

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

Assessment Data and Findings

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

Population Indicator Data for Initial Round of Health Needs

Of the 30 total health indicators reviewed by AGHL during the initial round of prioritization, **Table 5** below ranks 23 indicators (listed in no particular order) with available HDD data (IP/ED) or Death data based on 2022 overall age-adjusted rates per 100,000 population.[xvii] Higher rankings below indicate a higher priority in AGHL's PSA. Color gradients visually distinguish the rankings. The **top five** across multiple categories (IP/ED/Death) include: cardiovascular disease, all mental/behavioral disorders, and violence-related injuries.[xvii]

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

Indicator	IP	ED	Death
All Cancers	*		2
Breast Cancer	*		**
Cervical Cancer	*		**
Colorectal Cancer	*		**
Lung Cancer	*		10
Prostate Cancer	*		**
Stroke	4	**	7
Cardiovascular Disease	1	2	1
Congestive Heart Failure	**	**	4
Diabetes	6	6	**
Alzheimer's	**	**	**
Obesity/Overweight	10	**	**
Chronic Obstructive Pulmonary Disease	**	9	8
Asthma	**	5	**
High Blood Pressure	**	8	**
All Mental/Behavioral Disorders	2	4	*

Alcohol-related Injuries	**	**	9
All Drug Overdoses	**	10	5
Opioids- Unintentional Overdose	**	**	6
Intentional Self-Harm/Suicide	**	**	**
Motor Vehicle Crash	9	3	**
Fall-related Injuries	7	1	**
Violence-related (assault-related injuries)	8	7	3

Table 5. Top Health Issue Indicators in AGHL's PSA

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

*** Indicator didn't rank top 10.*

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

- **Race/Ethnicity:** Black/African American and American Indian/Alaska Native populations experienced higher rates of diabetes, violence related, and all drug overdoses.

- **Age:** Older adults (65+ years) had higher rates of breast/colorectal/lung/prostate cancer, chronic obstructive pulmonary disease, and stroke, while younger adults (25-44 years) showed higher rates of all mental and behavioral disorders, all drug overdoses, and assault-related injuries.

- **Sex:** Males had higher rates of lung cancer, cardiovascular disease, diabetes, and alcohol-related injuries.

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

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

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

<table>
<tr><th colspan="4">Significant Health Needs by Disproportionately Affected Populations in AGHL's PSA</th></tr>
<tr><th></th><th>Race/Ethnicity</th><th>Age (years)</th><th>Gender</th></tr>
<tr><td>Low Birth Weight*</td><td rowspan="5">Black/African American</td><td rowspan="2">25-44</td><td>Female</td></tr>
<tr><td>Preterm Births*</td><td>Male</td></tr>
<tr><td>Infant Mortality Rate*</td><td colspan="2">Data Not Available</td></tr>
<tr><td>All Cancers**</td><td rowspan="2">65+</td><td>Male</td></tr>
<tr><td>Breast Cancer**</td><td rowspan="3">Female</td></tr>
<tr><td>Cervical Cancer**</td><td>Hispanic/Latino</td><td>45-64</td></tr>
<tr><td>Lung Cancer**</td><td rowspan="3">Black/African American</td><td rowspan="3">65+</td></tr>
<tr><td>Colorectal Cancer**</td><td rowspan="2">Male</td></tr>
<tr><td>Prostate Cancer**</td></tr>
<tr><td>Stroke</td><td rowspan="2">IP/ED/Death: Black/African American</td><td rowspan="2">IP/ED/Death: 65+</td><td>IP/Death: Male
ED: Female</td></tr>
<tr><td>Cardiovascular Disease</td><td rowspan="3">IP/ED/Death: Male</td></tr>
<tr><td>Congestive Heart Failure</td><td>IP/Death: Black/African American
ED: White</td><td>IP/ED/Death: 65+</td></tr>
<tr><td>Diabetes</td><td>IP/ED: Black/African American
Death: American Indian/Alaska Native</td><td>ED: 45-64
IP/Death: 65+</td></tr>
</table>

	Race/Ethnicity	Age (years)	Gender
Alzheimer's	IP/Death: White ED: Hispanic/Latino	IP/ED/Death: 65+	IP/ED/Death: Female
Obesity/ Overweight	IP: Black/African American ED/Death: White	IP: 25-44 ED: 45-64 Death: 65+	IP/ED: Female Death: Male
Chronic Obstructive Pulmonary Disease		IP/ED/Death: 65+	IP/ED/Death: Female
Asthma	IP/ED: Black/African American Death: White	IP/ED: 0-14 *Death: Counts <5*	IP/ED/Death: Female
High Blood Pressure	*IP: Counts <5* ED/Death: Black/African American	*IP: Counts <5* ED/Death: 65+	
All Mental/Behavioral Disorders**	IP/ED: American Indian/Alaska Native	IP/ED: 25-44	IP/ED: Male
Alcohol-Related Injuries	IP/ED/Death: American Indian/Alaska Native	IP/Death: 45-64 ED: 25-44	IP/ED/Death: Male
All Drug Overdoses	IP/ ED: Black/African American Death: American Indian/Alaska Native	IP: 25-44 ED: 15-24 Death: 45-64	IP/ Death: Male ED: Female
Opioids - Unintentional Overdose	IP: Black/African American ED/Death: American Indian/Alaska Native	IP/ED/Death: 25-44	IP/ED/Death: Male
Intentional Self-Harm/Suicide	IP/ED: Black/African American Death: White	IP/ED: 15-24 Death: 45-64	IP/ED: Female Death: Male
Motor Vehicle Crash	IP/ED/Death: Black/African American	IP: 25-44 ED: 15-24 Death: 65+	IP/Death: Male ED: Female
Fall-related Injuries	ED: Black/African American IP/Death: White	IP/ED/Death: 65+	IP/ED/Death: Female
Violence-related (assault-related injuries)	IP/ED: Black/African American Death: American Indian/Alaska Native	IP: 65+ ED: 15-24 Death: 45-64	IP/Death: Male ED: Female

Table 6. Populations with the Greatest Rates of IP/ED/Death in AGHL's PSA

Community Input

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

Figure 6 displays 2023 CHNA survey data, highlighting the proportions of top health issues, access to care solutions, and the lowest and highest rated community assets as reported by survey respondents and/or the people they lived with or cared for.[v]

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

Figure 6. 2023 CHNA Survey Top Outcomes

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

Lowest-Rated Community Assets

Race/Ethnicity:

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

Special Population:

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

Highest-Rated Community Assets

Race/Ethnicity:

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

Special Population:

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

Figure 7 highlights themes identified from the 2023 CHNA focus groups with 366 participants from underserved and minority populations.[vi]

Figure 7. 2023 CHNA Focus Group Themes

Figure 8 highlights key themes from the 2024 key informant interviews with 24 key informants from 15 business, health, and community sectors.[vii]

Community Strengths and Assets

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

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

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

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

Built Environment

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

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

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

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

Forces of Change

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

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

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

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

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

Figure 8. 2024 CHNA Key Informant Interview Themes

Social Vulnerability Index

Social vulnerability describes populations at higher risk of harm from disasters, climate change, and extreme weather. To identify and support these areas, the Center for Disease Control and Prevention's Geospatial Research, Analysis, and Services Program created the Social Vulnerability Index. This index highlights communities that may need extra help during and after crises, focusing on four vulnerability categories: socioeconomic status, household composition and disability, minority status and language, and housing and transportation.[xxii] **Figure 9** shows the social vulnerability index in AGHL's PSA, with the following cities displaying high to moderate social vulnerability levels: *Glendale*, *Avondale*, *Phoenix*, and in the GRIC (*Maricopa Village* and *Komatke*).[xvii]

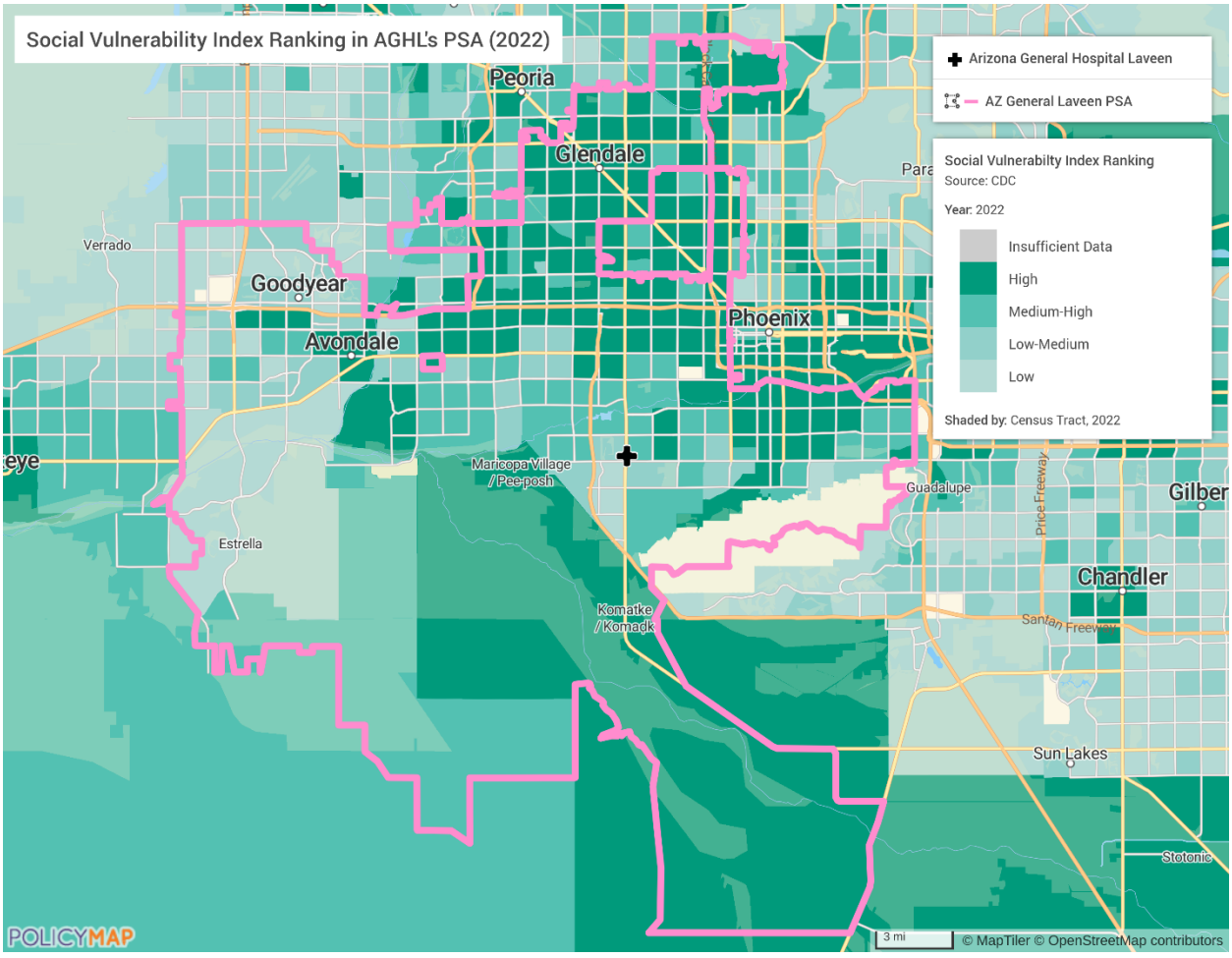


Figure 9. Social Vulnerability Index Map in AGHL's PSA

Vizient Vulnerability Index

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

- Economic
- Education
- Healthcare Access
- Neighborhood Resources
- Housing
- Clean Environment (EPA)
- Social Environment
- Transportation
- Public Safety

High vulnerability neighborhoods have barriers to care that exceed the national average and face greater challenges in accessing healthcare and resources.[xxiii] **Figure 10** highlights the domain areas and zip codes in AGHL's PSA classified as high vulnerability.

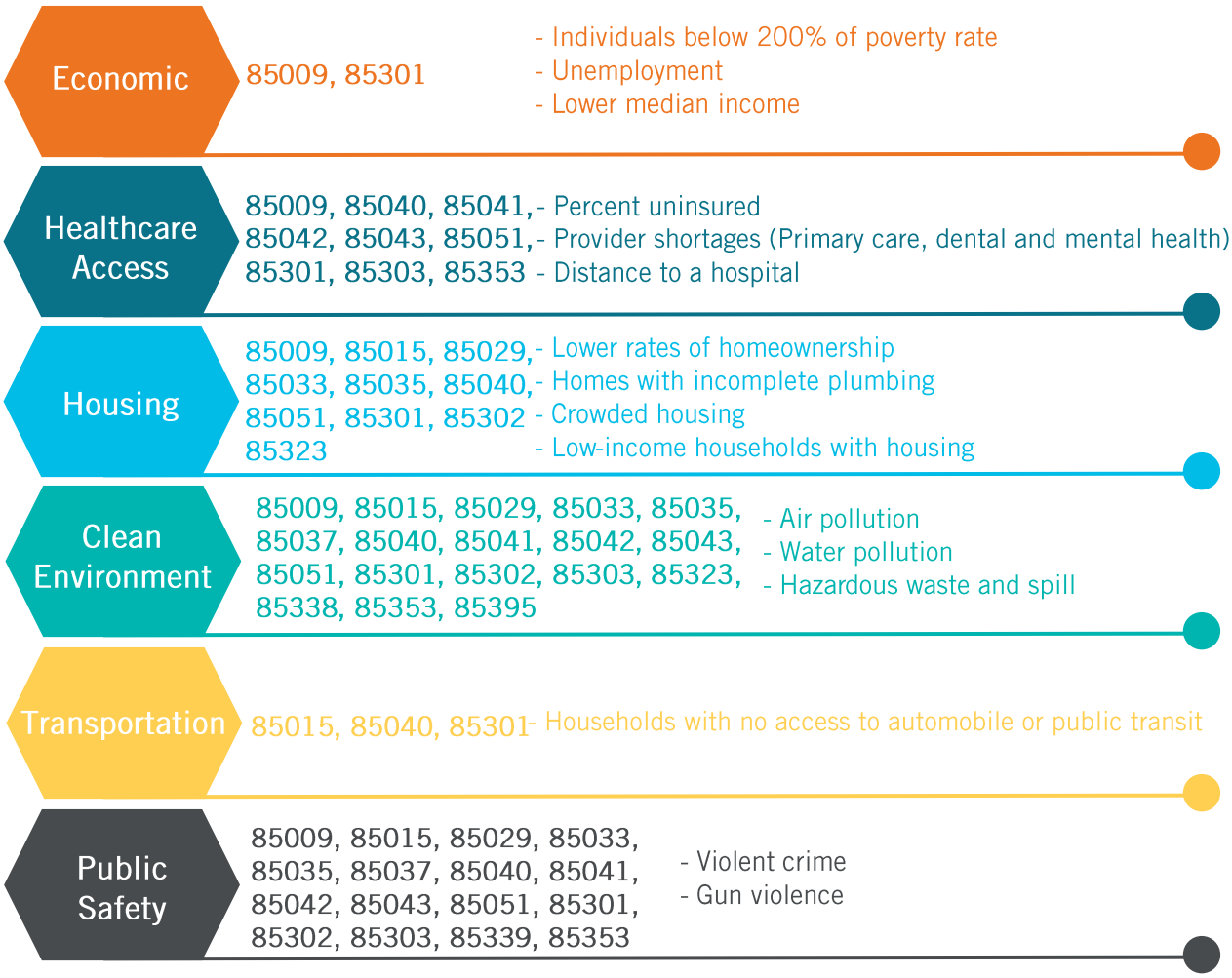


Figure 10. Vizient Vulnerability Index in AGHL's PSA

Climate and Health

CommonSpirit Health's mission focuses on enhancing the health of the communities they serve in mind, body, and spirit. A healthy environment is crucial for achieving better health outcomes, as access to clean air, fresh water, and fertile soil for growing food is fundamental to well-being. To foster healthier communities, CommonSpirit Health is committed to environmental sustainability efforts.[xxiv] Although AGHL did not identify climate and health as a significant health need in the CHNA, addressing climate and health remains essential for fostering healthier communities.

Derived from the Climate and Economic Justice Screen Tool, **Figure 11** displays disadvantaged communities that face burdens in climate change.[xvii] A census tract is considered disadvantaged if it meets thresholds in areas like environment, climate, housing, or health, has a socioeconomic burden (income/education), is surrounded by disadvantaged areas, and has over 50% low income.[xxv] Communities like *Avondale*, *Phoenix*, and in the GRIC (*Maricopa Village* and *Komatke*) have increased vulnerability to climate change.[xvii]

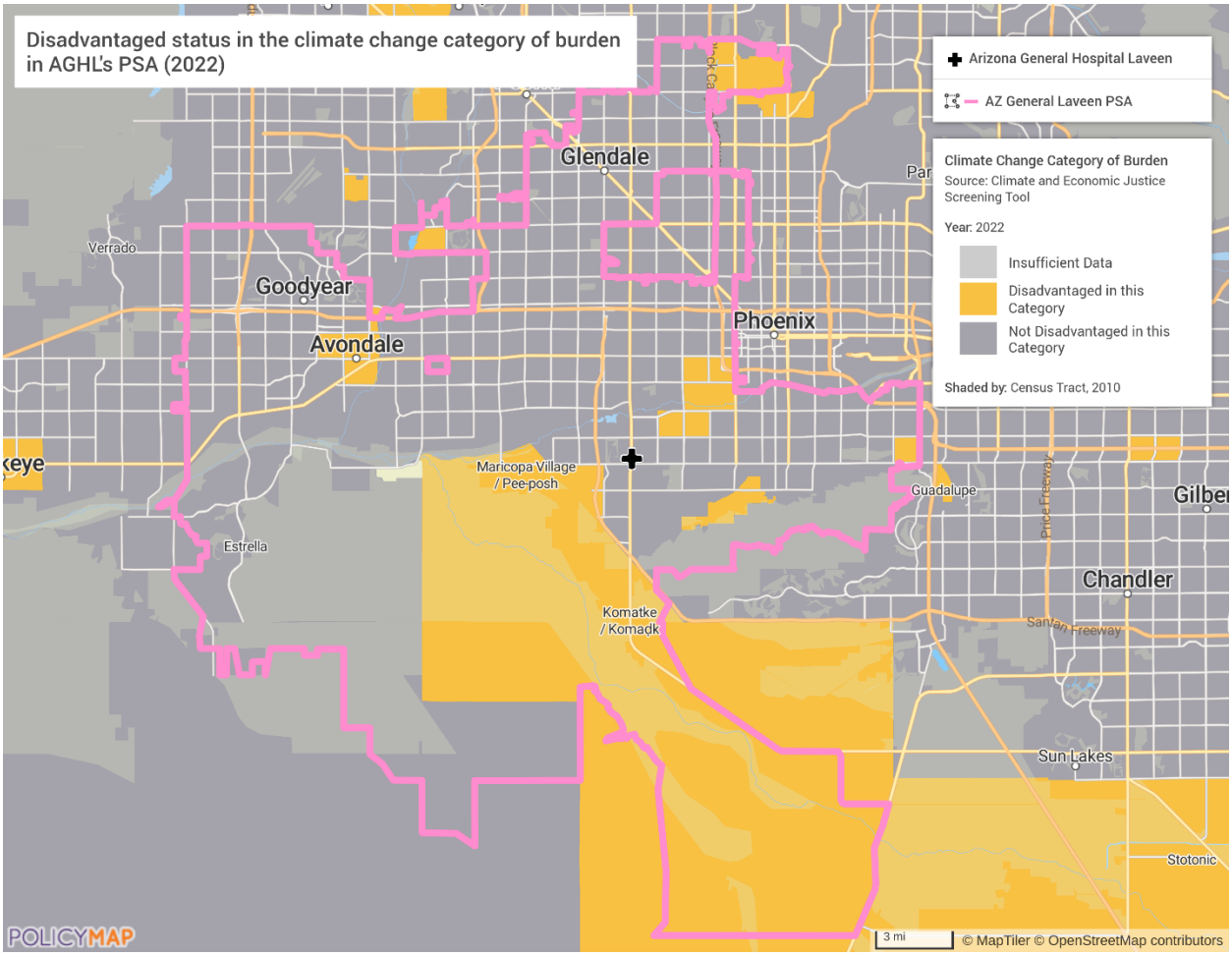


Figure 11. Climate Change Burden in AGHL's PSA

As global temperatures rise and weather patterns shift, the effect of climate change become increasingly apparent. While climate change is a widespread global issue, its consequences are not experienced equally around the world. In fact, its effects are often felt more intensely on a local and regional scale, where specific communities face unique challenges and vulnerabilities. The National Institute of Environmental Health Sciences leads the National Institute of Health's efforts to better understand climate change and health.[xxvi] Due to the state's unique climate and environmental conditions, AGHL identified the following indicators of focus: extreme heat, outdoor air quality, drought, and pollution. **Figure 12** demonstrates examples of extreme heat and outdoor air quality impacts on health.[xxvii]

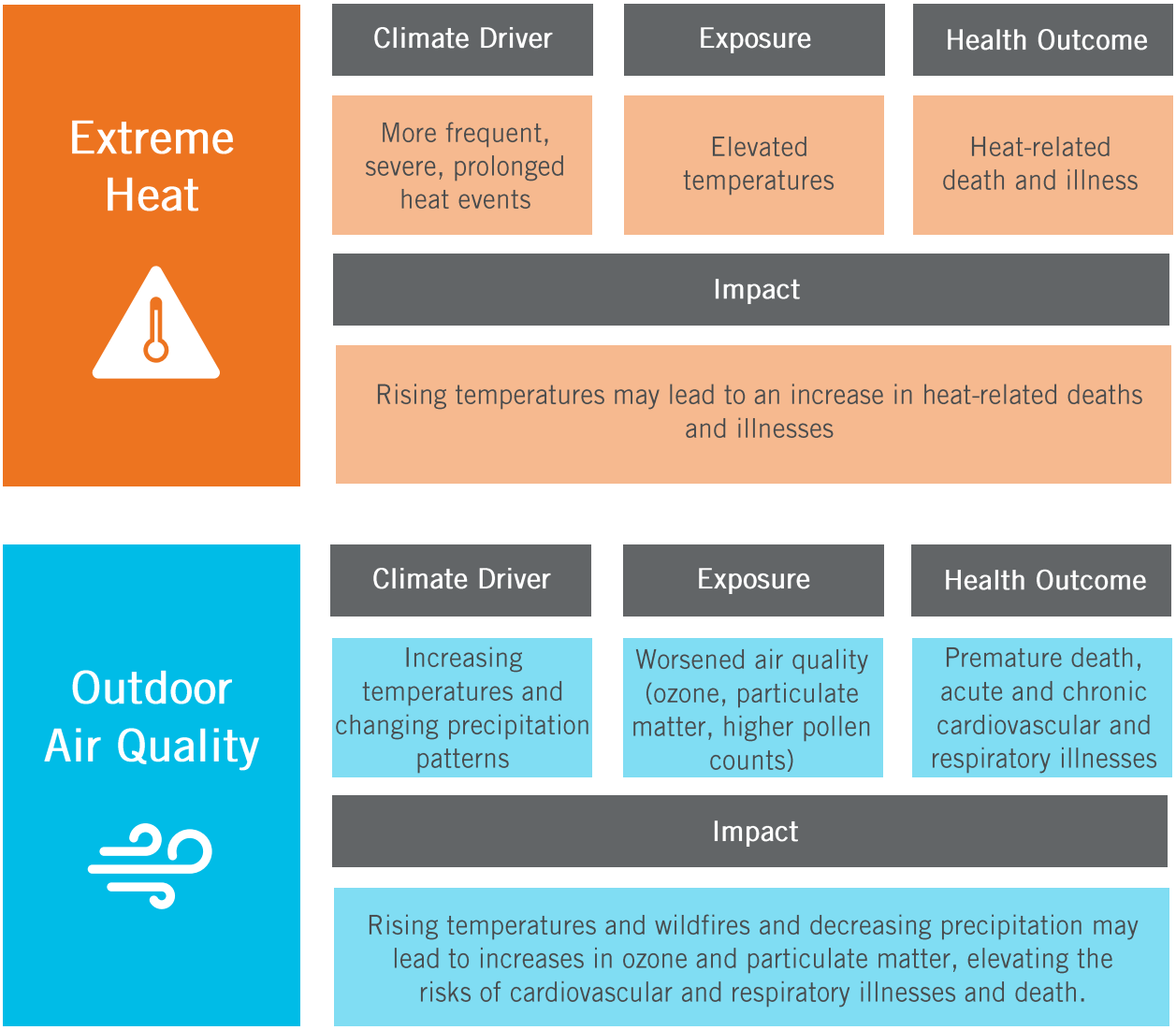


Figure 12. Examples of Extreme Heat and Outdoor Air Quality Impacts on Health

Major sources of air pollution include modes of transport (polluting fuels and vehicles), inefficient combustion of household fuels for cooking, lighting, and heat, coal-fired power plants, agriculture, and waste burning. Exposure to high levels of air pollution can increase health risks such as respiratory infections, heart disease, stroke, and lung cancer.[xxviii] Pollution from these sources release fine particles known as particulate matter, which significantly contribute to poor air quality. Particulate matter is defined as a mixture of solid particles (dust, dirt, soot, or smoke) and liquid droplets found in the air.[xxix] **Figure 13** shows the particulate matter 2.5 level in air in AGHL's PSA.[xvii]The particulate matter 2.5 (PM2.5) indicator measures the potential exposure to inhalable particles 2.5 microns or smaller (about 30 times smaller than the width of human hair) in terms of annual average concentration in micrograms per cubic meter. This indicator is normalized to the nation and the southwestern part of AGHL's PSA face more exposure to PM2.5.[xvii]

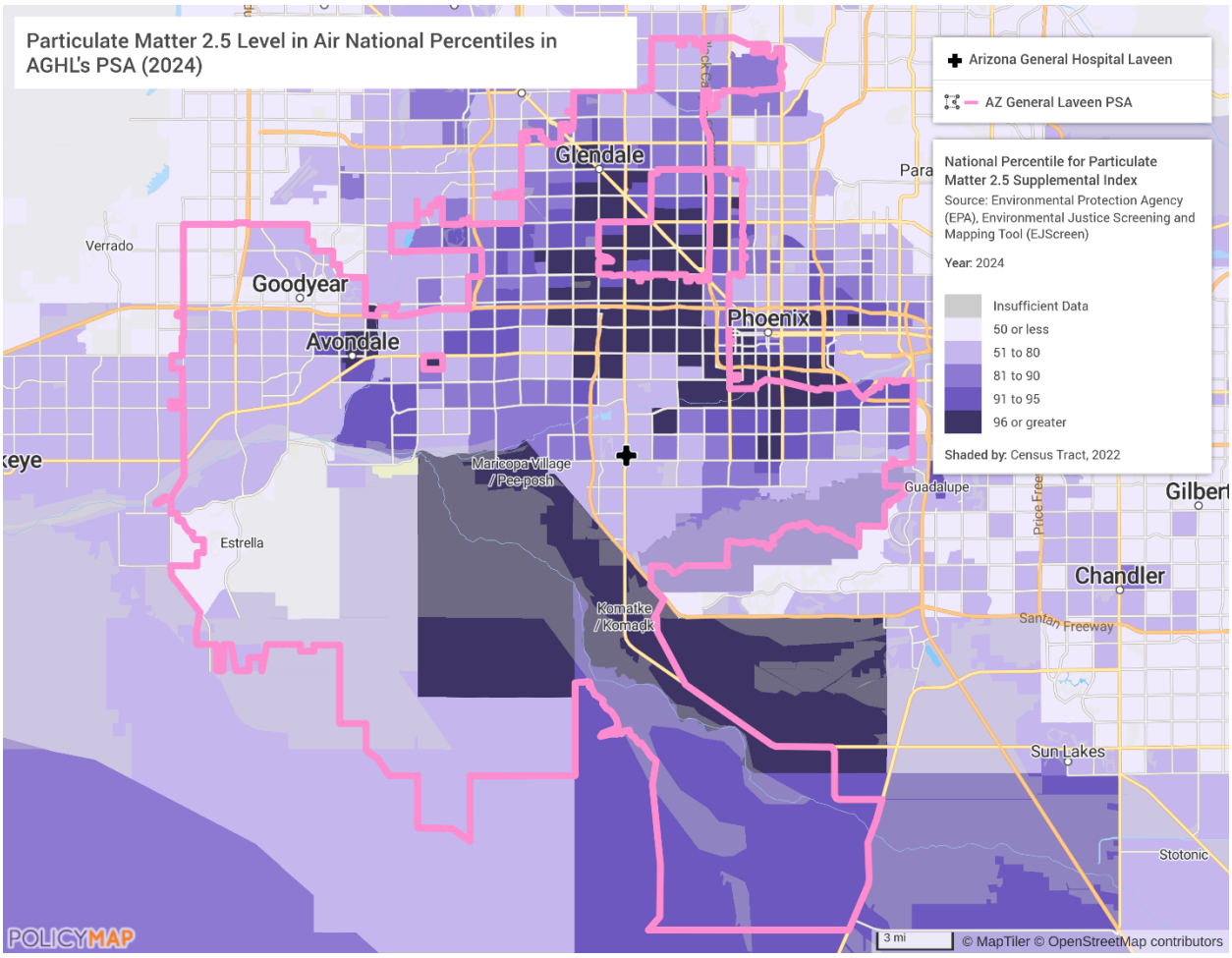


Figure 13. Particulate Matter 2.5 Level in Air National Percentiles in AGHL's PSA

Addressing drought is essential not only to protect the environment but also to safeguard public health and well-being. Drought increases the risk of various health outcomes including malnutrition, poor air quality, increase of disease vectors, and even mental health.[xxx] People at elevated health risk from drought exposure include those who:

- Have increased exposure to dust (e.g., people experiencing homelessness and/or work outdoors)
- Rely on water from private wells and small/poorly maintained municipal systems
- Work in agriculture and/or live in an agricultural community
- Have increased biologic sensitivity (e.g., those under age five, are age 65 or over, are pregnant, and/or have chronic health conditions such as a mental illness or a respiratory disease

Figure 14 displays the 2023 risk index rating for droughts in AGHL's PSA. Communities like in the GRIC (*Maricopa Village* and *Komatke*) and areas in *Goodyear* and *Avondale* have relatively higher drought risk compared to other communities.[xvii]

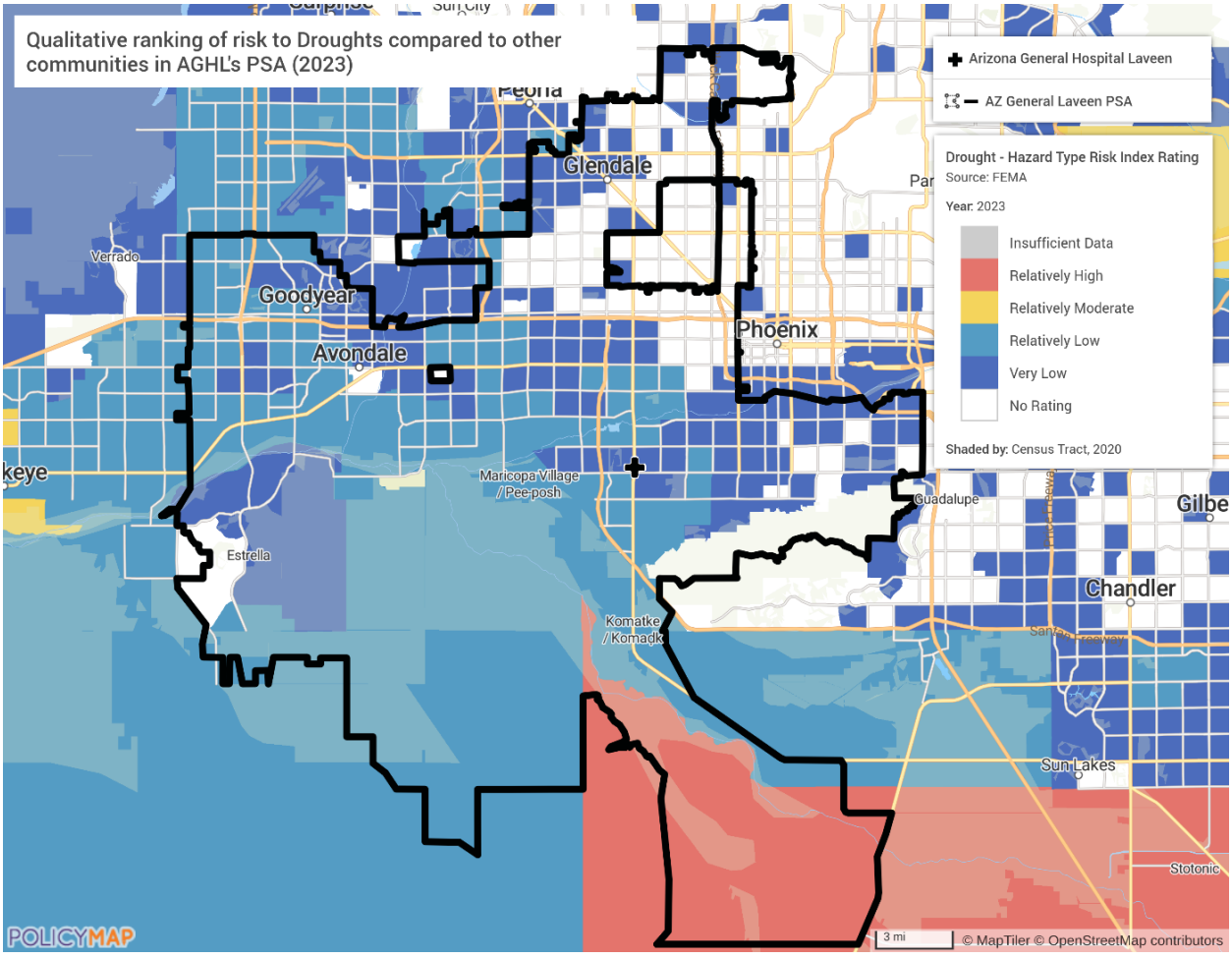


Figure 14. Risks to droughts in AGHL's PSA (2023)

Equity Lens

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

Health Equity

...is the commitment to remove barriers to a fair and just opportunity to be as healthy as possible, especially among underserved, poor, and vulnerable populations.

Social Equity

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

Racial Equity

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

Process to Prioritize Significant Community Health Needs

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

A total of 30 health and social indicators were established in collaboration with AGHL, selected based on disparities analyzed by race/ethnicity, sex, and age within AGHL's PSA. Of the indicators that were analyzed, a top 10 ranking chart along with more detailed data for IP, ED, and death were presented to the CHC, Community Grants Committee, community-based organizations, and internal leadership. AGHL and Maricopa County Department of Public Health co-designed and implemented a three-phased prioritization process **(Figure 15)**.

Figure 15. Phases of AGHL's Prioritization Process

Phase One

In Phase One, AGHL's Community Health team reviewed a comprehensive data workbook with 73 health and social indicators provided by the Maricopa County Department of Public Health Division of Epidemiology and Informatics. To streamline the process, the team identified and selected 30 indicators, prioritizing those that highlighted existing disparities and aligned with the focus areas of AGHL. These 30 indicators were selected for further in-depth analysis in the CHNA process to identify the most pressing needs within the PSA.

Phase Two

In Phase Two, Maricopa County Department of Public Health facilitated two prioritization workshops to narrow down the 30 data indicators. Before the workshops, AGHL collaborated with Maricopa County Department of Public Health to develop a set of prioritization criteria **(Figure 16)** to guide the process. These criteria, used with various other Synapse partners throughout their prioritization process, were tailored to meet the needs of AGHL and the workshop participants.

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

Figure 16. Prioritization Criteria

Prioritization Meeting 1

This meeting included the CHC, Community Grants Committee, community-based organizations, Dignity Health Executive Leadership, and external stakeholders (local town, faith community and governance, community members). At this in-person workshop, Maricopa County Department of Public Health provided a detailed review of the data for the 30 initial indicators. After reviewing the data for each indicator, participants were invited to score them based on the established criteria, using a scale of one (does not meet the criteria) to five (meets criteria). The scoring activity was facilitated through Menti, an interactive polling platform. **Figure 17** displays an example of the scoring activity for one of the 30 total indicators reviewed. This activity was conducted for all 30 health indicators.

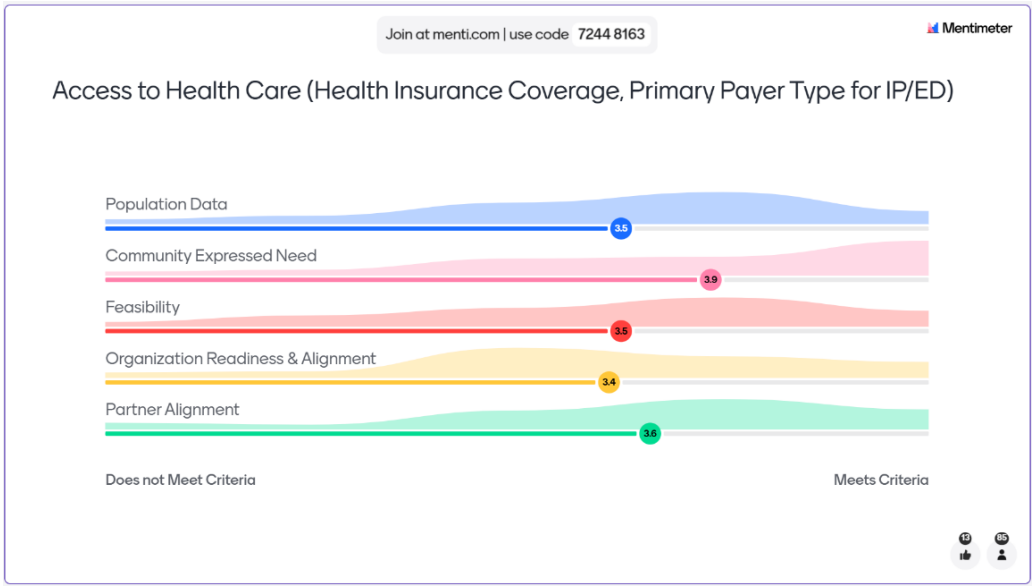


Figure 17. Prioritization Activity #1 Menti – Criteria for Rating Access to Health Care

Once scores for each criteria were provided for all indicators, the average score for each criteria was calculated. Then, the average scores for each criteria were combined to determine an overall average for each data indicator. The indicators were ranked in descending order based on their overall averages to identify the top 15 indicators, which advanced to the next round of prioritization in September **(Table 7)**.

Indicator	Average Rating
Cardiovascular Disease	3.936
All Mental & Behavioral Disorders	3.876
Diabetes	3.856
Access to Health Care	3.612
High Blood Pressure	3.592
Obesity	3.542
Unintentional Overdose (Opioids)	3.490
Housing; Cost Burdened	3.460
Access to Food, Low Income Low Access, Food Insecurity	3.436
Breast Cancer	3.418
Stroke	3.402
All Drug Overdoses	3.328
Intentional Self-Harm/Suicide	3.292
Low Birth Weight, Preterm Births	3.288
Fall-Related	3.282

Table 7. Top 15 Health Indicator Rankings

After the resulting 15 indicators were shared, participants were asked: *"Does this resonate with the work that you do or what you're seeing in the communities that you serve?"*. **Figure 18** displays a snapshot of the results. AGHL's Community Health team reviewed all responses to help inform finalization of priorities.

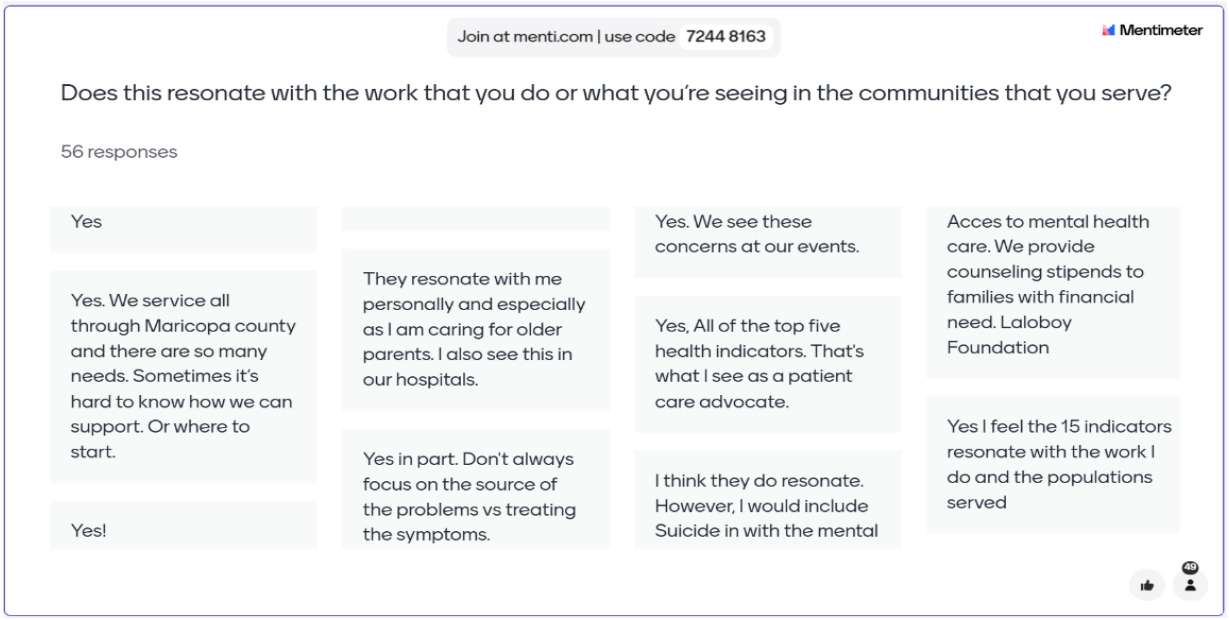


Figure 18. Prioritization Activity #2 Menti

Prioritization Meeting 2

At this hybrid workshop, Maricopa County Department Public Health and hospital community benefit leaders attended in person, while the CHC joined via Zoom. While the CHC attended the first prioritization meeting in August, this workshop served as a core oversight responsibility of the committee to pre-approve the CHNA priorities before the board's approval in May 2025.

During this workshop, Maricopa County Department of Public Health provided a detailed review of the data for the 15 indicators identified in the first prioritization meeting. The goal was to narrow the indicators down from 15 to six to eight. While similar prioritization criteria were used, the definitions were simplified for clarity based on feedback from the first workshop. Menti was used again to score each indicator, building on the success of the first workshop. To help participants better understand how to apply the established criteria for scoring, Maricopa County Department of Public Health developed a new approach, including an example data slide that demonstrated how each criterion applied to the indicator **(Figure 19)**.

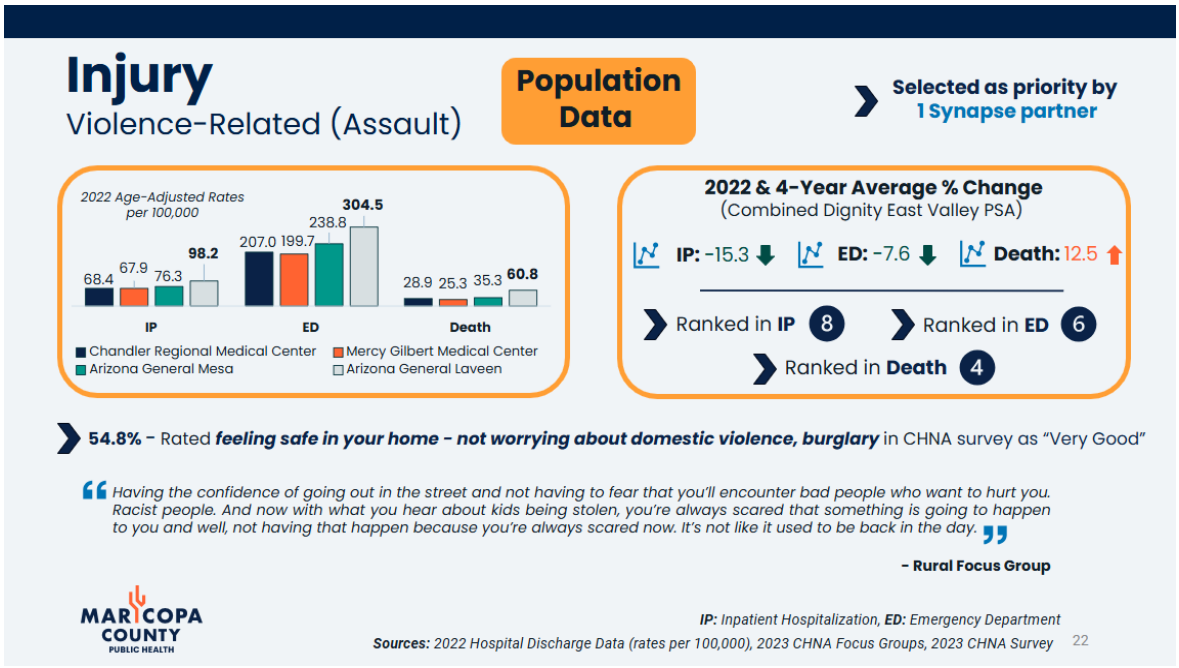


Figure 19. Example Data Indicator Criteria Slide

After this demonstration, participants gained a better understanding of all the criteria, except for "feasibility" and "organizational readiness". To address this, AGHL's Community Health team pivoted and provided supplemental information about current programing and initiatives at the organizational level that could support each health indicator. This approach helped CHC members feel more confident in voting on these two criteria.

Once scores were collected, the Maricopa County Department of Public Health team compiled the average scores, and the results were shared with CHC members **(Table 8)**.

Indicator	Average Rating
All Mental and Behavioral Disorders	4.552
Diabetes	4.398
Cardiovascular Disease	4.382
Breast Cancer	3.850
Access to Health Care	3.800
Obesity	3.750
Access to Food, Low Income Low Access, Food Insecurity	3.698

Table 8. Top 7 Health Indicator Rankings

Phase Three

In Phase Three, AGHL's Community Health team and CHC finalized the CHNA priorities. Following the second prioritization meeting with the CHC, the rating activity and further discussion resulted in a listing of identified priorities, some of which were grouped together. From this discussion, six main priorities with sub-priorities were identified and finalized **(Figure 20)**. After the CHC prioritization meeting, the committee received an email with the proposed recommendations, discussion notes, and request for approval. The proposed recommendations were approved by the CHC.

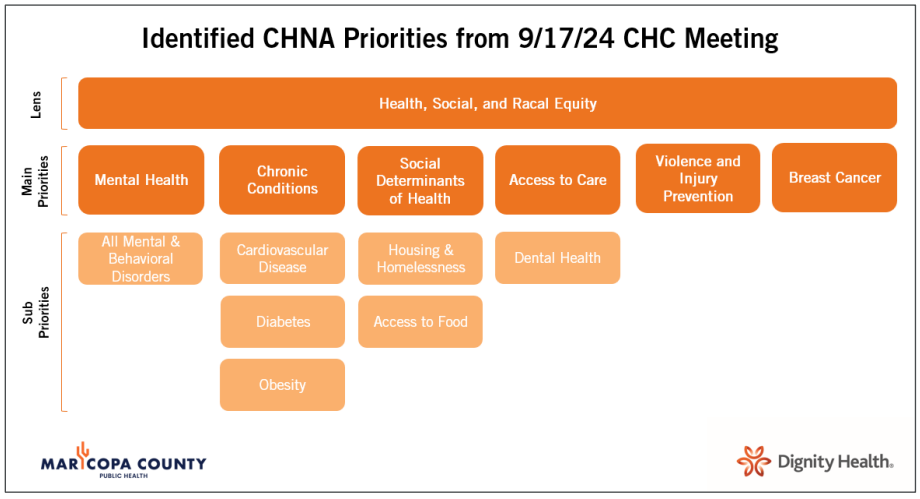


Figure 20. Identified CHNA Priorities from CHC Meeting

Prioritized Community Health Needs

The following section provides detailed primary and secondary data for each of AGHL's CHNA priorities and sub-priorities **(Figure 21)**. For areas with sub-priorities, it's important to note that these represent just one aspect of the broader priority and are not the sole focus, but part of a comprehensive approach to addressing the need. Recognizing disparities in health outcomes based on factors like race/ethnicity, sex, and age is crucial to achieving equitable access to healthcare and improving health outcomes.

Figure 21. AGHL's Final CHNA Priorities

Importance and Impact in AGHL's PSA

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

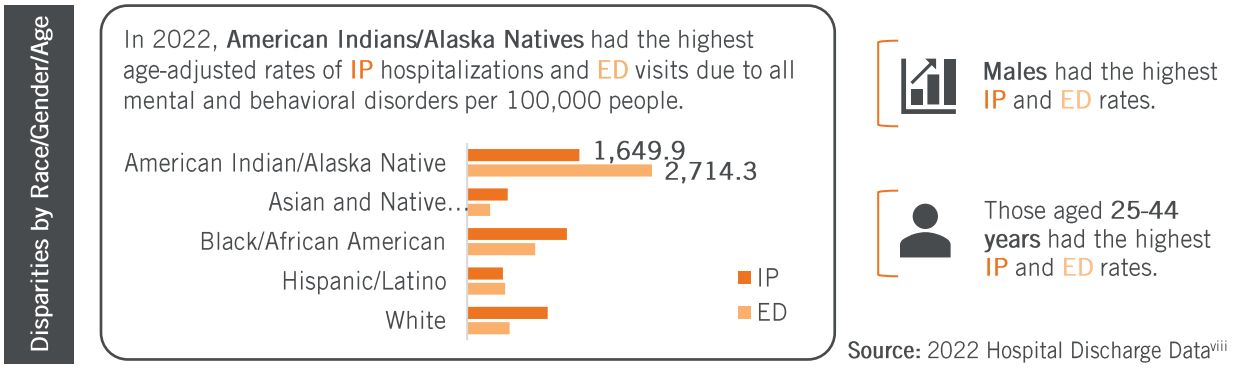


Figure 22. All Mental and Behavioral Disorders – AGHL's PSA

Substance Use and Self-Harm

Substance use and self-harm are closely linked to mental health and can affect physical, emotional, and social well-being. Mental health problems and substance use disorders often occur together, as substances can trigger mental health symptoms, while mental health issues may lead to substance misuse as a form of self-medication.[xxxvi] For many individuals, self-harm provides temporary relief and is used to cope with feelings of loneliness, anger, or hopelessness.[xxxvii]

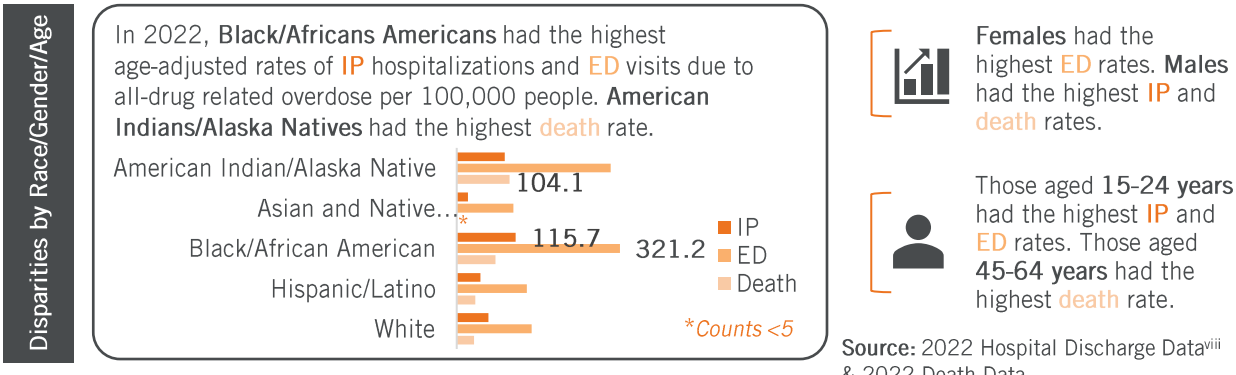
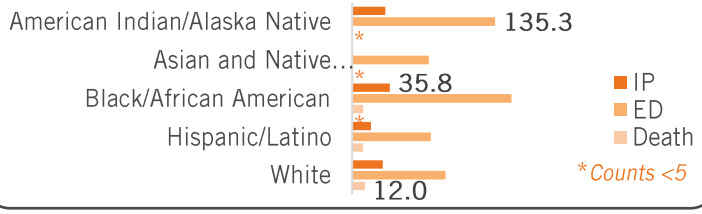


Figure 23. All Drug-Related Overdose – AGHL's PSA

Disparities by Race/Gender/Age

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



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

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

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

Figure 24. Self-Harm/Suicide – AGHL's PSA

Community-Identified Issues in Maricopa County

Recognizing that AGHL's PSA falls within Maricopa County, the following data provides additional insight into mental health based on needs in Maricopa County.

Mental Health Rating

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

Top Health Issues

Almost **4 in 10 (38.5%)** survey respondents indicated **anxiety** and **1 in 3 (33.5%)** indicated **depression** as the top two health issues that have the most impact on them and/or the people they live with or care for. Almost **1 in 10 (8.7%)** indicated **alcohol/ substance misuses** and under **1 in 20 (2.8%)** indicated **intentional injury** as health issues.

Unmet Mental Health Needs

Focus group participants reported that many are unable to receive **adequate formal mental health care** (treatment or support) due to lack of providers, increasing living costs, and long work hours. **Substance use** was identified as a **coping mechanism**, with many individuals **self-medicating** due to **limited access to care**.

Existing Stigma and Illicit Substances

Key informant interviewees highlighted that individuals living with mental health conditions face **stigma**, resulting in **poor treatment** by service providers and **decreased engagement** with services. There is also a **lack of services** for people with substance use disorders, the unhoused , and the undocumented populations.

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

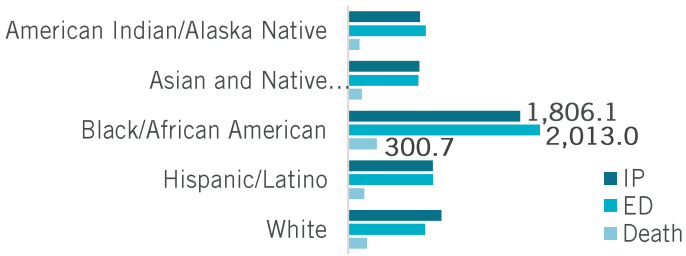
Sources: 2023 CHNA Survey, 2023 Focus Groups, 2024 Key Informant Interviews[v, vi, vii]

Importance and Impact in AGHL's PSA

Chronic conditions, including *cardiovascular disease*, *diabetes*, and *obesity* were selected as significant health needs for AGHL. Cardiovascular disease refers to conditions such as chronic rheumatic heart, hypertensive, ischemic heart, pulmonary heart, pulmonary circulation, cerebrovascular, arteries, arterioles, capillaries, and other forms of heart disease.[xxxviii] Diabetes includes both type 1 and 2 diabetes and other specified diabetes mellitus.[xxxix] Obesity is defined as primary diagnosis of overweight and obesity, including obesity due to excess calories, drug-induced obesity, morbid obesity with complications, and unspecific obesity.[xl] These chronic conditions are often interconnected, as they share common risk factors such as physical inactivity and poor dietary habits.[xli, xlii, xliii] By focusing on prevention and early intervention, the risk of developing additional chronic diseases can be reduced.

Disparities by Race/Gender/Age

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



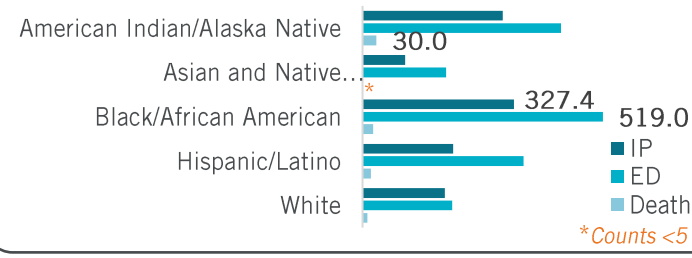
Males had the highest IP, ED, and death rates.

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

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

Figure 25. Cardiovascular Disease – AGHL's PSA

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



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

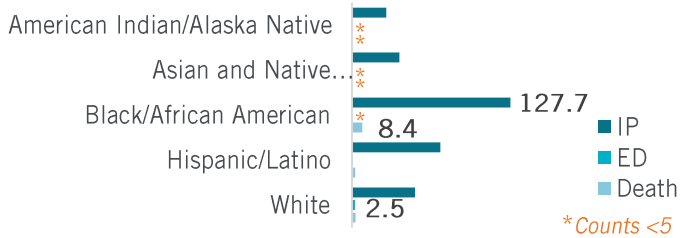
Those aged **45-64 years** had the highest ED rate. Those aged **65+ years** had the highest IP and death rates.

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

Figure 26. Diabetes – AGHL's PSA

Disparities by Race/Gender/Age

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



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

Those aged **25-44 years** had the highest IP rate. Those aged **45-64 years** had the highest ED rate. Those aged **65+ years** had the highest death rate.

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

Figure 27. Overweight – AGHL's PSA

Community-Identified Issues in Maricopa County

Recognizing that AGHL's PSA falls within Maricopa County, the following data provides additional insight into chronic conditions based on needs in Maricopa County.

Top Health Issue

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

Physical Health Rating

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

Prevalence of Obesity + Diabetes

Focus group participants shared they were seeing an increase in **obesity** in their communities, noting the **rising costs of unhealthy food**, **limited healthy food options**, and a **lack of places to be active**. Many participants, across various age groups, reported having or knowing someone with diabetes. They highlighted challenges in **accessing medication**, including issues related to cost, supply, or difficulty setting a specialist.

Experiences with Chronic Disease

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

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

> *...I am also overweight and have started my health more seriously. After losing 40 pounds, I reached a plateau and I want to change my diet but I am always busy and am a recovering picky-eater. I would love to meet with a nutritionist or anyone to help me fix my relationship with food.*
>
> - 2023 CHNA Survey Participant

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

Importance and Impact in AGHL's PSA

Social determinants of health, including *housing and homelessness* and *access to food,* were selected as significant health needs for AGHL. According to Healthy People 2030, social determinants of health are the conditions where people are born, live, work, play, worship, and age that impact their health quality-of-life.[xliv] Housing and food access are closely linked to economic stability and the built environment. People with stable incomes are more likely to afford safe housing and nutritious food, both of which are essential for good health. Housing quality and location can affect stress, mental health outcomes, and environmental risks.[xlv] The availability of food options – such as grocery stores, farmers markets can support or limit healthy eating.[xlvi] Recognizing these connections highlights the importance of having safe, stable housing, and reliable access to nutritious food.

Severely Cost Burdened Renters

Analyzing data on severely cost burdened renters helps to understand housing insecurity and the economic challenges within the community. Severely cost burdened renters are defined as renter households for whom gross rent is 50% or more of household income. In AGHL's PSA, cities like *Tolleson*, *Glendale*, and *Avondale* show higher proportions of severely cost burdened renters **(Figure 28)**.[xvii]

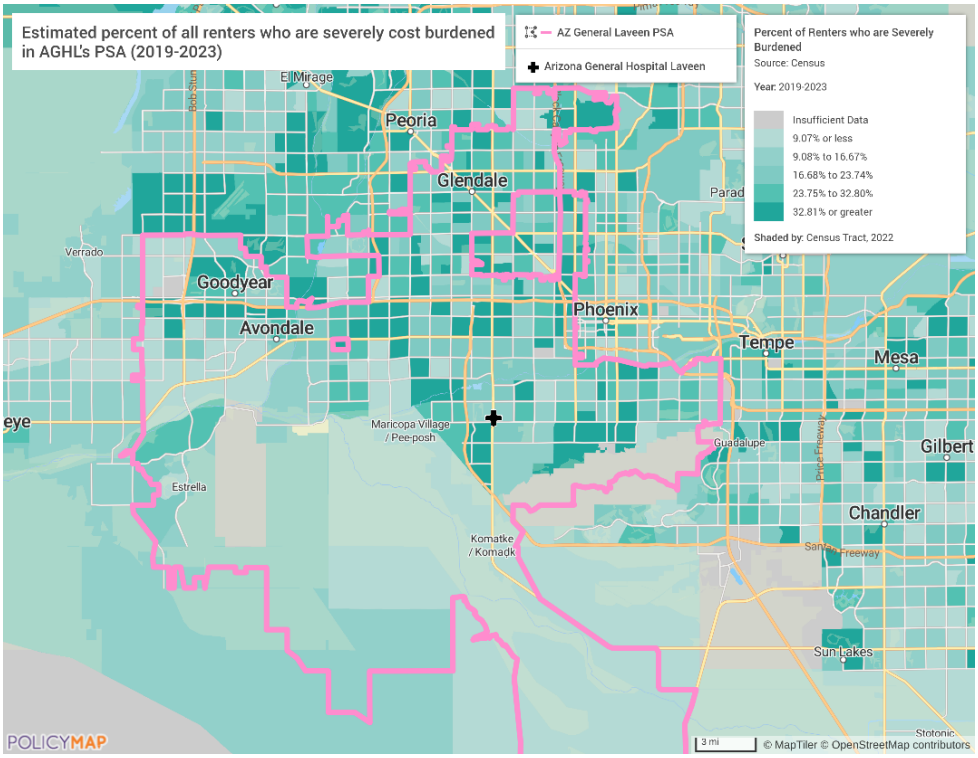
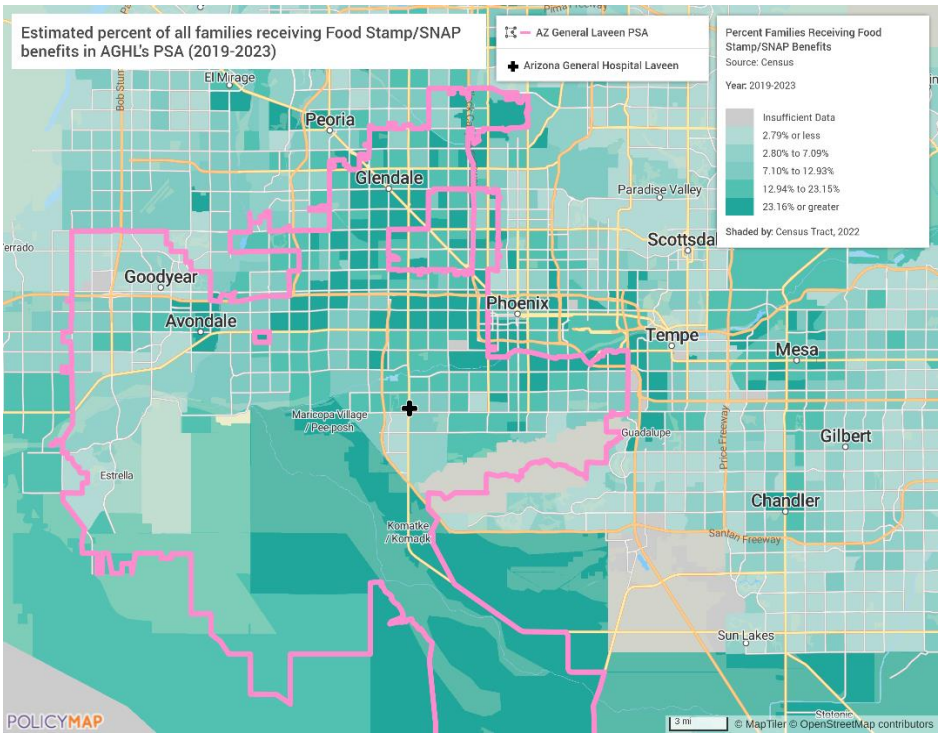


Figure 28. Severely Cost Burdened Renters – AGHL's PSA

Food Stamp/Supplemental Nutrition Assistance Program Benefits

Evaluating data on food stamp and SNAP benefits helps reveal areas with greater food insecurity.



By highlighting these disparities, resources like food assistance programs can be directed to locations with the greatest need. In AGHL's PSA, cities like *Glendale*, *Phoenix*, *Tolleson*, and in the GRIC (*Maricopa Village* and *Komatke*) have higher proportions of families receiving food stamp or Supplemental Nutrition Assistance Program benefits **(Figure 29)**.[xvii]

Figure 29. Families Receiving Food Stamp/Supplemental Nutrition Assistance Program – AGHL's PSA

Community-Identified Issues in Maricopa County

Recognizing that AGHL's PSA falls within Maricopa County, the following data provides additional insight into social determinants of health based on needs in Maricopa County.

Paying for Food and Housing

Over **3 in 10** survey respondents were **"Sometimes"** or **"Never"** able to pay for **food (30.5%)** and **mortgage/rent (30.4%)**.

Rating Community Assets

Over **half (56.3%)** of survey respondents rated **access to affordable healthy foods** and over **7 in 10 (71.9%)** rated **access to affordable housing** as **"Fair"** or **"Poor"** where they live.

Food Deserts

Key informant interviewees shared that **food deserts and limited access to healthy food** are more prevalent in **South Phoenix.** One participant mentioned that the nearest food options in the neighborhood were **convenience stores.**

> *So, the community garden is a way to get fresh produce into food deserts, because in South Phoenix, there are a lot of food deserts. And so, when I see community gardens, like Garden of Tomorrow and these spaces of opportunity, like these different places that folks, community folks come together to meet that need that's one of the examples…that resiliency…*
>
> - 2024 Key Informant Interviewee

Sources: 2023 CHNA Survey, 2024 Key Informant Interviews[v, vii]

Homelessness can affect various social determinants of health, creating significant barriers to health, stability, and well-being. The annual Point-in-Time homeless count tracks the number of people experiencing homelessness in Maricopa County during a given point in time. In 2022, there were 9,026 individuals experiencing homelessness in Maricopa County. From 2018 to 2022, the East Valley saw the second highest growth rate in unsheltered homelessness (*people living on the streets or other place not meant for human habitation*) in the County, which increased by 109%. The municipalities with the highest unsheltered count in 2022 are listed below, two of which are within AGHL's PSA (Mesa and Chandler).[ix]

Top Municipalities - Unsheltered Count

Mesa: 451	Tempe: 384	Chandler: 133	Scottsdale: 114	Guadalupe: 64

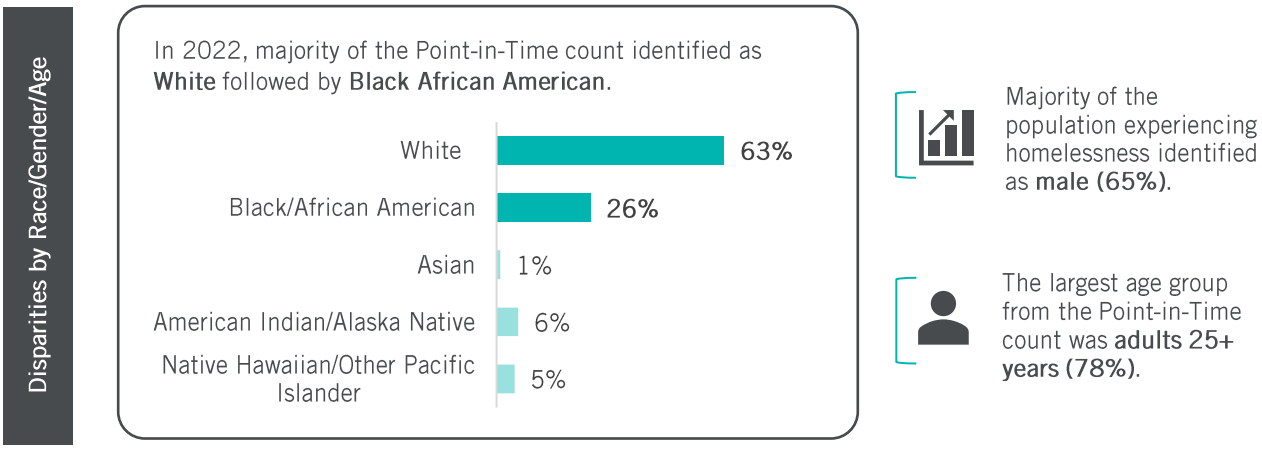


Figure 30. 2022 Maricopa County Point-in-Time Count by Race/Ethnicity

Food Insecurity

According to the U.S Department of Agriculture, food insecurity is defined as the lack of access, at times, to enough food for an active, healthy life. Key factors contributing to food insecurity include unemployment, poverty, and income shocks, which can hinder access to sufficient food. In 2022, 530,930 (12%) of individuals in Maricopa County were food insecure.[xv]

By Race/Ethnicity

25% Black/African American	18% Latino	10% White/Non-Hispanic

Sources: 2023 CHNA Survey, 2024 Focus Groups, Key Informant Interviews[v, vi, vii]

Importance and Impact in AGHL's PSA

Access to care, including *dental health*, was selected as a significant health need for AGHL. The concept of access to care varies based on community needs and perspectives. The National Academies of Sciences, Engineering, and Medicine defines access to health care as the "timely use of personal health services to achieve the best possible health outcomes."[xlvii] Having access to comprehensive, quality healthcare is essential for supporting health, preventing, and managing disease, and reducing premature death. According to County Health Rankings and Roadmaps, health insurance, local care options, and a usual source of care are key factors that ensure access to health care.[xlviii] Access to care is also closely tied to social determinants of health, such as income, employment, proximity to healthcare facilities, education, and social networks, all of which affect an individual's ability to receive access care.

Insurance Coverage

Health insurance coverage plays a critical role in supporting the health and well-being of individuals and communities. Studies show that it improves access to care, leads to better health outcomes, encourages the appropriate use of health care resources, and reduces financial strain.[xlix] In AGHL's PSA, cities such as *Phoenix*, *Avondale*, *Glendale*, Tolleson, and in the GRIC (*Maricopa Village* and *Komatke*) have higher proportions of people without health insurance **(Figure 31)**.[xvii]

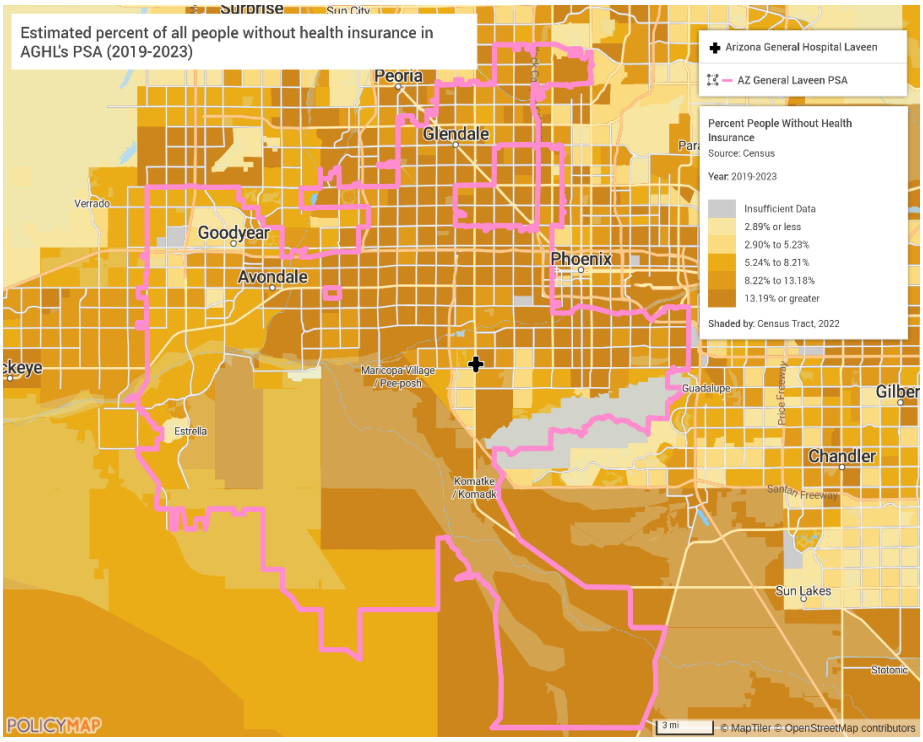


Figure 31. People Without Health Insurance – AGHL's PSA

Dental Visits

Preventative dental care is essential for maintaining oral health and preventing dental issues. Regular dental check-ups, cleanings, and early interventions can help detect and address oral health conditions like tooth decay (cavities), gum disease, tooth sensitivity, losing teeth, and abnormal teeth wear.[l] Preventive care can also encourage healthy oral health habits, all of which contribute to long-term dental and overall health and well-being. In AGHL's PSA, communities like *Glendale*, *Phoenix*, and in the GRIC (*Maricopa Village* and *Komatke*) contain areas with lower proportions of adults who visited a dentist or dental clinic in the past year **(Figure 32)**.[xvii]

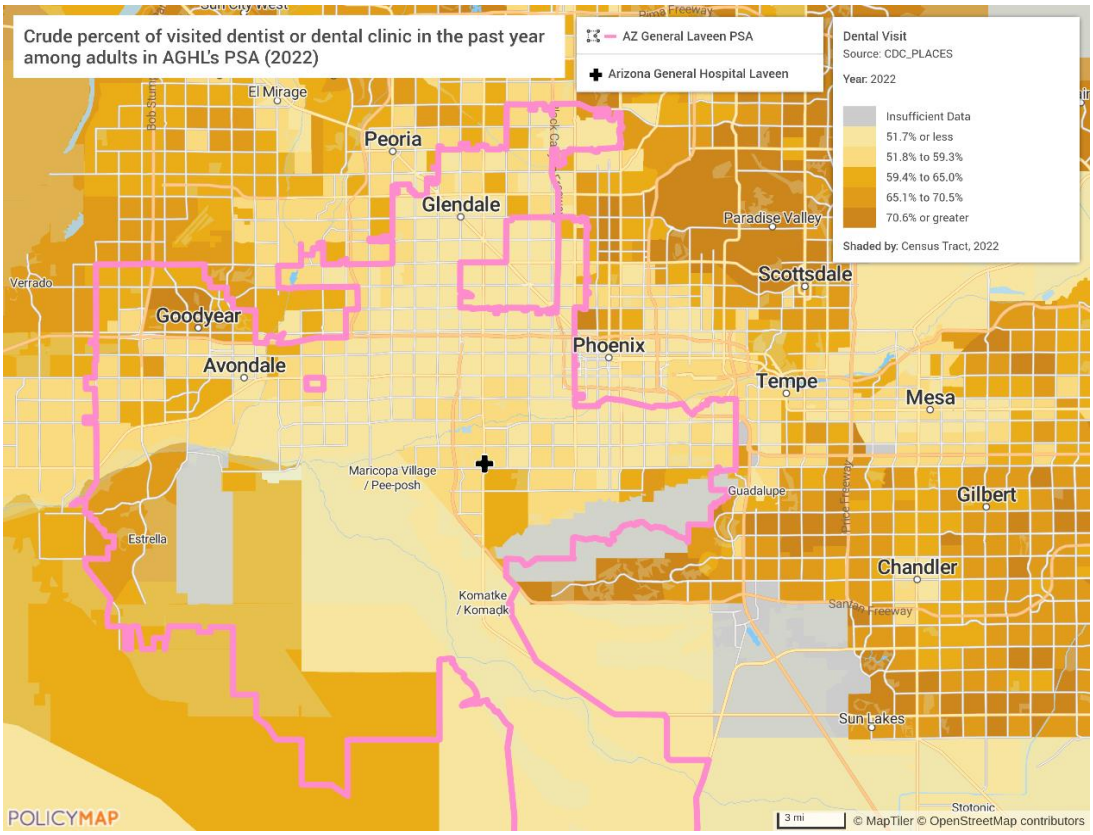


Figure 32. Adults who Visited the Dentist or Dental Clinic in Past Year in AGHL's PSA

Access to dental care and preventive services play a crucial role in reducing tooth loss and maintain oral health. **Figures 33** and **34** display the prevalence of teeth loss and the dentist ratio in Maricopa County, Arizona, and the United States.[li, lii]

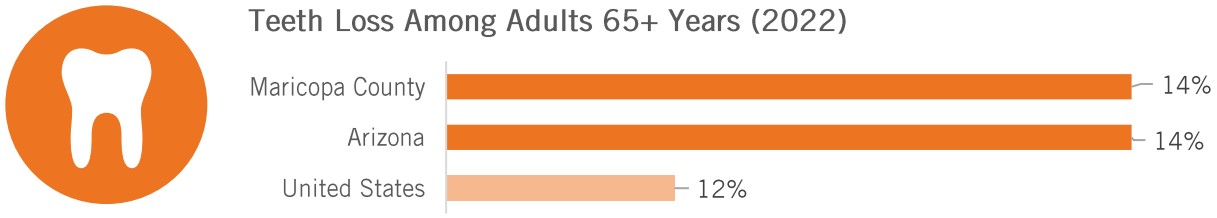


Figure 33. Teeth Loss among Adults 65+ Years in Maricopa County, Arizona, and U.S (2022)

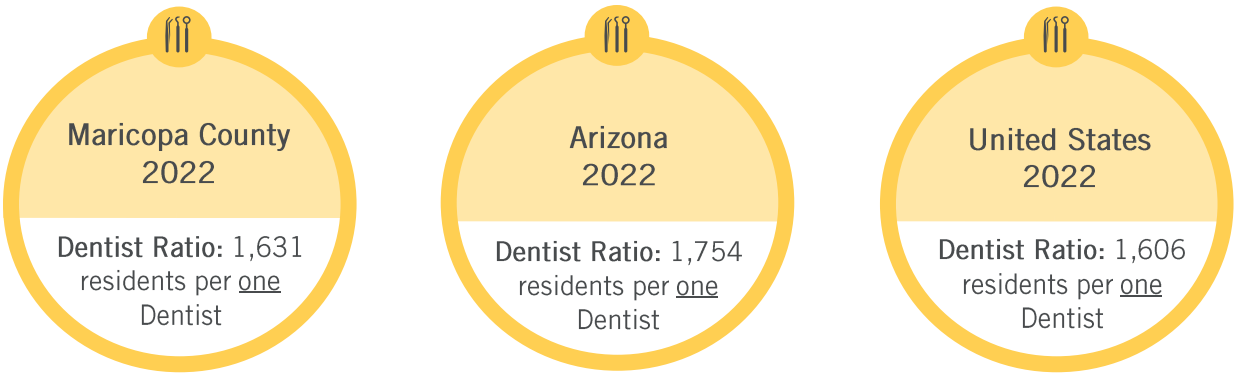


Figure 34. Dentist Ratio in Maricopa County, Arizona, and U.S (2022)

Community-Identified Issues in Maricopa County

Recognizing that AGHL's PSA falls within Maricopa County, the following data provides additional insight into access to care based on needs in Maricopa County.

Access to Medical Care

Almost **2 in 5 (35.8%)** survey respondents indicated that they **"Sometimes"** or **"Never"** had access to medical care within the past 12 months.

Health Care Solutions

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

Health Care Access and Quality

Focus group participants identified barriers to accessing care, including **long wait times** for procedures and appointments, **difficulties with insurance**, **high cost of care**, **limited medical facilities** equipped for emergencies or specialized needs**, inadequate provider training**, and **unreliable transportation**..

Healthcare Service Accessibility

Key informant interviewees expressed concerns about healthcare accessibility, noting challenges such as difficulties **accessing appointments**, **limited availability of healthcare facilities** in some communities, and a **lack of competency or sensitivity among health care providers** in supporting individuals who are blind or vision impaired.

> *I've needed dental work for years that I can't afford and mostly isn't covered by ahcchs (nor is it easy to find a dentist who accepts it) and as a previously "homeless person, I know easily over 68 people who need it as well....Being homeless was the single most difficult terrifying and lonely experience, I was left to fend for myself with nobody to reach out or offer to help.*
>
> - 2023 CHNA Survey Participant

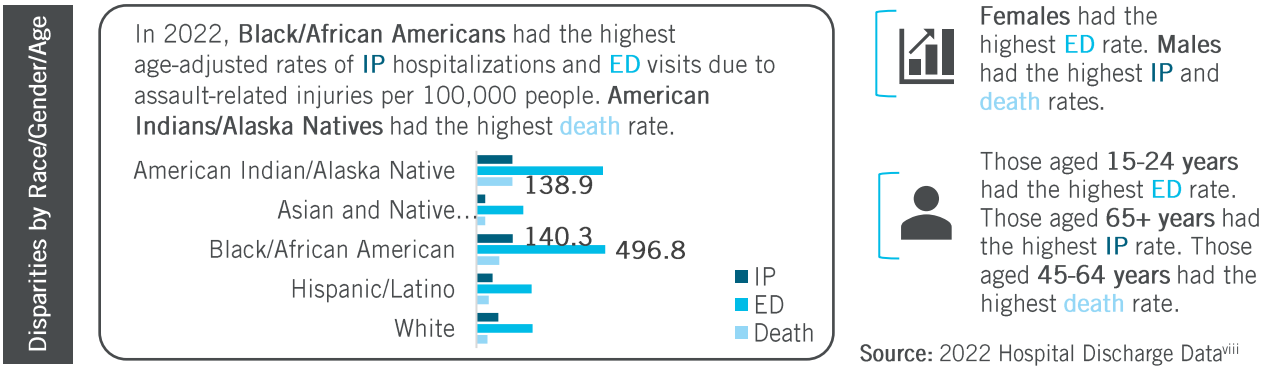
Sources: 2023 CHNA Survey, 2023 Focus Groups, 2024 Key Informant Interviews[v, vi, vii]

VIOLENCE AND INJURY PREVENTION

2025 CHNA PRIORITIES

Importance and Impact in AGHL's PSA

Violence and injury was selected as a significant health need for AGHL. Injuries can result from various factors, including road traffic accidents, falls, drowning, burns, poisoning, and acts of violence, whether self-inflicted or directed at others.[liii] The consequences of exposure to trauma, especially in childhood, are far-reaching. It can increase the risk of mental illness, suicide, substance abuse, chronic disease, and social issues like violence. Additionally, individuals who experience violence or injury are more likely to engage in harmful behaviors and perpetuate cycles of violence, which can affect families and communities for generations.[liv] The benefits of injury and violence prevention extend beyond the individual, contributing to significant improvements in overall public health, social cohesion, and economic stability.



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

Figure 35. Assault-Related Injuries – AGHL's PSA

Youth/Teen Violence

Youth and teen violence remain a pressing issue, often intertwined with gang involvement and delinquent behaviors.[xiv] The Arizona Youth Survey measures gang involvement by a series of questions centered on current and past gang membership for self and friends, and the major reason for membership. **Table 9** displays gang involvement in Maricopa County among eighth, tenth, and twelfth grade students for 2024.[xiv]

	Grade 8	Grade 10	Grade 12
Do you currently belong to a gang? (% of students who marked "Yes, but want to get out" or "Yes, belong now")	0.7% ↑	0.4% ↑	0.6% ↑
Have you ever belonged to a gang?	2.5%	1.7%	1.4%
In the past 12 months, has at least one of your four closest friends been a member of a gang?	5.4%	3.9%	3.3%

Table 9. Youth Gang Involvement in 2024 – Maricopa County

↑ Exceeded 2024 State %

The Arizona Youth Survey also measures delinquent behavior by a series of questions centered on whether youth have engaged in illegal behaviors over the past 12 months. **Table 10** displays delinquency prevalence in Maricopa County among eighth, tenth, and twelfth grade students for 2024.[xiv]

	Grade 8	Grade 10	Grade 12
Stolen something worth more than $5	23.2% ↑	18.6% ↑	16.8% ↑
Stolen or tried to steal a motor vehicle such as a car or motorcycle	1.5% ↑	1.4% ↑	1.3% ↑
Harassed or made fun of another person online or through text	27.0% ↑	19.1%	14.7% ↑
Sold illegal drugs	1.9% ↑	2.2% ↑	2.5% ↑
Been in a physical fight	18.1%	10.5%	6.8%
Physically assaulted (hit, slapped, pushed, kicked) your boyfriend/girlfriend	3.8% ↑	2.4% ↑	1.9% ↑
Attacked someone with the idea of seriously hurting them	7.9% ↑	3.9% ↑	2.7% ↑

Table 10. Delinquency Prevalence in 2024 – Maricopa County

↑ Exceeded 2024 State %

Community-Identified Issues in Maricopa County and Arizona

Recognizing that AGHL's PSA falls within Maricopa County, the following data provides additional insight into violence and injury prevention based on needs in Maricopa County.

Youth/Teen Violence

Addressing youth and teen violence is essential because it affects individual development, community safety, and long-term well-being. Youth violence includes behaviors like fighting, bullying, weapon threats, and gang involvement. It is linked to negative health outcomes and disproportionately impacts communities of colors. This violence increases the risk of mental health issues, substance abuse, obesity, risky sexual behaviors, depression, and suicide.[lv] Systemic health and social inequities, such as poverty, residential segregation, and racism, make minority groups more vulnerable to violence.[lv] **Figure 36** displays violence-related data collected from the Arizona Youth Survey among a sample of 8th, 10th, and 12 grade students.[xiv]

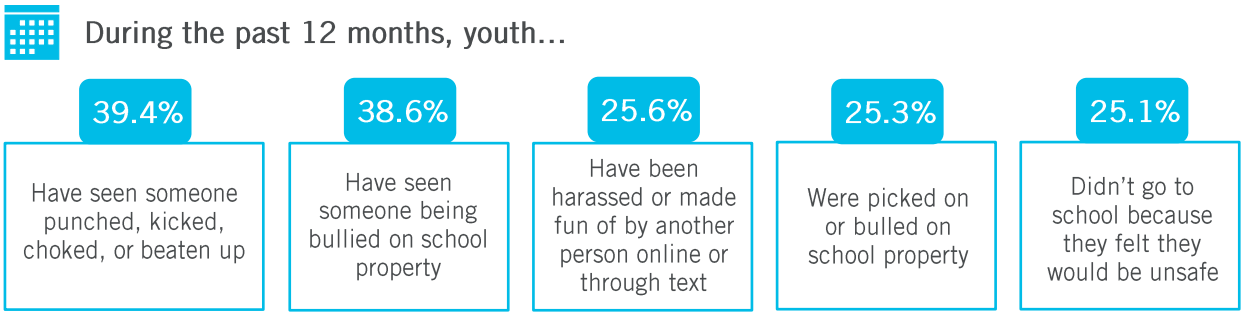


Figure 36. Violence among Grades 8, 10, 12 in Maricopa County (2022)

Human Trafficking

According to the National Human Trafficking Hotline, human trafficking occurs "when a trafficker uses force, fraud or coercion to control another person for the purpose of engaging in commercial sex acts or soliciting labor or services against his/her will."[lvi] Human trafficking is a critical health concern due to its physical, mental, and social impacts on victims and communities. These effects can include loss of basic human rights, disruption of childhood and families, and mental health issues such as anxiety disorders, posttraumatic stress disorder, depression, and substance abuse.[lvii] **Figure 37** displays a snapshot of human trafficking cases identified in 2022 for Arizona.[xii]

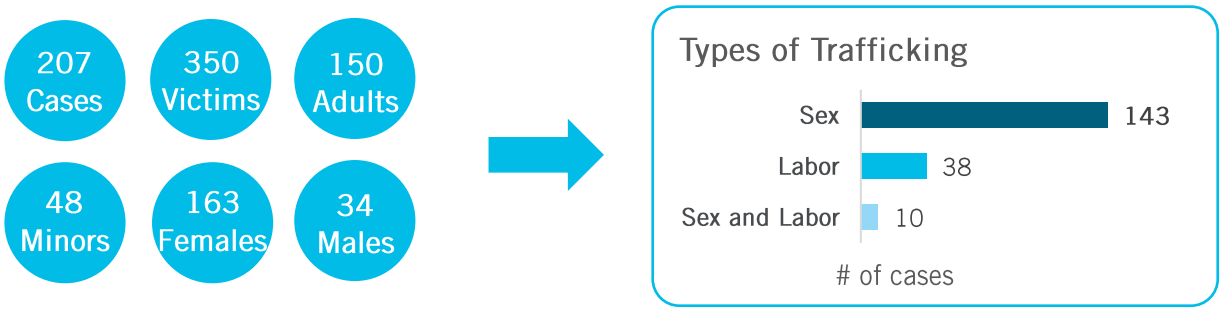


Figure 37. Human Trafficking Cases Identified in Arizona (2022)

Abuse, Neglect, and Violence Screening

Dignity Health's Human Trafficking Response Program has partnered with Clinical Informatics to compile aggregate data from the electronic health record system regarding patients who have been documented with concerns of abuse, neglect, and violence, including human trafficking. **Figure 38** displays data centered around the total screenings conducted, positive screenings for abuse observed, and positive for both safety concerns and abuse observed at AGHL during fiscal year 2024 (April 1 – June 30, 2024).[xiii]

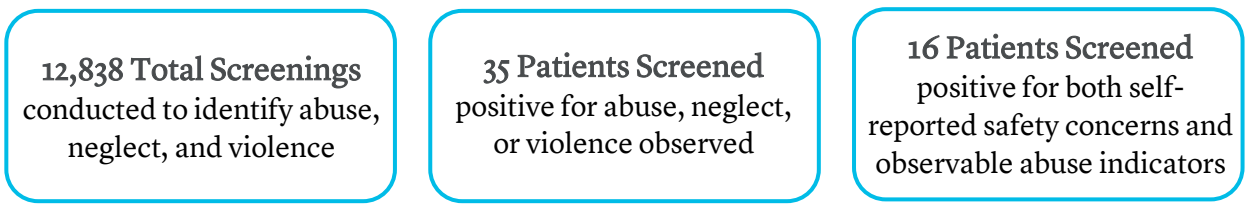


Figure 38. Abuse, Neglect, and Violence Screening at AGHL (2024)

Experiences of Discrimination

Over **3 in 10 (35.3%)** survey respondents indicated that they experienced discrimination in the past 12 months based on their **race**, followed by almost **1 in 4 (24.5%)** who reported **gender**.

Rating Community Assets

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

Community Safety

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

> *I was violent toward my fiancé and tried to get domestic violence counseling to help…I finally found a counseling agency…One was too far away to consider; the other I could get to only by using my fiancé's car. The quality of care was extremely poor. The counselor cancelled at the last minute for one session but didn't notify me so I went to the office for nothing. He was late for the next session, so I had to discontinue…I was in a traumatized state and really needed help to find a better solution for my relationship issues than violence. First responders also need to be better trained in how to manage domestic violence situations…*
>
> - 2023 CHNA Survey Participant

> *Born and raised in S. Phx. I watched our community from families meeting at parks for gatherings, children playing in the streets with neighborhood kids till the street light came on…I also grew up where gang violence took over our neighborhoods at this point it's not even about the Gangs anymore like it used to. It's a Hot House on every other street. Our children are poor, bored, and unstimulated, that they have no choice but turn to drugs and violence…Its physically draining and upsetting to drive in every direction to have the entire corner infested with mental illness, homelessness, drugs, and sexual misconduct…We can't even leave our homes to go for a walk on a nice day…*
>
> - 2023 CHNA Survey Participant

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

Importance and Impact in AGHL's PSA

Cancer, including *breast cancer*, was selected as a significant health need for AGHL. The World Health Organization defines cancer as a large group of diseases characterized by uncontrolled growth of abnormal cells that can invade nearby tissues and spread to other parts of the body. The cancer burden continues to increase, causing significant physical, emotional, and financial strain on individuals, families, communities, and healthcare systems.[lviii] While some risk factors for cancer such as alcohol and tobacco use, can be avoided , others, like family health history and human papillomavirus, cannot.[lix] Prevention through lifestyle changes, vaccinations, and regular screenings can help reduce cancer rates and promote overall health.

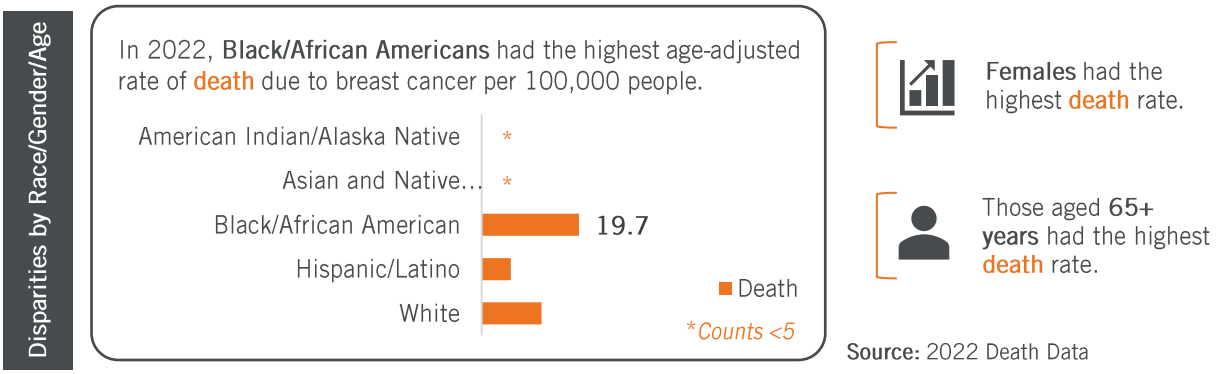


Figure 39. Breast Cancer – AGHL's PSA

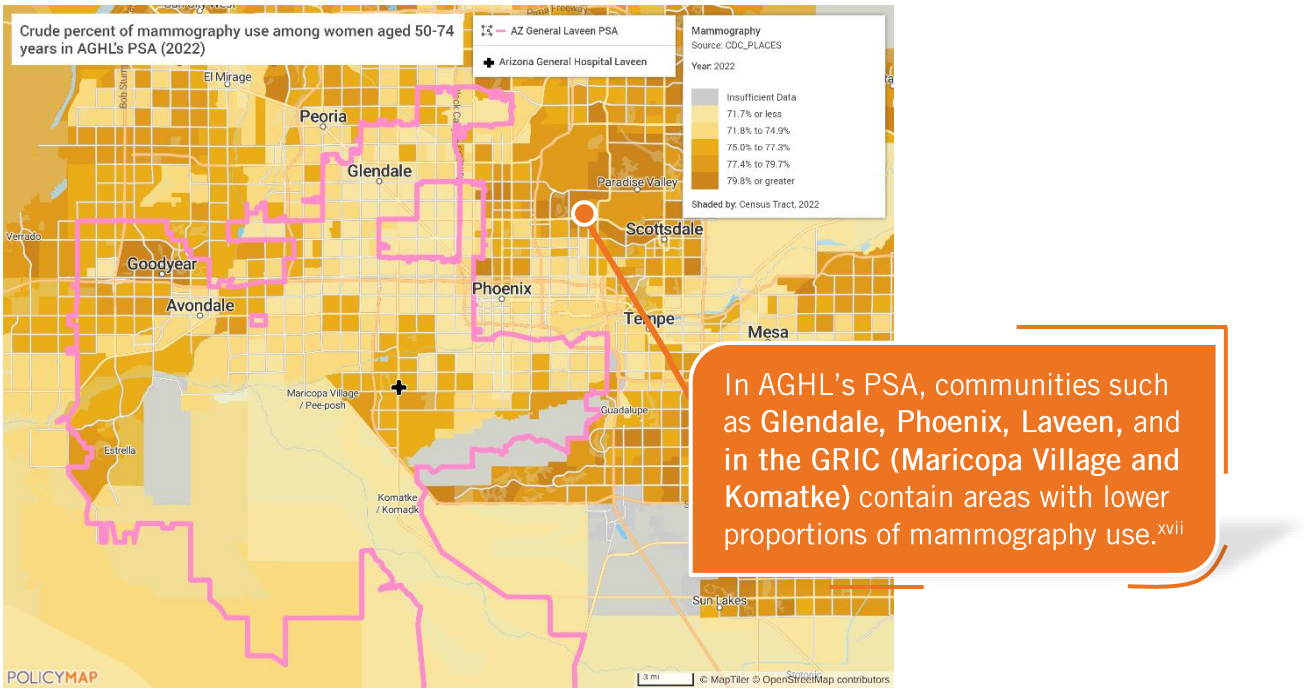


Figure 40. Mammography Use – AGHL's PSA

Community-Identified Issues in Maricopa County

Recognizing that AGHL's PSA falls within Maricopa County, the following data provides additional insight into cancer based on needs in Maricopa County.

Top Health Issues

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

Rating Community Assets

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

Cancer in the Community

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

Environmental Disparities

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

> *"On Navajo [land], we are located on areas [that include] uranium, so there's a huge increase in cancer*
> - 2024 Key Informant Interviewee

Sources: 2023 CHNA Survey, Focus Groups, 2024 Key Informant Interviews[v, vi, vii]

Top 10 Cancers in Maricopa County (2020 incidence rates per 100,000 people)[lx]

1	Breast Invasive – Female 106.0	6	Other Invasive 22.6
2	Prostate 64.6	7	Corpus Uteri and Uterus 21.4
3	Lung and Bronchus 36.4	8	Urinary Bladder 14.2
4	Cutaneous Melanoma 29.0	9	Non-Hodgkin Lymphoma 13.8
5	Colorectal 27.2	10	Kidney/Renal Pelvis 13.5

Figure 41. Top 10 Cancers in Maricopa County

Resources Potentially Available to Address Needs

AGHL is addressing key needs identified in its CHNA, including mental health, chronic conditions, social determinants of health, access to care, violence and injury prevention, and cancer. Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community-based organizations. Resources include access to hospitals and hospital systems providing emergency care, acute care, outpatient services, and community programs. AGHL also participates in the Health Improvement Partnership of Maricopa County — a collaborative effort between Maricopa County Department of Public Health and a diverse array of over 100 public and private organizations addressing healthy eating, active living, linkages to care, and tobacco-free living. The Health Improvement Partnership of Maricopa County is also a valuable resource to help AGHL connect to other community-based organizations that are addressing similar health priorities. **Table 11** identifies organizations offering resources to address the identified priorities.

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

Priority	Community Resources	Hospital Resources
Chronic Conditions (Cardiovascular Disease, Diabetes, Obesity)	• American Diabetes Association - Diabetes education and support • Arizona Diabetes Foundation - Education programs • Healthier Living Program - Chronic disease education program, cooking class • National Kidney Foundation of Arizona • Valley of the Sun YMCA - Diabetes Education program • Wesley Community & Health Centers - Acute and chronic disease management • Salud en Balance	• Healthier Living with Chronic Conditions / Tomando Control de tu Salud • Diabetes Empowerment Education Program • Muhammed Ali Parkinson's Center Programs
Social Determinants of Health (Housing & Homelessness, Access to Food)	• Chicanos Por La Causa – Housing • Elaine - Transportation for homeless and underserved • Central Arizona Shelter Services (CASS) - Homeless Shelter • Phoenix Rescue Mission - Homelessness • Circle the City - Respite Care, Homelessness • Phoenix Rescue Mission - Housing / Homelessness • St. Vincent de Paul - Rent and utility assistance, medical and dental clinic	• Transportation Services (Lyft) • Homeless resource navigator • CASS Hospital Transition Beds • ACTIVATE & Kindness Closet
Access to Care (Dental Health)	• Chicanos Por La Causa / Keogh Health Connection - Enrollment Assistance, Social Services, Economic Development • Foundation for Senior Living • Mission of Mercy - mobile clinic • Mountain Park Health Center - access to healthcare • Adelante Healthcare - access to healthcare	• Mission of Mercy (primary care to uninsured) • CATCH (Internal Medicine Clinic) • Unite Us (community referrals) • Keogh enrollment specialist • Cancer patient navigator • Community Health Worker Program • MOMobile • Financial Assistance Committee

	• Native American Connection - Medical and health services, oral health • Wesley Community & Health Centers - access to healthcare	
Priority	**Community Resources**	**Hospital Resources**
Violence and Injury Prevention	• A New Leaf - Domestic violence • Bloom365 - Dating violence • Control Alt Delete - Domestic violence • International Rescue Committee - Human trafficking • Jewish Family & Children's Service - Domestic violence • Phoenix Dream Center - Human trafficking • Streetlight USA - Human trafficking • The Faithful City - Domestic Violence, trafficking	• Stop the Bleed • Human Trafficking Taskforce • Trauma Injury Prevention Program • Barrow – Baseline Concussion Testing • Barrow – Brainbook • Barrow – Health professions education (concussion education for athletic trainers)
Cancer (Breast Cancer)	• Cancer Support Community of Arizona - Cancer Resource Navigator, access to care • American Cancer Society • The Froth and Bubble Foundation • Phoenix Cancer Support Network • Co-pay Relief Program • CancerCare Financial/Co-pay Assistance	• Patient Navigator (American Cancer Society) • Lifestyle management workshops • Medication assistance • Support groups • Transportation support • SJHMC Cancer patient navigator (Cancer Support Community of Arizona)

Table 11. Resources Potentially Available to Address Needs

Impact of Actions Taken Since the Preceding CHNA

Since the completion of AGHL's 2022 CHNA, AGHL has worked to address identified health priorities through targeted programs and initiatives. The following is an overview of the impacts of AGHL programs and services on significant health needs identified in the 2022 CHNA. Each significant health need includes a brief description and is followed by programs and activities conducted under each need.

Significant Need #1: Mental Health and Suicide

Mental health includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act. Suicide and suicide attempts cause serious emotional, physical and economic impacts.

- Community 43 – mental & behavioral health
- Community Bridges – mental health & recovery
- Connections Health Solutions – urgent psychiatric center
- Family Involvement Center – family support services

Significant Need #2: Substance Use

Substance use is caused by multiple factors, including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems.

- Overdose Data to Action Partnership
- Alcoholics Anonymous in Maricopa County
- Narcotics Anonymous in Maricopa County
- Nicotine Anonymous Meetings in Arizona
- Hushabye Nursery
- Maricopa County Crisis Line
- Arizona 24/7 Crisis Line
- National Substance Use and Disorder Issues Referral and Treatment Hotline (SAMHSA)
- Arizona Overdose Assistance Referral Line
- Terros Health: Substance use treatment
- Crossroads Substance Abuse, Recovery & Relapse Prevention Centers
- Community Bridges
- Community Medical Services
- NAMI Valley of the Sun

Significant Need #3: Cancer

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

- Cancer patient navigator
- SJHMC Cancer patient navigator

- Lifestyle management workshops
- Medication assistance
- Support groups

Significant Need #4: Chronic Disease (Diabetes, Cardiovascular Disease, Obesity, Oral Health)

Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Diabetes is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). Cardiovascular disease is a class of diseases that affect the heart or blood vessels. Obesity is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. Oral health, oral diseases ranging from dental cavities to oral cancers.

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

Significant Need #5: Injury Prevention

Injury prevention are activities to prevent, ameliorate, treat, and/or reduce injury-related disability and death.

- **Car Seat Clinic**
    - **Certified Safety Technicians**
      Rest assured, there are certified child passenger safety technicians at Chandler Regional and with the Chandler Fire who can ensure you have the appropriate car seat and that it's installed correctly. These technicians have been trained and certified by taking a 32-hour class to learn how to instruct you on the proper installation and use of your child safety seat.
    - **Schedule A Child Seat Inspection**
      In partnership with Chandler Fire, Chandler Regional Medical Center offers free child safety seat inspections. Registration is required. You do not need to be a Chandler resident.
- **Chandler Regional Trauma Injury Prevention and Outreach: Trauma Survivors Network**, Following a traumatic injury, patients and their families can participate in the Trauma Survivors Network support group. This program provides families impacted by traumas the opportunity to connect with other trauma survivors and begin rebuilding their lives

together. The support group provides participants with information and education about specific injuries. Some examples include the Brain Injury Association of Arizona (BIAAZ), Arizona Spinal Cord Injury Association (AZSPINAL) and the Amputee Coalition. At this time all peer support groups are being held virtually.

- **Indian Health Service: Injury Prevention Program:**
    - Ride Safe (targets motor vehicle related injuries to children ages 3-5 years)
    - Sleep Safe (targets fire and burn injuries to children ages 3-5 years)

Significant Need #6: Access to Care (Immunization)

Access to care means having the timely use of personal health services to achieve the best health outcomes. Access to health care consists of four components; coverage, services, timeliness, and workforce. Immunization is a key component of primary health care and is critical to the prevention and control of infectious diseases.

- MOMobile
- Financial Assistance Committee
- Transportation Services
- Keogh enrollment specialist
- CATCH Program
- Community Health Worker Program
- ACTIVATE & Kindness Closet
- Mission of Mercy Mobile Clinic Support
- Prenatal & Parenting classes
- CASS Hospital Transition Beds
- Unite Us
- Human Trafficking Taskforce
- Barrow – Baseline Concussion Testing
- Barrow – Brainbook
- Barrow – Health Professions education
- Barrow – Concussion Telemed
- Circle the City – The Parsons Family Health Center
- NOAH (Neighborhood Outreach Access to Health) Midtown Health Center
- Valle del Sol
- Chicanos por la Causa – Keogh Health Connection

Significant Need #7: Housing and Homelessness

Social determinants of health due to the range of ways in which a lack of housing, or poor-quality housing.

- **CommonSpirit Health: Homeless Initiative & Taxi Vouchers**, offers charity rides for homeless and economically disadvantaged patients, helping those unable to access

transportation after leaving the hospital. Taxi vouchers are provided to ensure safe and reliable transportation for vulnerable patients.

- Central Arizona Shelter Services (CASS)
- CASS Family Shelter (Vista Colina)
- Child Crisis Arizona – Phoenix Office (Children Only)
- UMOM
- Family Housing Hub
- A New Leaf Housing – East Valley Men's Center
- Phoenix Rescue Mission – Changing Lives Center for Women
- Phoenix Rescue Mission – Transforming Lives Center for Men
- Maggie's Place (housing program for expectant mothers)
- House of Refuge Sunnyslope
- House of Refuge Mesa
- Circle the City Homeless Resource Navigator

Significant Need #8: Violence (Domestic Violence, Human Trafficking)

Domestic violence is abuse or aggression that occurs in family relationships. Human trafficking is a crime that involves exploiting a person for labor, services, or commercial sex.

- **CommonSpirit Health: Human Trafficking Task Force**, is health care professionals with tools to identify & appropriately assist patients whose health, safety, may be affected by trafficking or other types of violence.
- Arizona Sexual & Domestic Violence Helpline
- National Human Trafficking Hotline
- Eve's Place Mobile Advocacy Program
- Jewish Family & Children's Service – Shelter Without Walls
- Bloom365 School-Based Mobile Advocacy
- Salvation Army Domestic Violence Shelter – Elim House Shelter

Significant Need #9: Equity (Racial, Health, Social Equity)

Racial equity is the systemic fair treatment of all races that produces equitable opportunities and outcomes for all people. Health equity means that "everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Social equity refers to all people experiencing impartiality, fairness, and justice in their daily lives. Social equity takes into account systemic inequalities to ensure everyone in a community has access to the same opportunities and outcomes.

- **CommonSpirit Health: Financial Assistance Policy**, is financial assistance program to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay.
- **CommonSpirit Health: Community Health Improvement Grants Program**, each year, 0.05% of the hospital's previous FY expenses are allocated to the Community Health Improvement Grants program, awarding nonprofits addressing health priorities focused on racial, social and health equity.
- **CommonSpirit Health Connected Community Network (CCN)**, partners with various organizations to enhance access to healthcare and social services for patients in need. The network addresses a wide range of social and economic needs, including housing, maternal and child health, chronic disease management, healthy food, and mental health and substance abuse counseling.

Significant Need #10: Nutrition (Food Access, Exercise)

Nutrition, the process of providing or obtaining the food necessary for health and growth. Food access is an important element of food security, which is having constant access to adequate nutritious food to support healthy eating patterns. Exercise is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes, and several cancers. It also can improve physical/mental health, quality of life and well-being.

- St. Mary's Food Bank
- Salvation army – Family Services
- Tempe Community Action Agency
- Andre House
- Paz de Cristo
- Nourish Phoenix
- St. Vincent de Paul Dining Rooms

Conclusion

The 2025 Community Health Needs Assessment for AGHL is a collaborative effort that helps shape health improvement strategies. Using a range of primary and secondary data sources, this assessment offers an overview of the community's health, guides leadership and staff engagement, and informs the hospital's priorities for the next three years **(Figure 42)**.

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

Figure 42. AGHL's 2025 CHNA Priorities

Appendices

The appendix includes the following documents:

Appendix A

Participating Organizations in the Prioritization Meetings

Appendix B

Leading Causes of Death in AGHL's Primary Service Area (2018-2022)

Appendix C

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

Appendix D

CHNA Assessment Tools and Reports

2023 CHNA Survey Methods

Survey Report

2023 CHNA Focus Group Methods

Focus Group Report

2023 CHNA Key Informant Interviews Methods

Key Informant Interview Report

Appendix E

Data Indicator Matrix

Appendix F

References

Appendix A: Participating Organizations in the Prioritization Meetings

Hospital Board & Community Health Committee			
4th Trimester Arizona	Central Arizona Shelter Services	Dignity Health Family Medicine Resident Gilbert	Semicolon Society volunteer/HK photo smiles
A.T. Still University	Chandler CARE Center	For Our Town Gilbert Member	Social Spin Foundation
Arizona Anti-Trafficking Network	Chandler Fire Department - Crisis Response	FSL ACTIVATE	Solari Crisis & Human Services
Activate Food Arizona	Chandler Men of Action	House of Refuge	Sonoran Prevention Works
Against Abuse Inc.	Chandler Regional Hospital	ICAN Positive Programs for Youth	SRP - Salt River Project
Aliento	Chicanos Por La Causa, CPLC Community Center	LaloBoy Foundation	Southwest Institute for Families and Children
All About You Placement and Senior Resources	Child Crisis Arizona	Maricopa County Department of Public Health	The Be Kind People Project
Amanda Hope Rainbow Angels	Community Housing Partnership	Mary Gloria Foundation	The Joy Bus
American Heart Association	City of Chandler	Matthew's Crossing Food Bank	ToolBank
Amore Senior Support	Compassion Connect	Mercy Care	Volunteer and Community Resources Manager Town of Gilbert
Arizona Care Network	Compudopt	Neighbors Who Care	Town of Gilbert Town Council Members
Arizona General Hospital-Dignity Health	Dignity Health Medical Group	notMYkid	Town of Queen Creek
Aunt Rita's Foundation	Chandler Regional Medical Center leadership	One Small Step	United Food Bank

Blue Cross Blue Shield of Arizona	Mercy Gilbert Medical Center leadership	One Step Beyond, Inc.	Unlimited Potential
Boys & Girls Clubs of the Valley	Dignity Health & First Things First Manager	Queen Creek Chamber of Commerce	Valley of the Sun United Way
Bring Change to Mind	Dignity Health Foundation East Valley	Raising Special Kids	Valley of the Sun YMCA
Cancer Support Community Arizona	Dignity Health Oral Health	Rayhons Financial Solutions, LLC	VOS YMCA Outreach Program for Aging Seniors
Cece's Hope Center	Families Raising Hope	Salt River Project (SRP)	

Appendix B: Leading Causes of Death in AGHL's Primary Service Area (2018-2022)

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

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

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

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

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

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

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

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

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

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

Appendix D: CHNA Assessment Tools and Reports

2023 CHNA Survey Methods

Methodology: Survey Questionnaire

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

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

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

Methodology: Survey Recruitment

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

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

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

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

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

Methodology: Survey Analysis

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

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

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

Survey Limitations

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

Limitations of convenience sampling include underrepresentation of groups and sampling bias. The effects of these limitations were mitigated by including outreach strategies that focused on areas of underrepresentation by promoting at various locations such as health fairs, senior centers, and farmer's markets.

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

2023 CHNA Focus Group Methods

Methodology: Focus Group Discussion Guide and Supplemental Survey Development

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

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

Methodology: Focus Group Recruitment

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

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

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

For participants with access to the internet, an anonymous Qualtrics survey lnk along with the focus group details (date, time, zoom link) was emailed by a SIRC Study Team member

before the focus group. For participants where the internet was not readily available, a paper copy of the survey along with the consent statement was administered on the day of the focus group prior to the start of the focus group. Those participating in person had the option to complete the survey either online or on paper.

Methodology: Qualitative and Quantitative Analysis

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

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

Focus Group Limitations

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

2023 CHNA Key Informant Interviews Methods

Methodology: Data Collection

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

Development of Interview Guide and Consent Form

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

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

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

- Community strengths and assets: What strengths and resources are in communities that support health and well-being? How can community strengths and assets be used to address health inequities? Which organizations support community health and well-being?
- Built environment: What physical and cultural assets are in the built environment in communities? How may resources vary by neighborhood? How can the built environment promote and/or hinder community health and well-being?

- Forces of change: What are the current and historical forces of change locally, regionally, and globally that have shaped the political, economic, and social conditions of communities?

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

Sample Population and Recruitment

Nomination Process

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

Recruitment

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

Sample

The 24 key informant interview participants were selected using purposive sampling, a non-probability sampling technique in which participants are selected because they have characteristics that are needed in a sample. MCDPH identified one to two participants in key leadership or senior management roles to represent the 15 sectors of interest across geographic regions in the county. OMNI documented the geographic region served, populations served (e.g., adults with special health care needs, housing insecure

community members, etc.) and ages served (e.g., children, adolescents, older adults, etc.) by the key informant.

Facilitation and Data Collection

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

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

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

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

Methodology: Data Analysis

Validity and Reliability

To carry out the thematic analysis, OMNI employed an analytical framework that used MAPP 2.0 a priori codes and inductive codes. Because the questions for this assessment centered on the MAPP 2.0 CCA tool, OMNI began by developing a deductive coding scheme around the three CCA domains of community strengths and assets, the built environment, and forces of change. To anticipate that some codes could emerge inductively, each parent code had a "miscellaneous" child code that coders could use. This provided flexibility for coders to incorporate new insights, while ensuring the a priori coding scheme was not altered between initial coders. The analysis team then reviewed

codes that were put under “miscellaneous” and determined if codes fell within existing themes or merited a new, inductive child code.

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

Thematic Analysis

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

Report Writing and Presentation of Findings

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

Methodology: Data Considerations and Limitations

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

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

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

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

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

Appendix E: Data Indicator Matrix

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

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

Resource Responsibility **HDD** - Hospital Discharge Data **BRFSS** - Behavioral Risk Factor Surveillance Survey **ACS** - American Community Survey (Census) **YRBS** - Youth Risk Behavior Survey **AYS** - Arizona Youth Survey **H-CUP** - The Healthcare Cost & Utilization Project **IP** - Inpatient hospitalization **ED** - Emergency Department Visits	**Source**	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	**Level**	Maricopa County	Regions	Zipcode	National	State
Mental/Behavioral Illness																	
Mood and Depressive Disorders		■									■		■	■	■	■	■
Schizophrenic Disorders		■									■		■	■	■	■	■
Drug-Induced Mental and Behavioral Disorders		■									■		■	■	■	■	■
All Mental/Behavioral disorders		■									■		■	■	■	■	■
Behavioral Health Risk Factors																	
Alcohol Related ED/IP		■									■		■	■	■	■	■
Alcohol Related Deaths						■							■	■	■		
Intentional Self-Harm/Suicide ED/IP		■									■		■	■	■	■	■
Intentional Self-Harm/Suicide Death						■							■	■	■		
Opioids - Unintentional overdose ED/IP		■									■		■	■	■	■	■
Opioids - Unintentional overdose Deaths						■							■	■	■		
Alcohol/Drug use			■										■			■	■
Youth Alcohol/drug use									■				■				
Smoking			■										■			■	■
Youth Smoking									■				■				
Nutrition/Diet			■										■			■	■
Youth Nutrition/Diet					■												■
Physical Activity			■										■			■	■
Youth Physical Activity					■												■
Obesity			■										■			■	■
Youth Obesity					■												■
Injury																	
Motor Vehicle Crash related ED/IP		■									■		■	■	■	■	■
Motor Vehicle Crash related Deaths						■							■	■	■		
Fall Related ED/IP		■									■		■	■	■	■	■
Fall Related Deaths						■							■	■	■		
Violence-related ED/IP		■									■		■	■	■	■	■
Violence-related Deaths						■							■	■	■		
Social Determinants of Health																	
Transportation; no vehicle households										■			■	■	■	■	■
Access to Food; Low Income Low Access										■			■	■	■	■	■
Housing; cost burdened										■			■	■	■	■	■

Appendix F: References

[i] United States Census Bureau (2022). Growth in the Nation's Largest Counties Rebounds in 2022. Retrieved from https://www.census.gov/newsroom/press-releases/2023/population-estimates-counties.html

[ii] United States Census Bureau (2022). Age and Sex. Retrieved from S0101: Age and Sex - Census Bureau Table

[iii] United States Census Bureau (2023). Annual Geographic Information Table. Retrieved from https://data.census.gov/table?q=square%20miles&g=050XX00US04013

[iv] Maricopa County Sheriff's Office. Quick Facts about Maricopa County. Retrieved from https://www.mcso.org/about-us/maricopa-facts-figures

[v] Maricopa County Department of Public Health (2023). 2023 Maricopa County Community Health Assessment: Community Surveys Report. Retrieved from Maricopa-County-CHNA-Survey-Report

[vi] Arizona State University Southwest Interdisciplinary Research Center (2023). Coordinated Community Health Needs Assessment Final Focus Group Results. Retrieved from MCDPH CHNA 2023 Focus Group Evaluation Report - Final_2.12.24_pagenumber (2).pdf (maricopa.gov)

[vii] The OMNI Institute (2024). Community Health Needs Assessment 2024 Key Informant Interviews. Retrieved from 2024-CHNA-Key-Informant-Interviews-Report_FINAL_52224 (maricopa.gov)

[viii] Hospital Discharge Data (2022). Obtained from Arizona Department of Health Services, cleaned and analyzed by MCDPH.

[ix] Maricopa Regional Continuum of Care. Point-in-Time (PIT) Count Report (2022). Retrieved from https://azmag.gov/Portals/0/Documents/MagContent/2022-PIT-Count-Report-Final.pdf

[x] United States Census Bureau (2022). American Community Survey. Retrieved from https://data.census.gov

[xi] Centers for Disease Control and Prevention BRFSS Prevalence & Trends Data (2022). Retrieved from https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByLocation&rdProcessAction=&SaveFileGenerated=1&irbLocationType=States&islLocation=04&islState=&islCounty=&islClass=CLASS13&islTopic=TOPIC57&islYear=2022&hidLocationType=States&hidLocation=04&hidClass=CLASS13&hidTopic=TOPIC57&hidTopicName=Teeth+Removed&hidYear=2022&irbShowFootnotes=Show&rdICL-iclIndicators=_EXTETH3&iclIndicators_rdExpandedCollapsedHistory=&iclIndicators=_EXTETH3&hidPreviouslySelectedIndicators=&DashboardColumnCount=2&rdShowElementHistory=divYearUpdating%3dHide%2cislYear%3dShow%2c&rdScrollX=0&rdScrollY=200&rdRnd=18828

[xii] National Human Trafficking Hotline (2022). Arizona. Retrieved from https://humantraffickinghotline.org/en/statistics/arizona

[xiii] Abuse, Neglect, and Violence EHR Data. Central Region: Arizona (AGHL). Retrieved from CommonSpirit Human Trafficking Response Program.

[xiv] Arizona Criminal Justice Commission (2024). Arizona Youth Survey Maricopa County. Retrieved from https://www.azcjc.gov/Portals/0/Documents/pubs/AYSReports/2024/2024_AYS_Maricopa_Report.pdf.

[xv] Feeding America Food Insecurity among the Overall Population in Maricopa County (2022). Retrieved from https://map.feedingamerica.org/county/2022/overall/arizona/county/maricopa

[xvi] IRS. Community Health Needs Assessment for Charitable Hospital Organizations – Section 501(r)(3). Retrieved from https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

[xvii] PolicyMap (2018-2024). Retrieved from https://www.policymap.com/newmaps#/

[xviii] Arizona Department of Health Services (2024). Arizona Medically Underserved Areas Biennial Report. Retrieved from https://www.azdhs.gov/documents/prevention/health-systems-development/data-reports-maps/reports/azmua-biennial-report.pdf

[xix] Healthy People 2030 (2020). Access to Health Services. Retrieved from Access to Health Services - Healthy People 2030 | health.gov

[xx] PolicyMap Health Resources and Services Administration (2023). Retrieved from https://www.policymap.com/data/dictionary#HRSA

[xxi] Institute for Healthcare Improvement (2023). Population Health. Retrieved from https://www.ihi.org/Topics/Population-Health/Pages/default.aspx#:~:text=Population%20health%20is%20defined%20as,such%20outcomes%20within%20the%20group.

[xxii] Center for Disease Control and Prevention Social Vulnerability Index (2020). Retrieved from https://www.policymap.com/data/dictionary#CDC%20Social%20Vulnerability%20Index

[xxiii] Vizient. Vizient Vulnerability Index Public Access (2022). Retrieved from https://www.vizientinc.com/what-we-do/health-equity/vizient-vulnerability-index-public-access

[xxiv] CommonSpirit. Eco Stewardship. Retrieved from https://www.commonspirit.org/impact/eco-stewardship#mission-action

[xxv] PolicyMap (2022). Council on Environmental Quality, Climate, and Economic Justice Screening Tool. Retrieved from https://www.policymap.com/data/dictionary#Council%20on%20Environmental%20Quality,%20Climate%20and%20Economic%20Justice%20Screening%20Tool

[xxvi] National Institute of Environmental Health Sciences (2024). Climate Change and Human Health. Retrieved from National Institute of Environmental Health Sciences: Climate Change and Human Health

[xxvii] National Institute of Environmental Health Sciences (2024). Climate Change and Human Health. Retrieved from Climate Change and Human Health Factsheet

[xxviii] World Health Organization (2024). Health Consequences of Air Pollution on Populations. Retrieved from https://www.who.int/news/item/25-06-2024-what-are-health-consequences-of-air-pollution-on-populations

[xxix] United States Environmental Protection Agency (2024). Particulate Matter Basics. Retrieved from https://www.epa.gov/pm-pollution/particulate-matter-pm-basics

[xxx] U.S. Department of Health and Human Services (2024). Drought. Retrieved from https://www.hhs.gov/climate-change-health-equity-environmental-justice/climate-change-health-equity/climate-health-outlook/drought/index.html

[xxxi] CommonSpirit. Health Equity Blueprint. Retrieved from https://www.commonspirit.org/content/dam/shared/en/pdfs/impact/commonspirit-blueprint/CommonSpirit-health-equity-blueprint-overview-web.pdf

[xxxii] United Way. What is Social Equity (2021). Retrieved from https://unitedwaynca.org/blog/what-is-social-equity/

[xxxiii] United Way. What is Racial Equity (2022). Retrieved from https://unitedwaynca.org/blog/what-is-racial-equity-definition/

[xxxiv] ICD10Data. Mental, Behavioral, and Neurodevelopmental Disorders. Retrieved from 2025 ICD-10-CM Codes F01-F99: Mental, Behavioral and Neurodevelopmental disorders

[xxxv] Substance Abuse and Mental Health Services Administration (2023). What is Mental Health? Retrieved from https://www.samhsa.gov/mental-health

[xxxvi] Substance Abuse and Mental Health Services Administration (2023). Mental Health and Substance Use Co-Occurring Disorders. Retrieved from https://www.samhsa.gov/mental-health/mental-health-substance-use-co-occurring-disorders

[xxxvii] Substance Use and Mental Health Services Administration (2023). Self-Harm. Retrieved from https://www.samhsa.gov/mental-health/self-harm

[xxxviii] ICD10Data. Diseases of the Circulatory System. Retrieved from https://www.icd10data.com/ICD10CM/Codes/I00-I99

[xxxix] ICD10Data. Diabetes Mellitus. Retrieved from https://www.icd10data.com/ICD10CM/Codes/E00-E89/E08-E13

[xl] ICD10Data. Overweight and Obesity. Retrieved from https://www.icd10data.com/ICD10CM/Codes/E00-E89/E65-E68/E66-

[xli] Centers for Disease Control and Prevention (2024). Heart Disease Risk Factors. Retrieved from https://www.cdc.gov/heart-disease/risk-factors/index.html

[xlii] Centers for Disease Control and Prevention (2024). Diabetes Risk Factors. Retrieved from https://www.cdc.gov/diabetes/risk-factors/index.html

[xliii] Centers for Disease Control and Prevention (2024). Risk Factors for Obesity. Retrieved from https://www.cdc.gov/obesity/risk-factors/risk-factors.html

[xliv] Healthy People 2030. Social Determinants of Health. Retrieved from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

[xlv] National League of Cities (2023). Exploring the Connection Between Healthy Housing & Mental Health. Retrieved from https://www.nlc.org/article/2023/05/31/exploring-the-connection-between-healthy-housing-mental-health/

[xlvi] Dixon BN, Ugwoaba UA, Brockmann AN, Ross KM. Associations between the Built environment and Dietary Intake, Physical Activity, and Obesity: A Scoping Review of Reviews. Obes Rev. 2021; 22(4). doi: 10.1111/obr.13171

[xlvii] Healthy People 2030. Access to Health Services. Retrieved from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

[xlviii] County Health Rankings & Roadmaps. Access to Care. Retrieved from https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care

[xlix] American Hospital Association. Report: The Importance of Health Coverage. Retrieved from https://www.aha.org/guidesreports/report-importance-health-coverage

[l] Delta Dental. What is Preventive Dental Care. Retrieved from https://www.deltadental.com/us/en/protect-my-smile/oral-health-habits/preventive-dental-care.html

[li] Centers for Disease Control and Prevention BRFSS Places (2022). Teeth Loss Among Adults Age 65 and Over. Retrieved from mySidewalk.

[lii] National Plan and Provider Enumeration System National Provider Identifier (2022). Dentist Ratio. Retrieved from mySidewalk.

[liii] World Health Organization (2024). Injuries and Violence. Retrieved from https://www.who.int/news-room/fact-sheets/detail/injuries-and-violence

[liv] My Sister's Place (2024). Generational Cycles of Violence. Retrieved from https://www.mysistersplacedc.org/generational-cycles-of-violence/

[lv] Centers for Disease Control and Prevention (2024). About Youth Violence. Retrieved from https://www.cdc.gov/youth-violence/about/index.html

[lvi] National Human Trafficking Hotline. What is Human Trafficking? Retrieved from https://humantraffickinghotline.org/en

[lvii]Novotney A (2023). 7 in 10 Human Trafficking Victims are Women and Girls. What are the Psychological Effects. Retrieved from https://www.apa.org/topics/women-girls/trafficking-women-girls

[lviii] World health Organization. Cancer. Retrieved from https://www.who.int/health-topics/cancer#tab=tab_1

[lix] Centers for Disease Control and Prevention (2024). Cancer Risk Factors. Retrieved from https://www.cdc.gov/cancer/risk-factors/index.html

[lx] Arizona Department of Health Services (2022). Arizona Cancer Registry. Retrieved from https://www.azdhs.gov/policy-intergovernmental-affairs/cancer-registry/index.php#data-dashboard

[lxi] National Association of County and City Health Officials. Example Community Health Survey. Retrieved from https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/Example-Survey-CTSA-Community-Health.pdf