Dignity Health®
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MARICOPA COUNTY
PUBLIC HEALTH

2025
Community Health Needs Assessment

Mercy Gilbert Medical Center

Adopted May 2025

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Executive Summary

Community Health Needs Assessment (CHNA) Purpose Statement

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by Dignity Health Mercy Gilbert Medical Center (MGMC). 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

MGMC 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:

- 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

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

MGMC 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 MGMC 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. A supplemental focus group was conducted in the winter of 2024.

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 MGMC 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 MGMC's PSA.

Phase Two
CHNA Prioritization Workshops

In collaboration with Maricopa County Department of Public Health, MGMC 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 MGMC 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 MGMC, based on data and insights gathered from both primary and secondary sources. While recognizing the health disparities present in the communities they serve, MGMC 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. MGMC applied this lens to better understand the factors driving inequities and to identify barriers faced by specific populations. By using this lens, MGMC 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 #5 for IP and #8 for ED, while overweight ranked #8 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 MGMC's PSA, about eight percent of the population were uninusured.[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] According to Dignity Health's Early Childhood Oral Health Program, 83% of children were rated as *high risk for caries* and 46% of expectant mothers had *untreated tooth decay* in fiscal year 2024.[xii]

Violence and Injury Prevention

According to 2022 age-adjusted overall rates, fall-related injuries ranked #2 for IP and #1 for ED visits in the 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.[xiii] At MGMC, there were 23,502 total screenings for abuse, neglect, and violence.[xiv] According to the Arizona Youth Survey for Gilbert, 14.3% of students from grades eight, 10, and twelve harassed or made fun of another person online or through text in 2022.[xv] From March-June 2024, falls followed by motor vehicle/motorcycle collisions were the top two trauma-related cases at MGMC.

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 MGMC 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 (MGMC PSA data, Source: 2022 HDD[viii], only hospitalization were reported)			
All Mental and Behavioral Disorders	American Indian/Alaska Native [1,2]	15-24 [1] 25-44 [2]	Male [1,2]
Chronic Conditions (MGMC 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	American Indian/Alaska Native [1,2] Hispanic/Latino [3]	65+ [1,2,3]	Male [1,2,3]
Obesity	Black/African American [1] White [2,3]	45-64 [1,2] 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[xvi])			
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 (MGMC PSA data, Sources: 2022 HDD[viii] and 2022 Death Data)			
Fall-related Injuries	American Indian/Alaska Native [1,2] White [3]	65+ [1,2,3]	Female [1,2] Male [3]

Assault-related Injuries	American Indian/Alaska Native [1] Black/African American [2] Hispanic/Latino [3]	15-24 [2] 25-44 [3] 65+ [1]	Female [1,2] Male [3]
Cancer (MGMC 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 MGMC'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

MGMC 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.[xvii] 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 62.

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 MGMC, 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 MGMC'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 MGMC's Community Health Office. Written comments on this report can be submitted to the MGMC's Community Health Department at 1750 E. Northrop Blvd., Chandler, AZ 85286 or by e-mail to mercy-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.

Mercy Gilbert Medical Center (MGMC) is one of eight Dignity Health acute care hospitals in the Arizona market. MGMC is a not-for-profit hospital in Gilbert, Arizona, which is in the east valley of the greater Phoenix metropolis and is committed to delivering expert and compassionate care to families in the growing community and beyond. Mercy Gilbert recently added a graduate medical education residency program to its campus, training approximately 28 future healthcare providers each year. The campus is expanding with the development of the Women's and Children's Pavilion – a joint project between Dignity Health and Phoenix Children's. It will provide high quality care to moms and children in one new and convenient location for fast, leading-edge responses to health care needs. As of fiscal year 2024, MGMC had 1,554 employees and 1,335 physicians representing all major specialties.

Community Health Needs Assessment

Hospitals like MGMC 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. MGMC 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

MGMC 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]

MGMC's community is defined as individuals residing within the primary service area (PSA) of MGMC. The PSA is defined by the top 75% of MGMC's inpatient and outpatient discharges and is outlined by zip codes that encompass all populations, including low-income and underserved populations. MGMC'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 MGMC came from the following zip codes: 85138, 85140, 85142, 85143, 85147, 85204, 85205, 85206, 85207, 85208, 85209, 85212, 85224, 85225, 85233, 85234, 85248, 85249, 85286, 85295, 85296, 85297, and 85298. **Figure 1** displays a map of MGMC's community.
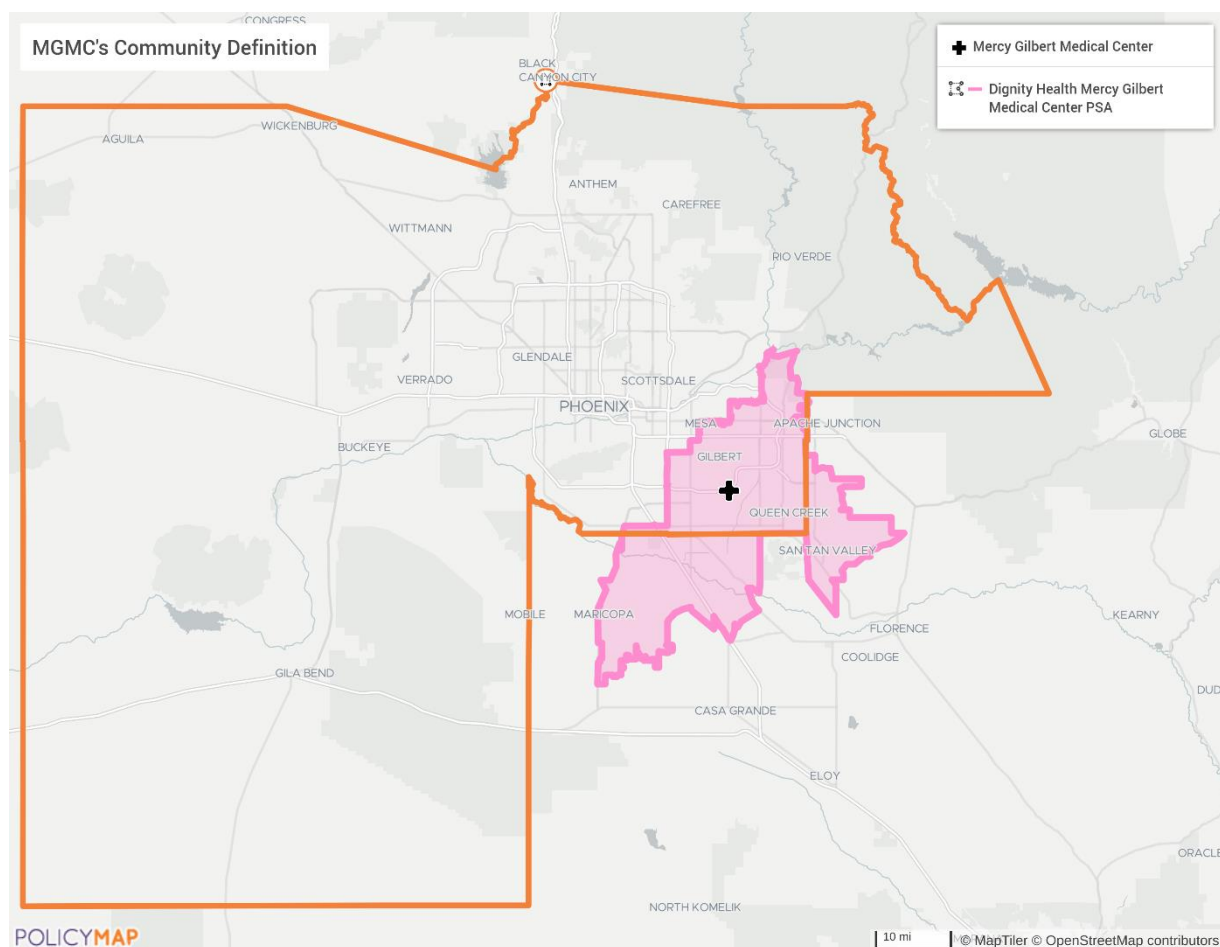
Figure 1. MGMC's Community Definition

Demographic and Socioeconomic Profile

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

	MGMC's PSA	Maricopa County	Arizona
Total Population Size	1,066,108	4,430,871	7,172,282
Population by Race/Ethnicity			
American Indian/Alaska Native (non-Hispanic)	1%	1%	4%
Asian and Native Hawaiian/Pacific Islander (non-Hispanic)	5%	4%	3%
Black/African American (non-Hispanic)	4%	5%	4%
White (non-Hispanic)	63%	53%	53%
Hispanic/Latino	22%	32%	32%
Population by Sex			
Male	49%	50%	50%
Female	51%	50%	50%
Population by Age Group			
0-14 years	21%	19%	18%
15-24 years	13%	14%	14%
25-44 years	27%	28%	26%
45-64 years	25%	24%	24%
65+ years	15%	16%	18%
Languages, among those 5 years and over			
Non-English Languages Spoken at Home	18%	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over			
Less than 9th grade	3%	5%	5%
9th – 12th grade, no diploma	4%	6%	6%
Employment Status			
Unemployed	4%	5%	5%
Median Household Income			
Income	$100,159	$80,675	$72,581
Poverty (based on income thresholds & family size)			
Below poverty level all ages	8%	12%	13%
Below poverty level all ages under 18 years	2%	16%	18%
Health Insurance Coverage			
Uninsured	8%	11%	11%

Health Insurance Type			
Medicaid	IP: 22%, ED: 31%	18%	21%
Health Professional Shortage Area	No	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	14	66	138

Table 2. MGMC'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.[xviii] 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.[xix]

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 MGMC'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 MGMC's PSA. The PSA has medically underserved areas in *Chandler* and in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*).[xviii]
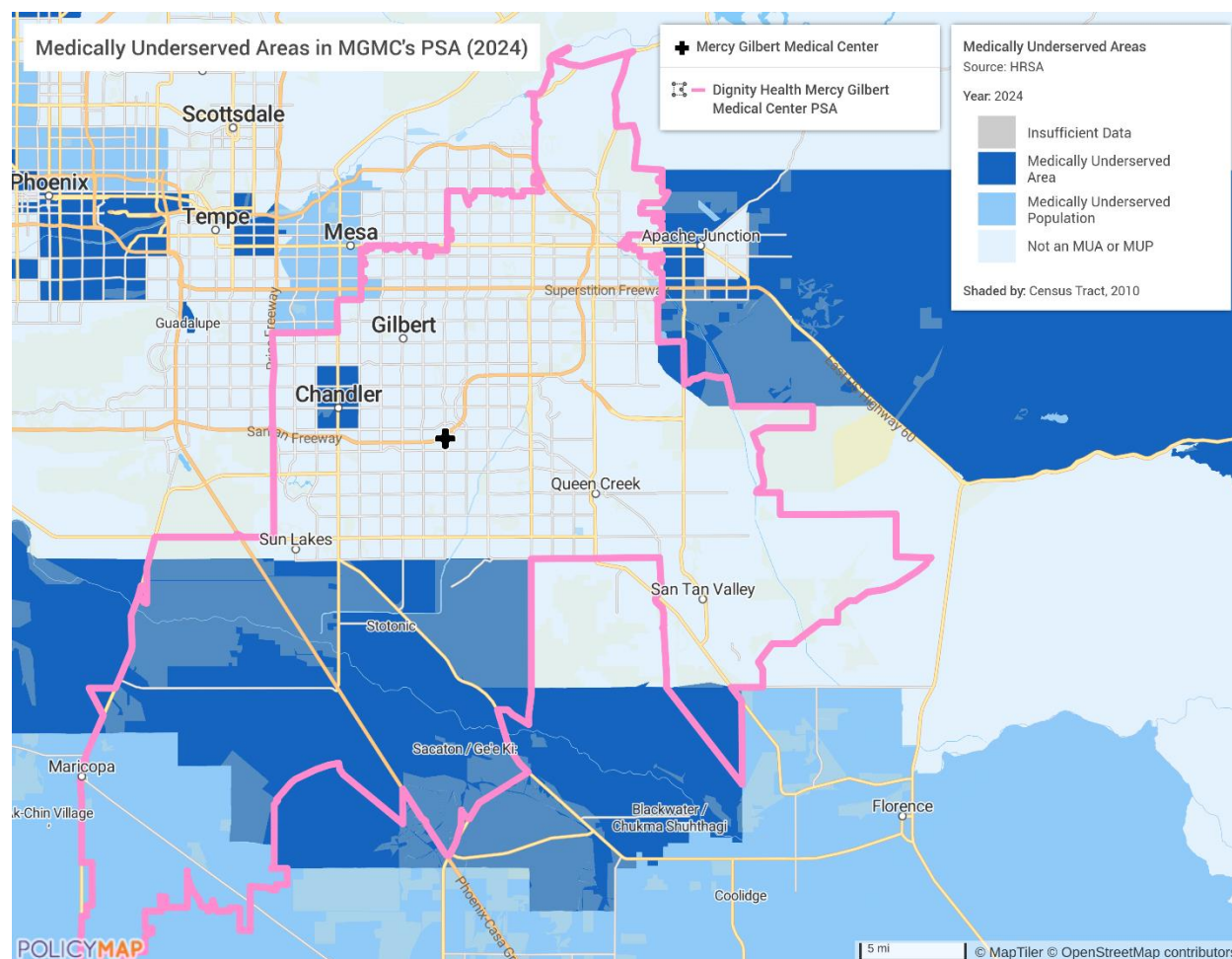
Figure 2. Medically Underserved Area/Population in MGMC's PSA

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.[xx] 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.[xxi]

Figure 3 displays the primary care health professional shortage areas status in MGMC's PSA in 2023. Primary care health professional shortage areas also consider infant mortality rate and low birth weight rate. The PSA has primary care health professional shortage areas in *Mesa*, *Maricopa*, in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*), and *San Tan Valley*.[xviii]
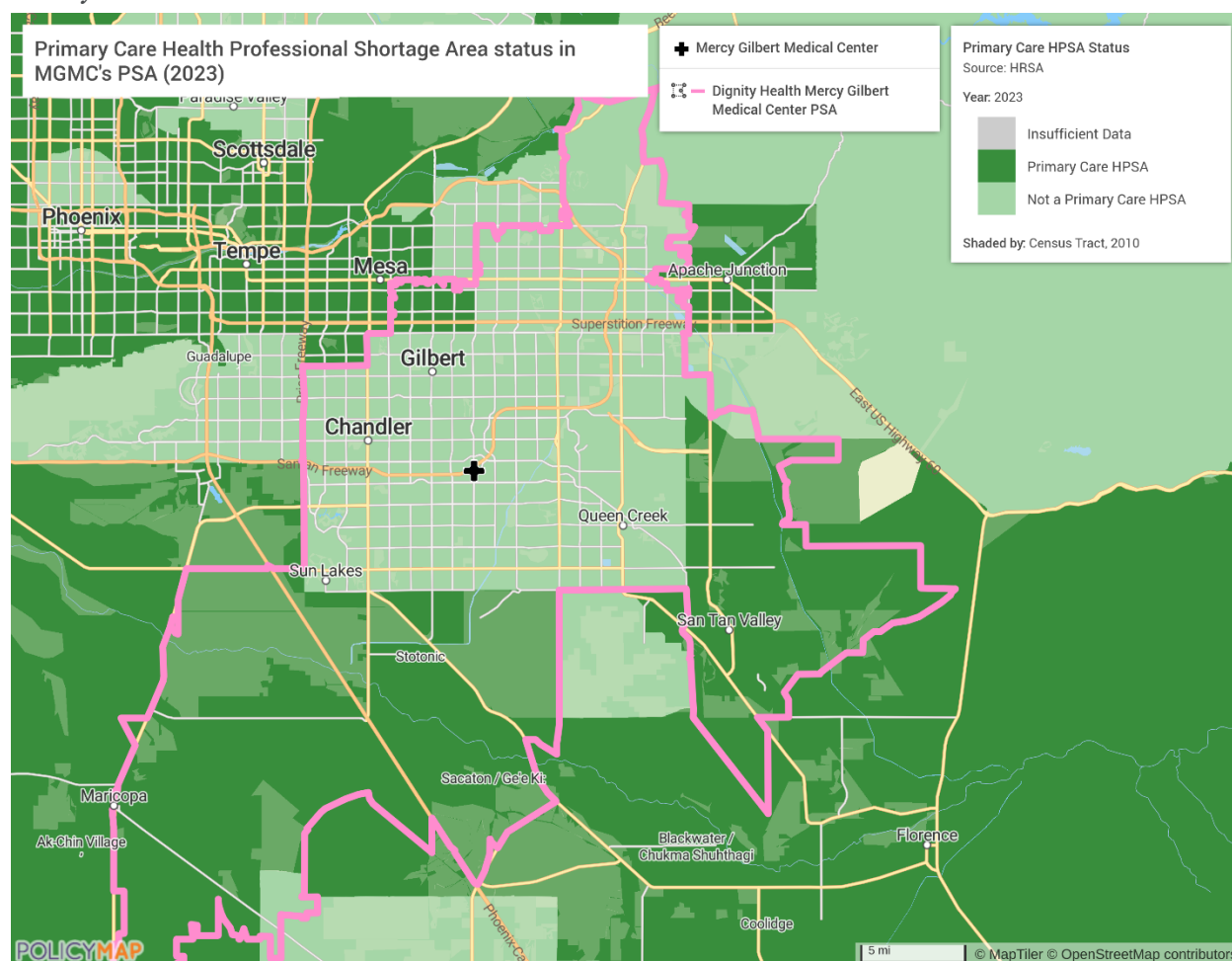
Figure 3. Primary Care Health Professional Shortage Areas Status in MGMC's PSA

Figure 4 displays the mental health professional shortage areas status in MGMC'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. The PSA has mental health professional shortage areas in *Mesa*, *Queen Creek*, and in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*).[xviii]
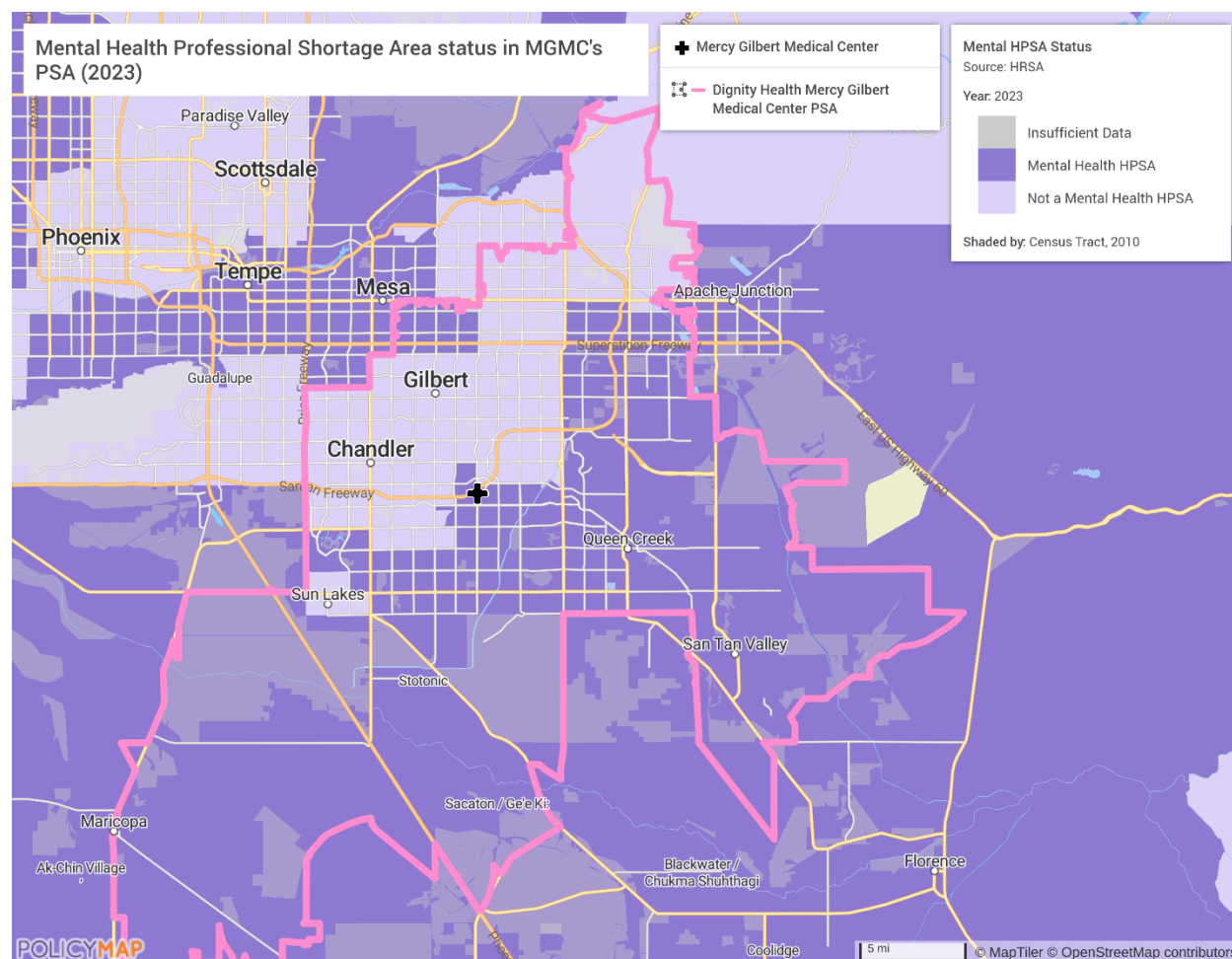
Figure 4. Mental Health Professional Shortage Areas Status in MGMC's PSA

Figure 5 displays the dental health professional shortage areas status in MGMC's PSA in 2023. Dental health professional shortage areas also consider an area's water fluoridation status. The PSA has dental health professional shortage areas in *Mesa*, *Maricopa*, and in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*).[xviii]
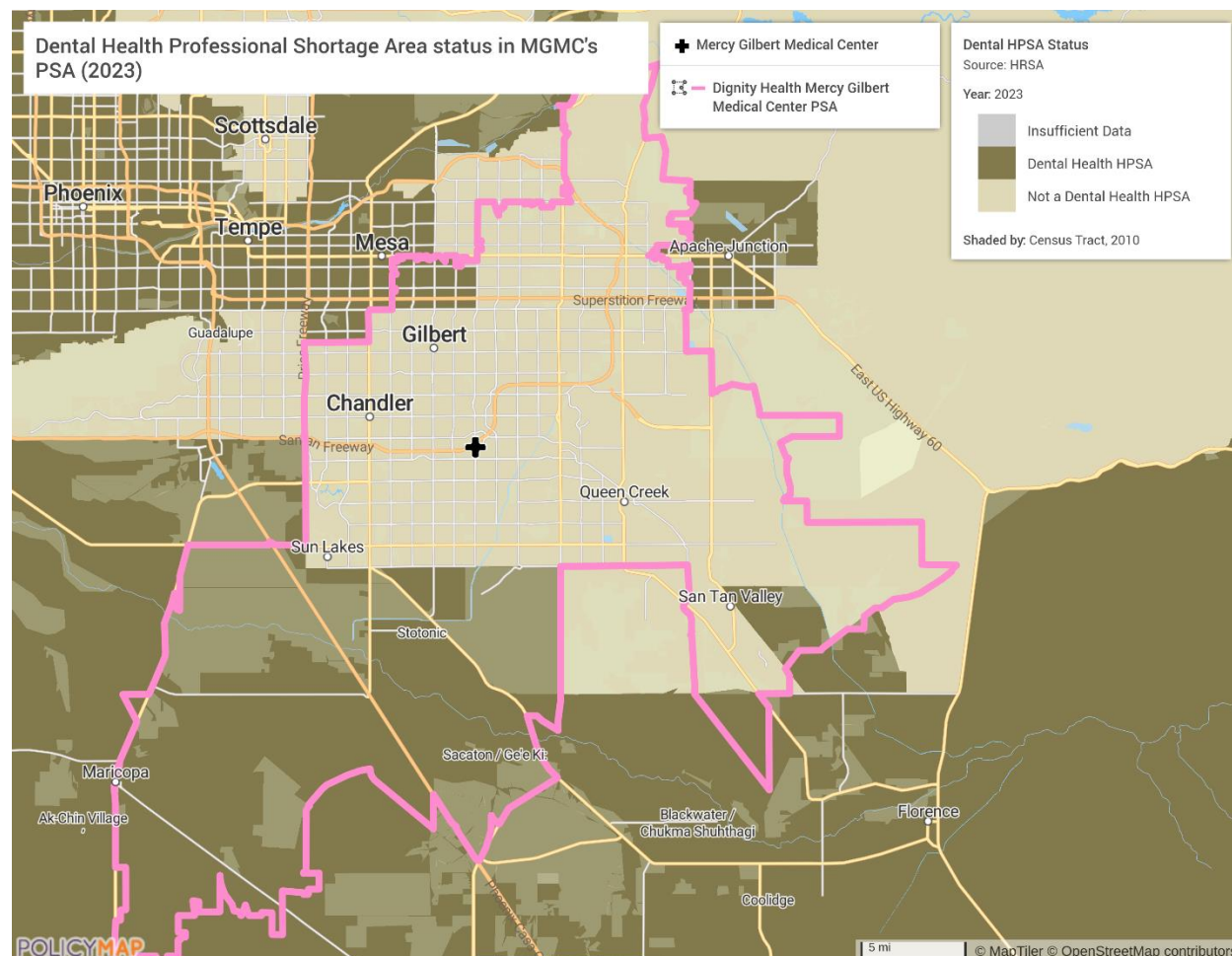
Figure 5. Dental Health Professional Shortage Areas Status in MGMC's PSA

Evaluating primary care, mental, and dental health professional shortage areas in MGMC's PSA is crucial for effectively allocating resources and minimizing overlapping efforts to address the identified health needs. This targeted approach supports MGMC 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, MGMC 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 MGMC 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 MGMC'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.

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."[xxii] 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 MGMC'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 MGMC'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. MGMC'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 MGMC selected for initial evaluation, which doesn't reflect any ranking. For the health indicators, hospital discharge and PolicyMap data were used for analysis.[viii, xviii]

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. MGMC's Initial Round of Health Indicators

Building on the initial round of health indicators, MGMC 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, MGMC aimed to ensure a comprehensive assessment of community needs.

Input Solicitation

MGMC 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 MGMC'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, MGMC 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, MGMC'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**. MGMC 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 MGMC 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.[viii] Higher rankings below indicate a higher priority in MGMC's PSA. The **top five** across multiple categories (IP/ED/Death) include: stroke, cardiovascular disease, all mental/behavioral disorders, and fall-related injuries.[xviii]

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		*	8
Prostate Cancer		*	**
Stroke	4	**	4
Cardiovascular Disease	1	2	1
Congestive Heart Failure	**	**	3
Diabetes	6	8	**
Alzheimer's	**	**	5
Obesity/Overweight	9	**	**

Chronic Obstructive Pulmonary Disease	**	10	6
Asthma	**	5	**
High Blood Pressure	**	7	**
All Mental/Behavioral Disorders	2	3	*
Alcohol-related Injuries	**	**	10
All Drug Overdoses	**	9	9
Opioids- Unintentional Overdose	**	**	**
Intentional Self-Harm/Suicide	**	**	**
Motor Vehicle Crash	10	4	**
Fall-related Injuries	4	1	**
Violence-related (assault-related injuries)	8	6	7

Table 5. Top Health Issue Indicators in MGMC'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 MGMC's PSA.[xviii]

➡ **Race/Ethnicity:** Black/African American and American Indian/Alaska Native populations experienced higher rates of infant mortality, cancer, and all drug overdoses.

➡ **Age:** Older adults (65+ years) had higher rates of breast/colorectal 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 colorectal/lung cancer, cardiovascular disease, and alcohol-related injuries.

Recognizing these disparities helps MGMC to create targeted solutions that address the unique needs of each group. By addressing these inequities, MGMC 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.*

Significant Health Needs by Disproportionately Affected Populations in MGMC's PSA			
	Race/Ethnicity	Age (years)	Gender
Low Birth Weight*	Asian and Native Hawaiian/Pacific Islander	25-44	Female
Preterm Births*	Black/African American	25-44	Male
Infant Mortality Rate*	Black/African American	Data Not Available	
All Cancers**	Black/African American	65+	Male
Breast Cancer**	Black/African American	65+	Female
Cervical Cancer**	White	45-64	Female
Colorectal Cancer**	Black/African American	65+	Male
Lung Cancer**	Black/African American	65+	Male
Prostate Cancer**	Hispanic/Latino	65+	Male
Stroke	IP/ED/Death: Black/African American	IP/ED/Death: 65+	IP/ED/Death: Male
Cardiovascular Disease	IP/ED/Death: Black/African American	IP/ED/Death: 65+	IP/ED/Death: Male
Congestive Heart Failure	IP/Death: Black/African American ED: White	IP/ED/Death: 65+	IP/ED/Death: Male
Diabetes	IP/ED: American Indian/Alaska Native Death: Hispanic/Latino	IP/ED/Death: 65+	IP/ED/Death: Male
Alzheimer's	IP/Death: White ED: Black/African American	IP/ED/Death: 65+	IP: Male ED/Death: Female

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

Table 6. Populations with the Greatest Rates of IP/ED/Death in MGMC'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 MGMC 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]

Community Strengths and Assets

1
- Neighbor Relatability and Impact on Families
- Strengths in Community Centers, Community Groups, and Medical Centers
- Education

Systems of Power, Privilege, and Oppression

2
- Discrimination, Racism or Oppression
- Provider Competency
- Community Safety
- Neighborhood Characteristics
- Social Connectedness
- Community Representation
- Community Care and Mutual Aid
- Structural Racism

Social Determinants of Health

3
- Health Care Access and Quality
- Health Information Access and Preferences
- Social and Community Context

Healthy Behaviors and Outcomes

4
- Prevention
- Exercise
- Self-Advocacy
- Unmet Mental Health
- Substance Use
- Poor Nutrition
- Obesity
- Chronic Disease

Chronic Diseases

5
- Mental Illness
- Diabetes
- Cancer

Additional Topics

6
- Innovation
- Trust

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.[xxiii] **Figure 9** shows the social vulnerability index in MGMC's PSA, with the following cities displaying high to moderate social vulnerability levels: *Chandler*, *Mesa*, in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*) and *San Tan Valley*.[xviii]
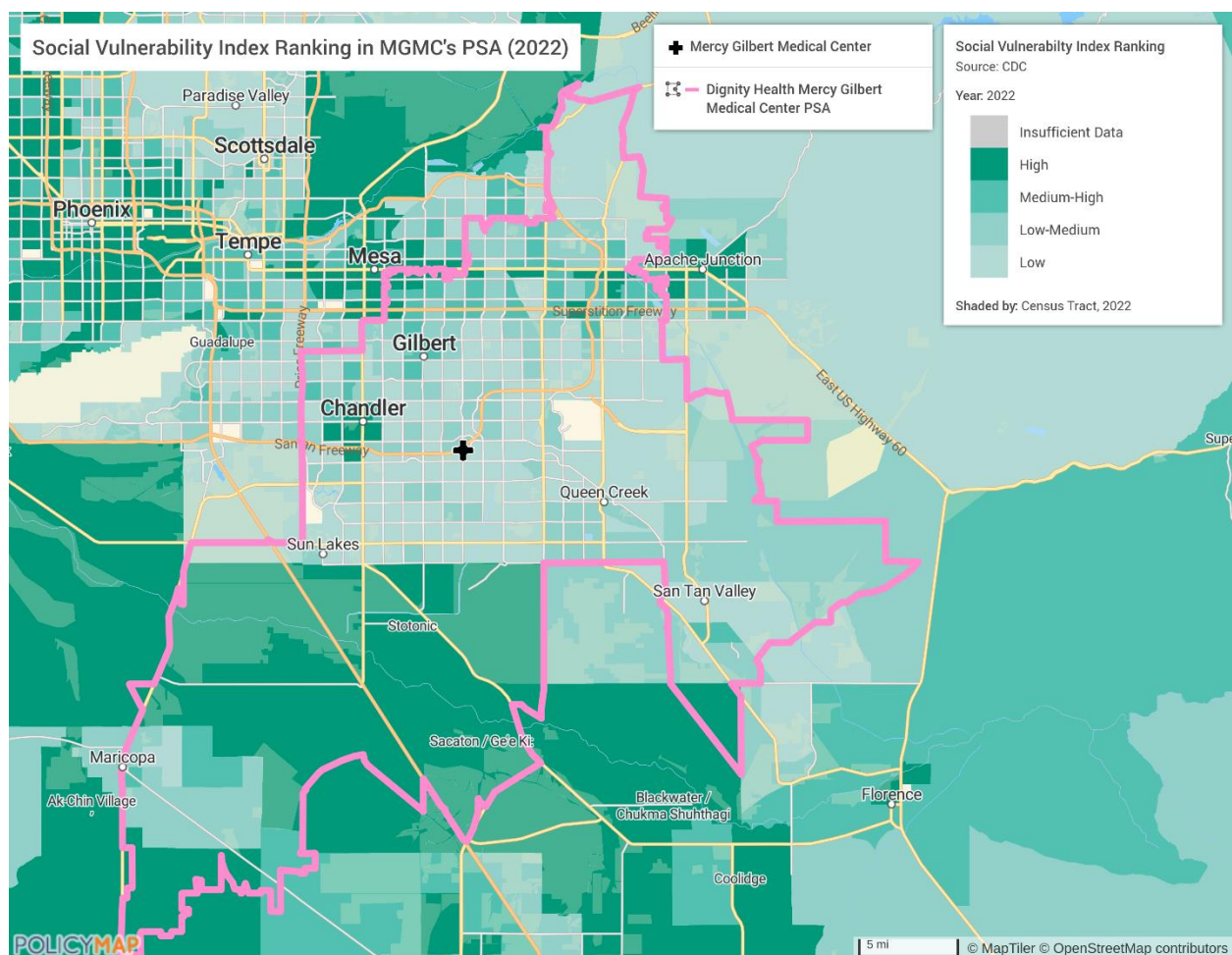
Figure 9. Social Vulnerability Index Map in MGMC's PSA

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:[xxiv]

- 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.[xxiv] **Figure 10** highlights the domain areas and zip codes in MGMC's PSA classified as high vulnerability.

Economic — 85147
- Individuals below 200% of poverty rate
- Unemployment
- Lower median income

Neighborhood Resources — 85147
- No park access
- Food deserts
- Broadband availability and household broadband subscriptions
- Alcohol sales
- Opioid dispensing

Housing — 85204
- Lower rates of homeownership
- Homes with incomplete plumbing
- Crowded housing
- Low-income households with housing expenses >50% income

Clean Environment — 85204-85206, 85208, 85209, 85212, 85224, 85225, 85233, 85234, 85248, 85286, 85295, 85296
- Air pollution
- Water pollution
- Hazardous waste and spill

Transportation — 85147
- Households with no access to automobile or public transit

Public Safety — 85204
- Violent crime
- Gun violence

Figure 10. Vizient Vulnerability Index in MGMC'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.[xxv] Although MGMC 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.[xviii] 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.[xxvi] Communities like in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*) have increased vulnerability to climate change.[xviii]
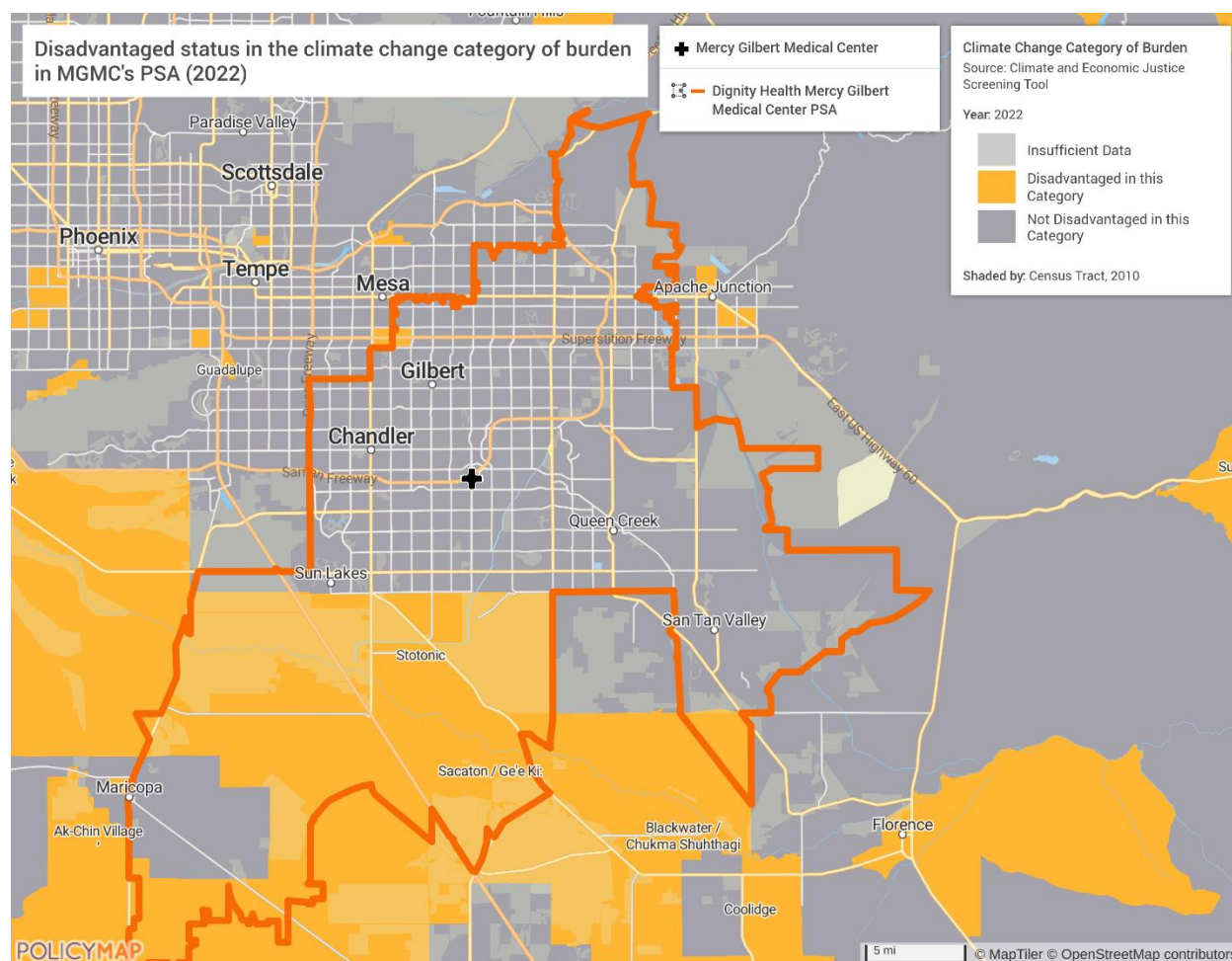
Figure 11. Climate Change Burden in MGMC's PSA

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.[xxvii] Due to the state's unique climate and environmental conditions, MGMC 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.[xxviii]

Extreme Heat	Climate Driver	Exposure	Health Outcome
	More frequent, severe, prolonged heat events	Elevated temperatures	Heat-related death and illness
	Impact		
	Rising temperatures may lead to an increase in heat-related deaths and illnesses		

Outdoor Air Quality	Climate Driver	Exposure	Health Outcome
	Increasing temperatures and changing precipitation patterns	Worsened air quality (ozone, particulate matter, higher pollen counts)	Premature death, acute and chronic cardiovascular and respiratory illnesses
	Impact		
	Rising temperatures and wildfires and decreasing precipitation may lead to increases in ozone and particulate matter, elevating the risks of cardiovascular and respiratory illnesses and death.		

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.[xxix] 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.[xxx] **Figure 13** shows the particulate matter 2.5 level in air in MGMC's PSA.[xviii] 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 MGMC's PSA face more exposure to PM2.5.[xviii]
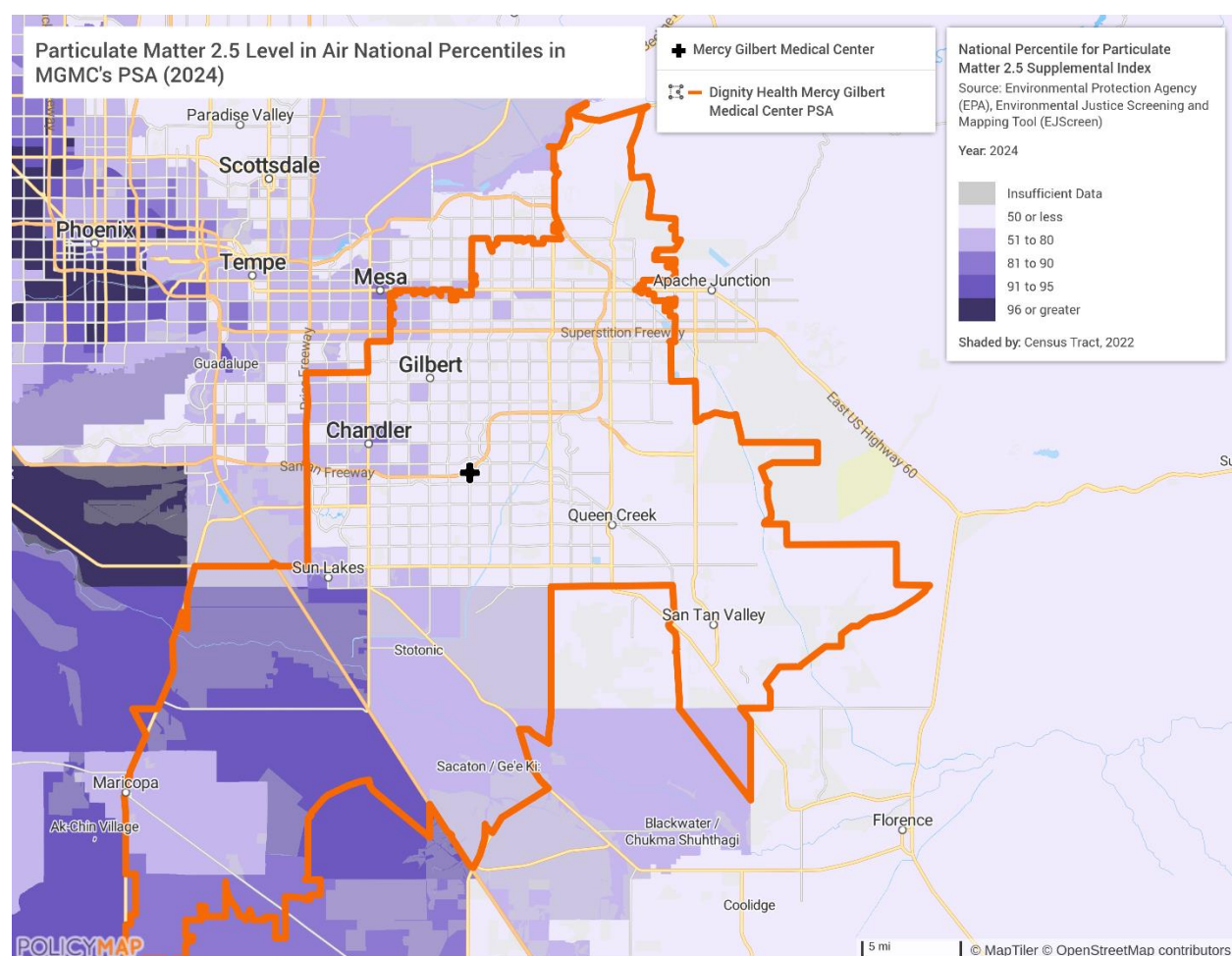
Figure 13. Particulate Matter 2.5 Level in Air National Percentiles in MGMC's PSA

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.[xxxi] 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 MGMC's PSA. Communities like in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*) and areas in *San Tan Valley* have relatively higher drought risk compared to other communities.[xviii]
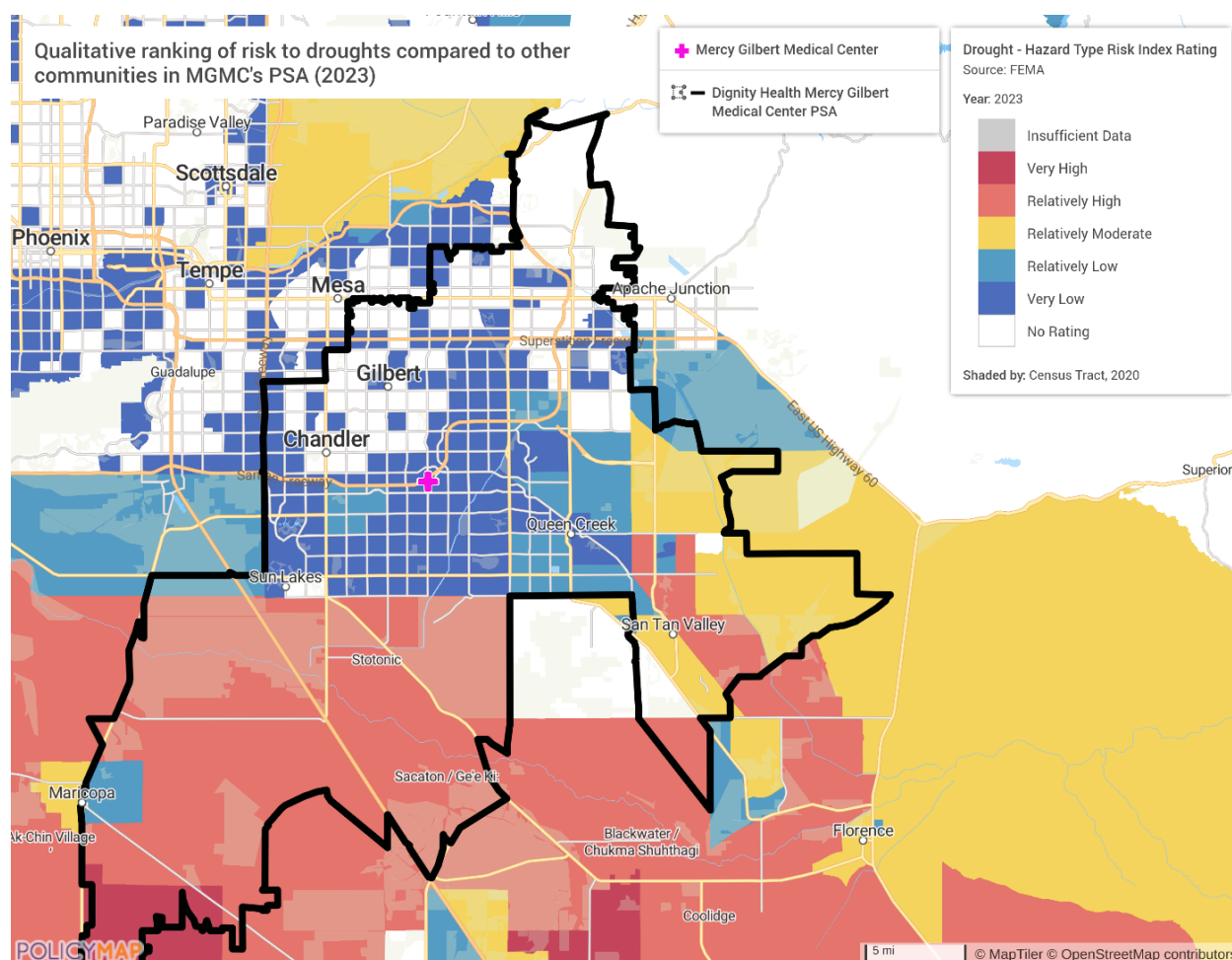
Figure 14. Risks to droughts in MGMC's PSA (2023)

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[xxxii], social[xxxiii], and racial[xxxiv] equity lens to the CHNA priorities, MGMC 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 MGMC'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 MGMC'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 MGMC, selected based on disparities analyzed by race/ethnicity, sex, and age within MGMC'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. MGMC and Maricopa County Department of Public Health co-designed and implemented a three-phased prioritization process **(Figure 15)**.

Phase One
Indicator Review and
Simplification

Phase Two
CHNA Prioritization
Workshops

Phase Three
Final Consensus of
CHNA Priorities

Figure 15. Phases of MGMC's Prioritization Process

Phase One

In Phase One, MGMC'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 MGMC. 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, MGMC 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 MGMC 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	*Community survey, focus group, and committee feedback demonstrates community health need*	*Dignity Health East Valley has ability to mobilize action to address need*	*Dignity Health East Valley has desire & adequate infrastructure to address need*	*Strategic/impactful alignment with community partners to address need*
Data Sources: Hospital Discharge Data, PolicyMap	**Data Sources:** CHNA Survey/Focus Groups, Dignity Health's Community Health Committee	**Data Sources:** Community Health Committee experience and expertise	**Data Sources:** Dignity Health's mission/vision/values & internal community health programs	**Data Sources:** Synapse Partner's CHNA Priorities
▪ Disproportionate indicator rates (2022, percent change between 2022 & 4-year average)	▪ Top health/social issues from CHNA survey	▪ Practicality of implementing immediate services and programming to address priority area based on available prevention and treatment	▪ Organization risks in supporting or expanding priority (insurance, policies & compliance implications)	▪ 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?
▪ Classified as top 10 indicator by overall rate	▪ Community experiences from CHNA focus groups	▪ Possibility to make improvements in 3 years based on available resources	▪ Alignment to hospital mission, purpose, scope, and current/planned services	▪ Lack of partners in community addressing need, Dignity Health East Valley would need to spearhead effort
▪ Indicator disparities displayed by mapping tool (as available)	▪ Alignment from Community Health Committee on health needs based on lived experiences	▪ Ability to track and measure progress to determine effectiveness.	▪ Staff/leadership capacity, financial ability, tools & technology, data collection/reporting ability	▪ 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.
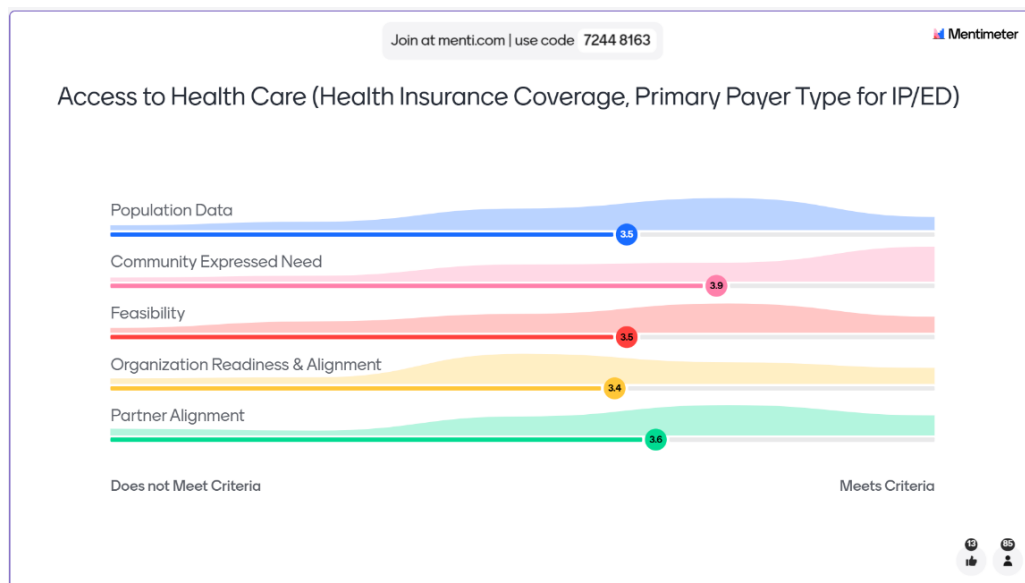
Figure 17. Prioritization Activity #1 Menti – Criteria for Rating Access to Health Care

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. MGMC's Community Health team reviewed all responses to help inform finalization of priorities.
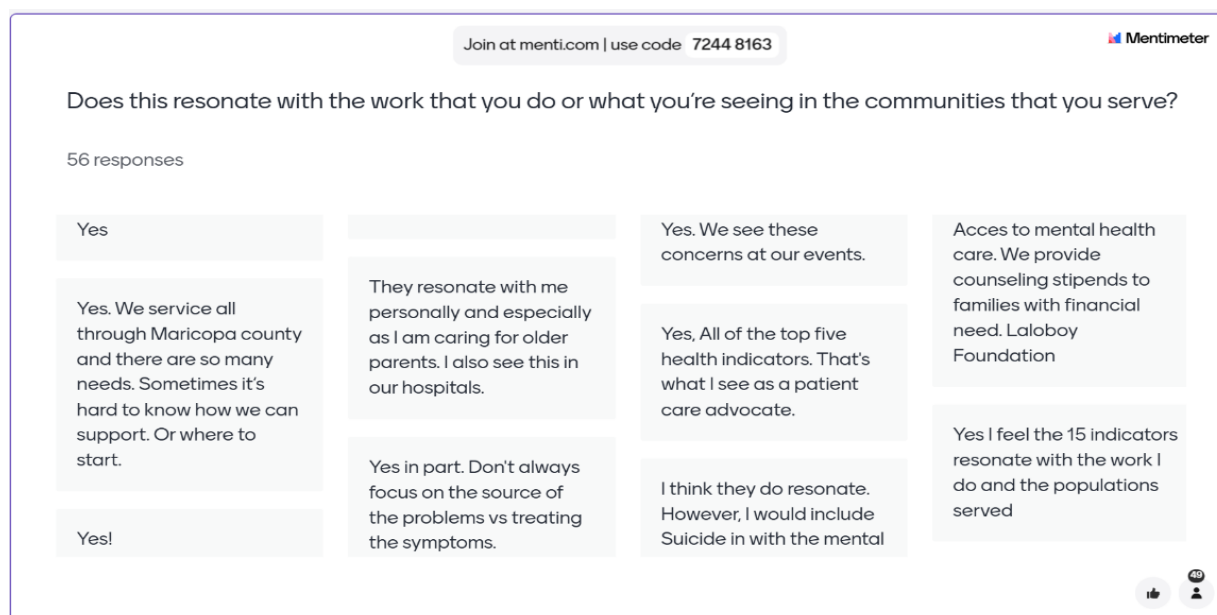
Figure 18. Prioritization Activity #2 Menti

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)**.
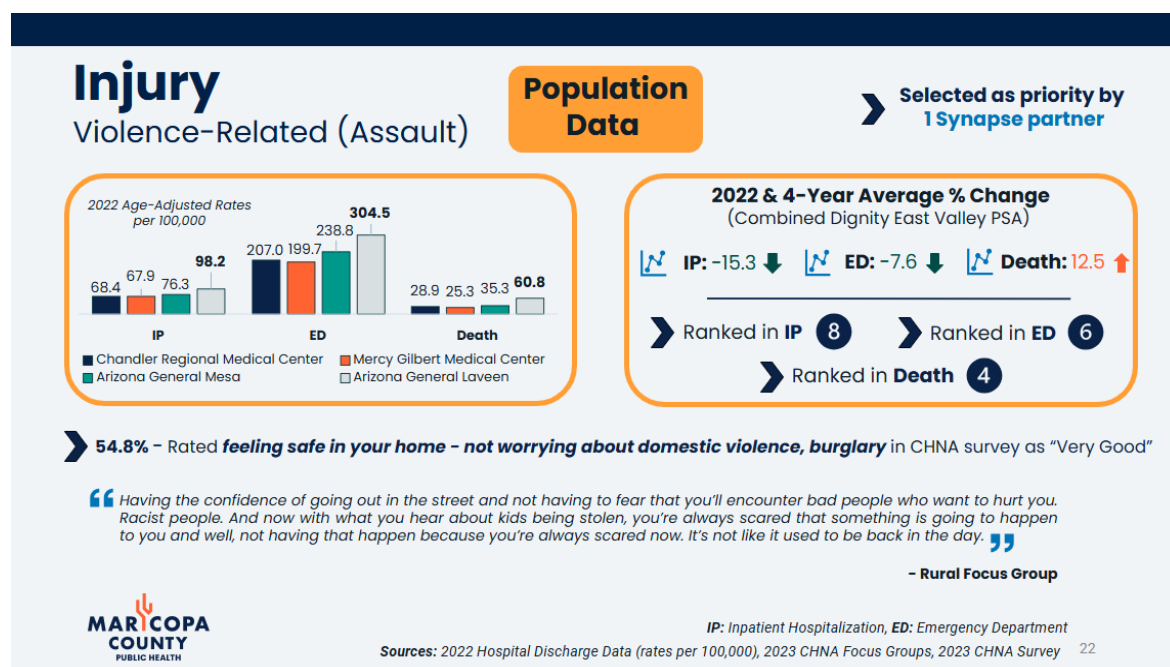
Figure 19. Example Data Indicator Criteria Slide

After this demonstration, participants gained a better understanding of all the criteria, except for "feasibility" and "organizational readiness". To address this, MGMC'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, MGMC'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 MGMC'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.

Health, Social, and Racial Equity Lens

Mental Health
↳ All Mental and Behavioral Disorders

Chronic Conditions
↳ Cardiovascular Disease   ↳ Diabetes   ↳ Obesity

Social Determinants of Health
↳ Housing and Homelessness   ↳ Access to Food

Access to Care
↳ Dental Health

Violence and Injury

Cancer
↳ Breast Cancer

Figure 21. MGMC's Final CHNA Priorities
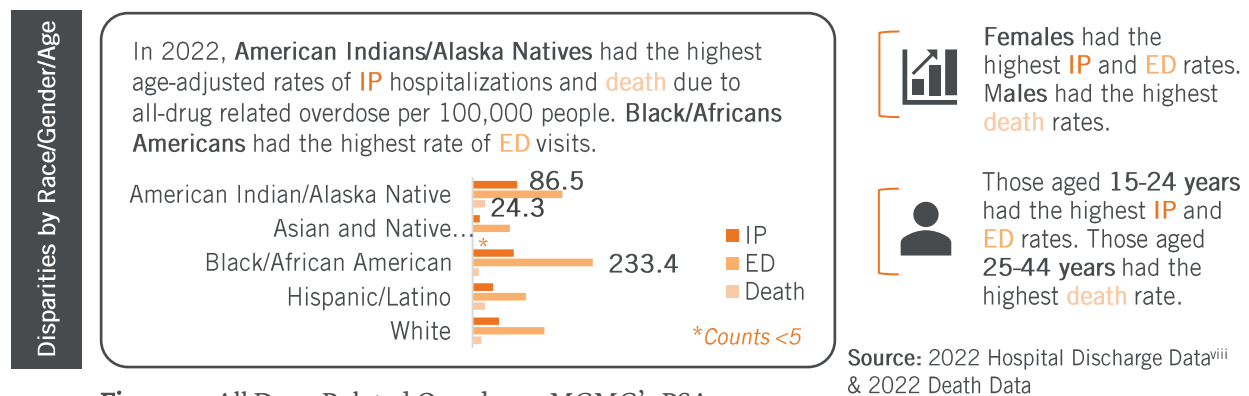
Importance and Impact in MGMC's PSA

Mental health, including *all mental and behavioral disorders* was selected as a significant health need for MGMC. All mental and behavioral disorders are defined as the primary diagnosis of a mental, behavioral, or neurodevelopment disorder.[xxxv] 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.[xxxvi] 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.

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

American Indian/Alaska Native — 1,281.2 / 1,897.5
Asian and Native…
Black/African American
Hispanic/Latino
White
IP
ED

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

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

Source: 2022 Hospital Discharge Data[viii]

Figure 22. All Mental and Behavioral Disorders – MGMC'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.[xxxvii] For many individuals, self-harm provides temporary relief and is used to cope with feelings of loneliness, anger, or hopelessness.[xxxviii]

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

American Indian/Alaska Native — 86.5 / 24.3
Asian and Native… *
Black/African American — 233.4
Hispanic/Latino
White
IP
ED
Death
*Counts <5

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

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

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

Figure 23. All Drug-Related Overdose – MGMC's PSA
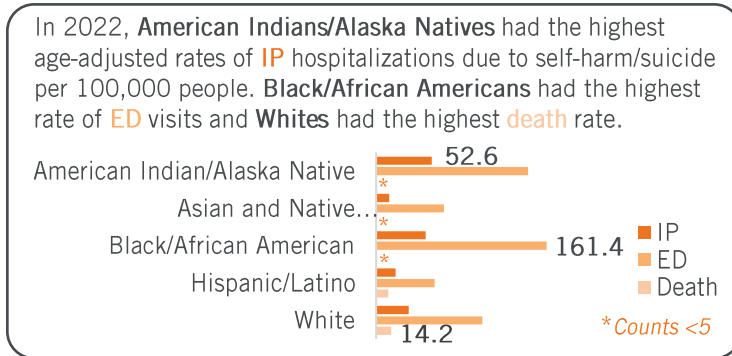
Disparities by Race/Gender/Age

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

American Indian/Alaska Native — 52.6
Asian and Native… *
Black/African American — 161.4 *
Hispanic/Latino
White — 14.2

■ IP
■ ED
■ Death

*Counts <5

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

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

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

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

Community-Identified Issues in Maricopa County

Recognizing that MGMC'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**. Queen Creek focus group participants shared challenges such as **long wait times, affordability,** and **lack of specialized mental health providers** covered by insurance.

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

> " *Access to that mental health can be difficult for young people is what I've found. As an educator, it can take a lot to get the children, students, young adults…get them the help that they need. One of the things I've heard very commonly over the last couple of years is the wait time is significant when you're dealing with a behavioral or mental health organization*
>
> - 2024 Queen Creek Focus Group Participant

Sources: 2023 CHNA Survey, 2023/2024 Focus Groups, 2024 Key Informant Interviews[v, vi, vii]
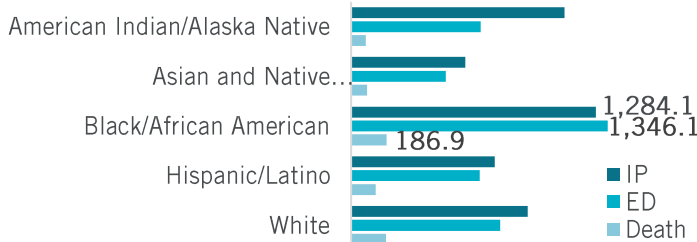
Importance and Impact in MGMC's PSA

Chronic conditions, including *cardiovascular disease*, *diabetes*, and *obesity* were selected as significant health needs for MGMC. 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.[xxxix] Diabetes includes both type 1 and 2 diabetes and other specified diabetes mellitus.[xl] 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.[xli] These chronic conditions are often interconnected, as they share common risk factors such as physical inactivity and poor dietary habits.[xlii, xliii, xliv] 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.

American Indian/Alaska Native
Asian and Native…
Black/African American — 1,284.1 / 1,346.1 / 186.9
Hispanic/Latino
White

IP
ED
Death

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 – MGMC's PSA

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

American Indian/Alaska Native — 562.8 / 484.1
Asian and Native… *
Black/African American
Hispanic/Latino — 23.5
White

IP
ED
Death

Counts <5

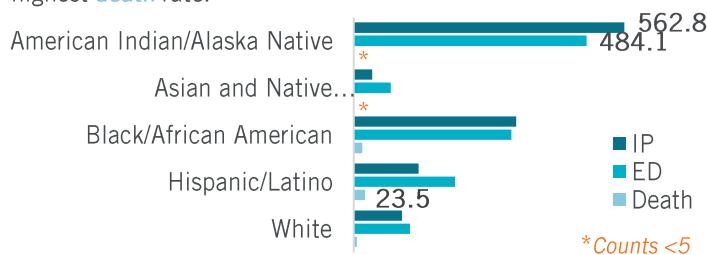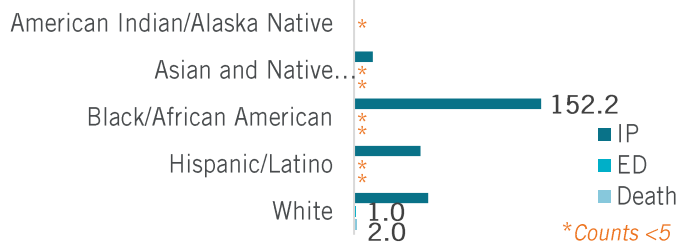**Males** had the highest IP, ED, and death rates.

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

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

Figure 26. Diabetes – MGMC's PSA

Figure 27. Overweight – MGMC's PSA

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

American Indian/Alaska Native *
Asian and Native... *
Black/African American 152.2 *
Hispanic/Latino *
White 1.0 2.0

■ IP
■ ED
■ Death

Counts <5

Disparities by Race/Gender/Age

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

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

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

Community-Identified Issues in Maricopa County

Recognizing that MGMC'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 MGMC's PSA

Social determinants of health, including *housing and homelessness* and *access to food,* were selected as significant health needs for MGMC. 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.[xlv] 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.[xlvi] The availability of food options – such as grocery stores, farmers markets can support or limit healthy eating.[xlvii] 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 MGMC's PSA, cities like *Gilbert*, *Chandler*, *Sun Lakes*, and *San Tan Valley* show higher proportions of severely cost burdened renters **(Figure 28)**.[xviii]
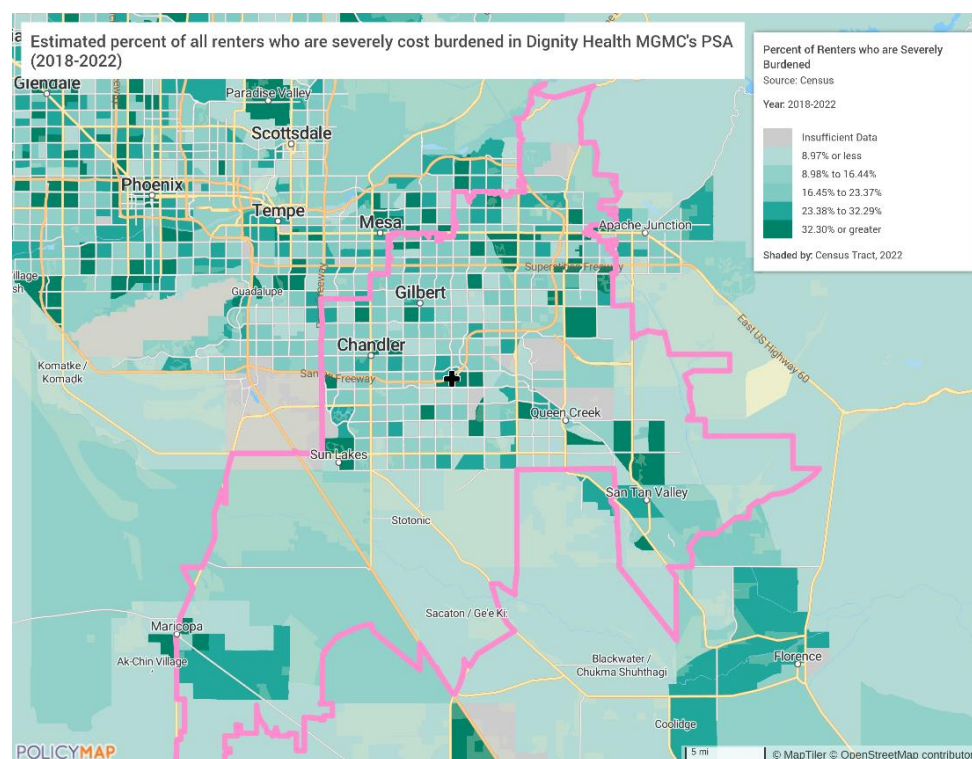
Figure 28. Severely Cost Burdened Renters – MGMC's PSA

Food Stamp/Supplemental Nutrition Assistance Program Benefits

Evaluating data on food stamp and SNAP benefits helps reveal areas with greater food insecurity.
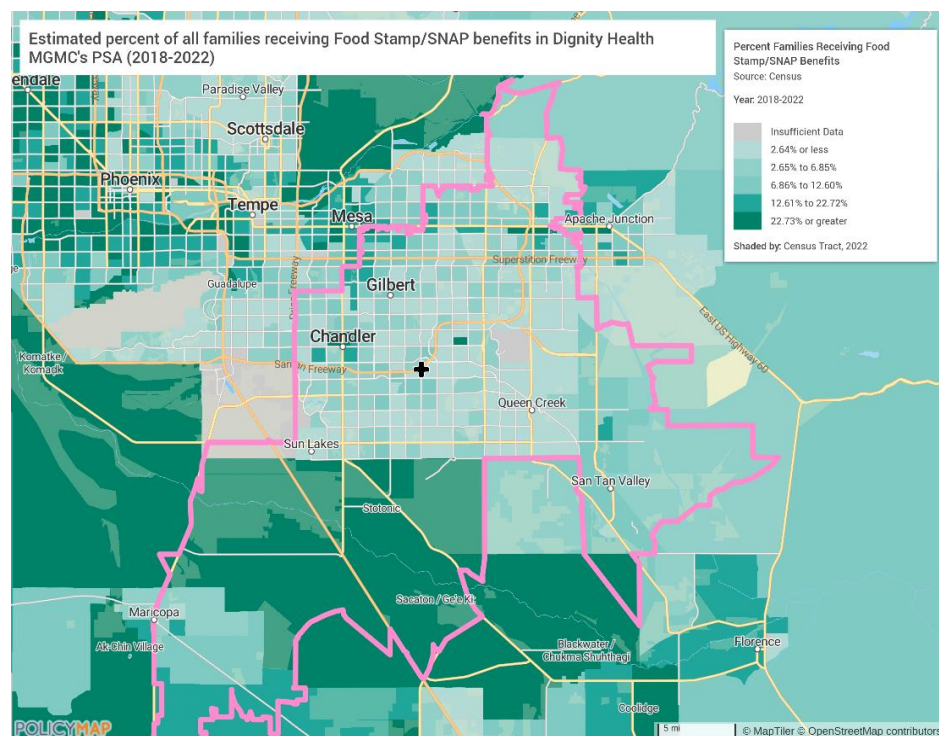
By highlighting these disparities, resources like food assistance programs can be directed to locations with the greatest need. In MGMC's PSA, cities like *Gilbert*, *Chandler*, *Maricopa*, and in the GRIC (*Stotonic, Sacaton*, and *Blackwater*) have higher proportions of families receiving food stamp or Supplemental Nutrition Assistance Program benefits **(Figure 29)**.[xviii]

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

Community-Identified Issues in Maricopa County

Recognizing that MGMC'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 MGMC's PSA (Mesa and Chandler).[ix]

Top Municipalities - Unsheltered Count

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

Disparities by Race/Gender/Age

In 2022, majority of the Point-in-Time count identified as **White** followed by **Black African American**.

White	63%
Black/African American	26%
Asian	1%
American Indian/Alaska Native	6%
Native Hawaiian/Other Pacific Islander	5%

Majority of the population experiencing homelessness identified as **male (65%)**.

The largest age group from the Point-in-Time count was **adults 25+ years (78%)**.

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

> *…You know, like substance use, type of services, especially for people without the medical, the insurance, and I'm thinking of even like some of the homeless population, because we are starting to see some homeless people in Queen Creek. How do they access those services? You know, there's not shelters either in the area that I'm familiar with.*
> - 2024 Queen Creek Focus Group Participant

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.[xvi]

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 MGMC's PSA

Access to care, including *dental health,* was selected as a significant health need for MGMC. 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."[xlviii] 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.[xlix] 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.[l] Queen Creek focus group participants discussed health care barriers such as lack of insurance coverage, affordability, and complex payment structures. Additionally, the disruption of changing insurance plans and establishing new doctor-patient relationships was identified as an obstacle.[vi] In MGMC's PSA, cities such as *Chandler*, *Mesa*, *Maricopa*, and in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*) have higher proportions of people without health insurance **(Figure 31)**.[xviii]
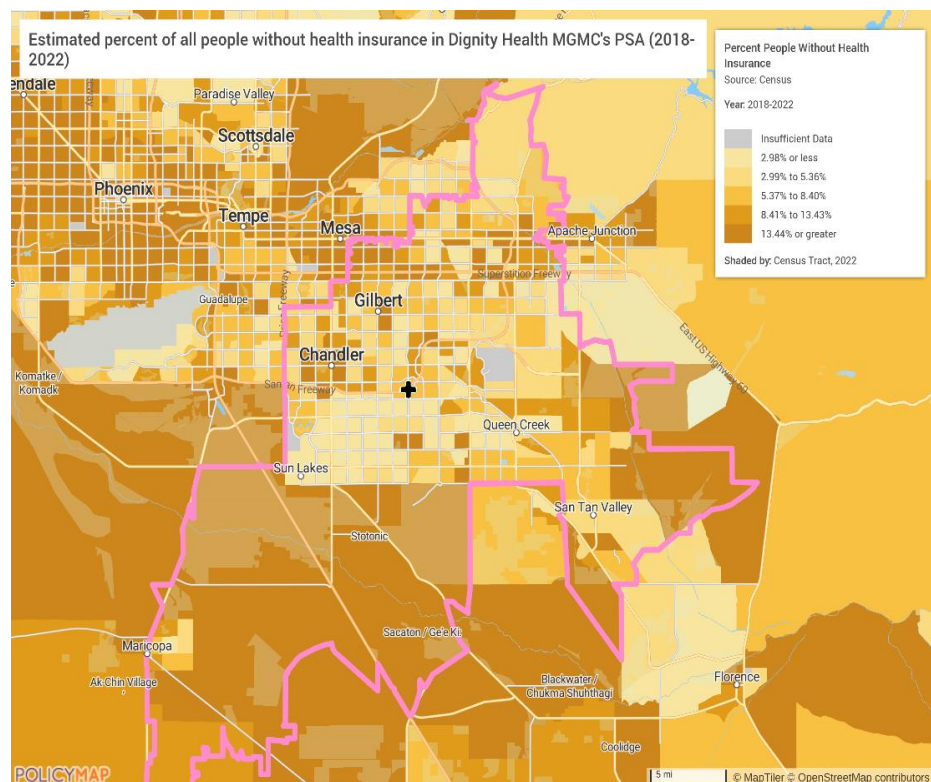
Figure 31. People Without Health Insurance – MGMC's PSA

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.[li] Preventive care can also encourage healthy oral health habits, all of which contribute to long-term dental and overall health and well-being. In MGMC's PSA, communities like in the GRIC (*Stotonic*, *Sacaton*, and *Blackwater*) contain areas with lower proportions of adults who visited a dentist or dental clinic in the past year **(Figure 32)**.[xviii]
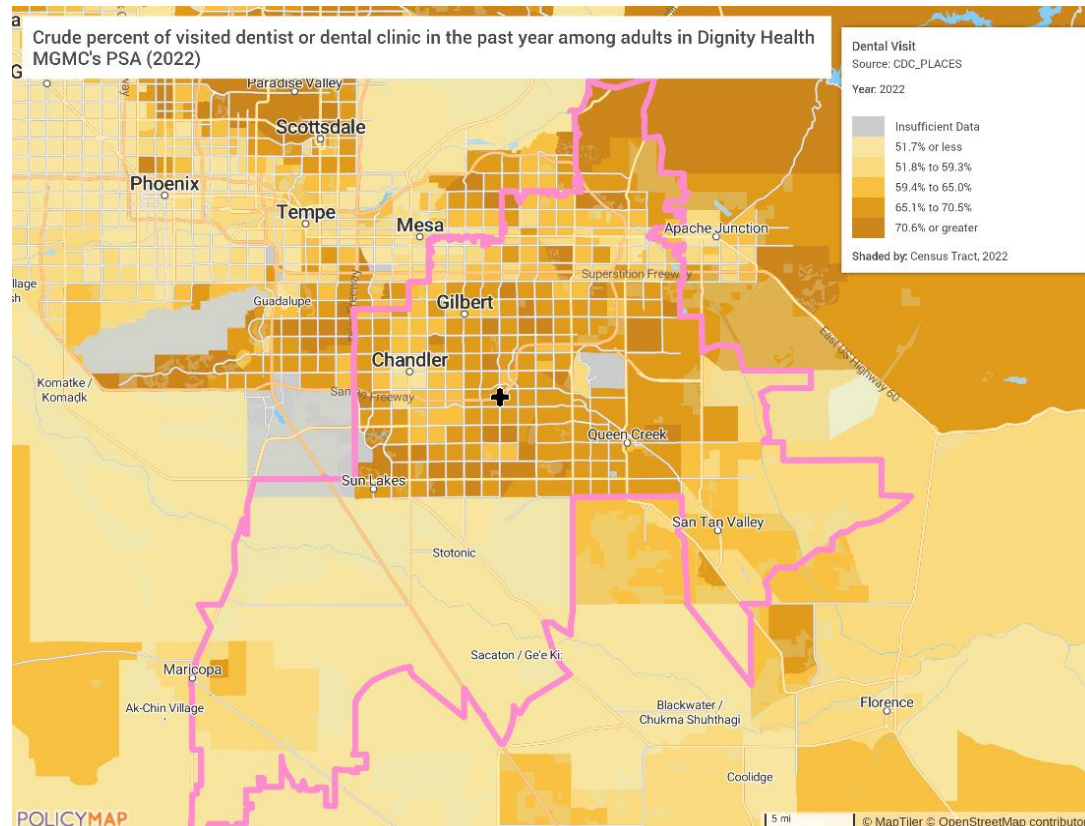
Figure 32. Adults who Visited the Dentist or Dental Clinic in Past Year in MGMC's PSA

Dignity Health Early Childhood Oral Health Program

Promoting early childhood oral health is crucial not only for a child's immediate health and well-being but also for establishing lifelong healthy habits. As teeth begin to emerge, tooth decay becomes a concern, leading to potential early tooth loss, which can affect speech, nutrition, and appearance.[lii] Regular dental screening can prevent tooth decay. Dignity Health East Valley's Early Childhood Oral Health Program offers free basic oral screenings, education and referrals to expectant mothers and children aged zero to five, who are not enrolled in kindergarten.[liii] **Figure 33** highlights the prevalence of children at high risk for caries (professional term for cavities) and the prevalence of children and expectant mothers who had untreated tooth decay in fiscal year 2024.[liii]

Of 2,337 children assessed

83% reported as **high risk** for **caries**

Of 2,337 children assessed

17% had **untreated tooth decay**

Of 118 expectant mothers who received oral health

46% had **untreated tooth decay**
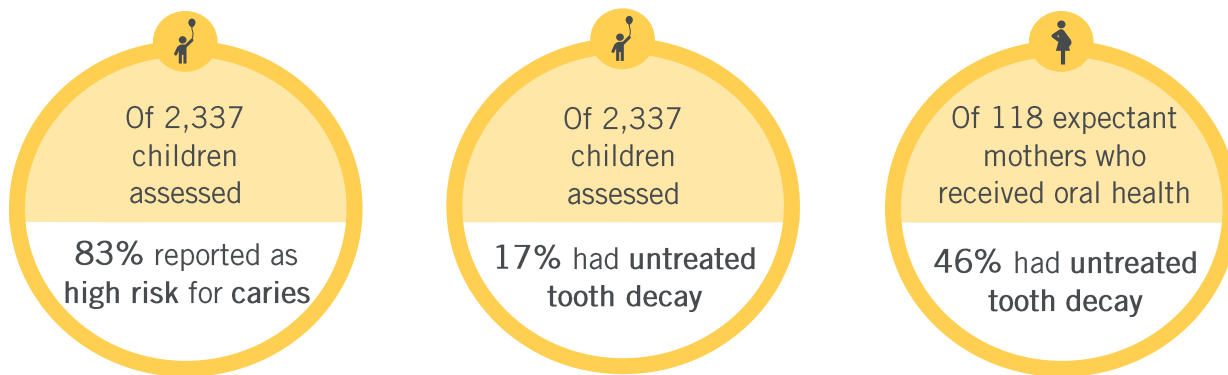
Figure 33. High Risk for Caries and Untreated Tooth Decay among Children and Expectant Mothers in MGMC's PSA (2024)

Community-Identified Issues in Maricopa County

Recognizing that MGMC'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.** Queen Creek focus group participants felt the access to **medical resources** such as **urgent care facilities** and **mobile health units** was a **community strength.**

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

> " I know for sure for dental, that's a big issue. Even people that get AHCSSS there's no dental coverage for them unless it's an emergency. So, you know...there's no preventative dental.
>
> - 2024 Queen Creek Focus Group Participant

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

Importance and Impact in MGMC's PSA

Violence and injury was selected as a significant health need for MGMC. 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.[liv] 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.[lv] The benefits of injury and violence prevention extend beyond the individual, contributing to significant improvements in overall public health, social cohesion, and economic stability.

In 2022, **American Indians/Alaska Natives** had the highest age-adjusted rate of IP hospitalizations due to assault-related injuries per 100,000 people. **Black/African Americans** had the highest rate of ED visits. **Hispanic/Latinos** 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 rate. Those aged **65+ years** had the highest IP rate. Those aged **25-44 years** had the highest death rate.

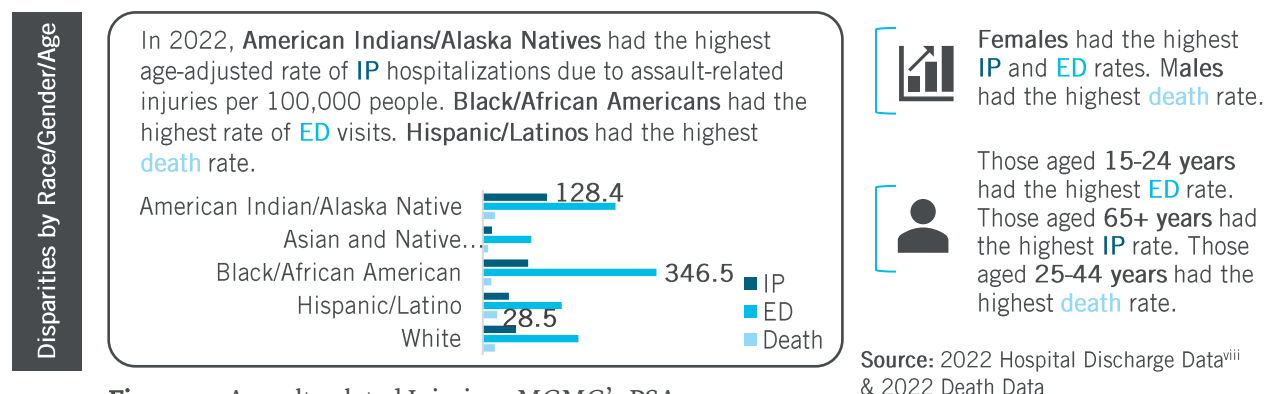Source: 2022 Hospital Discharge Data[viii] & 2022 Death Data

Figure 34. Assault-related Injuries – MGMC's PSA

Trauma Incidents[xiv]

From March-June 2024, falls followed by motor vehicle/motorcycle collisions were the top two leading causes of trauma-related cases at MGMC.
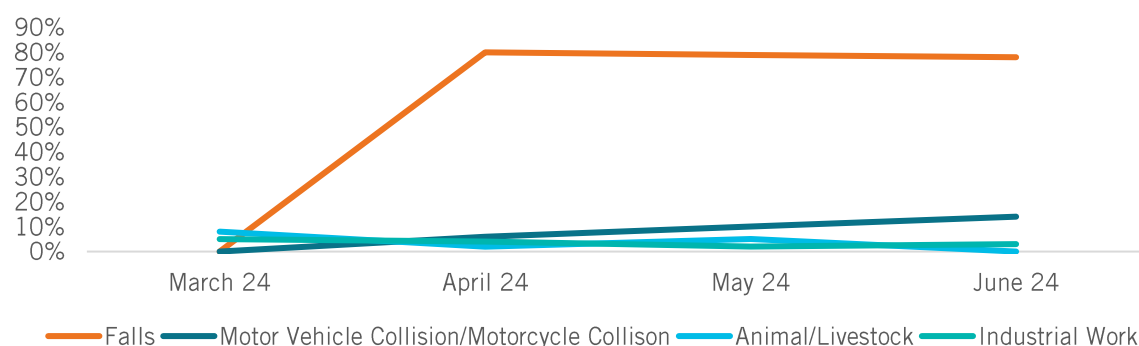
Figure 35. Trauma Incidents – MGMC's PSA

Youth/Teen Violence

Youth and teen violence remain a pressing issue, often intertwined with gang involvement and delinquent behaviors.[xv] 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 Gilbert among eighth, tenth, and twelfth grade students for 2024.[xv]

	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")	0.8% ↑	0.4% ↑	0.4%
Have you ever belonged to a gang?	1.8%	1.1%	1.2%
In the past 12 months, has at least one of your four closest friends been a member of a gang?	3.0%	2.7%	4.0% ↑

Table 9. Youth Gang Involvement in 2024 - Gilbert

↑ 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 Gilbert among eighth, tenth, and twelfth grade students for 2024.[xv]

	Grade 8	Grade 10	Grade 12
Stolen something worth more than $5	17.2%	17.3%	15.1%
Stolen or tried to steal a motor vehicle such as a car or motorcycle	1.2% ↑	1.2% ↑	0.6%
Harassed or made fun of another person online or through text	22.9%	17.6%	12.1%
Sold illegal drugs	0.8%	1.5%	1.6%
Been in a physical fight	13.5%	9.7%	6.2%
Physically assaulted (hit, slapped, pushed, kicked) your boyfriend/girlfriend	1.8%	1.8%	1.2%
Attacked someone with the idea of seriously hurting them	4.3%	2.6%	2.4%

Table 10. Delinquency Prevalence in 2024 - Gilbert

↑ Exceeded 2024 State %

Community-Identified Issues in Maricopa County and Arizona

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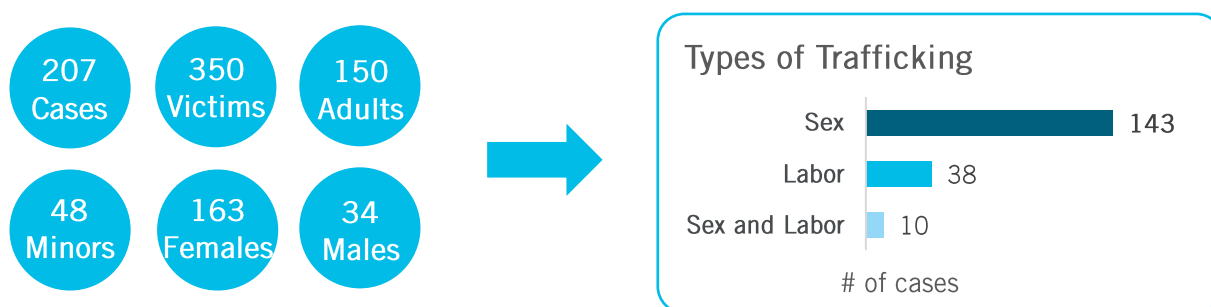
Youth/Teen Violence

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.[lvi] Systemic health and social inequities, such as poverty, residential segregation, and racism, make minority groups more vulnerable to violence.[lvi] **Figure 36** displays violence-related data collected from the Arizona Youth Survey among a sample of 8th, 10th, and 12 grade students.[lvii]

During the past 12 months, youth…

39.4%	38.6%	25.6%	25.3%	25.1%
Have seen someone punched, kicked, choked, or beaten up	Have seen someone being bullied on school property	Have been harassed or made fun of by another person online or through text	Were picked on or bulled on school property	Didn't go to school because they felt they would be unsafe

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."[lviii] 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.[lix] **Figure 37** displays a snapshot of human trafficking cases identified in 2022 for Arizona.[xiii]

207 Cases — 350 Victims — 150 Adults — 48 Minors — 163 Females — 34 Males

Types of Trafficking

	# of cases
Sex	143
Labor	38
Sex and Labor	10

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 MGMC during fiscal year 2024 (April 1 – June 30, 2024).[xiii]
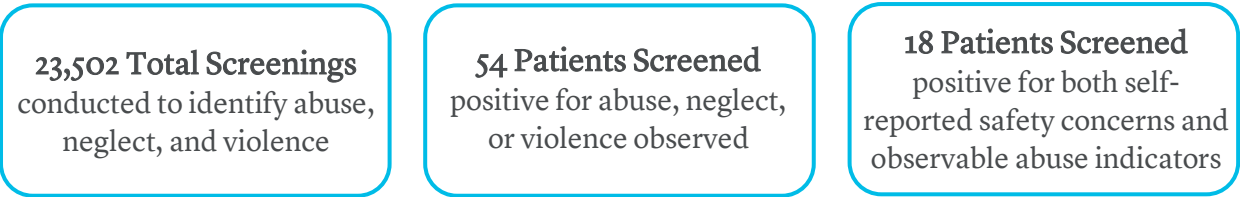
23,502 Total Screenings conducted to identify abuse, neglect, and violence	**54 Patients Screened** positive for abuse, neglect, or violence observed	**18 Patients Screened** positive for both self-reported safety concerns and observable abuse indicators

Figure 38. Abuse, Neglect, and Violence Screening at MGMC (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.

Queen Creek focus group participants shared their vision of a **healthy community**, and **feelings of safety** emerged as an important factor. When residents feel **secure**, they are **more likely to participate in community life**, thereby enhancing collective well-being.

> *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

> *Feeling safe in your community. You know your community, you can go out and do anything from getting resources to going out and play. And that contributes to your overall, mental, and physical health*
>
> - 2024 Queen Creek Focus Group Participant

Sources: 2023 CHNA Survey, 2023/2024 Focus Groups[v, vi]

Importance and Impact in MGMC's PSA

Cancer, including *breast cancer*, was selected as a significant health need for MGMC. 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.[lx] While some risk factors for cancer such as alcohol and tobacco use, can be avoided , others, like family health history and human papillomavirus, cannot.[lxi] Prevention through lifestyle changes, vaccinations, and regular screenings can help reduce cancer rates and promote overall health.

Disparities by Race/Gender/Age

In 2022, **Black/African Americans** had the highest age-adjusted rate of **death** due to breast cancer per 100,000 people.

American Indian/Alaska Native *
Asian and Native… *
Black/African American — 13.6
Hispanic/Latino
White

■ Death
*Counts <5

Females had the highest **death** rate.

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

Source: 2022 Death Data
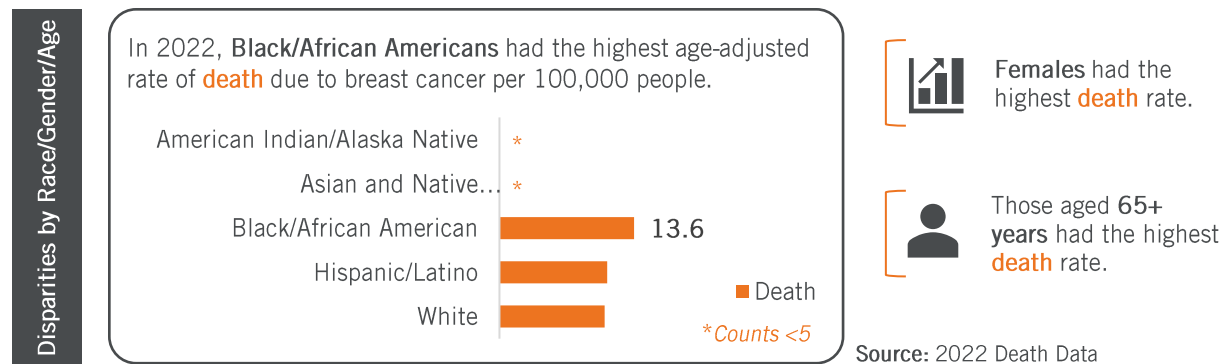
Figure 39. Breast Cancer – MGMC's PSA

Crude percent of mammography use among women aged 50-74 years in Dignity Health MGMC's PSA (2022)

Mammography
Source: CDC_PLACES
Year: 2022

Insufficient Data
71.7% or less
71.8% to 74.9%
75.0% to 77.3%
77.4% to 79.7%
79.8% or greater

Shaded by: Census Tract, 2022

In MGMC's PSA, communities such as **Maricopa and** in the GRIC **(Stotonic, Sacaton, and Blackwater)** contain areas with lower proportions of mammography use.[xviii]
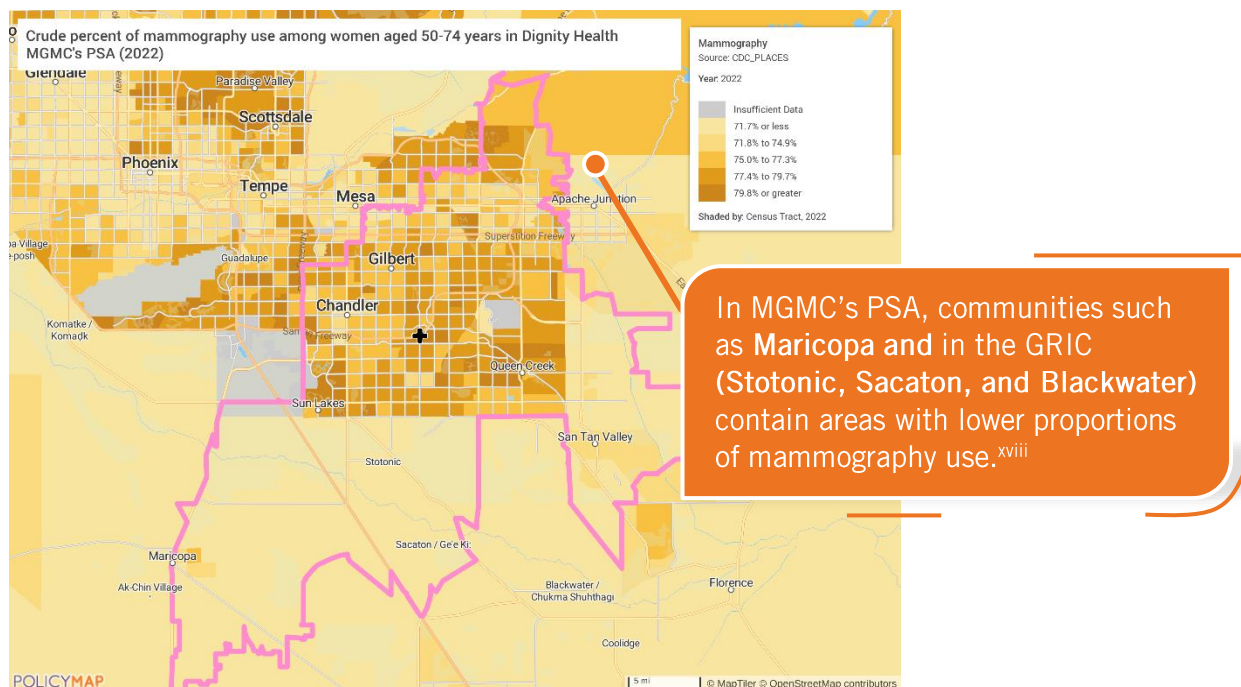
Figure 40. Mammography Use – MGMC's PSA

Community-Identified Issues in Maricopa County

Recognizing that MGMC'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)[lxii]

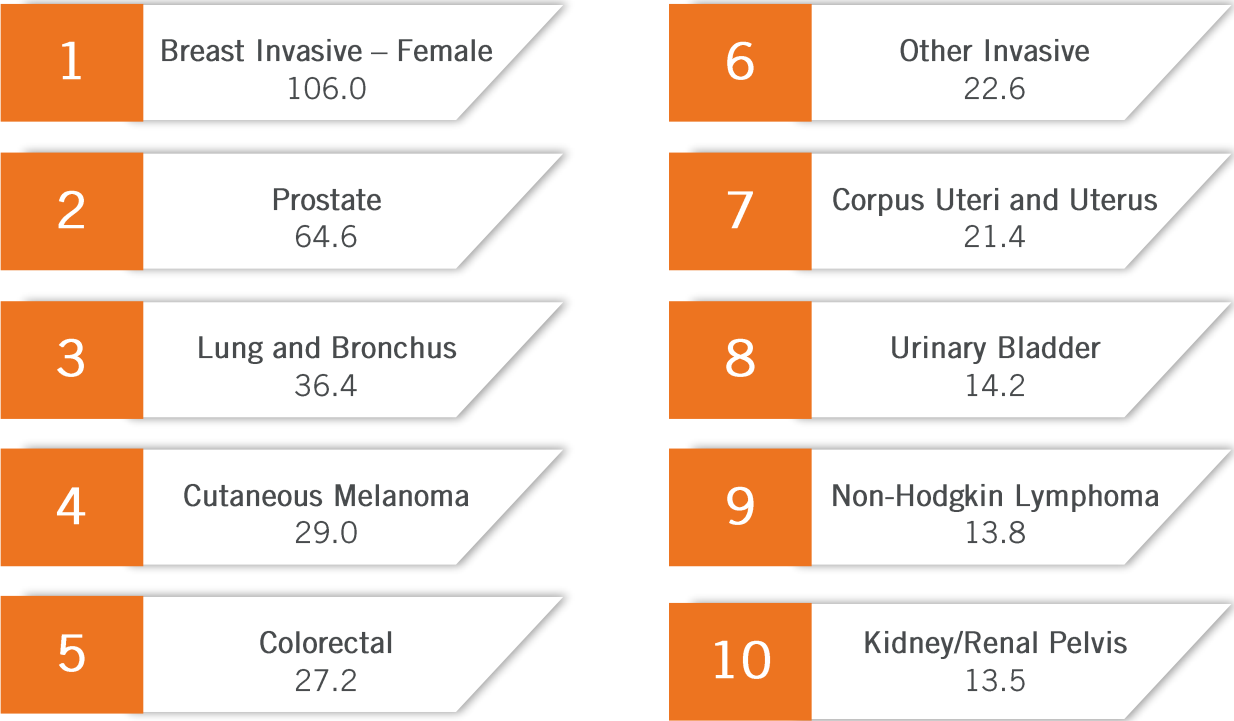| 1 | Breast Invasive – Female 106.0 | 6 | Other Invasive 22.6 |
2	Prostate 64.6	7	Corpus Uteri and Uterus 21.4
3	Lung and Bronchus 36.4	8	Urinary Bladder 14.2
4	Cutaneous Melanoma 29.0	9	Non-Hodgkin Lymphoma 13.8
5	Colorectal 27.2	10	Kidney/Renal Pelvis 13.5

Figure 41. Top 10 Cancers in Maricopa County

Resources Potentially Available to Address Needs

MGMC 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. MGMC 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 MGMC 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)	• Pinnacle Prevention, Chandler Seventh-day Adventist Church, Creighton Community Foundation, Inc. • Amanda Hope Rainbow Angels • Women's Health Innovations of Arizona, 4th Trimester Arizona, and Hope Women's Center • Semicolon Society	• Dignity Health East Valley: Spiritual Care Support Groups • Dignity Health: Mental Health Taskforce • Dignity Health: Postpartum Support Group • Dignity Health's Heaven's Hummingbirds Support Group • Dignity Health, Chandler Regional Medical Center, Eat, Sleep, Console Program
Chronic Conditions (Cardiovascular Disease, Diabetes, Obesity)	• Improving the Health of Uninsured Patients with Diabetes program at Mission of Mercy Inc., Unlimited Potential, AZCEND	• Dignity Health: Yoga of the Heart • Dignity Health: Pathways to Wellness Program • Dignity Health: Healthier Living Programs • Dignity Health: Children's Medical Clinic

- Dignity Health Foundation East Valley's Post-Stroke Programs
- Dignity Health: Chandler Regional Medical Center's, Staying Active and Independent for Life (SAIL) program
- Dignity Health: Chandler Regional Trauma Services

Priority	Community Resources	Hospital Resources
Social Determinants of Health (Housing & Homelessness, Access to Food)	**Housing & Homelessness** • AZCEND, Chandler/Gilbert, I-HELP (Interfaith Homeless Emergency Lodging Program) • Circle The City • East Valley Senior Home Sharing Program • House of Refuge • Child Crisis Arizona • Destination Diploma • Hope for Addiction's Liberty House • One Small Step | Clothes Cabin **Access to Food** • Matthew's Crossing Food Bank • TCAA's, Neighbors Helping Neighbors (NHN) program • Pinnacle Prevention, Chandler Seventh-day Adventist Church, Creighton Community Foundation, Inc. created Medical Food Box Program • Chandler CARE Center Food Bank	**Housing & Homelessness** • CommonSpirit: Homeless Initiative | Taxi Vouchers **Access to Food** • Dignity Health East Valley, Physician Residents Pantry Perfect: Food Box Prescription Program

Priority	Community Resources	Hospital Resources
Access to Care (Dental Health)	- Mary Gloria Foundation, Southwest Institute, Raising Special Kids created Southeast Valley Family Resources - Foundation for Senior Living: ACTIVATE Program - Smiles of Grace Clinic - Chandler CARE Center - Gilbert Heritage Center - Mission of Mercy	- Dignity Health: Children's Dental Clinics - Dignity Health: Early Childhood Oral Health Programs - CommonSpirit: Financial Assistance Policy - Dignity Health East Valley's Residency Programs
Violence and Injury Prevention	- CeCe's Hope Center - Arizona Anti-Trafficking Network, Aris Foundation, Starfish Partnerships, and Tempe PD - Winged Hope - Hope for Addiction's Freedom House	Dignity Health: Stop the Bleed Program Dignity Health: Child Car Seat Donation	Car Seat Safety - Dignity Health: Healthy Families Program - Dignity Health: Human Trafficking Task Force - Dignity Health: Chandler Regional Medical Center's, Trauma Survivors Network - Dignity Health Chandler Regional Medical Center's, A Matter of Balance
Cancer (Breast Cancer)	Desert Cancer Foundation of Arizona	Chandler Regional Medical Center and Ironwood Cancer Center

Table 11. Resources Potentially Available to Address Needs

Impact of Actions Taken Since the Preceding CHNA

Since the completion of MGMC's 2022 CHNA, MGMC has worked to address identified health priorities through targeted programs and initiatives. The following is an overview of the impacts of MGMC's 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.

- **Dignity Health East Valley: Spiritual Care Support Groups**, Two separate 8-week mental health support sessions: one for general mental health and one for serious mental illness, both non-religious.

- **Dignity Health East Valley: Mental Health Taskforce** is a Multi-disciplinary task force to develop and implement strategies to better address needs of patients: **Behavioral Emergency Response Team (BERT)** team a specialized team in healthcare that responds to behavioral emergencies, focusing on de-escalation and providing support to patients and staff in situations involving behavioral health crises and **Zero Suicide** is a commitment to suicide prevention in health care systems and is also a specific set of strategies and tools.

- **Dignity Health East Valley: Pregnancy & Postpartum Support Group (PPSG)** is a free, peer-based support group offering a safe, judgment-free space for moms to connect and share experiences. Support for women and families facing challenges during pregnancy, postpartum, and the transition into parenthood. served 1578 clients from FY 2022 through 2024.

- **Semicolon Society,** is an Arizona nonprofit organization providing free mental health education, resources, and events in the community, with an emphasis on suicide prevention programs at events at semicolonsociety.org

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.

Community Health Improvement Grant projects awarded by CommonSpirit Health:

- **Freedom House** supports single mothers and their children transitioning from substance abuse treatment. In collaboration by Hope for Addiction, Inc. and Jesus Cares Ministries, the 12- to 24-month program provides safe shelter, individualized care plans, trauma-

informed counseling, financial education, parenting support, and aftercare services, serving 14 families from January 2022 to December 2023.

- **Nurtured Beginnings,** supports women with maternal mental health disorders, including those with a history of mental health challenges, substance use, or trauma. A Women's Health Innovations of Arizona (WHI) perinatal coach provides bedside support at Mercy Gilbert and Chandler Regional hospitals twice a week, conducting depression screenings, offering bilingual educational materials, and connecting mothers to collaborative partners; Hope Women's Center, 4th Trimester Arizona, and WHI. The program aimed to serve 200 mothers but has already supported 624 from January to December 2024.

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.

- **Amanda Hope Rainbow Angels (AHRA)**, supports the here-and-now needs of families impacted by childhood cancer and other life-threatening illnesses through FREE Comfort and Care counseling, Comfycozy's for Chemo adaptive apparel, Financial Assistance, and Major Distractions events.

- **Chandler Regional and Ironwood Cancer Center** have come together to offer you or a family member who is suffering from cancer a variety of cancer support groups and classes. Nurse Navigator provides personalized attention helping to guide each patient through their own personal journey.

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.

- **Dignity Health East Valley: Pathways to Wellness** is a Community Health Worker (CHW) program providing culturally tailored education and support to underserved patients post-discharge. Through partnerships within Dignity Health, CHWs address social determinants of health such as housing, insurance, and food security to promote long-term well-being for Maricopa County residents aged 50+ with chronic conditions. From January to December 2024, the program enrolled 51 seniors, initiated 369 Pathways, and achieved a 94% success rate in preventing hospital readmissions within 30 days.

- **Improving the Health of Uninsured Patients with Diabetes program**, Community Health Improvement Grant projects awarded by CommonSpirit Health, is a collaboration between Mission of Mercy Inc., Unlimited Potential, and AZCEND. The program provides uninsured patients at Chandler First Church of the Nazarene with diabetes care, including medical treatment, A1C monitoring, nutrition education, and mental health support, aiming to improve health outcomes and reduce isolation.

- **Dignity Health East Valley: Yoga of the Heart** empowers women (18-75) to prioritize their health through self-care and self-love. It supports those with or at risk of heart disease by incorporating breathing exercises, meditation, and yoga to improve heart health. The program helps lower cardiovascular risk factors, anxiety, depression, and chronic stress. In FY 2023, 503 women participated.

- **Dignity Health East Valley: Children's Dental Clinics** provide dental exams, cleanings, X-rays, fluoride varnish, minimally invasive treatments, and oral health education. Services are available for patients 18 years of age or younger, and qualify for a federal, state, county or local health care program or qualify for a free or reduced federal school meal program.

- **Dignity Health East Valley: Early Childhood Oral Health Programs**, provides in-person dental screenings for newborns to age five, promoting good oral health through education, free oral screenings, fluoride applications, and referrals. Parents receive guidance on oral care, assistance with dental visits, and awareness on the importance of a child's first dental visit by age one. **Dental Screenings for Expectant Mothers**, provides in-person dental screenings for expectant mothers, offering oral health education and essential items like an electric toothbrush, finger brush, toothpaste, and diapers. It also facilitates dental visits with referrals and follow-up calls for urgent cases and facilitates **Oral Health Training for Early Childhood Professionals**

Significant Need #5: Injury Prevention

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

- **Dignity Health's Chandler Regional Medical Center's, Staying Active and Independent for Life (SAIL) program,** enhances balance and healthy aging with strength and aerobic exercises, held twice weekly for an hour. Each session includes fall prevention education, exercise, socializing, and upbeat music, running in 6-week increments.

- **Dignity Health East Valley: Healthier Living Program Workshops, Matter of Balance** is a free 8-week workshop aimed at improving balance, strength, and flexibility while reducing the fear of falling. It emphasizes practical strategies to boost strength, increase activity levels, and help participants feel more confident in preventing falls.

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.

- **Dignity Health's Chandler Children's Medical Clinic** offers sick and well visits, diagnostics, and education for uninsured children. Services include obesity screening, education, and resources to support children's health and well-being.

- **Community Partner: Foundation for Senior Living - ACTIVATE Program**, offers post-discharge navigation and support, including assistance with medication management, durable medical equipment (DME), case management, and access to other health and social resources.

- **Dignity Health East Valley: Community Outreach Immunization Program**, in collaboration with Arizona's Vaccine for Children Program and Maricopa County, offers free immunization clinics for children, as well as for adults.

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.

- **I-HELP (Interfaith Homeless Emergency Lodging Program)**, created by AZCEND and Tempe Community Action Agency, offers personalized support and case management to help individuals access essential resources and achieve stability, aiming to break the cycle of homelessness.

- **East Valley Senior Home Sharing Program**, a Community Health Improvement Grant project awarded by CommonSpirit Health is a collaboration between Aster Aging, AZCEND, and Tempe Community Action Agency, matches older adults for shared housing. The program includes background checks, assessments, and provides ongoing support to ensure successful co-housing.

- **Destination Diploma**, a Community Health Improvement Grant project awarded by CommonSpirit Health, organized by Child Crisis Center Arizona, Matthew's Crossing Food Bank, and Chandler Education Foundation, supports students with food, clothing, hygiene products, tutoring, and a monthly stipend for maintaining good grades and attendance.

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.

- **Compassion Connect: EV Collaborative Response to Human Trafficking**, a Community Health Improvement Grant project awarded by CommonSpirit Health, created by Arizona Anti-Trafficking Network, Aris Foundation, Starfish Partnerships, and Tempe PD, conducts bi-monthly outreach to identify trafficking victims. The program offers specialized resources and year-long case management through the Arizona Human Trafficking Hotline.

- **Community Organization: Winged Hope**, a victim shelter provides wraparound services and support for victims of domestic violence, helping them heal and rebuild their lives.

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.

- **Dignity Health East Valley: Healthy Eating, Active Living (HEAL),** is a CDC-approved, evidence-based program focused on preventing and managing Type 2 diabetes for adults over 45. The program promotes healthy lifestyle changes through a behavioral approach, providing tools and education on nutrition, physical activity, mindset, and managing chronic conditions. In 2023, HEAL served 30 participants.

- **Community Organization: Chandler CARE Center Food Bank** provides emergency food boxes every two weeks to Chandler residents who meet income eligibility, along with additional holiday food boxes throughout the year.

- **Community Organization: Matthew's Crossing Food Bank,** provides Emergency Food Boxes providing 3 days worth of balanced meals, Weekend Backpack programs offer students meals in packs for home for each meal for the entire weekend. Senior Food Boxes, delivery is available and Mobile Marketplace pop-ups, in partnership with ASU Pitchfork Pantry, distribute fresh food to 350 students monthly.

- **Dignity Health East Valley: Healthier Living Program Workshops,** Diabetes Empowerment Education Program (DEEP), a 6-week workshop series is for adults with diabetes, pre-diabetes, a family history of diabetes, or anyone interested in learning more. The workshop covers how diabetes affects the body, prevention strategies, and essential diabetes management skills to help navigate and manage the condition effectively.

Conclusion

The 2025 Community Health Needs Assessment for MGMC 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 MGMC's Implementation Strategy. Through this plan, MGMC is able to make a meaningful impact in the communities that they serve.

Health, Social, and Racial Equity Lens

Mental Health (Including All Mental and Behavioral Disorders)

Chronic Conditions (Including Cardiovascular Disease, Diabetes, Obesity)

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

Access to Care (Including Dental Health)

Violence and Injury Prevention

Cancer (Including Breast Cancer)

Figure 42. MGMC'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 MGMC'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 MGMC's Primary Service Area (2018-2022)

		Leading Causes of Death in MGMC'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.

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

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	Access to affordable housing	Ability to communicate with local leadership and feel my voice is heard	Access to quality and affordable childcare
Homebound	Access to affordable housing	Access to quality public transportation	Access to programs and activities for seniors 65+
Senior living in a Group	Access to affordable housing	Access to quality and affordable childcare	Access to quality public transportation
Person with Disability	Access to affordable housing	Access to quality and affordable childcare	Ability to communicate with local leadership and feel my voice is heard
Person Experiencing Homelessness	Access to affordable housing	Access to programs and activities for seniors 65+	Ability to communicate with local leadership and feel my voice is heard
Refugee, Immigrant, Migrant	Access to affordable housing	Access to programs and activities for seniors 65+	Ability to communicate with local leadership and feel my voice is heard
Elderly	Access to quality public transportation	Access to substance use treatment services	Access to affordable education after high school
Military Member/Veteran	Access to quality public transportation	Access to affordable housing	Ability to communicate with local leadership and feel my voice is heard
Caregiver	Access to quality and affordable childcare	Access to affordable housing	Feeling safe while driving

Top 3 Highest-Rated Community Assets by Race/Ethnicity

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

	1st	2nd	3rd
Black or African American	Access to parks and green spaces	[Opportunity to participate in religious,] 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 parks and green spaces	Access to public libraries, community centers, and educational events
Native Hawaiian or Other Pacific Islander	Feeling safe in your home (not worrying about burglary, domestic violence)	Opportunity to participate in religious, spiritual, or cultural events	Accepting of all people (different cultures, identities)
Asian	Feeling safe in your home (not worrying about burglary, domestic violence)	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 parks and green spaces	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	Access to public libraries, community centers, and educational 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.[lxiii] 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≥50) and numerator size (n≥5).

Survey Limitations

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

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

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

2023 CHNA Focus Group Methods

Methodology: Focus Group Discussion Guide and Supplemental Survey Development

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

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

Methodology: Focus Group Recruitment

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

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

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

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

before the focus group. For participants where 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.

2024 Queen Creek Supplemental Focus Group Methods

Methodology: Focus Group Discussion Guide

The focus group discussion guide was created in collaboration with the MCDPH CHNA team, Synapse partners, and the ASU Southwest Interdisciplinary Research Center (SIRC) for the CHNA 4.0 focus groups. This guide addressed several key topics, including General Quality of Life/Community Questions, Community Health Needs and Concerns, Access to Services, Information, and Resources (which includes subsections on Health Services and Health Information), and Community Health Recommendations. For further details on the development of the discussion guide, please refer to Appendix C of the [2023 CHNA Focus Group Findings](#).

Methodology: Supplemental Survey

A supplemental survey was distributed to focus group participants to gather information about the characteristics of those attending. It inquired about demographics, including age, race/ethnicity, gender identity, and employment status. Participants were also asked if they identified as a member of specific groups, such as foster youth, homebound individuals, seniors living in a group setting, people with disabilities, homeless/houseless individuals, military members/veterans, immigrants, and refugees. Additionally, participants had the option to provide a written response regarding group membership.

Methodology: Sample Population, Inclusion Criteria, and Recruitment

Purposive sampling was employed to recruit participants, focusing on attracting and selecting individuals who met specific inclusion criteria while adhering to certain exclusion criteria. The inclusion criteria required participants to have lived in Maricopa County for at least six months of the year and to be at least 18 years old. The recruitment target was ten individuals (seven participants and three alternates). Recruitment efforts were supported by the Queen Creek Chamber of Commerce. These efforts included social media posts on Facebook, announcing the focus group during community meetings over two months, and sending an email blast to all chamber members. Further, a convenience sampling approach was utilized the day of the focus group to secure a final participant who met inclusion/exclusion criteria.

Methodology: Participants

The targeted sample size for each 60-minute focus group was between six and ten participants. Participants received a $25 gift card as a stipend for their involvement. Prior to participation, individuals were informed of any associated risks, benefits, and expectations. Participants were asked to sign an informed consent to acknowledge their understanding and agreement to participate in the study.

Methodology: Facilitation and Data Collection

The focus group was held at Queen Creek Chamber of Commerce on December 5, 2024. The focus group was conducted by two MCDPH staff (facilitator and co-facilitator/note-taker) who were specifically trained to be focus group facilitators. The facilitator and co-facilitator utilized the Focus Group Discussion Guide to assure adherence to protocol in following procedures and asking questions. The focus group recordings were transcribed by Otter AI. In order to maintain participant anonymity, all names were redacted from the transcripts.

Methodology: Analysis

The qualitative method employed for data analysis involved inductive techniques. This approach entails a comprehensive examination of the data to identify emerging codes, categories, patterns, and themes, rather than applying pre-established codes. The analysis was carried out in January 2025 by the facilitator of the focus group, who reviewed transcripts and notes to identify commonalities and themes in the data. To enhance rigor and reduce subjectivity, an evaluator conducted a peer review of the data analysis process, offering constructive feedback and recommendations. This methodology led to the validated themes included in the final PowerPoint presentation.

Limitations

There are several limitations to consider when examining the findings of the focus group. Firstly, the sample was restricted to participants who were English speakers and volunteered to engage in the focus group, introducing potential selection bias and limiting the diversity of perspectives included in the study. Additionally, the supplemental survey instrument used for data collection was a self-report measure, which is inherently susceptible to biases such as social desirability bias. Furthermore, the study was confined to participants residing in Maricopa County, meaning that the conclusions drawn may not apply to populations outside of this geographic locale.

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.

<u>Facilitation and Data Collection</u>

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

<u>Validity and Reliability</u>

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:

- **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.

- **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.

- **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

Indicator	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										Level				
	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	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									■		■	■	■	■	■

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