Dignity Health.
Chandler Regional Medical Center

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Community Health Needs Assessment 2019

Maricopa County Coordinated Community Health Needs Assessment

Dignity Health
Chandler Regional Medical Center
Chandler, AZ

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

January 15, 2019

SYNAPSE
A Platform for Community Health Partnership

Maricopa County Public Health
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Executive Summary

Community Health Needs Assessment (CHNA) Background

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

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

Purpose Statement

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

Community Definition

The geographic area for this CHNA is Maricopa County, the common community for all partners participating in the SYNAPSE collaborative. Maricopa County is the fourth most populous county in the United States. With an estimated population of 4 million and growing, Maricopa County is home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations. Maricopa County is ethnically and culturally diverse, home to more than 1.2 million Hispanics (30% of all residents), 197,000 African Americans, 156,000 Asian Americans, and 65,000 American Indians. According to the U.S. Census Bureau, 14% percent of the population does not have a high school diploma, 17% are living below the federal poverty level, and over 600,000 are uninsured[i].

Dignity Health defines the community served by a hospital as those individuals residing within its Primary and Secondary Service Areas. For this report the focus will be on the Primary Service Area of CRMC. The Primary Service Area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. The city of Chandler is primarily served by CRMC. Chandler is a growing and diverse city in Maricopa County, Arizona with over 250,000 residents of many ethnicities, various incomes and education levels. Surrounding communities include Gilbert, Mesa, Tempe, Ahwatukee, Sacaton, Apache Junction, Casa Grande, Pinal County, Gila River Indian Reservation, and Guadalupe. Chandler is home to several major industrial firms that include Intel, Microchip, and Orbital. However, despite strong economic growth,

there continue to be many factors and social determinants of health in the suburban Chandler communities that need to be addressed in order to improve the health and wellbeing for the broader community and the underserved. According to the Community Need Index (CNI), a proprietary tool developed by Dignity Health, the primary service area includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85122, 85128, 85139, 85202, 85225, 85282, and 85283[ii].

Assessment, Process and Methods

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

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

Summary of Prioritization Process

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

The process for prioritization included engagement with both internal Dignity Health stakeholders and community partners. The first step of the process was a comprehensive presentation by MCDPH that included an overview of the CHNA findings and key emerging health needs. The second step in the process involved review and prioritization of the key emerging health needs outlined in the MCDPH presentation by Dignity Health Leadership, the Community Benefit Committee (CBC), and community partners. On October 16, 2018, Dignity Health and MCDPH internal teams led a strategy session using a strategy grid. Throughout the

presentation, stakeholders in attendance responded to survey questions that would later be used during strategy sessions to identify health priorities. After completion of the presentation, stakeholders were given the opportunity to provide additional feedback and recommendations. The second step in the process involved review and prioritization of the key emerging health needs outlined in the MCDPH presentation.

Dignity Health and MCDPH staff scheduled the East Valley Community Health Assessment strategy session and partners were invited. The session entailed assigning participants to groups and instructing them to visit six stations. Each station included data and information on specific health needs. As participants discussed each health need, consideration was given to the size of the problem, disparity and equity, known effective interventions, resource feasibility and sustainability, and community salience. Participants rotated tables until all six health needs had been discussed. Through discussion, participants were able to determine what health need would feasibly result in a greater impact. Dignity Health and MCDPH staff led the group in an activity using a 4-square grid 'Need" and 'Feasibility' criteria grid. The grid included four quadrants and each quadrant was labeled, 'High Need/High Feasibility,' 'Low Need/High Feasibility, 'High Need/Low Feasibility,' 'Low Need/Low Feasibility.

Participants were then asked to place competing labels on the grid. Information was gathered and a follow up survey was sent to provide another opportunity for feedback and recommendations. Participants were also asked to rank each health priority and/or add more strategies to identified needs, or other issues. A survey monkey was administered after the session and participants made final recommendations and ranked the health issues. The recommended health priorities approved by the CBC and presented to the board on November 20, 2018 include: Access to Care, Mental/Behavioral Health, Diabetes, Breast Cancer, Injury Prevention, and Social Determinants of Health.

Summary of Prioritized Significant Health Needs

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

1. Access to Care

Community members and key informants overwhelmingly felt that access to care is an important issue for the community. Within CRMC's primary service area, community survey respondents reported access to care as the number one most important "Health Problem" that impacts their community. There are also disparities experienced across members of certain racial/ethnic backgrounds, with Hispanics and American Indians being least likely to have insurance and poverty rates among American Indians (30.1%) in the CRMC primary service area, higher than Maricopa County rates (27.4%).

2. Mental/Behavioral Health

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

Mental health was ranked as the most important health problem impacting the community by key informants. This was echoed by participants in the focus groups who believe mental health is one of top health issues impacting community residents. Mental health is ranked 9th in leading causes of emergency department visits

and 7th in inpatient hospitalizations for CRMC's primary service area, and the highest rates of visits can be attributed to adults ages 25 to 34[iii].

Substance abuse was one of the top concerns for both focus group participants and key informants. Key informants listed alcohol and drug abuse as two of the riskiest health behaviors community members are engaging in.

Suicide is the tenth leading cause of death in the United States, accounting for more than 1% of all deaths[iv]. Suicide was the eighth leading cause of death for Maricopa County and CRMC's primary service area in 2016 (Appendix A). Although women are more likely to attempt suicide, men have higher rates of death by suicide. In Maricopa County, rates of suicide are highest among age groups 45-54 and 75+, which could indicate a potential health disparity in identification, referral or treatment of suicidal ideation[v].

3. Diabetes

In 2016, the number of deaths related to diabetes decreased in Maricopa County compared to 2015, but it is still the seventh leading cause of death in both Maricopa County and CRMC's primary service area indicating a sustained health need. In CRMC primary service area diabetes mortality rates are highest among ages 75+ years of age[vi].

4. Breast Cancer

Breast Cancer is the second leading cause of cancer among U.S. women[vii]. About 1 in 8 women in the U.S. will develop invasive breast cancer during their lifetime. While advancements continue to be made in the fight against breast cancer, incidence rates in Maricopa County continue to be highest among white non-Hispanic and blacks[viii]. In the CRMC primary service area, breast cancer mortality rates among women ages 35-44 are higher than Maricopa County[ix].

5. Injury Prevention

Injuries are not accidents, they are predictable and preventable. Unintentional injuries, including traffic-related, injuries, falls, burns, poisonings, and drowning were responsible for lost lives in the CRMC primary service area. Unintentional injury is the fifth leading cause of death in Maricopa County and sixth leading cause of death in the CRMC's primary service area. It is also the leading cause of emergency department visits and the second leading cause of inpatient discharges. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females.

6. Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks[x]. Dignity Health CRMC is dedicated to making a positive impact on the social determinants of health, particularly on the health of those economically-disadvantaged communities. Resources that enhance quality of life can have a significant influence on population health outcomes. CRMC will focus on addressing homelessness, food insecurity, and transportation within their primary service area.

Resources Potentially Available

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

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

This CHNA report was adopted by the Dignity Health East Valley Community Board in January 2019.

This report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at Chandler Regional Medical Center's Community Integration Department. Written comments on this report can be submitted to the Chandler Regional Medical Center's Community Integration Department or by e-mail to CHNA-Chandler@DignityHealth.org.

Assessment Purpose and Organizational Commitment

Community Health Needs Assessment (CHNA) Background

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

Purpose Statement

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

Organizational Commitment

Rooted in Dignity Health's mission, vision and values, CRMC is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

CRMC is committed to meeting the health needs of the community by ensuring implementation of successful programs that meet the specific needs of the people it serves. Success is achieved through assessment of community needs, involvement of key hospital leaders, and implementation of community benefit activities.

Organizational and community commitment includes:

Executive Leadership Team: The CRMC Executive Leadership Team is responsible for reviewing the Community Benefit Report and Plan prior to presentation and approval by the Community Board. The Executive Leadership Team's contribution to the community benefit plan includes reviewing alignment of the Community Benefit Plan with the CHNA, the hospital's overall strategic plan, and budgeting for resources.

Community Benefit Committee: The Community Benefit Committee (CBC), chaired by a board member, assists the community board in meeting its obligations by reviewing community needs identified in CHNA, recommending health priorities, recommending implementation strategies, presenting the hospital's annual Community Benefit Report and Plan, presenting the hospitals CHNA Implementation Strategy, and monitoring progress.

Community Board: The Community Board is responsible for oversight and adoption of the CHNA and, Implementation Strategy, approval of the Community Benefit Report and Plan, and program monitoring. Throughout the fiscal year the community board receives reports on community benefit programs. The chair of the Community Benefit Committee reports to the board regarding strategies, programs, and outcomes.

Community Health Department: The Community Benefit Department, under the Vice President of Mission Integration, is accountable for planning, implementing, evaluating, reporting, and ultimately for the success of designated programs. The Community Benefit Department is directly responsible for the CHNA and Implementation Strategy, Community Benefit Report and Plan, Dignity Health Community Grants committee, program implementation, evaluation, and monitoring, community collaboration, and reporting of community benefit activities. Key staff positions include: Director of Community Integration, Senior Coordinator for Community Benefit, Manager of Center for Diabetes Management, Manager of Community Education, Manager of Oral Health Program, Manager of Community Wellness, and Clinical Supervisor of Lactation Services.

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

In addition to the community grants program, Dignity Health provides financial support to nonprofit organizations in the community through the Community Investment Program that offers below market interest rate loans. The investments listed below are a reflection of the hospitals mission and its commitment to improving community health and well-being.

Arizona Community Foundation (ACF): ACF has been a partner with Dignity Health since 2012. It is using its current 5-year $5,000,000 loan approved in 2016 to extend financing for the creation of health clinics, charter schools and affordable housing for low-income families and communities in Phoenix and the surrounding area.

Chicanos Por la Causa (CPLC): In January 2017 Dignity Health approved a 7-year $3,000,000 loan to CPLC, a multifaceted nonprofit organization offering a wide array of bilingual and bicultural services that include education, advocacy, small business lending, and affordable housing development. This loan complements CPLC's Neighborhood Stabilization Program grant specifically to help acquire, rehabilitate, and manage 95 units of affordable multi-family housing in Phoenix, Arizona with wraparound services. Another 7-year loan for $1,000,000 was approved in 2018 to provide bridge financing for the development of 187 units of affordable mixed-use and mixed-income housing as part of a comprehensive revitalization for the City of Mesa.

Trellis: In January 2018 Dignity Health approved a 7-year $500,000 loan to this CDFI specializing in promoting home ownership to low- and moderate-income residents of Maricopa County though first and second mortgages and down payment assistance. Trellis also provides financial counseling and homeownership education.

Community Definition

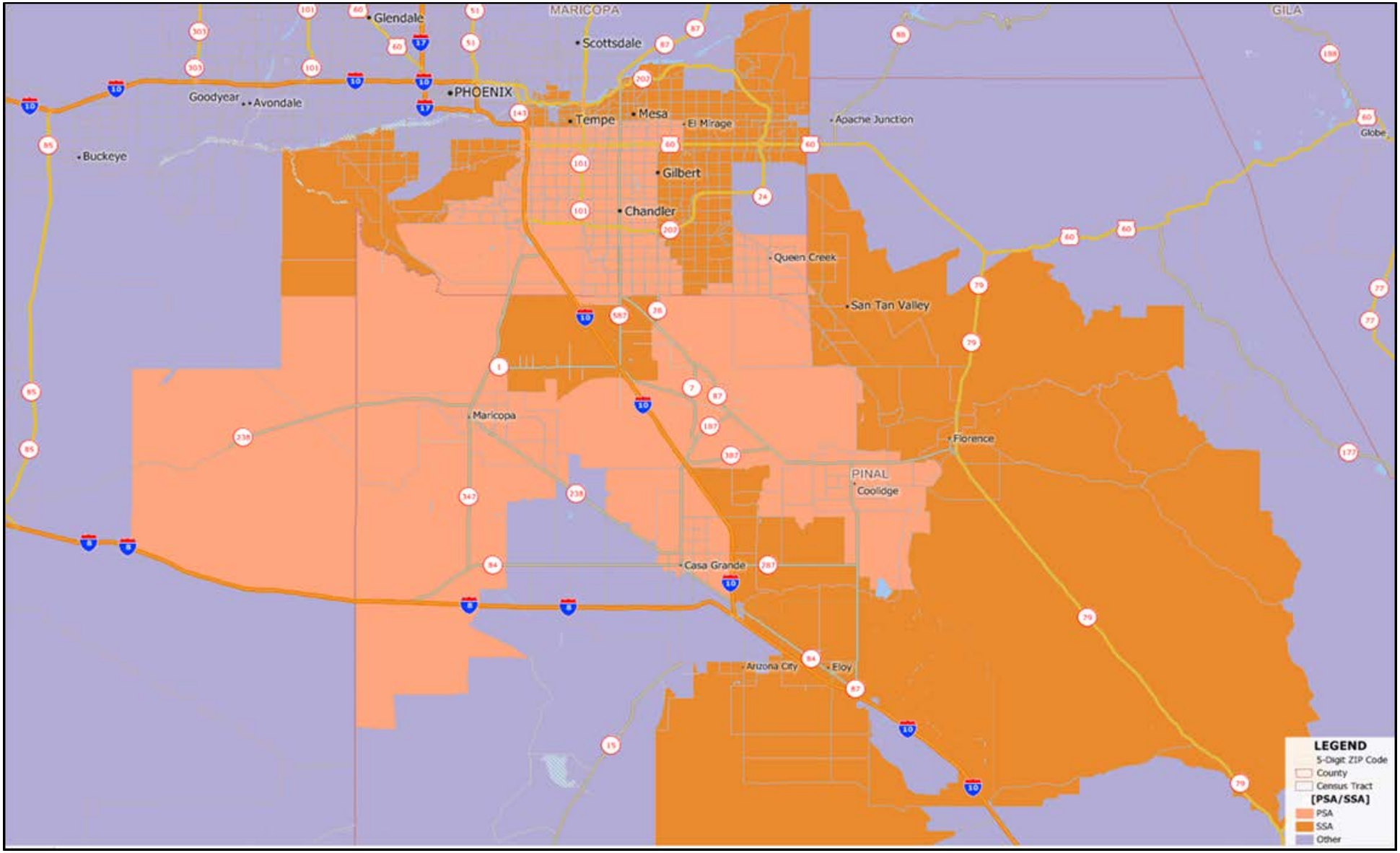
Definition of Community

The geographic area for this CHNA is Maricopa County, the common community for all partners participating in the Synapse coalition. However, CRMC's Primary Service Area (PSA) specific information will also be provided when available.

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

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

The city of Chandler is primarily served by CRMC for acute care and trauma services. Surrounding communities also being served by CRMC include Gilbert, Mesa, Tempe, Ahwatukee, Sacaton, Apache Junction, Casa Grande, Pinal County, Gila River Indian Reservation, and Guadalupe.



Chandler Regional Medical Center Primary and Secondary Service Areas

Demographic and Socioeconomic Profile

Primary Care Area (PCA) Statistical Profiles are revised annually and provide detailed information on the demographics, health resources, hospital utilization, and health status indicators in defined geographic areas throughout Arizona. According to the Arizona Department of Health Services (ADHS), the Chandler Central PCA has been federally designated as a Medically Underserved Area[xii]. More than half of the population of CRMC's primary service area is adults between 20-64 years of age. Nearly 8.7% of residents do not have a high school diploma, 7.1% are unemployed and approximately 13.6% are without health insurance[xiii]. This data shows that the population as a whole is majority white, and with a median income above Maricopa County and the state of Arizona. Table 1 provides the specific age, sex, and race/ethnicity distribution and data on key socio-economic drivers of health status of the population in the CRMC's primary service area compared to Maricopa County and the state of Arizona.

Table 1. Demographic information for the Chandler Regional Medical Center Primary Service Area.

	CRMC PSA	**Maricopa County**	**Arizona**
Population: estimated 2015	861,827	4,088,549	6,728,577
Gender			
• **Male**	49.8%	49.5%	49.7%
• **Female**	50.2%	50.5%	50.3%
Age			
• **0 to 9 years**	14.0%	13.8%	13.3%
• **10 to 19 years**	14.1%	13.8%	13.6%
• **20 to 34 years**	22.2%	21.2%	20.5%
• **35 to 64 years**	38.2%	37.3%	36.7%
• **65 to 74 years**	7.0%	8.0%	9.2%
• **75 years and over**	4.5%	5.9%	6.7%
Race			
• **White**	58.6%	56.9%	77.8%
• **Asian/Pacific Islander**	5.4%	4.0%	3.2%
• **Black or African American**	4.4%	5.0%	4.3%
• **American Indian/ Alaska Native**	2.7%	1.5%	4.4%
• **Other**	29.0%	32.6%	10.3%
Ethnicity			
• **Hispanic**	26.0%	30.3%	30.5%
Median Income	$65,654	$53,694	$51,340
Uninsured	11.1%	13.9%	13.6%
Unemployment	4.2%	4.4%	5.4%
No HS Diploma	10.7%	14.0%	13.8%
Limited English Proficiency	6.6%	9.3%	9.1%
Renters	33.7%	39.6%	37.5%
CNI Score	3.1	3.4	-
Medically Underserved Area	Yes	-	-

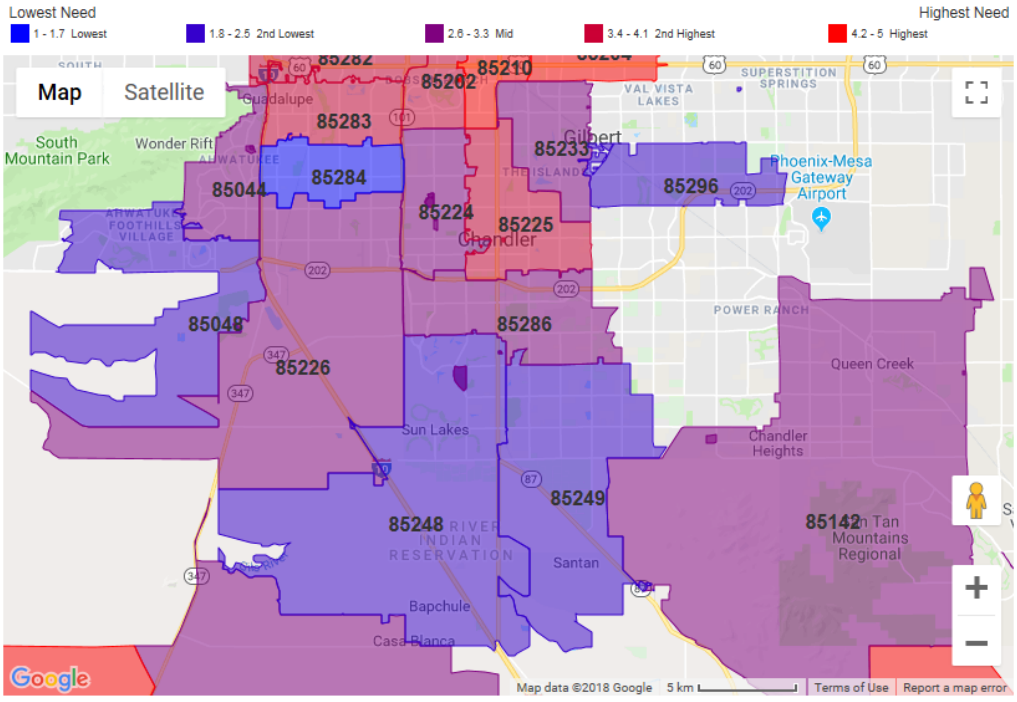
Source U.S. Census American Community Survey, 5 year estimates 2012-2016

Chandler is home to several major industrial firms that include Intel, Microchip and Orbital. Despite strong economic growth, there continue to be many factors and social determinants of health in the suburban Chandler community that needs to be addressed in order to improve the health and wellbeing for the broader community, and the underserved. Challenges for this community include high rates of poverty, violence-associated injuries, a large non-English speaking population, and low education attainment, all of which create barriers to access.

Downtown Chandler has a significant population of uninsured and underinsured non-English speaking persons of all age groups. A large majority of this population is also indigent with their primary source of income through day labor and seasonal work.

Community Need Index

Dignity Health has developed the nation's first standardized Community Need Index (CNI) in partnership with Truven Health Analytics. The CNI identifies the severity of health disparity for every zip code in the United States based on specific barriers to healthcare access. The CNI considers multiple factors that are known to limit health care access such as income, language, educational, insurance and housing barriers. The ability to pinpoint neighborhoods with significant barriers to health care access is an important new advancement for public health advocates and care providers. According to the CNI illustrated below, the primary service area has a mean CNI score of 2.8 and includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85282, 85202, 85210, 85204, 85283, 85225, 85139, 85122, and 85128[xiv].



Mean(zipcode): 3.2 / Mean(person): 3.2 CNI Score Median: 2.8 CNI Score Mode: 2.6

Zip Code	CNI Score	Population	City	County	State
85044	2.6	40284	Phoenix	Maricopa	Arizona
85048	2.4	35704	Phoenix	Maricopa	Arizona
85122	4.2	57888	Casa Grande	Pinal	Arizona
85128	4.8	21273	Coolidge	Pinal	Arizona
85138	2.6	43214	Maricopa	Pinal	Arizona
85139	4.2	21616	Maricopa	Pinal	Arizona
85142	2.6	64024	Queen Creek	Maricopa	Arizona
85202	4	40636	Mesa	Maricopa	Arizona
85204	4.4	66676	Mesa	Maricopa	Arizona
85210	4.6	39243	Mesa	Maricopa	Arizona
85224	3	46593	Chandler	Maricopa	Arizona
85225	4	75370	Chandler	Maricopa	Arizona
85226	2.6	38868	Chandler	Maricopa	Arizona
85233	2.8	39943	Gilbert	Maricopa	Arizona
85248	2.2	36325	Chandler	Maricopa	Arizona
85249	2	48083	Chandler	Maricopa	Arizona

Primary Service Area CNI scores for Chandler Regional Medical Center

Assessment Process and Methods

Process and Methods

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

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

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

Secondary Data

Many of the challenging health problems facing the United States in the 21st century require an understanding of the health not just of individuals but also of communities. The challenge of maintaining and improving community health has led to the development of a "population health" perspective[xv]. Population health can be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group[xvi]." A focus on population health implies a concern for the determinants of health for both individuals and communities. The health of a population grows directly out of the community's social and economic conditions as well as the quality of its medical care. As a result, the CHNA utilized a community health framework for this report to develop criteria for indicators used to measure health needs.

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

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

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

Table 2. Health factor and health outcome indicators

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

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

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

Prevention Quality Indicators

Prevention Quality Indicators (PQI) measure hospital visits for health "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease." Thus, the incidence of hospitalizations for these ambulatory care sensitive conditions (ACSC) can "provide insight into the community health care system or services outside the hospital setting." This can include the availability and accessibility of primary and preventive health care services. PQI data also can be used to help identify health disparities.

During the calendar year 2016, the largest inpatient hospitalization rates of prevention quality indicators were for a perforation or abscess of the appendix (637.2 per 100,000), chronic obstructive pulmonary disease or asthma in older adults (276.9 per 100,000), and congestive heart failure (169.4 per 100,000). See Table 3.

For the emergency department visits, the highest rates of prevention quality indicators to be seen during calendar year 2016 from residents in the CRMC primary service area were urinary tract infections (840.2 per 100,000), hypertension (326.8 per 100,000) and chronic obstructive pulmonary disease or asthma in older adults (307.4 per 100,000).

Table 3: Prevention Quality Indicators CRMC Primary Service Area, CY16

	IP rates per 100,000 in the CRMC PSA	**ED rates per 100,000 in the CRMC PSA**
Asthma in Younger Adults	27.4	241.1
Bacterial Pneumonia	143.4	211.9
Congestive Heart Failure	169.4	56.1
COPD or Asthma in Older Adults	276.9	307.4
Diabetes Long Term Complications	73.2	31.3
Diabetes Short Term Complications	39.6	3.3
Hypertension	31.1	326.8
Low Birth Weight	69.5	
Lower Extremity Amputation among Diabetes Patients	15.9	0.0
Perforation or Abscess of the Appendix	637.2	106.7
Uncontrolled Diabetes	28.7	144.1
Urinary Tract Infection	92.9	840.2

Source: Hospital Discharge Data from ADHS, analyzed by Maricopa County Department of Public Health.

Primary Data

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

Focus Groups

A series of 36 focus groups with medically underserved populations across Maricopa County were conducted between September 2015 and June 2016. Focus groups helped to identify priority health issues, resources, and barriers to care within Maricopa County through a community-driven process known as Mobilizing for Action through Planning and Partnership (MAPP). The focus group process moved through five phases: (1) initial review of literature; (2) focus group discussion guide development; (3) focus group recruitment and securement; (4) focus group collection; and (5) report writing and presentation findings.

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

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

Recommended strategies for health improvement discussed amongst the participants included:

- More health care navigators/advocates
- More community education/awareness of resources
- More transparency in health care (e.g. insurance, side effects, alternatives, toxins, etc.)
- Better access to healthy, and affordable food

- Increased training/education of health care professionals (e.g., proper use of pronouns for transgendered individuals, updated technologies/medical research, alternative medicine options, etc.)

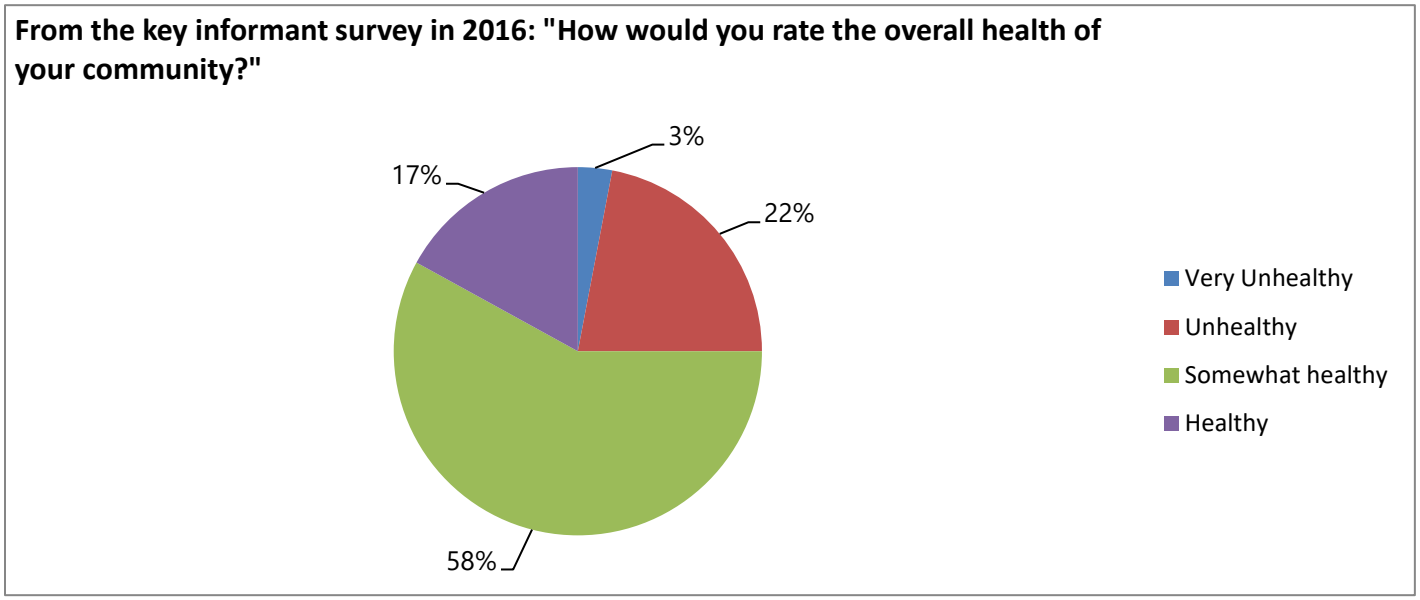
Key Informant Surveys

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

The survey was administered to 100 key informants who provide services throughout CRMC's primary service area. The survey asked respondents about factors that would improve "quality of life," most important "health problems," in the community, "risky behaviors" of concern, and their overall rating of the health of the community (Appendix B).

When surveyed about the overall health of the community, 22% of respondents felt the community was Unhealthy and 3% Very Unhealthy. (Graph 1).

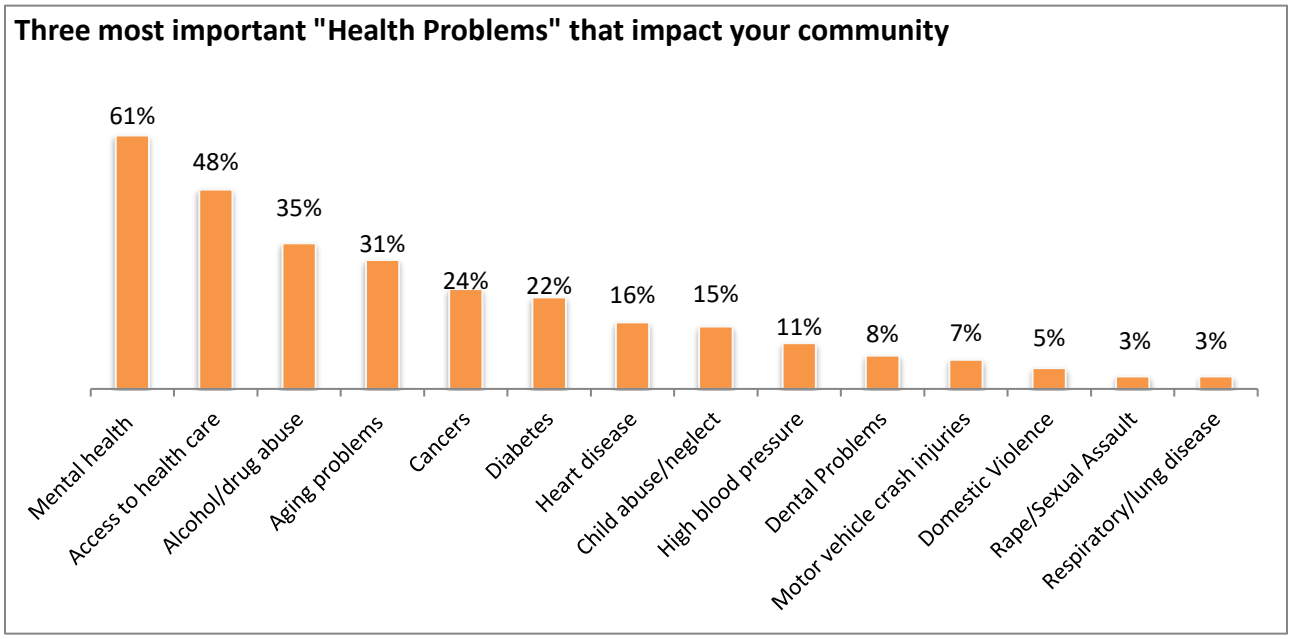
Graph 1



Source: Key Informant Survey

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

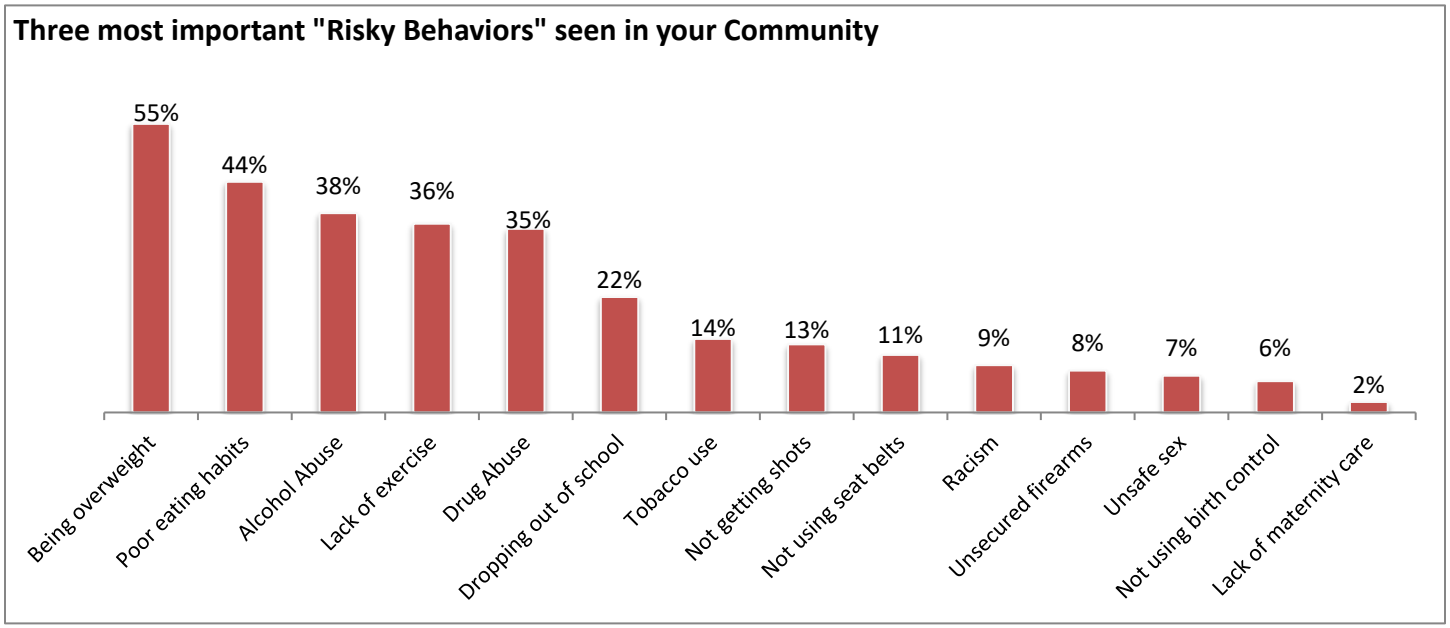
Graph 2



Source: Key Informant Survey

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

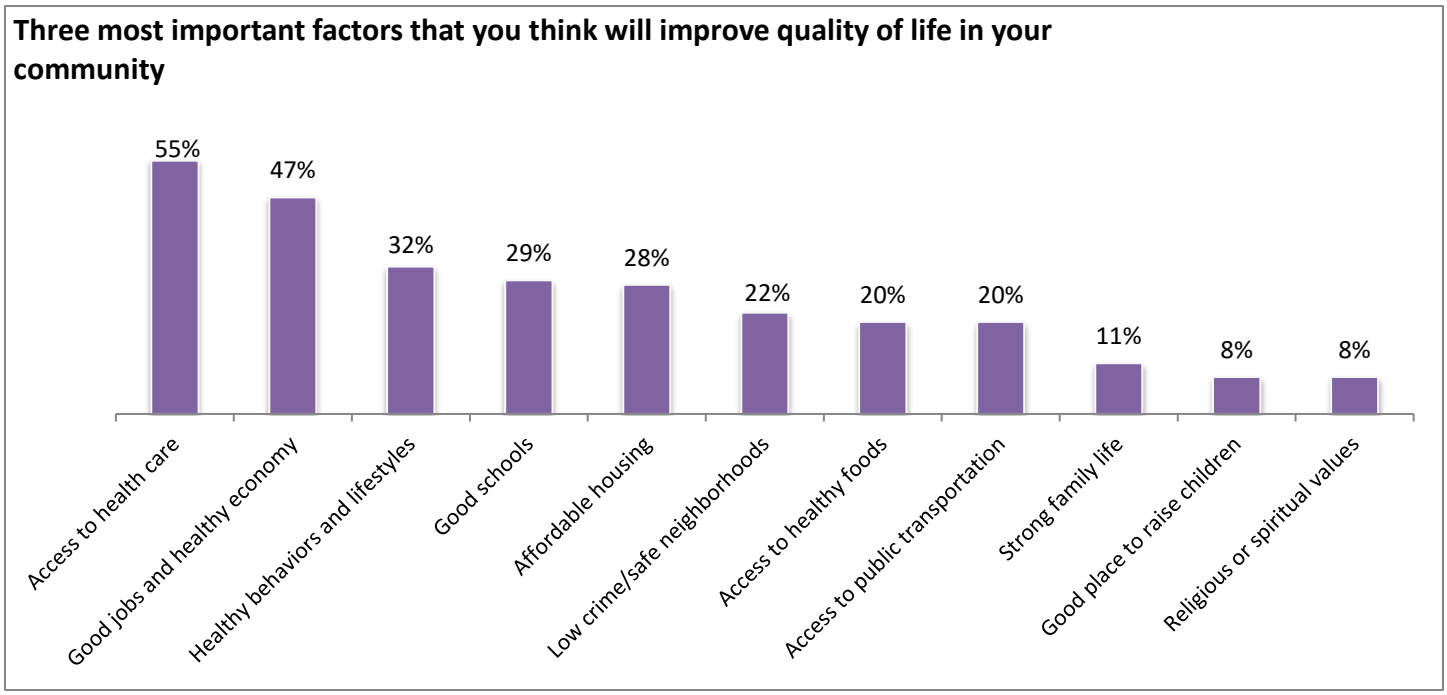
Graph 3



Source Key Informant Survey

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

Graph 4



Source: Key Informant Survey

Community Input/Engagement

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

Chandler Regional Medical Center and Mercy Gilbert Medical Center Community Benefit Committee (CBC)
The Community Benefit Committee is a sub-committee of the Dignity Health East Valley Community Board and comprised of representation from Dignity Health, community agencies, and community members. A key function of the Community Benefit Committee is to participate in the process of establishing program priorities based on the community needs and assets and to review, advise and make recommendations to Dignity Health – Chandler Regional Medical Center.

Chandler Regional Medical Center and Mercy Gilbert Medical Center Community Partnership Collaboration
The Community Partnership Collaboration involves Dignity Health leadership, Dignity Health Community Grants Committee members, Dignity Health Community Benefit Committee members, community agencies, and community members. The collaboration works collectively address health needs of the community, with particular focus on disenfranchised populations. Throughout the year, the Community Partnership Collaboration (open to all community agencies) meets to share information, ideas, and/or recommendations to improve health through Dignity Health Community of Care Grant Program and other initiatives that include the CHNA process.

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

Data Limitations and Gaps

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

The survey data used from our state and national partners also have limitations since they are self-reported surveys. The Behavioral Risk Factor Surveillance System survey (BRFSS) is a survey of adults within Maricopa County. This data could not be drilled down to each hospitals primary service area. The survey questions can be personal in nature and individuals have the option of not responding, or they may answer what they feel the best answer is, causing issues with the data. The Youth Risk Behavior survey (YRBS) is a survey of students in 8th, 10th, and 12th grades of school. The survey is done every other year and cannot be drilled down to the

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

Prioritized Descriptions of Significant Community Health Needs

Identifying Community Health Needs

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

Process and Criteria for Prioritization

The process for prioritization included engagement with both internal Dignity Health stakeholders and community partners from the Community Benefit Board and the Community Partnership Collaboration (See Appendix A for list of participating organizations). The first step of the process was a comprehensive presentation by MCDPH that included an overview of the CHNA findings and key emerging health needs. Throughout the presentation, stakeholders in attendance responded to survey questions that would later be used during strategy sessions to identify health priorities. After completion of the presentation, stakeholders were given the opportunity to provide additional feedback and recommendations. The second step in the process involved review and prioritization of the key emerging health needs outlined in the MCDPH presentation. Dignity Health and MCDPH staff scheduled the East Valley Community Health Assessment strategy session and partners were invited. The session entailed assigning participants to groups and instructing them to visit six stations. Each station included data and information on specific health needs. As participants discussed each health need, consideration was given to the size of the problem, disparity and equity, known effective interventions, resource feasibility and sustainability, and community salience. Participants rotated tables until all six health needs had been discussed. Through discussion, participants were able to determine what health need would feasibly results in a greater impact. Dignity Health and MCDPH staff led the group in an activity using a 4-square grid 'Need" and 'Feasibility' criteria grid. The grid included four quadrants and each quadrant was labeled, 'High Need/High Feasibility,' 'Low Need/High Feasibility, 'High Need/Low Feasibility,' 'Low Need/Low Feasibility. Participants were then asked to place competing labels on the grid. Information was gathered and a follow up survey was sent to provide another opportunity for feedback and recommendations. Participants were also asked to rank each health priority and/or add more strategies to identified needs, or other issues. Final CRMC health priority recommendations were made and approved by the Community Benefits Committee and presented to the board on November 20, 2018.

Description of Prioritized Community Health Needs

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

<u>Access to Care</u>

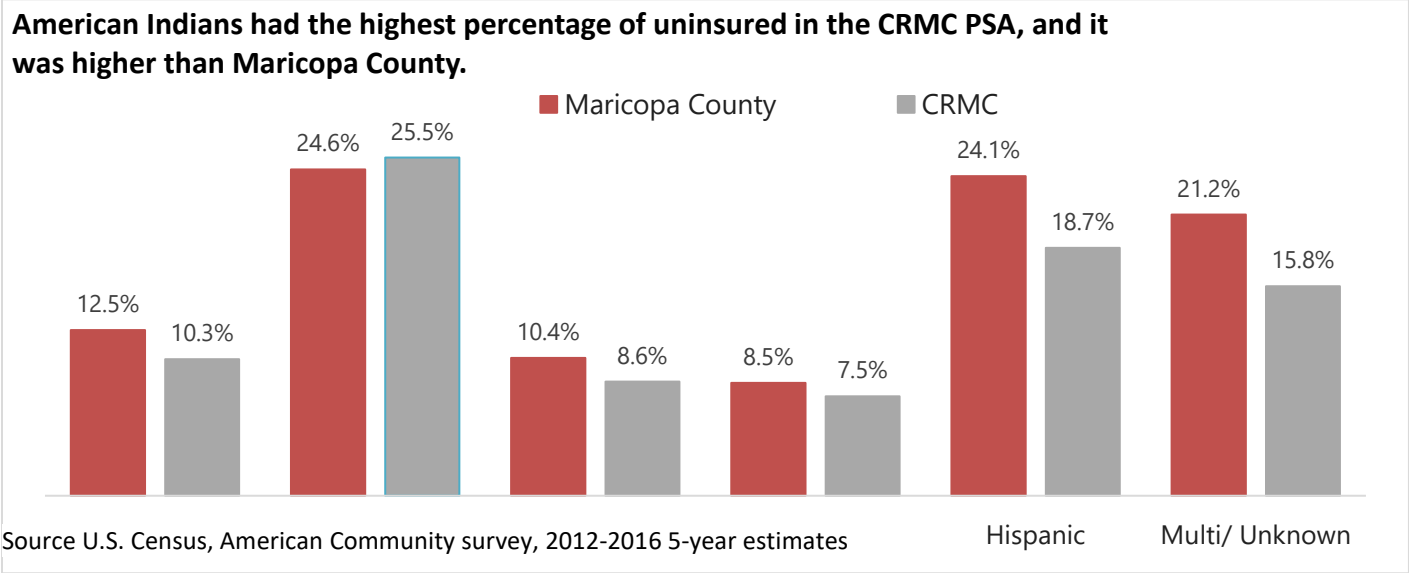
Overall, the percentage of people without health care insurance in Maricopa County has declined noticeably in the years since the implementation of the Affordable Care Act. In 2016, the percentage of Maricopa County's

population without health insurance was 13.9% and respondents to the community survey reported that 15.1% had no health insurance[xviii].

Maricopa County has seen a decrease in the percent of adults who could not afford needed healthcare, falling from 20.8% in 2011 to 16.9% in 2013. However, many adults may still face difficulty accessing care -- 45.9% of respondents to our 2016 community survey indicated that 45.9% sometimes did not have enough money to pay for health care expenses on a monthly basis[xix]. According to the American Community Survey estimates from 2012-2016, the percentage of uninsured residents within the CRMC primary service area was 11.1%. This was lower than Maricopa County overall with 13.9% of uninsured residents.

There are disparities experienced across members of certain racial/ethnic backgrounds, with Native Americans having the highest uninsured rates in CRMC primary service area. In the 2012-2016 5-yr estimates, American Indians in the CRMC PSA also had a higher percentage of uninsured compared to Maricopa County (Graph 4).

Graph 4



In 2016, Maricopa County conducted a community survey for the county. One of the questions asked residents how often they had enough money for healthcare expenses. It was found that 63% of all survey respondents indicated they sometimes or never have enough money for healthcare expenses.

Community health assessment survey participants were asked about healthcare needs, responses included:

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

Community survey participants also shared some common barriers to care. Responses included:

- *Distrust of medical providers*
- *Financial limitations*
- *Lack of access to existing resources*
- *Lack of access to existing resources*
- *Health Literacy*

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

Mental/Behavioral Health

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

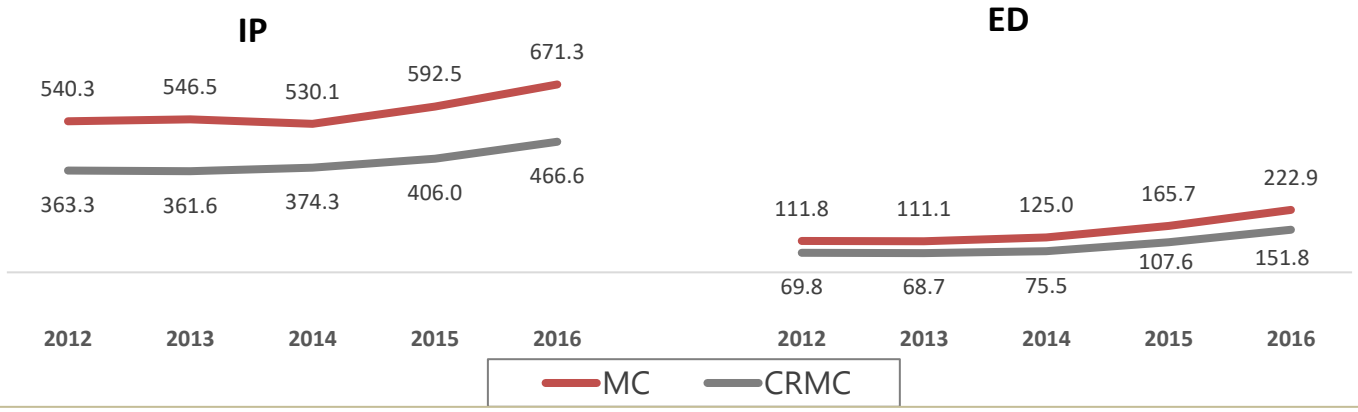
"It's hard to care about being physically healthy when you're not happy, or you just feel like there's an invisible ceiling, there's a road block everywhere. I think it starts with the mental health."

-Focus Group Participant

Visits to the emergency department and inpatient hospitalizations due to mental health diagnoses have been increasing over the last 5 years in Maricopa County in the CRMC primary service area. The mental conditions analyzed are categorized as Organic Psychotic (which includes dementia, alcohol and drug-induced disorders, transient and persistent mental disorders, etc.), Other Psychoses (includes schizophrenic disorders, episodic mood disorders, other nonorganic psychoses and pervasive developmental disorders, etc.), and Neurotic Related disorders (including but not limited to personality disorders, disorders due to psychoactive substances, anxiety disorders, OCD, stress and adjustment disorders, etc.). The two figures below display the Neurotic Related (Graph 5) and Other Psychotic mental health diagnoses (Graph 6).

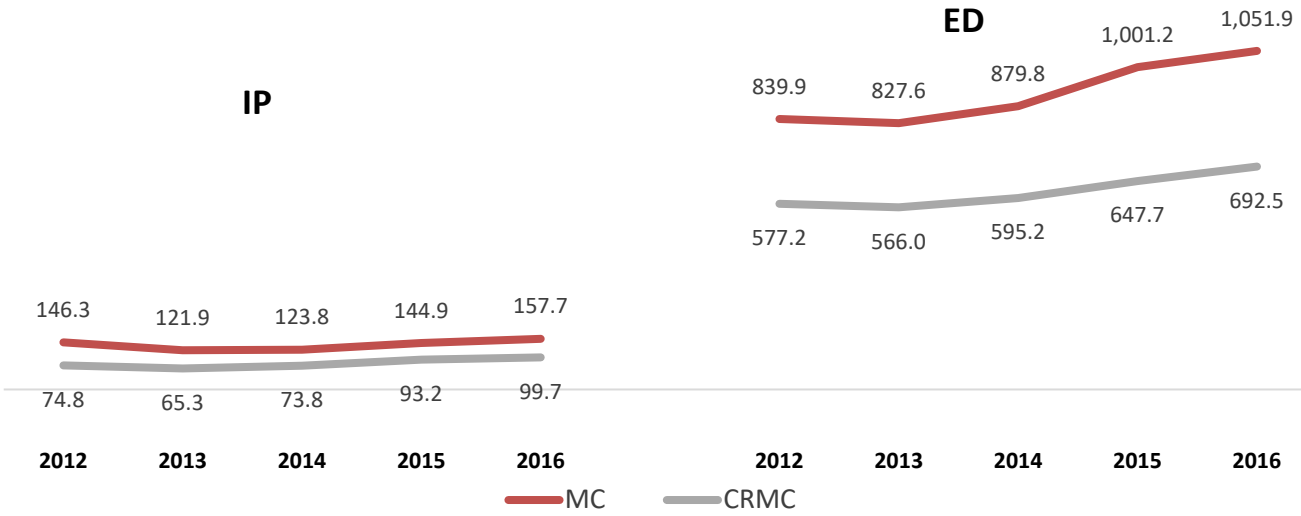
Graph 5

Other Psychoses mental health ED and IP rates, per 100,000, are both increasing in the CRMC PSA and Maricopa County overall, and the IP rates are significantly higher than the ED rates.



Graph 6

Neurotic related mental health ED and IP rates, per 100,000, have both been increasing since 2013 in the CRMC PSA and Maricopa County overall, and the ED rates are significantly higher than the IP rates.



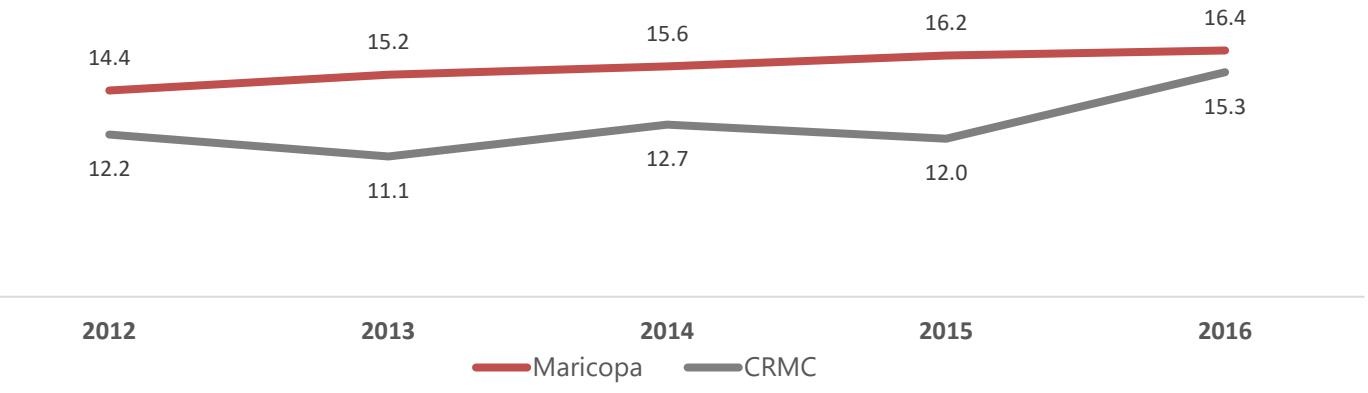
Source: Hospital Discharge Data from ADHS, analyzed by MCDPH

For the organic psychoses conditions, the data showed that only the ED rates have been increasing since 2013. The rate, per 100,000, in 2013 was 56.2 and by 2016 the rate had increased to 79.5 per 100,000. The IP rates have fluctuated and overall decreased. In 2013 the rate was 92.8 but in 2016 it had decreased to 66.5.

Suicide is a major public health problem and a leading cause of death in the United States[xx]. (Suicide in America, n.d.) In Arizona, the latest data shows 1,310 Arizonans died by suicide in 2016[xxi]. In 2016, suicide was the eighth leading cause of death for Maricopa County residents and in the CRMC primary service area (Appendix A). Overall rates of suicide have been rising over the past 5 years in Maricopa County and the CRMC primary service area (graph 7). The mortality rates for suicide in the CRMC primary service area are lower than Maricopa County, including when we looked at the rates by race and age categories.

Graph 7

Suicide related death rates have been increasing in Maricopa County and also in the CRMC primary service area.



Source: Hospital discharge data from ADHS, analyzed by MCDPH

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

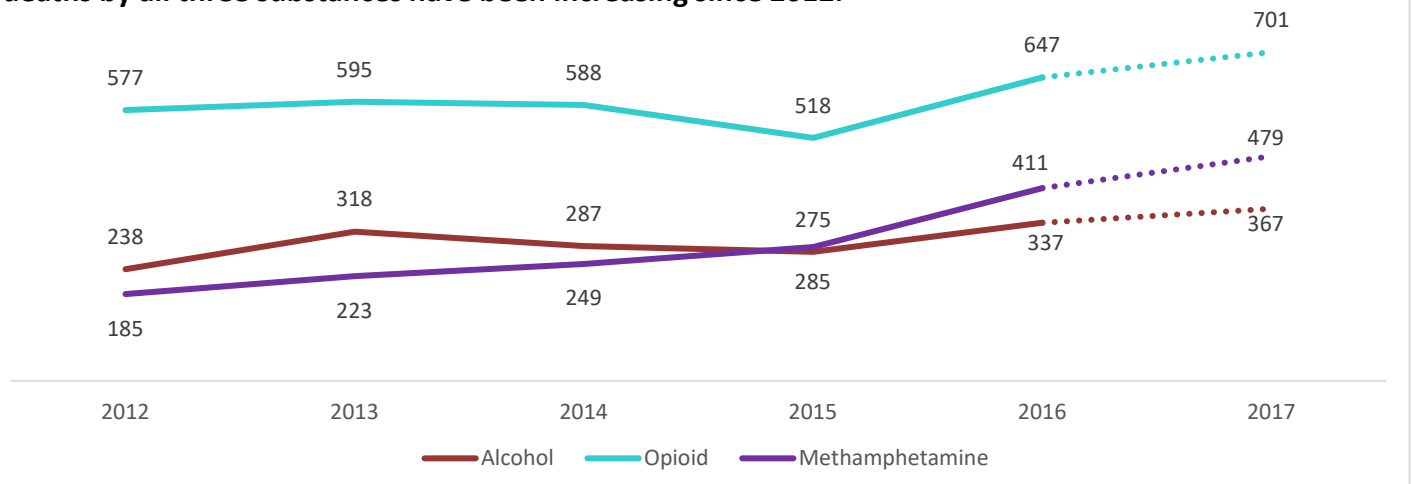
Key informants listed alcohol and drug abuse as two of the top risky health behaviors community members are engaging in. The substances most frequently cited in the survey as being of concern included methamphetamines, prescription drugs, heroin, marijuana, cocaine and alcohol. Additionally, substance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

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues. Examples are morphine and heroin[xxv]. In 2016 there were 790 deaths attributed to opioids in Arizona. This represents a 16.3% increase in opioid deaths since 2015, and a 74% increase since 2012[xxvi].

In Maricopa County, opioids are found more often than alcohol and methamphetamine, and all three substances are trending upward. In Graph 8 we can see the number of deaths found by the Medical Examiner's Office in the years since 2012. Opioid-related mortality rates have risen over the past 5 years and match the trend nationally. In June of 2017 Arizona Governor Doug Ducey declared a public health emergency to address this epidemic.

Graph 8

In Maricopa County, opioids are the most common substance leading to an overdose death, followed by methamphetamine and alcohol. The number of deaths by all three substances have been increasing since 2012.

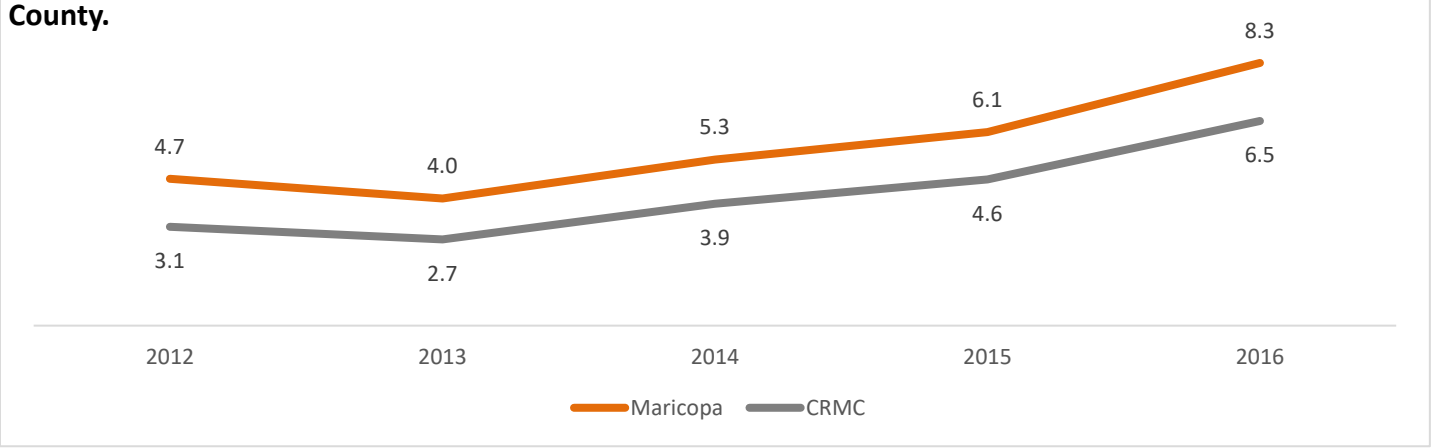


Source: Office of the Medical Examiners in Maricopa County

Note: Deaths for the year 2017 are still being finalized as of December 2018. To compare the CRMC primary service area with Maricopa County as a whole, the rates for opioid-related deaths were calculated and plotted in Graph 9. The CRMC primary service area's opioid mortality rates are lower than Maricopa County as a whole, but are definitely following the same increasing trend of deaths as Maricopa County.

Graph 9

Opioid-related mortality rates in the CRMC PSA are increasing at nearly the same rates as Maricopa County overall although the rates are lower than Maricopa County.

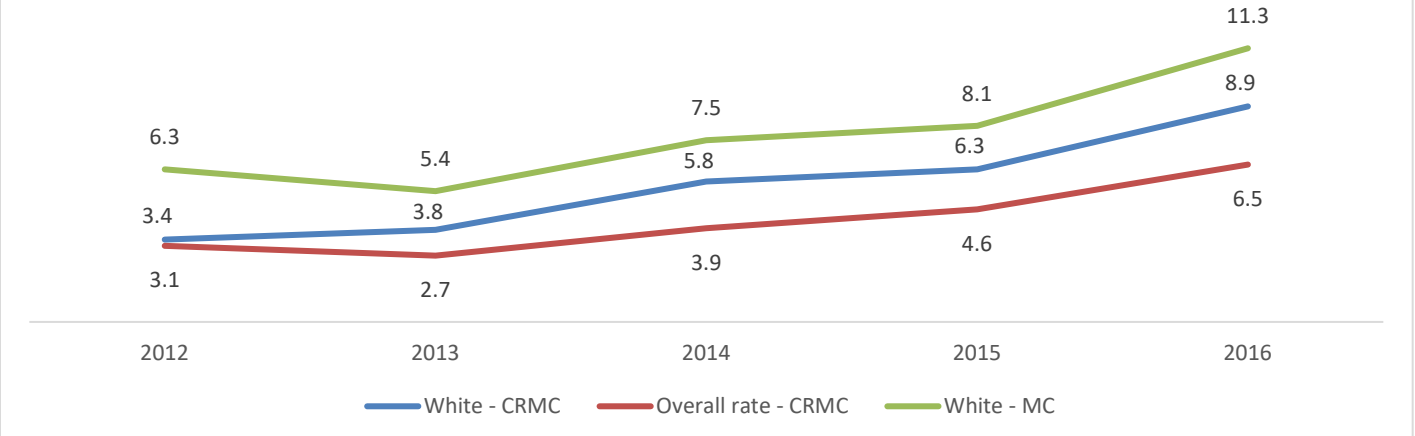


Source: Death data from ADHS, analyzed by MCDPH

In the CRMC primary service area, Whites have the highest mortality rates due to opioid overdoses. In graph 10 below, it shows that the Whites in the CRMC PSA are higher than the overall rates for that primary service area, but lower than the rates among Whites for Maricopa County as a whole. In 2016, Asians in the CRMC PSA had a higher rate of deaths due to opioid overdoses than Maricopa County with a rate of 4.3 deaths per 100,000. Asians in Maricopa County were only 1.9 deaths per 100,000. In 2012 and 2015, American Indians had higher opioid related deaths than Maricopa County overall as well with 9.3 and 9.1 deaths per 100,000 compared to 8.5 and 6.2 deaths per 100,000, respectively.

Graph 10

Whites in the CRMC PSA have higher rates of death due to opioid overdoses compared to the PSA as a whole, but the rates are lower than whites in Maricopa County overall.

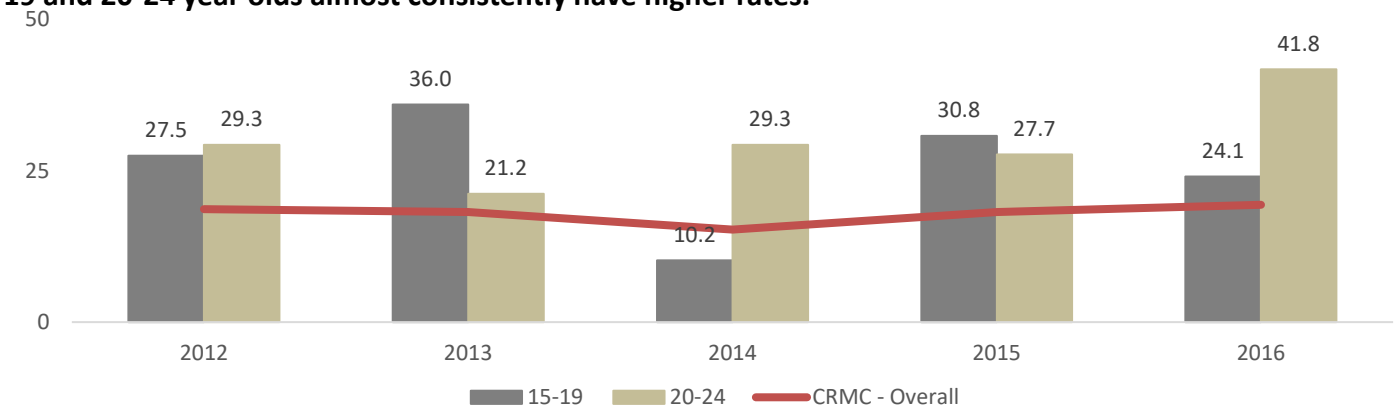


Source: Death data from ADHS, analyzed by MCDPH

Opioid-related overdose rates for the emergency department has been increasing every year for Maricopa County as a whole. When looking at just the CRMC primary service area, the 15-19 and 20-24 year olds have the highest rates of visits to the emergency department due to Opioid overdoses, and since 2012, they're almost always higher than CRMC as a whole (Graph 11).

Graph 11

Compared to the ED rates due to opioid overdoses for the CRMC PSA as a whole, 15-19 and 20-24 year olds almost consistently have higher rates.

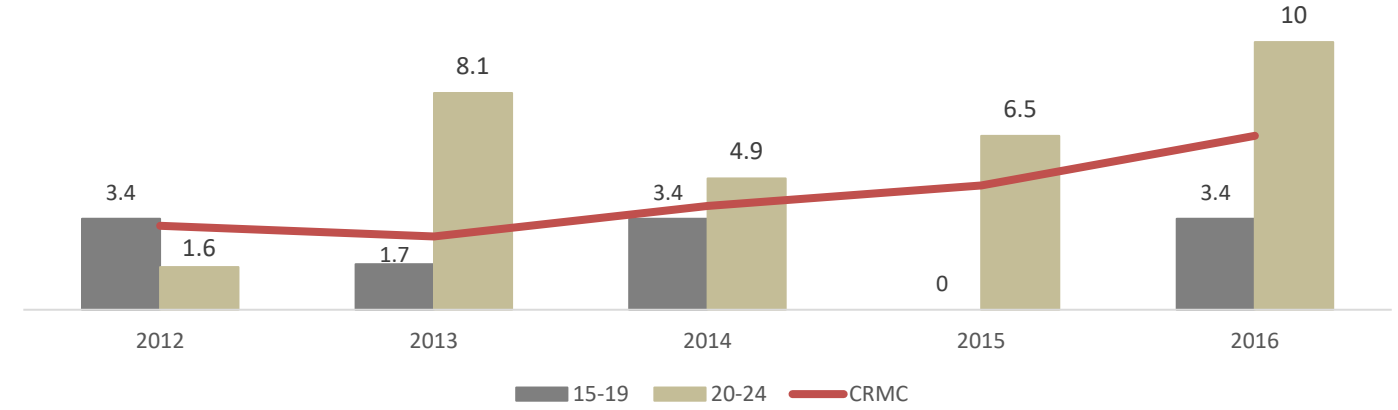


Source: Death data from ADHS, analyzed by MCDPH

The mortality rates for the CRMC primary service area among the 15-19 and 20-24 year olds are also higher than CRMC's PSA overall opioid overdose mortality rates (Graph 12). The 20-24 year olds are especially of great concern.

Graph 12

The mortality rates due to opioid overdoses among the 15-19 and 20-24 year olds are often higher than the CRMC PSA as a whole.



Source: Mortality Data from ADHS, analyzed by MCDPH

Overall unintentional drug overdose mortality rates have increased from 2012-2016 in Maricopa County and the CRMC primary service area. Maricopa County had an unintentional mortality rate of 10.1 per 100,000 in 2012 and 14.3 per 100,000 in 2016. For the CRMC primary service area, the mortality rate was 5.3 per 100,000 in 2012 and increased to 10.1 per 100,000 in 2016.

Alcohol related mortality rates in Maricopa County have increased from 19.2 deaths per 100,000 in 2012 to 25.1 deaths per 100,000 in 2016. American Indians have significantly higher alcohol mortality rates than any other race, and the rates have also been increasing every year from 106.7 deaths per 100,000 in 2012 to 142.8 deaths per 100,000 in 2016. The age group with the highest death rates due to alcohol use is among the 55-64 year olds.

According to the Behavioral Risk Factor Surveillance survey for Arizona, alcohol use among youth has been going down, but female rates are higher than males and higher rates are seen in Hispanic 8th, 10th, and 12th graders than white non-Hispanic (over 10% higher).

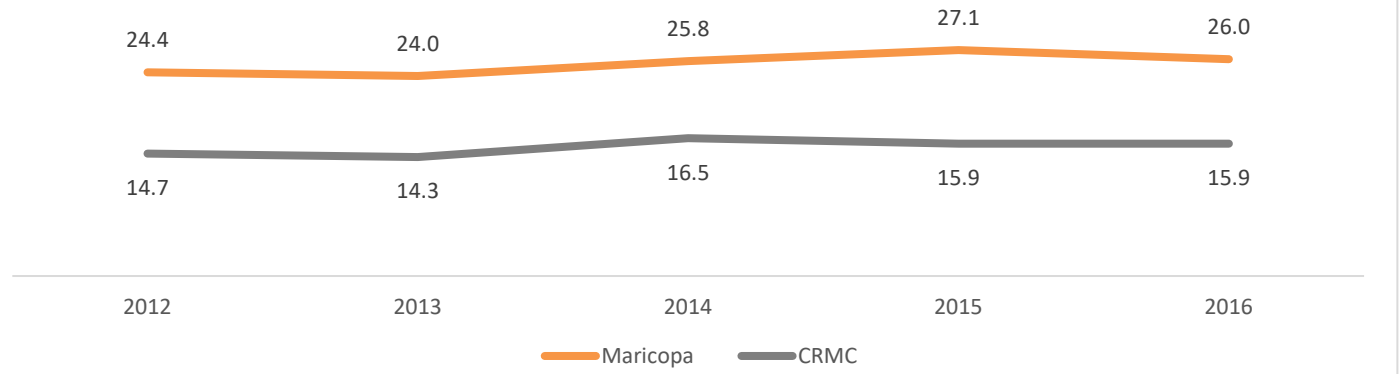
Diabetes

In 2016, the number of deaths related to diabetes decreased in Maricopa County compared to 2015. Diabetes is the seventh leading cause of death in both Maricopa County and CRMC's primary service area, indicating a sustained health need. In CRMC primary service area diabetes mortality rates are highest among ages 75+ years of age.

There has been an approximate 10% increase in people diagnosed with diabetes from 2011 to 2016 in Arizona[xxvii]. In Maricopa County, the number of deaths related to diabetes have fluctuated from 2012-2016 with death rates ranging from 24.4 per 100,000 to 27.1 per 100,000. Those rates are higher than the CRMC's primary service area with a range of 14.7 deaths per 100,000 to 16.5 per 100,000 13. The rates of death increase significantly with age.

Graph 13

The mortality rates due to Diabetes for both Maricopa County and the CRMC primary service area have been slightly increasing overall since 2012, but the CRMC PSA is consistently lower than Maricopa County.

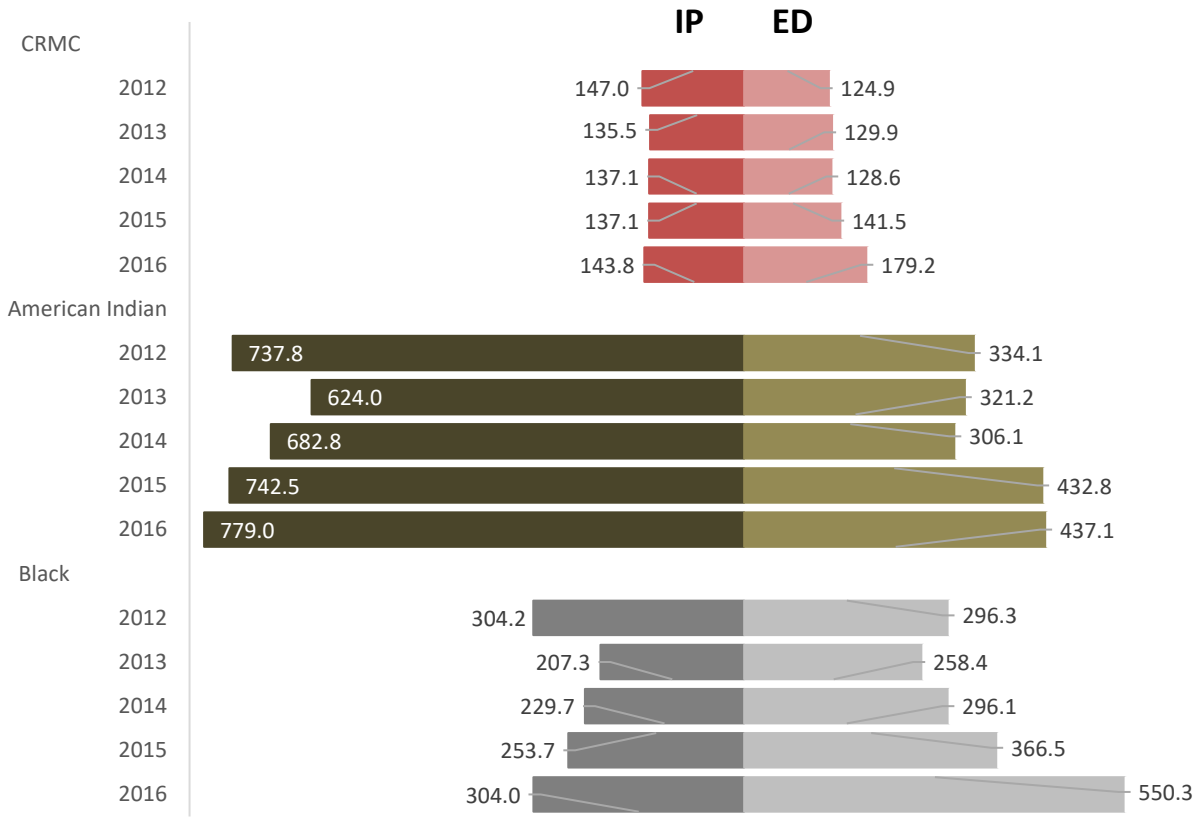


Source: Mortality Data from ADHS, analyzed by MCDPH

African American and American Indian adults that participated in the focus groups identified diabetes as one of the most concerning health problems within their communities. This is supported by the rates of hospital visits for these populations within Maricopa County and also within the CRMC primary service area, which can be seen in graph 14. The higher rates of inpatient discharges and emergency department visits for these populations indicates a potential health disparity in diabetes diagnoses, treatments, or preventative care.

Graph 14

In the CRMC PSA, the highest IP and ED rates for Diabetes, per 100,000, were among the American Indian and Black populations, which were significantly higher than the overall Diabetes hospital rates for the CRMC PSA.

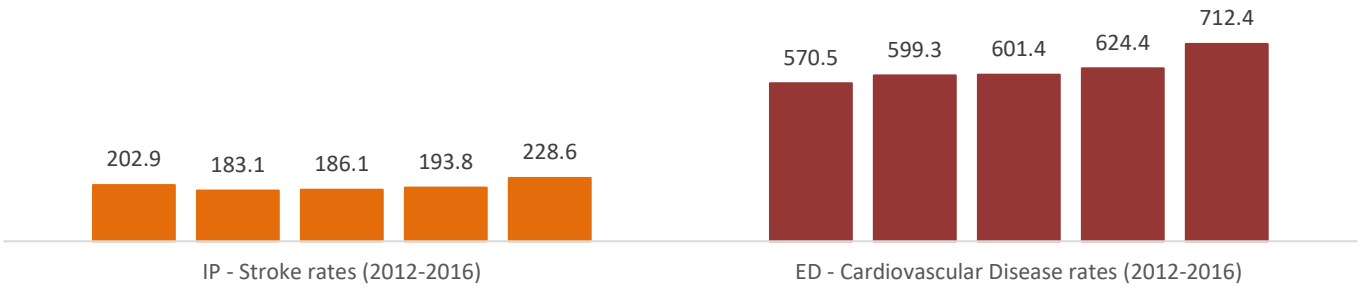


Source: Mortality Data from ADHS, analyzed by MCDPH

Commonly, a diagnosis of diabetes is accompanied by other diagnoses. Two common comorbidities were found to be trending upward in the CRMC primary service area: stroke and cardiovascular disease (graph 15).

Graph 15

Common cormorbidities to Diabetes are Stroke and Cardiovascular Disease. Both the IP rates for stroke and the ED rates for cardiovascular disease have been increasing in the CRMC primary service area from 2012-2016.



Source: Mortality Data from ADHS, analyzed by MCDPH

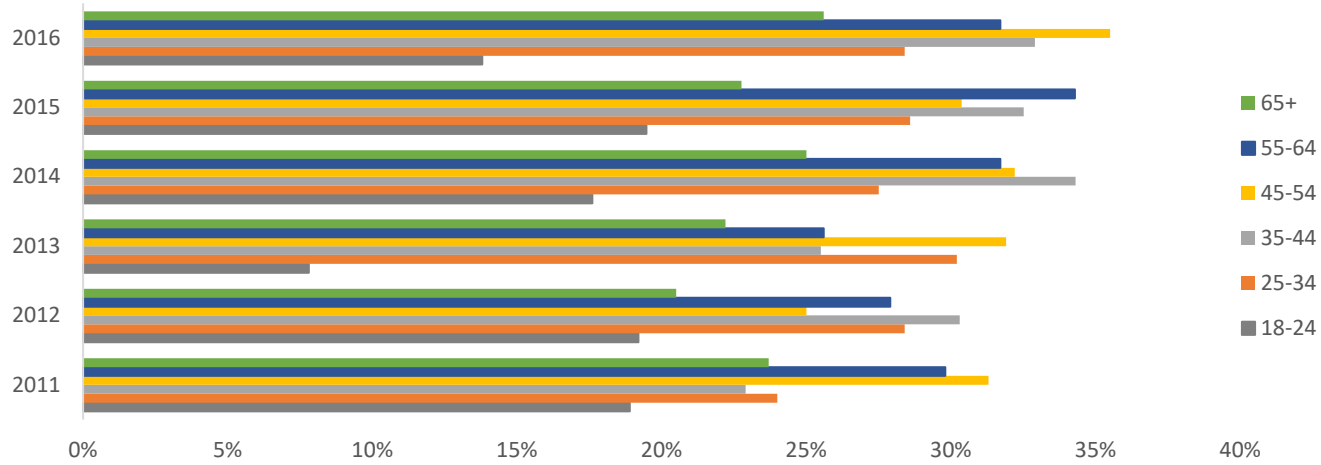
Obesity is known to be a strong predictor of developing type II Diabetes. According to the Behavioral Risk Factor Surveillance Survey for Arizona, men are more likely to be obese than women, and the age groups with the highest percentages of obesity are the 35-64 year olds (Graph 16)[xxix]. From this same survey, we know that Hispanics are significantly more likely to be obese than White, non-Hispanics, see Table 1 below.

Table 1	Obese Body Mass Index					
	2011	2012	2013	2014	2015	2016
White non-Hispanic	21.4%	21.9%	19.9%	26.5%	25.5%	25.9%
Hispanic	35.4%	33.8%	34.1%	33.1%	36.3%	34.8%

Source: Behavior Risk Surveillance Survey for Arizona, CDC

Graph 16

Maricopa County residents considered obese by age group



Source: Behavior Risk Surveillance Survey for Arizona, CDC

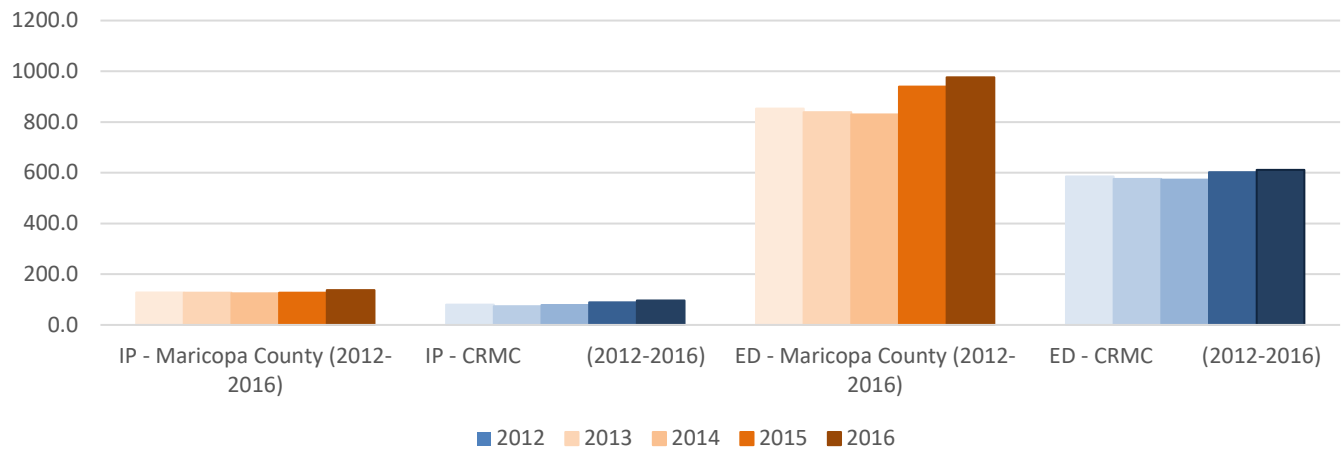
Injury Prevention

In 2016 unintentional injury was the fifth leading cause of death in CRMC's Primary Service Area (Appendix A). Unintentional injuries are preventable and largely due to lifestyle choices. Nationally, nearly one-third of these deaths are due to car crashes and nearly another one-third is due to accidental poisonings[xxx]. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females.

The rate of motor vehicle accident-related inpatient discharges, emergency department visits and mortality within the primary service area are not higher than the average Maricopa County rates (Graphs 17 and 18), and are better than the Healthy people 2020 goal of 12.4 deaths per 100,000 individuals. However, in 2016 approximately 5,200 emergency department and 830 inpatient hospitalization visits were attributed to motor vehicle accidents in the CRMC primary service area[xxxi].

Graph 17

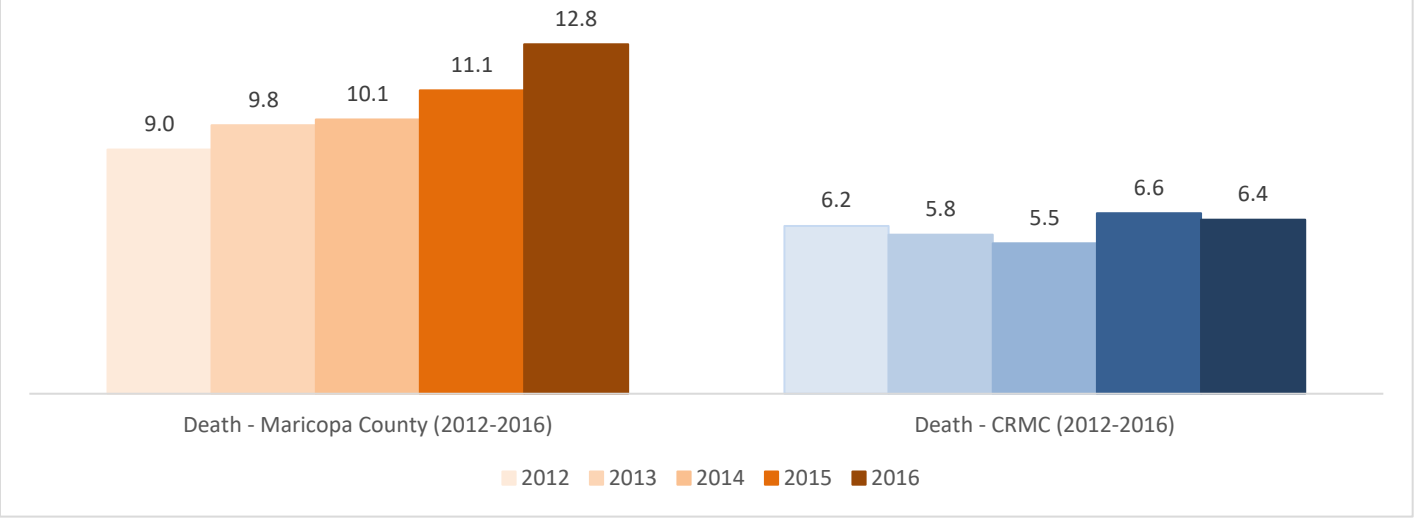
The ED and IP rates due to motor vehicle accident in the CRMC PSA are lower than the rates for Maricopa County overall.



Source: Hospital Discharge Data from ADHS, analyzed by MCDPH

Graph 18

The death rates due to motor vehicle accident in the CRMC PSA are lower than the rates for Maricopa County overall.

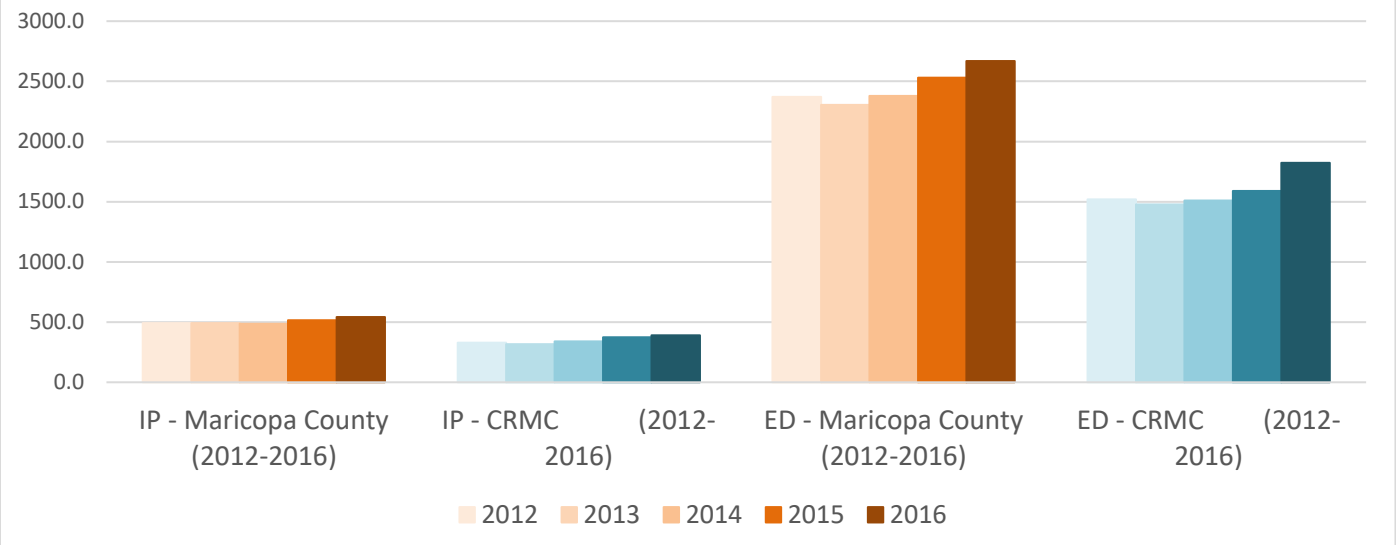


Source: Death Data from ADHS, analyzed by MCDPH

Of major concern for the CRMC are injuries related to falls due to the growing aging population in this primary service area. The rate of fall-related injury inpatient discharges and emergency department visits are not higher than the average Maricopa County rate (Graph 19). However, in 2013 approximately 12,700 hospitals visits were attributed to fall-related injuries in the primary service area.

Graph 19

The ED and IP rates due to falls in the CRMC PSA are lower than the rates for Maricopa County overall. The rates are increasing every year.

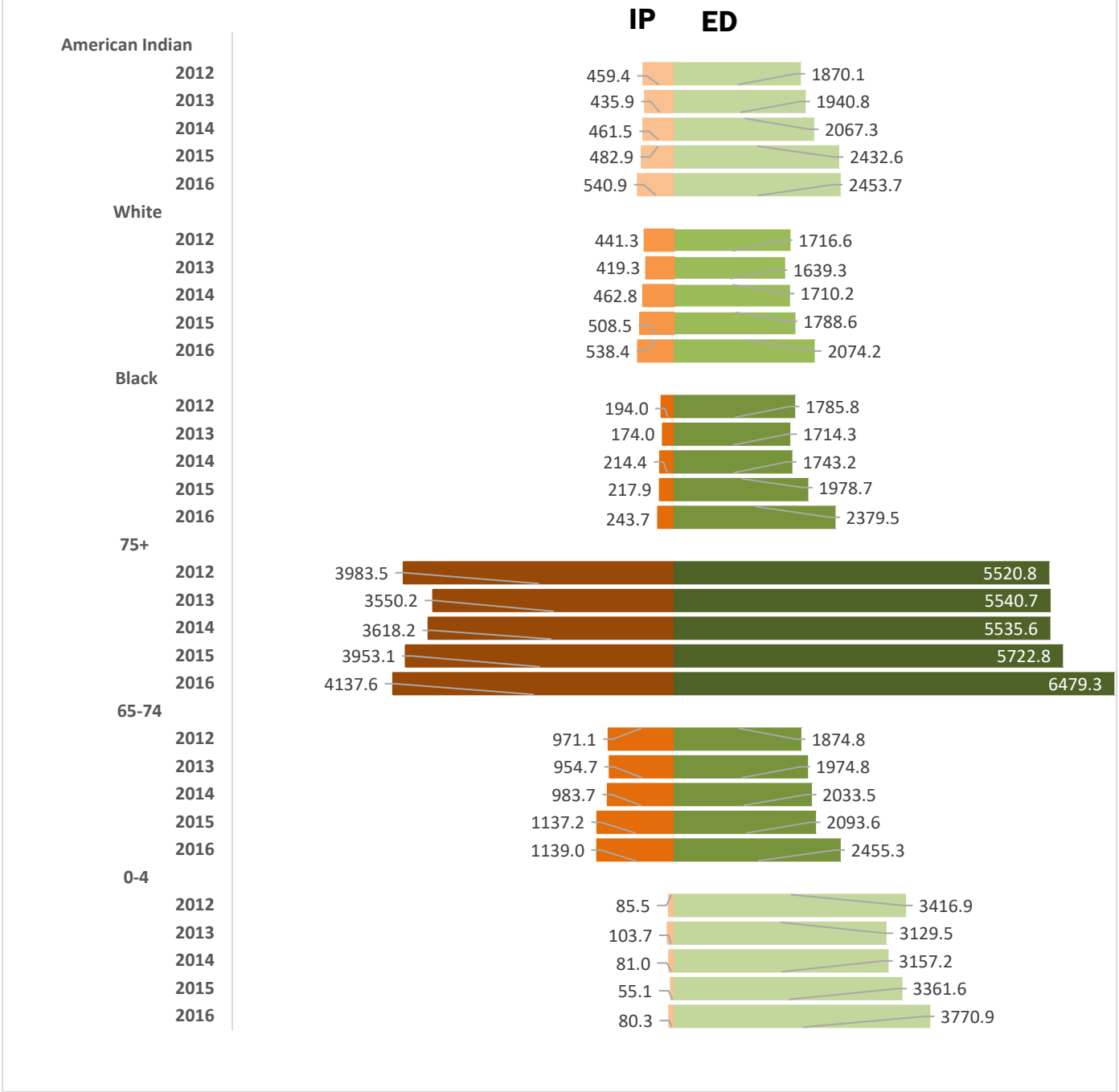


Source: Death Data from ADHS, analyzed by MCDPH

American Indians, White non-Hispanics, Blacks and residents aged 0-4, 65-74, and 75+ have the highest IP and/or ED rates of injuries due to falls (Graph 20). Many older adults may feel that falls are an inventible part of aging, however improving muscle strength and balance can have a tremendous impact on the prevention of fall-related injury.

Graph 20

In the CRMC PSA, the highest IP and ED rates for Fall injuries, per 100,000, were among the American Indians, Whites, Blacks, 0-4, 65-74 and 75+ year olds. The ED rates are significantly higher than the IP rates.



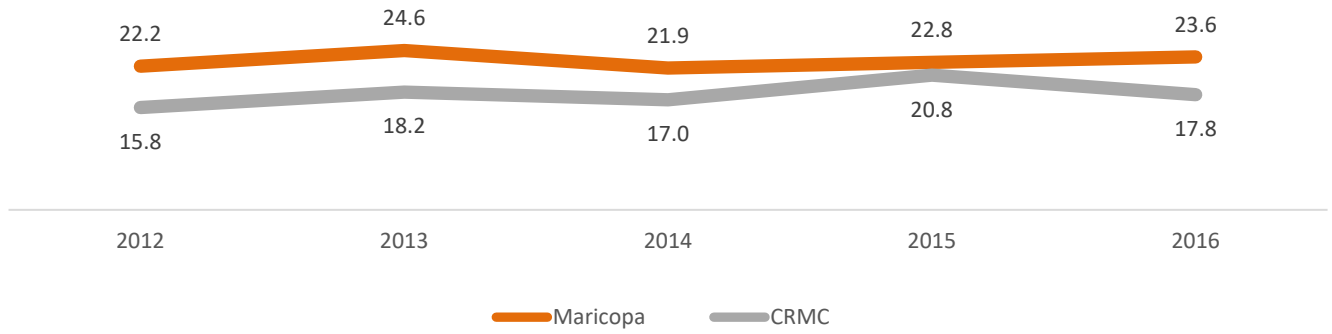
Source: Hospital Discharge Data from ADHS, analyzed by MCDPH

Breast Cancer

Breast cancer is the most common cancer in American women, except for skin cancers[xxxii] and in Arizona, breast cancer was the number one most common cancer among women in 2016[xxxiii]. While breast cancer incidence rates have slightly declined overall from 2010-2015 in Maricopa County, it remains an important health priority in the CRMC primary service area and was identified as one of the top five areas of concerns from key informants (Appendix A). Referring to graph 21, the Maricopa County breast cancer mortality rates are consistently higher than the CRMC primary service area. The breast cancer mortality rates fluctuate only slightly from the years 2012 – 2016.

Graph 21

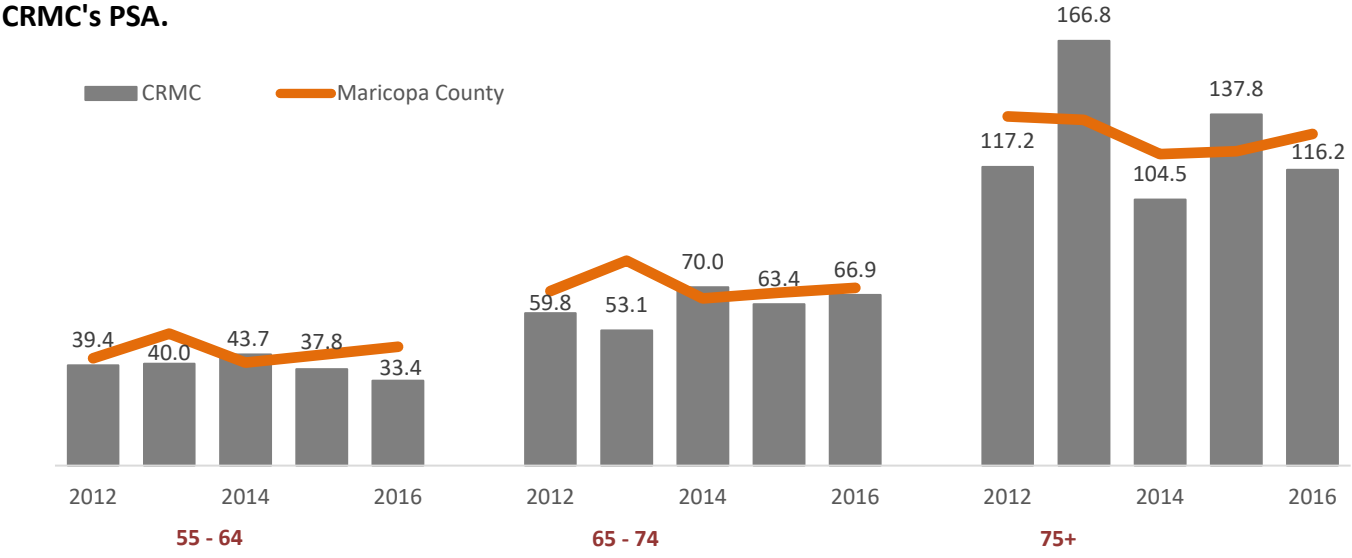
The breast cancer mortality rates in the CRMC PSA are consistently lower than the rates for Maricopa County.



With the increase of death by breast cancer increasing with age, graph 22 visually displays the rates among the 55-64, 65-74 and 75+. Source: Death data from ADHS but analyzed by MCDPH.

Graph 22

The risk of death by breast cancer increases with age. For most years since 2012, the Maricopa County breast cancer mortality rates were higher than the rates for CRMC's PSA.

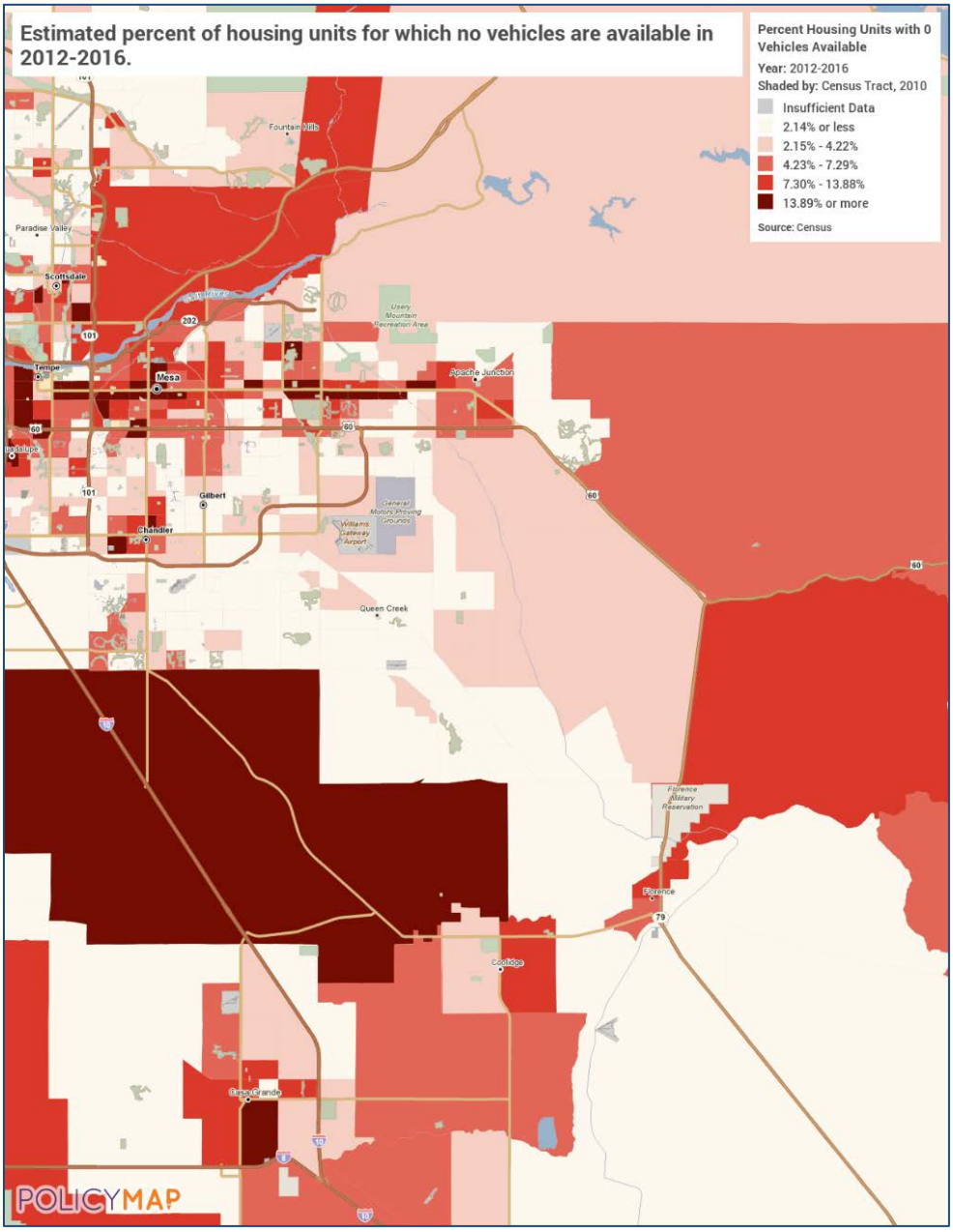


Social Determinants of Health

According to Healthy People 2020, a social determinant of health is a condition in the environment in which a person is born, lives, learns, works, plays, worships, etc. that can play a role or affects health and qualify-of-life outcomes. For the CRMC's primary service area, transportation, access to food, and housing were mapped to better understand those social determinants of health for this primary service area.

If a household has no vehicle, it can greatly inhibit the ability to access employment, seek medical care, obtain healthy food, etc. A map of the primary service area for Chandler Regional Medical Center displays some of the census tracts where a higher percentage of the residents do not have a vehicle for the home.

Figure 2. No Vehicles in Household – East and South Phoenix Metro Area and Pinal County



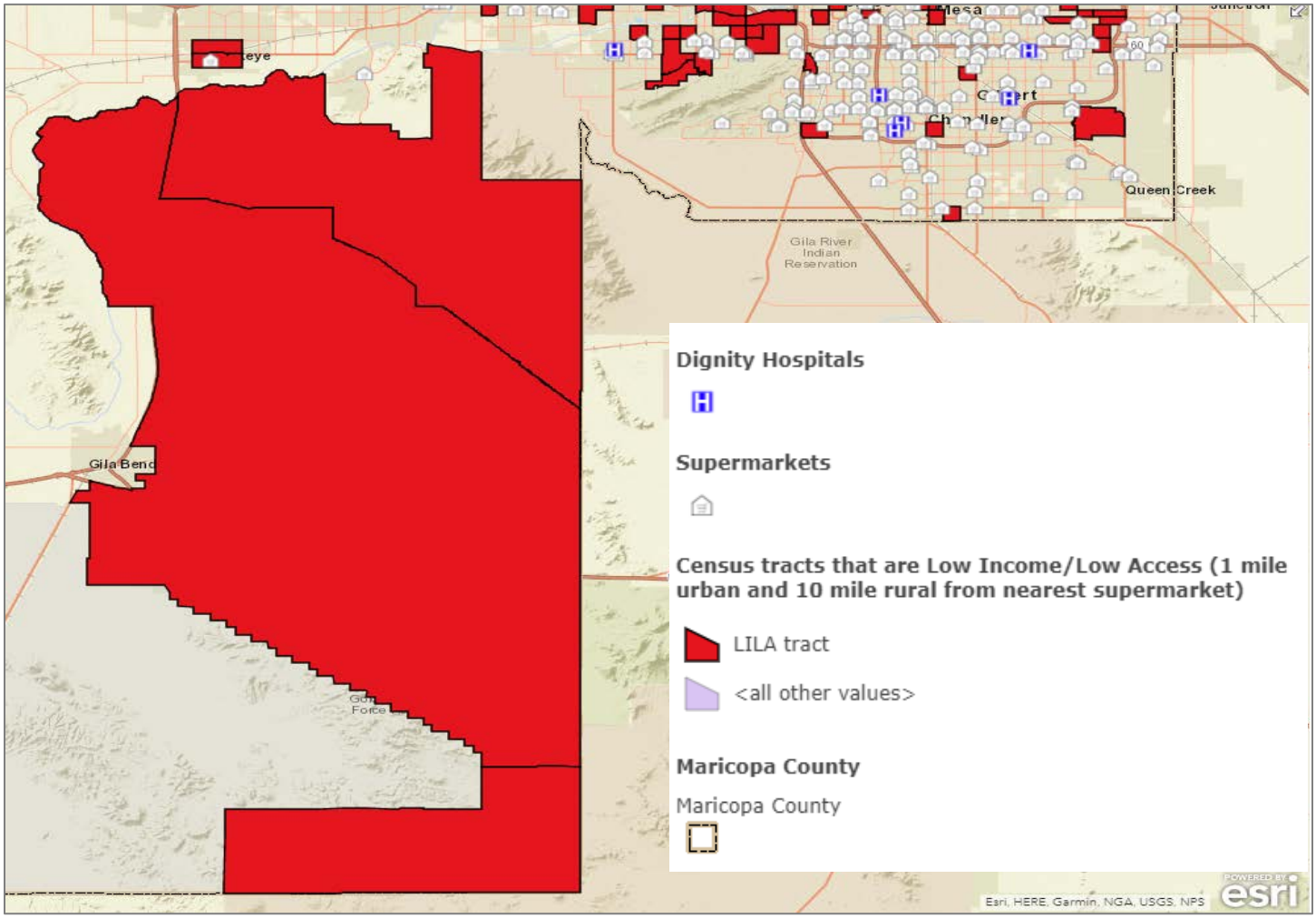
Source: www.policymap.com

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

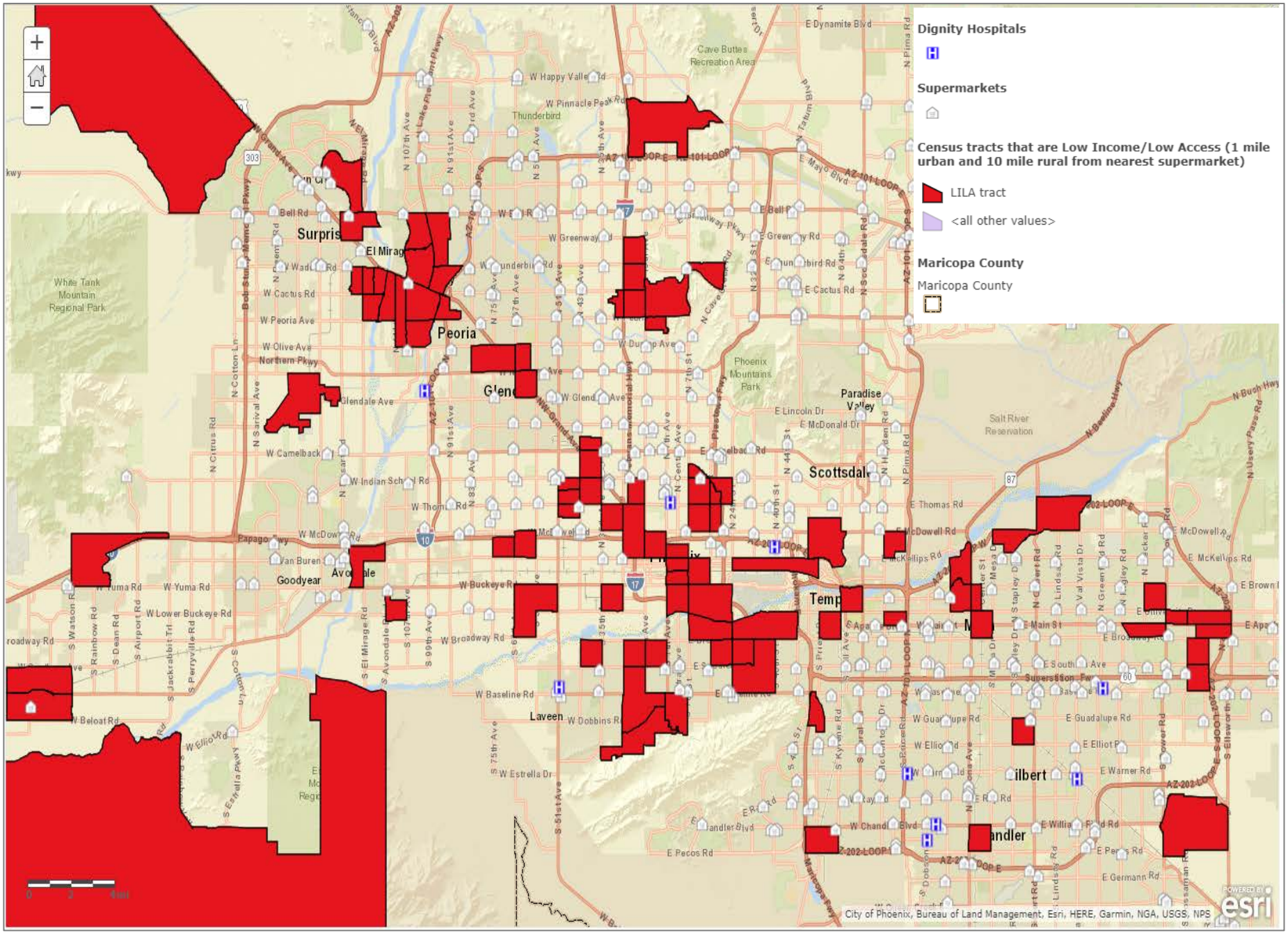
Every individual needs access to healthy food to live and sustain health. Without the ability to access, afford and consume healthy food, a person is at an incredible risk of developing a chronic disease, such as cardiovascular disease and diabetes, and the chance of living a long and healthy live is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

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

Access to Food – Low-Income and Low-Access Graphs



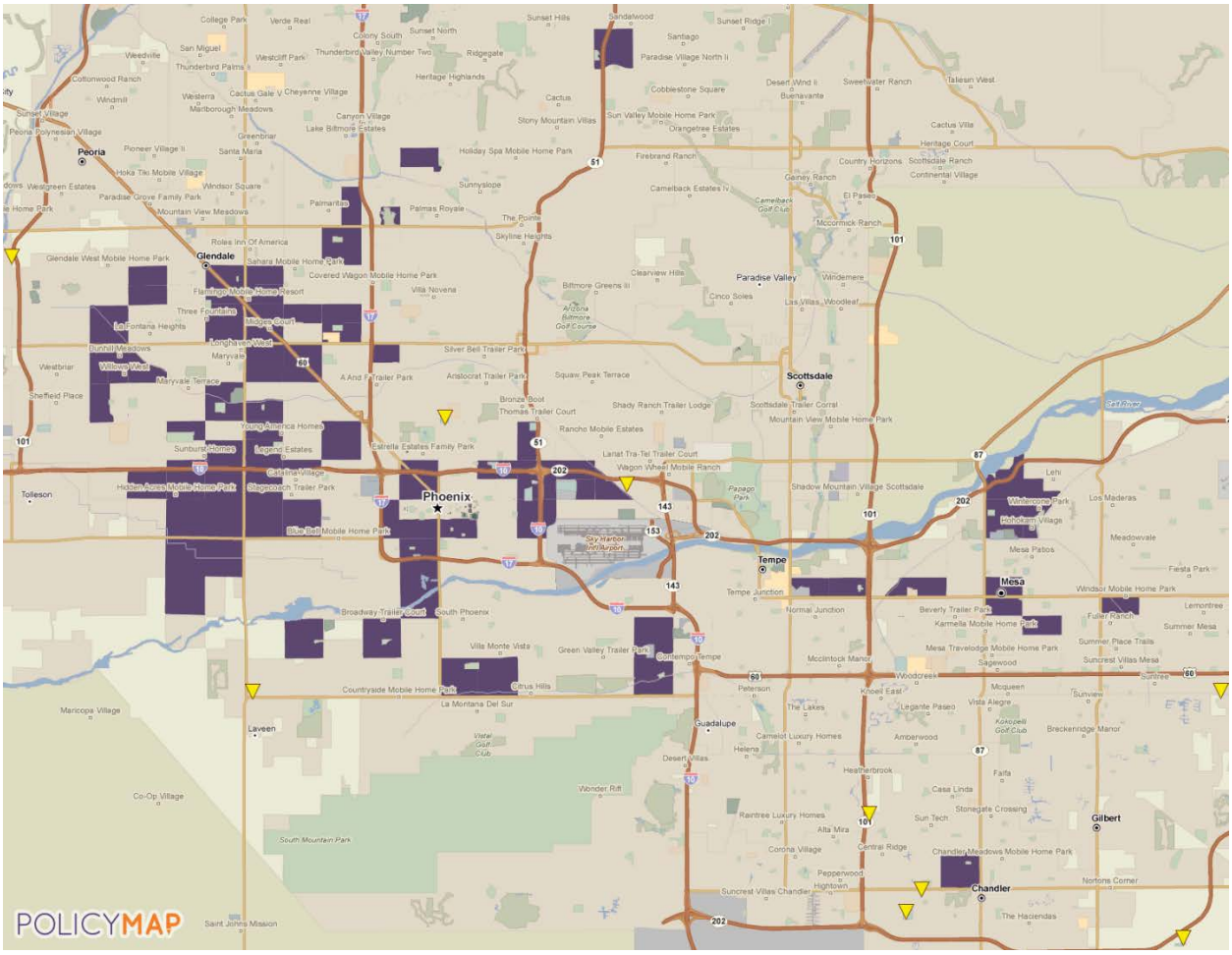
Source: Maricopa County Department of Public Health


Dignity Hospitals
Supermarkets
Census tracts that are Low Income/Low Access (1 mile urban and 10 mile rural from nearest supermarket)
LILA tract
<all other values>
Maricopa County
Maricopa County
Surprise
El Mirage
Peoria
Glendale
Paradise Valley
Scottsdale
Goodyear
Avondale
Laveen
Gilbert
Chandler
Phoenix Mountains Park
White Tank Mountain Regional Park
Cave Buttes Recreation Area
Salt River Reservation
City of Phoenix, Bureau of Land Management, Esri, HERE, Garmin, NGA, USGS, NPS
esri

Homelessness/Housing

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

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



Source: PolicyMap

Resources Potentially Available to Address Needs

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

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

- Arizona Heart Hospital
- Banner Health
- Dignity Health
- Honor Health
- Ironwood Cancer and Research Center
- Maricopa County Integrated Health System
- Phoenix Children's Hospital
- Valley Hospital
- OASIS Hospital
- Arizona Orthopedic Surgical Hospital

Community-Based Agencies:

Organization Name	**Services Provided**
Keogh Health Connection	Heath insurance enrollment and navigation
Foundation for Senior Living	Adult Health Services
Mission of Mercy Mobile Health Program	Primary medical care for uninsured/underserved
Society of St. Vincent De Paul	Medical, dental, food, clothing for underserved
Circle the City	Medical care and respite for homeless
Mountain Park Health Center	Primary medical care for uninsured/underserved
Mathew's Crossing	Food bank
Clinica Adelante	Primary medical care for uninsured/underserved
Faith Community/Churches	Parish Nurse Program
Community Action Program	Emergency Assistance
I-Help Interfaith Homeless	Shelter, food, and resources for homeless, Emergency Lodging Program
A New Leaf	Shelter, housing, support services for homeless and underserved
Chandler Care Center	Medical, Dental, WIC, Food bank, Behavioral Health, and support services for Chandler school children and their families.

Rebuilding Together Valley of the Sun	Home repair and modification
AZCEND	Family Resource Center, Food Bank, Emergency Services
Community Action Program (CAP)	Emergency Services
Tempe Community Action Agency	Temporary Shelter, Food, elderly services and Support
Lutheran Social Services of the Southwest	Temporary shelter, Food, elderly, housing, support services
ICAN (Improving Chandler Area Neighborhoods)	After school programs for Chandler School Children
About Care and Neighbors Who care	Transportation and case management for the elderly
United Food bank	Food Bank
Valley of the Sun United Way/Ahwatukee YOPIS	Transportation and health and wellness,
Valley of the Sun United Way Chandler/Gilbert YMCA	Health and wellness
Living Well Institute	Chronic Disease Management
East Valley Adult Resources	Support services for senior citizens
AT Still University	Falls prevention education, oral health
Public Service Agencies (Fire Department, Police Department)	Health and injury prevention collaborative
Indian Health Services	Health Services for Native American Population
Women's Health Innovations	Licensed behavioral health agency in Arizona that specializes in Maternal Mental Health Services
House of Refuge	Families in crisis. Provides safe, stable housing to families who are experiencing homelessness.

The Health Improvement Partnership of Maricopa County (HIPMC) is a collaborative effort between MCDPH and a diverse array of public and private organizations addressing healthy eating, active living, linkages to care and tobacco-free living. The HIPMC provides a forum to share ideas and resources as well as a data-driven process to identify gaps and barriers to health improvement, especially among vulnerable populations. With more than 100 partner organizations, this is a valuable to resource to help Chandler Regional Medical Center connect to other community based organizations that are targeting many of the same health priorities[xxxiv].

Impact of Actions Taken Since Preceding CHNA

From fiscal year 2016 through fiscal year 2018, Dignity Health – Chandler Regional Medical Center Medical Center provided for $138,751,655 in patient financial assistance, unreimbursed cost of Medicaid, community health improvement services, and other benefits. Including the unreimbursed cost of caring for patients covered by Medicare, the hospital's total community benefit expense from 2016 – 2018 was $232,232,880.

In addition, the number of persons served through financial assistance and community health improvement services between fiscal year 2016-2018 further demonstrates the impact of Dignity Health actions through community outreach services. For Chandler Regional Medical Center 13,384 people received financial assistance and 254,159 people were served through community health services. Below is a listing of key community health services:

- East Valley I-Help Coalition – AZCEND, Tempe Community Action Agency, & Lutheran Social Services of the Southwest
- Senior Community Wellness Coalition- Neighbors Who Care, About Care, Valley of the Sun YMCA Ahwatukee; Y OPAS
- Partnership to Build Resilient Families- ICAN Positive Programs for Youth, Chandler CARE Center, Chandler Coalition on Youth Substance Abuse, Valley of the Sun YMCA, Chandler/Gilbert
- Safe at Home - East Valley Adult Resources, Rebuilding Together Valley of the Sun, AT Still University
- East Valley Perinatal Network - Women's Health Innovations of Arizona, Hushabye Nursery, Haven 107
- Destination Diploma- Homeward Bound, Pappas Kids Schoolhouse Foundation, Fans Across America
- Dignity Health Community Education – Prenatal classes, injury prevention, support groups
- Dignity Health Perinatal Mood Disorder – Let's Talk
- Dignity Health Early Childhood Oral Health Program
- Dignity Health Children's Dental Clinic
- Dignity Health Chronic Disease Self-management Program
- Dignity Health Healthier Living
- Dignity Health Center for Diabetes Management
- Dignity Health Center for Health Faith Ministries
- Dignity Health Think First Injury Prevention Program
- Dignity Health Immunization Program
- Dignity Health Building Blocks for Children Hearing and Vision Program
- Pregnancy Care Center of Chandler
- Chandler Education Foundation
- Valley of the Sun YMCA, Chandler/Gilbert Family YMCA
- Big Brothers Big Sisters of Central Arizona (BBBSAZ)
- Mission of Mercy
- Foundation for Senior Living: ACTIVATE
- Circle the City

Input Received on Most Recent CHNA and Implementation Strategy

A formal mechanisms is in place to receive and track written comments regarding the Community Benefit Report and Plan, CHNA, or Implementation Strategy. The Dignity Health website, and embedded in each report, is the email and contact information for either questions or comments. This process ensures Dignity Health compliance with the regulatory requirement to solicit and take into account input received from written comments.

Positive feedback on the value and benefit of the CHNA report has been received verbally by many internal and external stakeholders. In addition, many individuals and agencies have requested the CHNA report to use for grant applications, assessments, planning, and for student assignments at various colleges and universities.

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

Written comments on this report can be submitted to the Chandler Regional Medical Center's Community Integration Department or by e-mail to CHNA-Chandler@DignityHealth.org.

Appendix A - List of Data Sources

Data Sources

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

Data Indicators

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

2. **Access to Health Care**

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

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

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

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

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

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

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

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

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

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

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

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

Key Informant Survey

Total Number of Participants	100
Characteristic	Percentage of Participants
Male	20%
Female	80%
0-17	0%
18-24	1%
25-39	18%
40-54	37%
55-64	31%
65 or older	13%
American Indian/Alaskan Native	0%
Asian/Pacific Islander	1%
African American	4%
Hispanic	11%
White	84%

Top 10 Leading Causes of Death, 2016

Rank	Maricopa County	Chandler Regional Medical Center
1	Cancer	Cancer
2	Cardiovascular Disease	Cardiovascular Disease
3	Chronic Lower Respiratory	Alzheimer's
4	Alzheimer's	Chronic Lower Respiratory
5	Unintentional Injury	Stroke
6	Stroke	Unintentional Injury
7	Diabetes	Diabetes
8	Suicide	Suicide
9	Fall	Fall
10	Liver Disease	Liver Disease

Focus Groups (Conducted in 2016)

Total Number of Participants = 367

Cycle 1 Focus Group Schedule

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

Cycle 2 Focus Group Schedule

Date	Time	Population	Location
2/27 (Sat.)	10:00-12:00pm	Older adults (50-64) [Spanish; n=8]	Guadalupe Town Office (9241 S Avenida del Yaqui Guadalupe, AZ 85283)
3/5 (Sat.)	11:30-1:30pm	Adults with children [Spanish; n=12]	Dysart Community Center (14414 N El Mirage Rd, El Mirage, AZ 85335)
3/12 (Sat.)	9:30-11:30am	Adult males [Spanish; n=8]	Glendale Community College (6000 W Olive Ave, Glendale, AZ 85302)
3/12 (Sat.)	1:00-3:00pm	Adult females [Spanish; n=12]	Open Door Fellowship Church (8301 N 19th Ave, Phoenix, AZ 85021)
3/15 (Tues.)	5:30-7:30pm	Lower income adults [n=9]	Escalante Community Center (2150 E Orange St, Tempe, AZ 85281)
3/19 (Sat.)	9:30-11:30am	Older adults [75+] [n=10]	Red Mountain Multigenerational Center (7550 E Adobe Rd, Mesa, AZ 85207)
3/19 (Sat.)	9:30-11:30am	Caregivers [n=8]	Red Mountain Multigenerational Center (7550 E Adobe Rd, Mesa, AZ 85207)
3/22 (Tues.)	5:30-7:30pm	African American adults [n=9]	Tanner Community Development Corporation [TCDC] (700 E Jefferson St # 200, Phoenix, AZ 85034)
3/24 (Thurs.)	5:30-7:30pm	Native American adults [n=6]	Mesa Community College (1833 W Southern Ave, Mesa, AZ 85202)
3/29 (Tues.)	5:30-7:30pm	Adults with children [n=8]	Paradise Valley Community College (18401 N 32nd St, Phoenix, AZ 85032)
4/2 (Sat.)	9:30-11:30am	Asian American adults [n=8]	Chandler Downtown Library (22 S Delaware St Chandler, AZ 85225)

Cycle 3 Focus Group Schedule

Date	Time	Population	Location
4/21 (Thurs.)	9:30-11:30am	Adults ages 65 – 74 [Spanish]	Mexican Consulate 320 E. McDowell Rd., Phoenix, AZ 85004
4/21 (Thurs.)	5:30-7:30pm	African American males	Arizona Opportunities Industrialization Center (AZOIC) 39 E. Jackson St., Phoenix, AZ 85004
4/26 (Tues.)	12:30-2:30pm	Adults 75+ [Spanish]	Matthew Henson Senior 1045 S. 8th Ave., Phoenix, AZ 85007
5/3 (Tues.)	5:30-7:30pm	Adults without children [Spanish]	Esther Angulo Community Center 9555 W. Van Buren St. Tolleson, AZ 85353
5/4 (Weds.)	9:30-11:30am	Older adults 50-64	Wickenburg Public Library 164 E. Apache St., Wickenburg, AZ 85390
5/4 (Weds.)	5:30-7:30pm	Adults with children under age 18	Saguaro Library 2808 N 46th St., Phoenix, AZ 85008
5/9 (Mon.)	5:30-7:30pm	Adults without children	Foothills Branch Public Library 19055 N 57th Ave., Glendale, AZ 85308
5/10 (Tues.)	5:30-7:30pm	Adults with low SES	Estrella Mountain Community College 3000 N. Dysart Rd., Avondale, AZ 85392
5/16 (Mon.)	5:30-7:30pm	Young adults 18-30	Gila Bend Family Resource Center 303 E. Pima St., Gila Bend, AZ 85337
5/17 (Tues.)	1:30-3:30pm	Asian American adults [Mandarin]	Chinese Senior Center 734 W. Elm St., Phoenix, AZ 85013
5/17 (Tues.)	5:00-7:00pm	Adults with children under age 18 [Spanish]	Buckeye Downtown Library 319 N. 6th St. Buckeye, AZ 85326
5/19 (Sun.)	9:30-11:30am	Asian American adults [Vietnamese]	Vietnamese Center 2051 W. Warner Rd., Chandler, AZ 85224
6/1 (Weds.)	10:00-12:00pm	Adults who care for senior parents	Church of the Beatitudes 555 W. Glendale Ave., Phoenix, AZ 85021

Stakeholders- Participating Organizations

- Dignity Health Leadership
- Dignity Health East Valley Community Board
- Dignity Health East Valley Community Benefit Committee (CBC)
- Dignity Health East Valley Care Coordination
- Dignity Health Community Grants Committee
- Mission of Mercy
- Town of Gilbert
- Town of Queen Creek, Chamber of Commerce
- Maricopa County Department of Public Health
- Catholic Charities
- Neighbors Who Care
- Marc Community Recourses
- Pregnancy Care Center
- Community members
- Pan de Vida Foundation
- Valley of the Sun United Way
- Desert Cross Lutheran Church
- Pinnacle Prevention
- Amanda Hope Rainbow Angels
- City of Chandler/ Fire Department
- Town of Gilbert/ Police Department
- Church of Celebration Maricopa
- ICAN: Positive Program for Youth
- Nami Valley of the Sun
- Ak- Chin Indian Community
- Lutheran Social Services
- Family Home Care
- Tempe Community Action Agency
- Women's Health Innovations
- Community Alliance Against Family Abuse
- Y OPAS/ YMCA-Outreach Program for Ahwatukee Seniors
- AZCEND
- Chandler Coalition on Youth Substance Abuse
- Rebuilding Together
- Mental Health America of Arizona
- About Care
- Homeward Bound
- Addition Haven
- Aurora Behavioral Health
- Legacy Home Care
- Honor Health Forensic Nurse

- St. Matthew’s Episcopal Church
- Hushabye Nursey

Appendix B – Primary Data Collection Tools

CHNA Focus Group Questions

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

Opening Question (5 minutes)

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

General Community Questions (20 minutes)

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

2. What does quality of life mean to you?

3. What makes a community healthy?

4. Who are the healthy people in your community?

    a. What makes them healthy?

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

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

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

Family Questions (20 minutes)

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

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

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

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

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

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

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

Improvement Questions (20 minutes)

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

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

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

[Prompts]

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

CHNA Focus Group Questions Cont'd

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

Ending Question (5 minutes)

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

Facilitator Summary & Closing Comments (5-10 minutes)

Let's take a few minutes to reflect on responses you provided today. We will review the notes we took and the themes we observed. This is your opportunity to clarify your thoughts or to provide alternative responses.

[Co-facilitator provides a brief summary of responses for each of the questions or asks clarifying questions if she thinks she may have missed something.]

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

Community Health Survey

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

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

In this survey, "community" refers to the major area where you provide services. Please check one from the following list:
__ Northeast (Scottsdale, Carefree, Fountain Hills, Cave Creek)
__ Northwest (Peoria, Surprise, El Mirage, Sun City)
__ Central (Phoenix, Paradise Valley)
__ Central west (Glendale, Avondale, Litchfield Park)
__ Central East (Tempe, Mesa)
__ Southeast (Chandler, Ahwatukee, Gilbert)
__ Southwest (Tolleson, Buckeye, Goodyear)

Part I: Community Health

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

Check only three:

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

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

Check only three:

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

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

Check only three:

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

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

_____

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

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

Part II: Demographics

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

6. Zip code where you work: _____

7. Age:

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

8. Sex: ____Male ____Female

9. Ethnic group you most identify with:

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

Appendix C –References

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