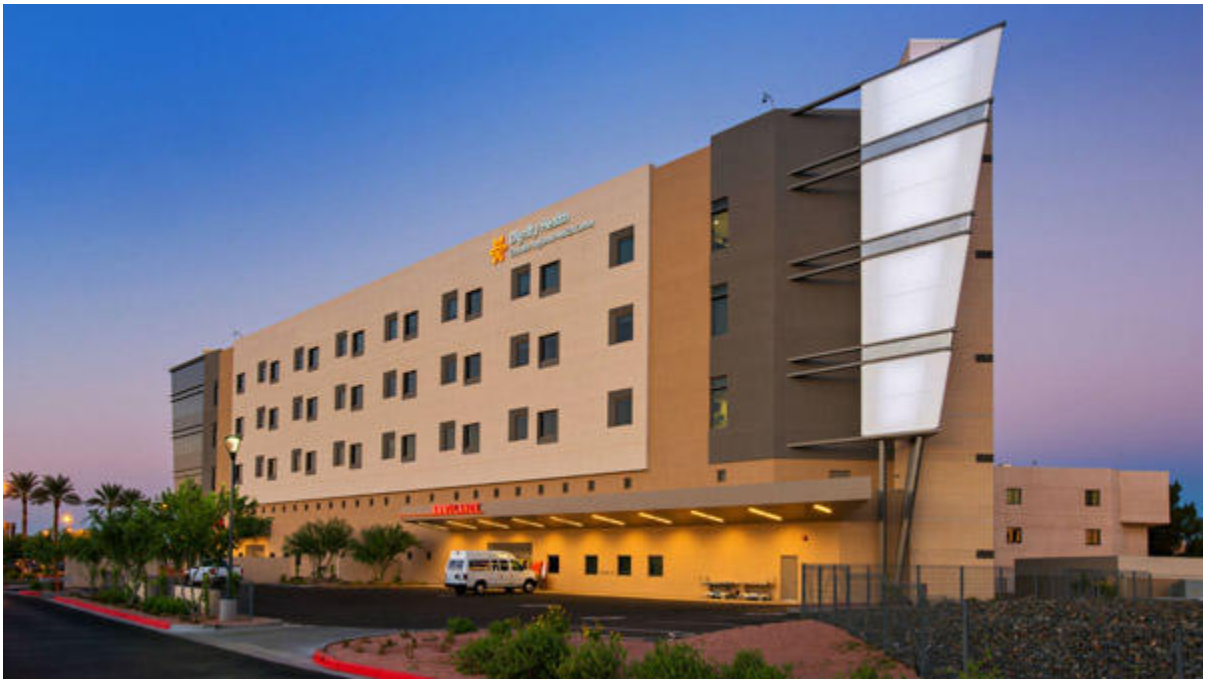
Dignity Health Chandler Regional Medical Center

Community Health Needs Assessment 2022 – Main Report

Adopted May 2022



Dignity Health
Chandler Regional Medical Center

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Executive Summary

CHNA Purpose Statement

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Chandler Regional Medical Center (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 (ACA) that non-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment and Mission Statement

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

CHNA Collaborators

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. 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, the Synapse partnership (Banner Health, Dignity Health, Mayo Clinic Hospital, Native Health, Neighborhood Outreach Access to Health (NOAH), Phoenix Children's Hospital, and Valleywise Health) has joined forces with the Health Improvement Partnership of Maricopa County (HIPMC) and Maricopa County Department of Public Health (MCDPH) to identify the communities' strengths and greatest needs in a coordinated community health needs assessment. CRMC participates in Synapse and contracted with MCDPH to lead the development of the CHNA report. With input from Synapse, MCDPH spearheaded development of the CHNA survey, and partnered with many diverse local community-based organizations to provide stipends for survey translation, distribution and promotion. MCDPH contracted with Arizona State University Southwest Interdisciplinary Research Center (ASU SIRC) to conduct and analyze focus groups.

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. 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, as it is home to more than 1.3 million Hispanic/Latino individuals; 302,042 African

Americans; 233,328 Asian Americans; and 124,128 American Indians.[i] According to the U.S. Census Bureau, 15% percent of the population does not have a high school diploma[ii], 14% are living below the federal poverty level[iii], and over 456,584 are uninsured.[iv] The city of Chandler is primarily served by CRMC. Chandler has experienced exponential growth and continues to be a diverse community with a population of over 252,000 residents in 2019.[v]

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 (PSA) 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. 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[vi]. Zip code areas with the top three highest need include 85122 Casa Grande, 85202 Mesa and 85210 Mesa.

Assessment Process and Methods

Health needs were identified through the combined analysis of primary and secondary data with four rounds of community input. **Primary data sources** include the 2019 and 2021 community surveys and focus groups. **Secondary data sources** include health and social indicators from local, state, and sources that encompass health outcomes, economic factors, health behaviors, physical environment, and health care. The first round of community data collection occurred in the fall of 2019 and involved a community survey as well as a series of focus groups. In response to the severe changes in the community health landscape due to the COVID-19 pandemic, a supplemental survey and focus group cycle was conducted in the summer of 2021. Local organizations including CRMC partnered with MCDPH to recruit members of diverse communities to take the surveys. In both rounds of data collection, focus groups included representatives of minority and underserved populations who identified community concerns and assets.

Data was analyzed by MCDPH and shared with the Synapse group, as well as representatives from the community, healthcare organizations, and other local initiatives. Through a structured feedback process, the data was narrowed down to ten priorities of focus for CRMC.

Process and Criteria to Identify and Prioritize Significant Health Needs

The health needs prioritization process began with an initial review and analysis of primary and secondary data sources. Primary sources included data that was derived from the 2019 and 2021 community survey and focus group sessions. Secondary sources included data that was derived from County inpatient

hospitalization, emergency department, and death rates to assemble 12 total health indicators. Additionally, external data sources such as PolicyMap were utilized to analyze and highlight nine social indicators. The health and social indicators were established in collaboration with the Dignity Health East Valley Community Health Committee (CHC) by selecting indicators of interest that have historically demonstrated high rates or have known disparities when broken out by race/ethnicity, gender and age.

The Dignity Health East Valley CHC exists to ensure that the Community Board is involved in establishing and monitoring priorities, plans, and programs to enhance the health status of the communities they serve. The CHC will assist the East Valley Hospitals Community Board in meeting its obligations by reviewing community needs, discussing alternative strategies and monitoring progress toward identified goals. The CHC represents a broad range of stakeholders meeting periodically to engage in the hospitals' community health assessment and identification of priorities to address disproportionate unmet health needs. The committee will give voice to those who may benefit from the Dignity Health Community Investment and Community Grants.

Compiled primary and secondary data sources were presented at three meetings with the CHC. Data presentations were interactive, embedding virtual polling and breakout sessions which opened an opportunity for the community to share their voices into the refinement and prioritization process of significant health needs for CRMC. All feedback received from CHC meetings was compiled and evaluated through a health equity lens, which led to the prioritization of ten significant health needs, several of which included multiple sub-priorities.

"The community health needs assessment report serves as a foundation for our ministry to care for the community, particularly vulnerable populations. The primary and secondary data findings, including the COVID assessment, highlight long standing health, racial and social inequities. Through this assessment meaningful strategies will be developed in partnership with the community to improve health, equity, and social justice."

Kathleen Dowler, Director Community Health,
East Valley Dignity Health

List 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.

Mental Health and Suicide

Mental health and suicide were selected as a top priority issue for CRMC. Mental health includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act.[vii] Suicide and suicide attempts cause serious emotional, physical, and economic impacts.[viii] In the 2021 COVID-19 impact survey, almost half of Maricopa County residents noted that in addition to COVID-19, mental health issues were one of the health conditions that had the greatest impact on the community's overall health and wellness. In the 2019 and 2021 focus groups, mental health including suicide, depression, anxiety, and isolation was noted as a frequently cited community concern.

Substance Use

Substance use was selected as a priority issue for CRMC. Substance use is caused by multiple factors, including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems. In the 2021 COVID-19 impact survey, alcohol/substance abuse was ranked as the third most important health condition that had the greatest community impact. In the 2019 focus groups and supplemental survey, alcohol and substance abuse were rated as top threats to community health.

Cancer

Cancer was selected as a priority issue for CRMC. Cancer is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.[ix] In the 2021 COVID-19 impact survey, Maricopa County residents noted that in addition to COVID-19, cancers were ranked in the top ten health conditions that had the greatest impact in their community. In 2019 focus groups, cancer was noted as one of the greatest threats to community health.

Chronic Disease

Chronic disease (diabetes, cardiovascular disease, obesity, oral health) were selected as priority issues for CRMC. In the 2021 COVID-19 impact survey, Maricopa County residents ranked diabetes as the fifth, cardiovascular disease as the seventh, and obesity as the second most important health conditions in their community. The 2019 focus group participants also mentioned diabetes, high blood pressure/cholesterol, and overweight/obesity as some of the greatest threats to community health. Additionally, the community health committee discussed Oral Health as a growing need for many. As a chronic condition, it was approved as priority health need.

> "I wanted to share some exciting news. When I started this diabetes journey I was at A1C of 14 and my glucose was 300ish. Just got 4 month labs back and my A1C is now 5.9 and my average glucose for October is 98. All of my Cholesterol numbers have improved and have risen/fallen into acceptable levels. Thank you all for your help through the classes and your caring!! Be well."
>
> *Patient, Thomas*
> *Center for Diabetes Management 10/21*

- **Diabetes** is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). The most common is type 2 diabetes and simple lifestyle measures such as being physically active, consuming a healthy diet, and avoiding tobacco use have been shown to be effective in preventing or delaying the onset of this disease.[x]
- **Cardiovascular Disease** are a class of diseases that affect the heart or blood vessels. The most important behavioral risk factors of heart disease and stroke are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.[xi]

- **Obesity** is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. Behaviors can include physical activity, inactivity, dietary patterns, medication use, and other exposures.[xii]
- **Oral Health** is a key indicator of overall health, well-being, and quality of life. Oral diseases ranging from dental cavities to oral cancers cause pain and disability for many. A growing body of evidence has linked oral health to several chronic diseases including diabetes, heart disease, and stroke.[xiii]

Injury Prevention

Injury prevention was selected as a priority issue for CRMC. Injuries are a significant cause of death burden of disease, and some people are more vulnerable than others depending on the conditions in which they are born, grow, work, live and age. In the 2021 COVID-19 impact survey, Maricopa County residents noted that since March of 2020, one of the greatest community issues was motor vehicle and motorcycle crash injuries. Many unintentional injuries can be predictable and preventable. Leading causes of nonfatal injury include traffic-related injuries, falls, burns, poisonings, and drownings.

List of Prioritized Significant Social Needs

Access to Care

Access to healthcare was selected as a priority issue for CRMC. Health insurance helps individuals and families access needed primary care, specialists, and emergency care.[xiv] In the 2021 COVID-19 impact survey, Maricopa County residents noted that since March of 2020, one of the top five barriers to seeking or accessing healthcare was difficulty finding the right provider for their care. In the 2019 and 2021 focus groups, participants shared several major barriers to healthcare access including financial limitations, transportation, insurance, inconvenience, communication issues, lack of awareness of existing services and resources, and lack of cultural understanding and sensitivity.

- **Immunization** is a key component of primary health care and is critical to the prevention and control of infectious diseases. Vaccines reduce risks of getting a disease by working with the body's natural defenses to build protection.[xv] The COVID-19 pandemic has highlighted the need

for rapid dissemination of effective vaccination, both to protect against emerging disease and to maintain community immunity for endemic disease such as measles and influenza.

Housing and Homelessness

Housing and homelessness were selected as a priority issue for CRMC. Housing is often identified as an important social determinant of health due to the range of ways in which a lack of housing, or poor-quality housing, can negatively affect health and wellbeing. In the 2021 COVID-19 impact survey, almost one fifth of residents in Maricopa County noted that since March of 2020, they did not have enough money to pay for essentials such as housing. Affordable housing and homelessness were frequently cited concerns mirrored in the 2019 and 2021 focus groups.

Violence

Violence was selected as a priority issue for CRMC. Violence affects people in all stages of life – from infants to the elderly – and has a profound impact on lifelong health, opportunity, and well-being. In both the 2019 focus groups and the 2021 COVID-19 impact survey, Maricopa County residents noted domestic violence/sexual assault as one of the top ten issues that had the greatest impact on their community's health and wellness.

- **Domestic Violence (DV)** is abuse or aggression that occurs in family relationships. **Intimate partner violence (IPV)** specifically refers to abuse in romantic relationships. DV and IPV can include four types of behavior: physical violence, sexual violence, stalking, and psychological aggression.[xvi]

- **Human Trafficking** is a crime that affects individuals, families, and communities across generations. There are two types of severe human trafficking: labor trafficking and sex trafficking. Individuals from any class, religious, cultural, or ethnic group can be targeted in human trafficking schemes, however some groups may be more vulnerable than others.[xvii]

Equity

Equity was selected as a priority issue for CRMC. At CRMC we are dedicated to improving access to care and promoting health equity for across all prioritized significant health needs.

- **Racial Equity** is the systemic fair treatment of all races that produces equitable opportunities and outcomes for all people.[xviii]

- **Health Equity** means that "everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care".[xix]

- **Social Equity** refers to all people experiencing impartiality, fairness, and justice in their daily lives. Social equity takes into account systemic inequalities to ensure everyone in a community has

access to the same opportunities and outcomes. Policies promoting social equity address factors such as education, policing, welfare, housing, and transportation.[xx]

Nutrition

Nutrition was selected as a priority issue for CRMC. Better nutrition is related to improved infant, child and maternal health, stronger immune systems, lower risk of non-communicable diseases, and longevity.[xxi] In the 2021 COVID-19 impact survey, Maricopa County residents noted food was one of the top five essentials that they sometimes or never had enough money to pay for since March of 2020. In the 2021 focus groups, getting enough food to eat was distinguished as one of the largest quality of life challenges that respondents experienced during the COVID-19 pandemic.

- **Food Access** is an important element of food security, which is having constant access to adequate nutritious food to support healthy eating patterns.

- **Exercise** is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes, and several cancers. It also can improve physical/mental health, quality of life and well-being.[xxii]

Health and Social Issues: Disparities

Mental Health and Suicide – In CRMC's PSA, Black/African American patients had the highest IP rate, American Indians had the highest ED rate, and White/Caucasian patients had the highest death rate.[xxxii, xxxiii]

Substance Use – In CRMC's PSA, patients aged 15-24 had the highest IP and ED rates, while patients aged 25-44 had the highest death rate. [xxxii, xxxiii]

Cancer – In CRMC's PSA, Black/African American patients had the highest death rate for breast cancer while White/Caucasian patients had the highest death rate for lung cancer. [xxxiii]

Chronic Disease – In CRMC's PSA, Black/African American patients had the highest ED rates for CVD and diabetes. White/Caucasian patients had the highest death rate from CVD and diabetes. American Indian patients had the highest IP rate for diabetes. [xxxii, xxxiii]

Injury Prevention – In CRMC's PSA, White/Caucasian patients had the highest IP and death rate for falls and hip fracture. Black/African American patients had the highest ED rate for falls. [xxxii, xxxiii]

Access to Care – In 2019, 14.1% of adults under the age of 65 were uninsured in Maricopa County.[lxviii lxviii]

Housing and Homelessness – From 2015-2019, 58.34% of renters aged 65+ were considered cost-burdened (rent is 30% or more of household income) in Maricopa County. [lxviii lxviii]

Violence – In CRMC's PSA, American Indian patients had the highest IP, ED, and death rates from assault. [xxxii, xxxiii]

Equity – In 2019, the city of Chandler ranked #13 out of 99 on the Racial Equity Index.[lxxviii]
In 2020, Chandler, Arizona had a Municipal Equality Index (MEI) final score of 66. A Municipal Equality Index (MEI) Scorecard demonstrates the ways that many cities can—and do—support the LGBTQ people who live and work there, even where states and the federal government have failed to do so. (Cannot exceed 100). (Campaign, 2020)

Nutrition – In 2019, 37.1% of Maricopa County residents consumed less than 1 serving of fruit per day while 21.3% consumed less than 1 serving of vegetable per day.[xlix]

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, over 21 transitional housing & 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. Additionally, CRMC coordinates with eight domestic violence and human trafficking partners to combat Safety & Violence.

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. Along with providing direct services CRMC has community outreach programs including: Center for Diabetes Management, Community Education, Community Wellness and Community Oral Health.

Dignity Health's Children's Dental Clinic serves disenfranchised patients 6 - 17 years of age (existing patients 18-21 years old). The clinic has an Affiliated Practice Hygienists who received specialty training to provide prescribed treatment for patients with Orofacial Myofunctional Disorders (OMD). Recently, a 20-year-old patient presented with open mouth/low tongue posture and atypical swallowing. She exhibited low tone of various orofacial muscles and had great difficulty coordinating movements of her tongue. With the support from the hygienist, she has found many of the OMD prescribed exercises very challenging but continued to progress each week.

Dignity Health Staff,
Children's Dental Clinic 01/20

CRMC partners with many local organizations to provide continuity of care for patients. These include over 15 organizations focused on serving and supporting diverse populations, providing education and counselling, navigating healthcare systems, and leading prevention initiatives. Overall, CRMC continues to develop and leverage these networks to reach the community.

Report Adoption, Availability, and Comments

This CHNA report was adopted by the Dignity Health East Valley Hospital Community Board in May 2022. 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 Dignity Health Community Health Department at 1750 E. Northrop Blvd., Suite #200 Chandler, AZ 85286 or by e-mail to chandler-chna@dignityhealth.org.

Community Definition

The geographic area for this CHNA spans a majority of Maricopa County, and will include information gathered from residents at the county-level. CRMC's PSA-specific information will be provided when available to demonstrate a more detailed view of CRMC's service area. Figure 1 below displays the PSAs serviced by CRMC. A list of CRMC's PSA zip codes is located in Appendix D.

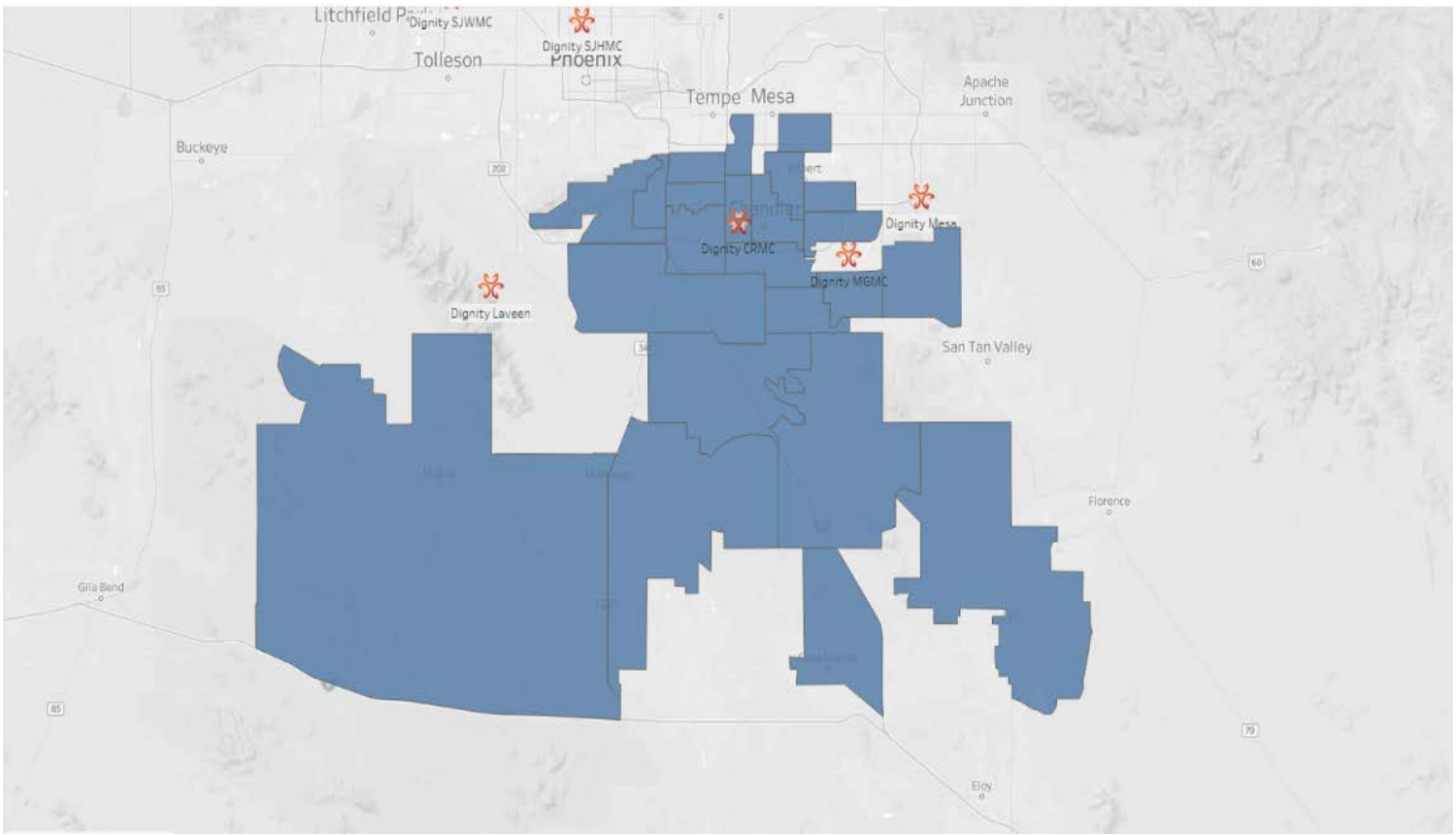
Maricopa County is the fourth most populous county in the United States. Based on 2019 American Community Survey ACS five-year estimates, Maricopa County has an estimated population of over 4.3

million and growing, 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.

During fiscal year 2020 Chandler zip codes were found to be the largest percent of patients served for acute care and emergency services at CRMC. Chandler's population in 2019 was 252,692 with a median age of 36.3 years.[v] The city of Chandler is made up of predominantly Caucasian/White individuals (78.2%), followed by Latino/Hispanic (20.8%), Asian (12.5%), Black/African American (7.1%), American Indian/Alaska Native (2.6%), and Native Hawaiian and Other Pacific Islander (0.4%).[v] In 2019, the median household income in Chandler was $82,925 with a poverty rate of 7.6%.[xxiii] The educational attainment in 2019 for Chandler were as follows: less than high school graduate (13.6%), high school graduate (31.6%), some college/associate's degree (40.4%), and bachelor's degree or higher (14.4%).[xxiv]

Figure 1.

CRMC PSA



For this report, the focus will be on the primary service area of CRMC. The primary service area for CRMC includes the zip codes making up the top 75% of the total patient cases. 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 Health Resources and Services Administration (HRSA), the Chandler PCA has been federally designated as a Medically Underserved Area.[xxv] Medically Underserved Areas are areas or population designed by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.[xxv]

[xxv]Table 1 provides the specific age, sex, 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.

	CRMC PSA	Maricopa County	Arizona
Population: estimated 2019	579,952	4,328,810	7,050,299
Gender			
• **Male**	49.0%	49.4%	49.7%
• **Female**	51.0%	50.6%	50.3%
Age			
• **0-9 yrs**	12.6%	13.0%	12.6%
• **10-19 yrs**	13.3%	13.8%	13.4%
• **20-34 yrs**	21.3%	21.3%	20.6%
• **35-64 yrs**	39.0%	37.2%	36.3%
• **65-74 yrs**	8.4%	13.1%	15.2%
• **75+ yrs**	5.4%	1.7%	1.9%
Race			
White	*77.8%	*77.6%	*77.2%
Asian/Pacific Islander	*4.0%	*4.2%	*3.3%
Black/African American	*5.5%	*5.6%	*4.5%
American Indian/Alaska Native	*2.5%	*2.0%	*4.5%
Other/Unknown	*6.5%	*6.7%	*6.5%
Ethnicity			
Hispanic	*30.9%	*31.0%	*31.3%
Median Income	$76,233	$64,468	$58,945
Uninsured	9.1%	10.6%	10.4%
Unemployment	4.7%	5.0%	5.9%
No HS Diploma	9.0%	12.3%	12.9%
% of Population 5+ non-English speaking	21.6%	27.0%	27.1%
Renters	34.7%	*37.8%	*35.6%
CNI Score	2.9	3.4	-
Medically Underserved Area	Yes	-	-

**Source: PolicyMap; Census ACS 2019 5-Year Estimates*

Community Need Index

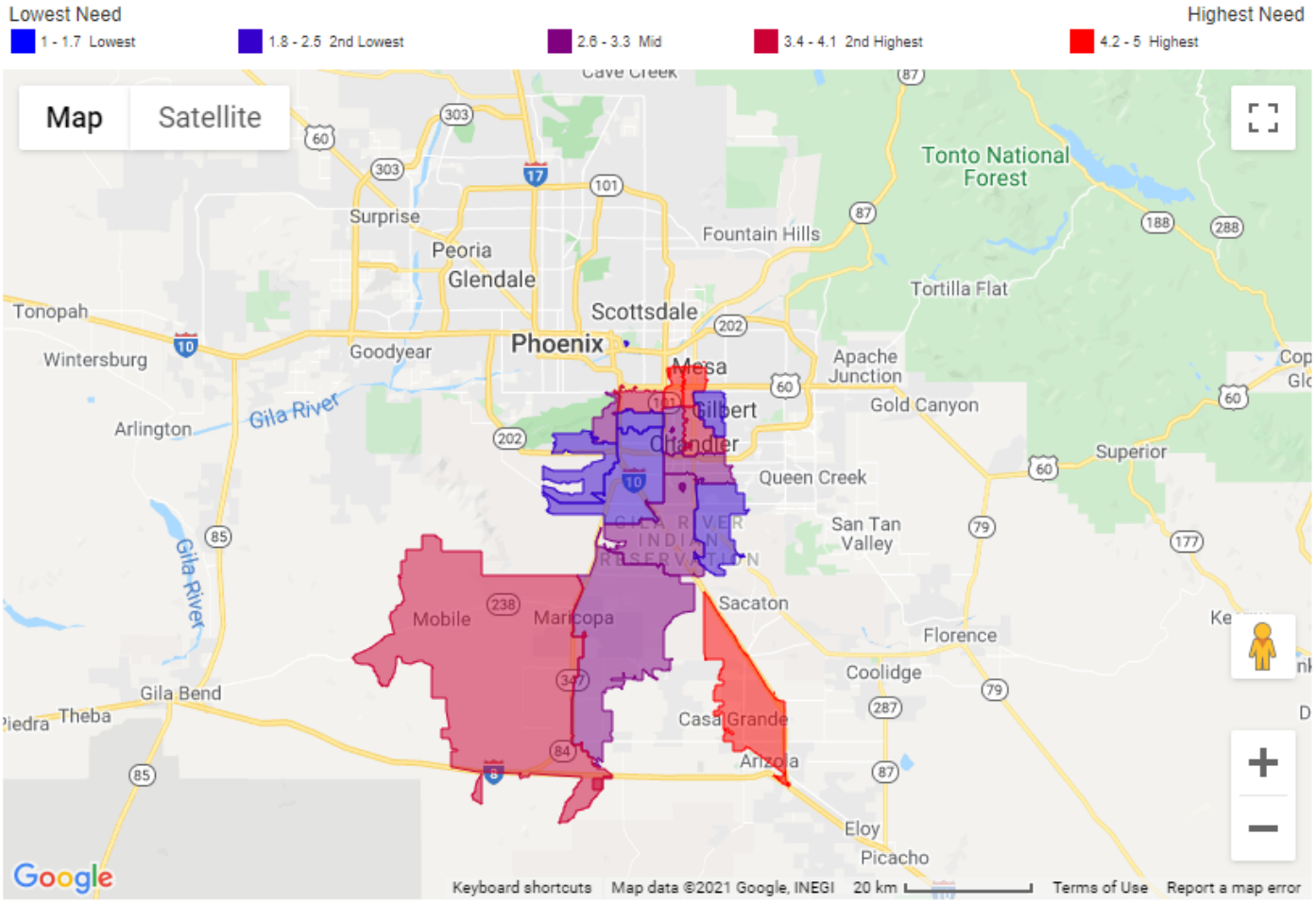
One tool used to assess health need is the Community Need Index (CNI). The CNI analyzes data at the zip code level on five factors that facilitate or prevent health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community.

Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

According to the CNI illustrated in Figure 2, the primary service area has a mean CNI score of 2.9. Zip code areas with the top three highest need include 85122 Casa Grande, 85202 Mesa and 85210 Mesa.

Figure 2.



Mean(zipcode): 3.1 / Mean(person): 3.2 CNI Score Median: 2.9 CNI Score Mode: 2.4

Zip Code	CNI Score	Population	City	County	State
85044	2.8	41142	Phoenix	Maricopa	Arizona
85048	2.4	37131	Phoenix	Maricopa	Arizona
85122	4.2	63323	Casa Grande	Pinal	Arizona
85138	3	48865	Maricopa	Pinal	Arizona
85139	4	23605	Maricopa	Pinal	Arizona
85202	4.2	42249	Mesa	Maricopa	Arizona
85210	4.6	41364	Mesa	Maricopa	Arizona
85224	3	46967	Chandler	Maricopa	Arizona
85225	4	77747	Chandler	Maricopa	Arizona
85226	2.4	41511	Chandler	Maricopa	Arizona
85233	2.4	42024	Gilbert	Maricopa	Arizona
85248	2.6	40009	Chandler	Maricopa	Arizona
85249	1.8	50502	Chandler	Maricopa	Arizona
85283	3.4	48890	Tempe	Maricopa	Arizona
85284	1.8	19686	Tempe	Maricopa	Arizona
85286	2.6	55019	Chandler	Maricopa	Arizona

Assessment, Process and Methods

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, Banner Health, Dignity Health, Mayo Clinic Hospital, Native Health, Neighborhood Outreach Access to Health, Phoenix Children's Hospital, and Valleywise Health have joined forces with MCDPH through the Synapse partnership to identify the communities' strengths and greatest needs in a coordinated community health needs assessment. CRMC, as a member of Synapse, contracted with MCDPH to conduct the CHNA process. The CHNA utilizes a mixed-methods approach that includes the collection of secondary data from existing data sources and community input data from focus groups, surveys, and meetings with community stakeholders. The process was iterative 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.

Primary Data

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

2019 Coordinated Community Health Needs Assessment Focus Groups (Appendix B)

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

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

COVID-19 Focus Groups (Appendix B)

Between February and June 2021, a series of 33 focus groups were conducted which included 186 participants across various community regions, service providers and individual residents to better understand the impact of COVID19 on Maricopa County residents. Focus groups helped to identify and address health needs, resource allocation, and long-term services needed for COVID-19 response efforts. Members of the community representing subgroups, defined as groups with unique attributes (race 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 the impact of COVID-19 on Maricopa County residents. In all, a total of 33 focus groups were conducted with 186 community members from five geographic Maricopa County locations based on the following groups: (1) older adults; specific ethnic groups (2) African American; (3) Hispanics/Latino; (4) Native American; (5) Asian American; (6) ethnic minority young adults; (7) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) persons; (8) veterans; (9) new parents; (10) parents of young children, and (11) refugees.

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

2019 Maricopa County Community Health Assessment Community Survey (Appendix B)

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

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

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

COVID-19 Community Impact Survey (Appendix B)

COVID-19 was declared a global pandemic in March of 2020, and this set off a series of drastic changes to everyday life for residents of Maricopa County. From May - July 2021, MCDPH mobilized data collection resources and community partnerships to explore how COVID-19 had impacted residents. This COVID-focused survey is part of the Coordinated Maricopa County Community Health Needs Assessment (CCHNA) designed to identify priority health issues, resources, and barriers to care. Survey questions were grouped into the following sections: Demographics, Physical and Mental Health, Health Care and Living Expenses, COVID-19 Impact on Employment, Barriers, Strengths, Health Conditions, Community Issues, Survey Usability, and Other Noteworthy COVID-19 Experiences. The questionnaire was primarily provided on a digital platform using Alchemer© and was provided in over 12 languages (Arabic, Burmese, Chinese, English, French, Kinyarwanda, Korean, Lao, Spanish, Swahili, Tagalog, Thai, and Vietnamese).

The foundation for this survey questionnaire was developed by the National Association of County and City Health Officials (NACCHO). The survey was modified from its original version by CRMC, members of the Synapse Coalition, a group of non-profit hospitals and federally qualified health care providers, the Health Improvement Partnership of Maricopa County (HIPMC), and MCDPH staff. Additional questions and response options were added and modified from the original format to assess the impact of COVID-19 on Maricopa County residents and explore additional health issues and social determinants of health. Free response questions were analyzed through a thematic analysis. A codebook was developed inductively based on the response data, and key themes were identified with the consensus of the MCDPH epidemiology team. At least 50% of the collected responses from each region in Maricopa County were analyzed and coded with key themes, totaling 2,186 responses analyzed. Key themes were ranked by frequency.

The goal for the community survey was 15,000 responses, however a total of 14,380 surveys were completed by residents of Maricopa County. MCDPH partnered with an extensive network of community-based organizations and healthcare partners to collect community surveys from residents and professionals within Maricopa County. The MCDPH team wanted to ensure diverse community representation and that the survey provided insight from all regions (Northeast, Northwest, Central,

Southeast and Southwest) of the county. MCDPH collaborated with several community-based organizations to provide stipends from $2,000 - $5,000 to support survey translation, distribution & completion, social media outreach via networks, purchase of incentives for survey completion, and administrative expenses. In addition, CRMC also solicited input on the CHNA process from the Community Health Committee.

Secondary Data

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

Quantitative data used in this report are high quality, population-based data sources and were analyzed by MCDPH, Office of Epidemiology. Secondary data was collected from local, state, and national sources such as the Maricopa County Department of Public Health, Arizona Department of Health Services, Arizona Criminal Justice Commission, American Census Survey, and U.S. Centers for Disease Control and Prevention (CDC). Secondary data includes Maricopa County Hospital Discharge Data, Maricopa County Death Data, Maricopa County Birth Data, Behavioral Risk Factor Surveillance Survey (BRFSS), Youth Risk Factor Surveillance Survey (YRBSS), PolicyMap, and the American Census Survey.

Hospital Discharge Data, Death Data, and Birth Data

MCDPH receives Hospital Discharge Data (HDD) bi-annually from the Arizona Department Health Services (ADHS). HDD consists of inpatient (IP) and emergency department (ED) discharge data for most Maricopa County hospitals. Data is collected based on the discharge date of the patient. Since 2015, diagnoses are coded using ICD-10.

MCDPH receives vital Death data annually from ADHS for the previous year. This data includes deaths in Maricopa County regardless of residency status. The finalized and cleaned vital data consists of death data for residents of Maricopa County. Data is collected based on the event date of the patient, i.e. date of death. The death database is coded using ICD-10. MCDPH receives vital Birth data annually from ADHS. This data includes births in Maricopa County regardless of residency status. Data is collected based on the event date of the patient, e.g. birth date.

Hospital Discharge Data, Death and Birth Data are obtained from ADHS and cleaned by MCDPH to use for analyses. These datasets are used along with population estimates from the American Census Survey to analyze health indicators for Maricopa County residents. All health indicator rates are age adjusted using the 2000 Standard Population.[xxviii] Age-adjustment methods allow for fairer comparisons between population groups even if the size of the groups is different. The National Center for Health Statistics recommends using the 2000 Standard Population when calculating age-adjusted rates. In this report, the

2000 Standard Population is used to standardize HDD and vitals data. Health indicators that were analyzed include fatal and nonfatal chronic conditions, fatal cancer indicators, fatal and non-fatal injuries, mental and behavioral health indicators, and infant birth indicators. Each indicator is analyzed as an overall rate for Maricopa County, and then further analyzed by age, race, and gender to highlight disparities. In 2019, there were around 4.5 million Maricopa County residents.

Other Secondary Data

Other secondary data includes publicly accessible data from the U.S. Census, CDC, and PolicyMap to elaborate on health and social indicators. The Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System surveys are developed by the CDC and conducted for each state to monitor the health and social behaviors of adults and youth. In this assessment, BRFSS and YRBSS are analyzed by county and state levels. The American Census Survey by the U.S. Census Bureau measures the social and economic characteristics of U.S. populations. For this assessment, 2019 data is used to analyze Maricopa County population and demographics. PolicyMap provides geographic data that maps demographic, social, and health indicators across the United States. PolicyMap is used in this assessment to evaluate social indicators in Maricopa County for 2018, 2019, and 2020 when accessible.

Synapse partners selected approximately 100 data indicators to help examine the health needs of the community. 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.[xxix] From the approximately 100 data indicators, Table 2 displays the initial round of 12 health indicators and nine social indicators that CRMC selected for further analysis. For the health indicators, hospital discharge and death databases were utilized to perform these analyses.

Table 2.

Initial Round Health Indicators
Cardiovascular Disease
Chronic Obstructive Pulmonary Disease
Mental Health Disorders
Asthma
Unintentional Falls
Hip Fractures
Stroke
Flu/Pneumonia
Diabetes
Alzheimer's
Cancer (Lung, Breast)
All Drugs Overdose, Stimulant and Opioid Overdose

Initial Round Social Indicators
Access to Care
Transportation
Housing
Access to Food
Income
Employment
Racism/Discrimination
Suicide
Violence

Input from the Community

CRMC engaged in a community-based process to gather input from the community. The CHC involves community partners and members, community of care grantees, Dignity Health East Valley hospital staff and executives who work on the shared goal of improving the health and well-being of Maricopa County

residents while reducing health disparities. A full list of participating organizations in the CHC meetings can be found in Appendix E. On January 25, 2022, CRMC and MCDPH presented 21 health indicators to the community committee and solicited community feedback. On February 8, 2022, CRMC and MCDPH hosted a virtual prioritization session to select the final ten priorities from 21 priorities. On February 24, 2022, CRMC hosted an in-person strategy session to gather community feedback about resources to address the prioritized health needs.

Chandler Regional Medical Center invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received. Details of the prioritization process is detailed under the section "Prioritized Description of Significant Community Health Needs."

From a workshop evaluation: "The information in the Diabetes class was very useful and presented in an easy to understand style. I found this workshop very helpful. I now have a much better understanding of diabetes in general and how to use diet, exercise, and medication to control my own blood sugar levels. I also gained knowledge so that I can better talk to my doctor about my treatment plans. Thank you very much. I highly recommend this class."

Healthier Living Workshops 02/22

Assessment Data and Findings

This section includes overall data and findings from the community surveys, focus groups, and health indicator analysis. These combined assessments provide a comprehensive picture of the top issues and concerns facing the community, from looking at rates of health conditions to the social and environmental factors that contribute to well-being. Whenever possible, the measures of interest are evaluated through a health equity lens to identify any disparities based on race, gender, age or other factors.

In this Section:

- **Indicator data for top social issues and top health issues (Tables 3-5)**
- **Qualitative data themes from 2019 and 2021 focus groups and open-ended survey questions. (Table 6)**
- **Quantitative data from 2019 and 2021 community surveys**
  - Top health and social issues from 2021 COVID-19 Impact Survey
  - Comparison of top issue rankings from 2019 and 2021 survey results (Table 7)
  - Top health and social issue rankings analyzed by race and special populations (Tables 8-9)

Top Social and Health Needs

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Some examples of SDOH include housing, access to care, transportation, financial security, food insecurity, and racial equity. SDOH can contribute to wide health disparities and inequities.[xxx] Table 3 displays the top social issues identified in Maricopa County and Arizona.

Table 3.

Top Social Issues Identified in Maricopa County (MC) and Arizona		
Indicator	Data highlights in **MC**	Data highlights in **AZ**
Access to Care	10.62% of residents were considered uninsured.	10.4% of residents were uninsured.
Housing	45.1% of renters were considered cost-burdened. 21.7% of homeowners are cost-burdened.	44.5% of renters were considered cost-burdened. 21.6% of homeowners are cost-burdened.
Violence	248.6 aggravated assaults were reported per 100,000 people	291.4 aggravated assaults were reported per 100,000 people
Racial Equity	Maricopa County ranked #248 out of 359 on the Racial Equity Index at the county level.	Arizona ranked #33 out of 50 on the Racial Equity Index at the state level.
Food Insecurity	In 2018, 9.5% of residents received food stamps.	In 2018, 11.3% of residents received food stamps. Since the beginning of the pandemic, 32% of Arizona household experience food insecurity compared to 25% the year prior.
Source: PolicyMap & National Equity Atlas - data in this table was collected in 2019 unless stated otherwise		

The Racial Equity Index is a data tool designed to help communities identify priority areas for advancing racial equity, track progress over time, and set specific goals for closing racial gaps. The Index is based on nine Atlas indicators (median wage, unemployment, poverty, educational attainment, disconnected youth, school poverty, air pollution, commute time, and rent burden). The Racial Equity Index value is based on the inclusion score and prosperity score. The **inclusion score measures how a given geography is doing compared to its peers in terms of **racial gaps** across nine indicators. The **prosperity score** measures how a*

*given geography is doing compared with its peers in terms of overall **population outcomes** for the nine indicators included in the equity index.*[xxxi]

Of the **health** indicators that were analyzed, the following indicators displayed in Table 4 had the highest overall rates per 100,000 for inpatient hospitalization (IP), emergency department visits (ED), and deaths. Each number within the table represents the ranking of each health indicator for either IP, ED and deaths. The color gradients are used to help visualize the different rankings among the health indicators.

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

Table 4.

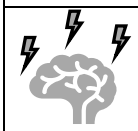
Top Health Indicators Identified in CRMC's PSA			
Indicator	**Inpatient Hospitalizations (IP)**	**Emergency Department Visits (ED)**	**Deaths**
Cardiovascular Disease	1	2	1
Mental Health Disorders	5	8	7
Asthma	6	5	22
Falls	2	1	8
Stroke	11	21	6
Flu/Pneumonia	13	10	12
Diabetes	14	13	16
Traumatic Brain Injury	3	3	20
COPD	16	14	4
Hip Fracture	4	18	15
Liver Disease	17	22	10
Drug Overdose	7	6	9
Assault	10	4	18
Lung Cancer	21	26	5
Opioid Overdose	12	11	2
Alzheimer's	24	25	3
Breast Cancer	25	27	11
Self-Harm	8	7	.
Alcohol Related Injuries	9	16	.
Motor vehicle Crash	19	9	.

Health Equity

According to the Robert Wood Johnson Foundation, "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare."[xix] Addressing health equity requires understanding differences in health outcomes based on race, gender, age, and socio-economic status – among other factors.

The following health indicators are broken down by gender, age, and race in Table 5 to highlight potential health disparities.[xxii, xxiii]

Table 5.

Top Health Indicators Disparities in CRMC's PSA			
Indicator	**Gender Disparity**	**Age Disparity**	**Racial Disparity**
 **Cardiovascular Disease**	Males had higher IP and death rate while females had a higher ED rate.	Patients aged 65+ had the highest IP, ED and death rates.	Black/African American patients had the highest IP and ED rates while White/Caucasian patients had the highest death rate.
 **All Mental Health Disorders**	Males had higher IP and ED rates while females had a higher death rate.	Patients aged 15-24 had the highest IP rates, patients aged 45-64 had the highest ED rates, and patients aged 65+ had the highest death rate.	Black/African American patients had the highest IP rate, while American Indians had the highest ED rate, and White/Caucasian patients had the highest death rate.
 **Asthma**	Females had higher IP and ED rates while males had a higher death rate.	Patients aged 65+ had the highest IP rate, patients aged 15-24 had the highest ED rate, and patients aged 45-64 had the highest death rate.	American Indian patients had the highest IP rate while Black/African American patients had the highest ED and death rates.
 **Falls**	Females had higher IP, ED, and death rates than males.	Patients aged 65+ had the highest IP, ED, and death rates.	White/Caucasian patients had the highest IP and death rate, while Black/African American patients had the highest ED rate.
 **Stroke**	Males had higher IP rate, while females had a higher ED and death rate.	Patients 65+ had the highest IP, ED, and death rates.	Black/African American patients had the highest IP rate, while White/Caucasian patients had the highest ED and death rate.
 **Flu/ Pneumonia**	Females had higher IP and ED rates while males had a higher death rate.	Patients aged 65+ had the highest IP and death rate, while patients aged 1-14 had the highest ED rate.	American Indian patients had the highest IP rate, Black/African American patients had the highest ED rate, and White/Caucasian patients had the highest death rate.

Diabetes	Males had higher IP, ED, and death rates than females.	Patients aged 65+ had the highest IP and death rate, while patients aged 45-64 had the highest ED rates.	American Indian patients had the highest IP rate, Black/African American patients had the highest ED rate, and White/Caucasian patients had the highest death rates.
Traumatic Brain Injury	Males had higher IP and death rate, while females had a higher ED rate.	Patients aged 65+ had the highest IP and death rate, while patients aged 15-24 had the highest ED rate.	American Indian patients had the highest IP rate, Black/African American patients had the highest ED rate, and White/Caucasian patients had the highest death rate.
COPD	Females had higher IP, ED and death rates than males.	Patients aged 65+ had the highest IP, ED, and death rates.	White/Caucasian patients had the highest IP and death rate, while Black/African American patients had the highest ED rate.
Hip Fracture	Females had higher IP, ED, and death rates than males.	Patients aged 65+ had the highest IP, ED, and death rates.	White/Caucasian patients had the highest IP, ED, and death rates.
Liver Disease	Males had higher IP, ED, and death rates than females.	Patients aged 65+ had the highest IP and death rates, while patients aged 45-64 had the highest ED rate.	American Indian patients had the highest IP and ED rates while White/Caucasian patients had the highest death rate.
Drug Overdose	Females had higher IP and ED rates while males had a higher death rate.	Patients aged 15-24 had the highest IP and ED rates, while patients aged 25-44 had the highest death rate.	American Indian patients had the highest IP rate, while Black/African American patients had the highest ED and death rates.
Assault	Males had higher IP, ED, and death rates than females.	Patients aged 15-24 had the highest IP and ED rates, while patients aged 45-64 had the highest death rate.	American Indian patients had the highest IP, ED, and death rates.
Opioid Overdose	Males had higher IP, ED, and death rates than females.	Patients aged 15-24 had the highest IP and ED rates while patients aged 65+ had the highest death rate.	American Indian patients had the highest IP rate, Black/African American patients had the highest ED rate, and White/Caucasian patients had the highest death rate.
Alzheimer's	Males had higher IP and ED rates while females had a higher death rate.	Patients aged 65+ had the highest IP, ED and death rates.	White/Caucasian patients had the highest IP and death rates, while Black/African American patients had the highest ED rate.
Lung Cancer	Males had a higher death rate than females.	Patients aged 65+ had the highest death rate.	White/Caucasian patients had the highest death rate.
Breast Cancer	Females had a higher death rate than males.	Patients aged 65+ had the highest death rate.	Black/African American patients had the highest death rate.
Source: Maricopa County's 2019 Hospital Discharge and Death Database			

Qualitative Themes from Focus Groups

Table 6 displays themes that were identified from 2019 and 2021 focus groups data and open-ended survey responses from the 2021 COVID-19 impact survey. In focus groups, participants were asked questions about how they perceive their own health status, how COVID-19 affected their family, where they get information about health/COVID-19, barriers and facilitators to accessing care and how health/COVID-19 messaging could be improved.

Table 6.

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

Maricopa County Overall COVID-19 Impact Survey Results

The following data from the 2021 CHNA survey reflect top healthcare barriers, health conditions, community issues, and community strengths experienced by Maricopa County participants.

Top Healthcare Barriers

46% of respondents said they had no barriers to healthcare. The three barriers for others were:

- Fear of exposure to COVID-19 in a healthcare setting **28%**
- Unsure if healthcare need is a priority during this time **15%**
- Difficulty finding the right provider for my care **12%**

Top Health Conditions

48% of respondents reported that mental health issues have had the greatest impact on their community.

48%	40%	29%
Mental Health Issues	Overweight/ Obesity	Alcohol/ Substance Use

Community Issues

30% of respondents reported that lack of people immunized to prevent disease has had the greatest impact on their community.

1. Lack of people immunized to prevent disease **30%**
2. Distracted driving **29%**
3. Homelessness **26%**

Community Strengths

47% of respondents reported that access to COVID-19 vaccine events has been the greatest strength of their community.

1. Access to COVID-19 vaccine events **47%**
2. Access to COVID-19 testing events **41%**
3. Access to safe walking and biking routes **30%**

Comparison of 2019 and 2021 Community Survey Results

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

Table 7 below displays a comparison of community survey rankings for community issues, strengths, health conditions, and barriers to accessing healthcare in 2019 and 2021.

A 2-year-old who had been recently diagnosed with autism came by to be screened. I sat with the child, gave her a princess light up ball as I talked to the parents. Working together as a team we were able to complete both vision and hearing screenings! The Mom started to cry and explained they had been to two other places and not one took the time to try to communicate with her child.

Dignity Health Staff,
Building Blocks/Hearing and Vision Screening 02/19

Table 7.

Rank	2019	2021
Community Issues		
1	Distracted driving (46.1%)	Lack of people immunized to prevent disease (29.5%)
2	Homelessness (28.9%)	Distracted driving (28.5%)
3	Illegal drug use (24.1%)	Homelessness (25.8%)
4	Lack of affordable housing (21.1%)	Lack of affordable housing (24.6%)
5	Lack of public transportation (20.1%)	Racism/discrimination (20.6%)
Community Strengths		
1	Access to parks and recreation sites (55.9%)	*Access to COVID-19 vaccine events (46.7%)
2	Access to public libraries and community centers (50.3%)	*Access to COVID-19 testing events (41.1%)
3	Clean environments and streets (39.1%)	Access to safe walking and biking routes (29.7%)
4	Low crime/safe neighborhoods (35.7%)	Access to parks and recreation sites (26.9%)
5	Access to safe walking and biking routes (34.3%)	Access to support networks such as neighbors, friends, and family (24.4%)
Health Conditions		
1	Alcohol/substance abuse (48.3%)	Mental health issues (47.8%)
2	Overweight/obesity (38.4%)	Overweight/obesity (39.6%)
3	Mental health issues (37.5%)	Alcohol/substance abuse (28.6%)
4	High blood pressure or cholesterol (31.8%)	High blood pressure or cholesterol (21.3%)
5	Cancers (26.6%) / Diabetes (26.5%)	Diabetes (17.3%)
Barriers to Accessing Healthcare		
1	Not enough health insurance coverage (32.9%)	*Fear of exposure to COVID-19 in a healthcare setting (28.2%)
2	Difficulty finding the right provider for my care (32.1%)	*Unsure if healthcare need is a priority during this time (14.7%)
3	Inconvenient office hours (25.4%)	Difficulty finding the right provider for my care (11.6%)
4	No health insurance coverage (20.0%)	Inconvenient office hours (9.4%)
5	Distance to provider (17.0%)	Not enough health insurance coverage (8.0%)

**Response was not available in 2019 survey*

In the 2021 COVID-19 Impact survey, participants were asked: **"Since March of 2020, which of the following issues have had the greatest impact on your community's health and wellness?"** The following Tables 8 & 9, display the greatest community issues broken out by race/ethnicity and special populations.

Table 8. Greatest Community Issues – Race/Ethnicity

	1	2	3	4	5
African American/Black	Racism/discrimination	Lack of affordable housing	Homelessness	Lack of people immunized to prevent disease	Distracted driving
American Indian/Native American	Homelessness	Distracted driving	Lack of affordable housing	Drug/substance abuse	Lack of people immunized to prevent disease
Asian/Native Hawaiian/ Pacific Islander	Racism/discrimination	Lack of people immunized to prevent disease		Lack of jobs	Distracted driving
Caucasian/White	Lack of people immunized to prevent disease	Distracted driving	Homelessness	Lack of affordable housing	Limited access to mental/behavioral health services
Hispanic/Latinx	Homelessness	Lack of affordable housing	Distracted driving	Racism/discrimination	Lack of people immunized to prevent disease
Two or more races		Racism/discrimination	Lack of affordable housing	Limited access to mental/behavioral health services	Distracted driving
Unknown/Not Given	Distracted driving	Homelessness		Lack of safe spaces to exercise & be physically active	Lack of people immunized to prevent disease

Table 9. Greatest Community Issues – Special Populations

	1	2	3	4	5
Adult with Kids	Lack of people immunized to prevent disease	Distracted driving	Lack of affordable housing	Homelessness	Limited access to mental/behavioral health services
Single Parent	Lack of affordable housing	Homelessness	Lack of people immunized to prevent disease	Distracted driving	
LGBTQI+	Racism/discrimination	Lack of affordable housing Homelessness		Lack of people immunized to prevent disease	

Person experiencing homelessness	Lack of affordable housing Homelessness		Racism/discrimination	Lack of safe spaces to exercise and be physically active Lack of jobs	
Person with disability	Lack of people immunized to prevent disease	Lack of affordable housing	Homelessness	Distracted driving	Limited access to mental/behavioral health services
Immigrant	Homelessness	Distracted driving Racism/discrimination		Lack of affordable housing	Lack of people immunized to prevent disease
Refugee	Distracted driving	Racism/discrimination	Lack of people immunized to prevent disease Lack of jobs		Suicide
Veteran		Lack of people immunized to prevent disease	Homelessness	Lack of safe spaces to exercise and be physically active	Racism/discrimination
Person living with HIV/AIDS	Racism/discrimination		Lack of affordable housing Homelessness		Domestic violence / sexual assault

Prioritized Description of Significant Community Health Needs

The top social and health issues were identified based on data collection and community feedback. CRMC engaged in a three-stage process to gather input from the community on determining health priorities:

1. Assessment data presentation

On January 25, 2022, CRMC and MCDPH presented a total of 21 indicators to the community health committee and solicited community feedback. Health conditions and outcomes were assessed from County inpatient hospitalization, emergency department, death along with external data sources. All data were presented to community partners, who provided feedback about what they experience in their life and work. A total of 12 health indicators with several subcategories and nine social indicators were analyzed. These indicators were established in collaboration with CRMC by selecting health indicators of interest that have historically demonstrated high rates or those with known disparities when broken out by race/ethnicity, gender and age.

Of the 21 indicators that were analyzed, a chart of the top ten rankings and rates for inpatient hospitalizations, emergency department visits, and death was presented to community partners. For each top ranked indicator, existing data trends and disparities broken out by race/ethnicity, age group, and gender were also shared. Participants responded to the following poll questions:

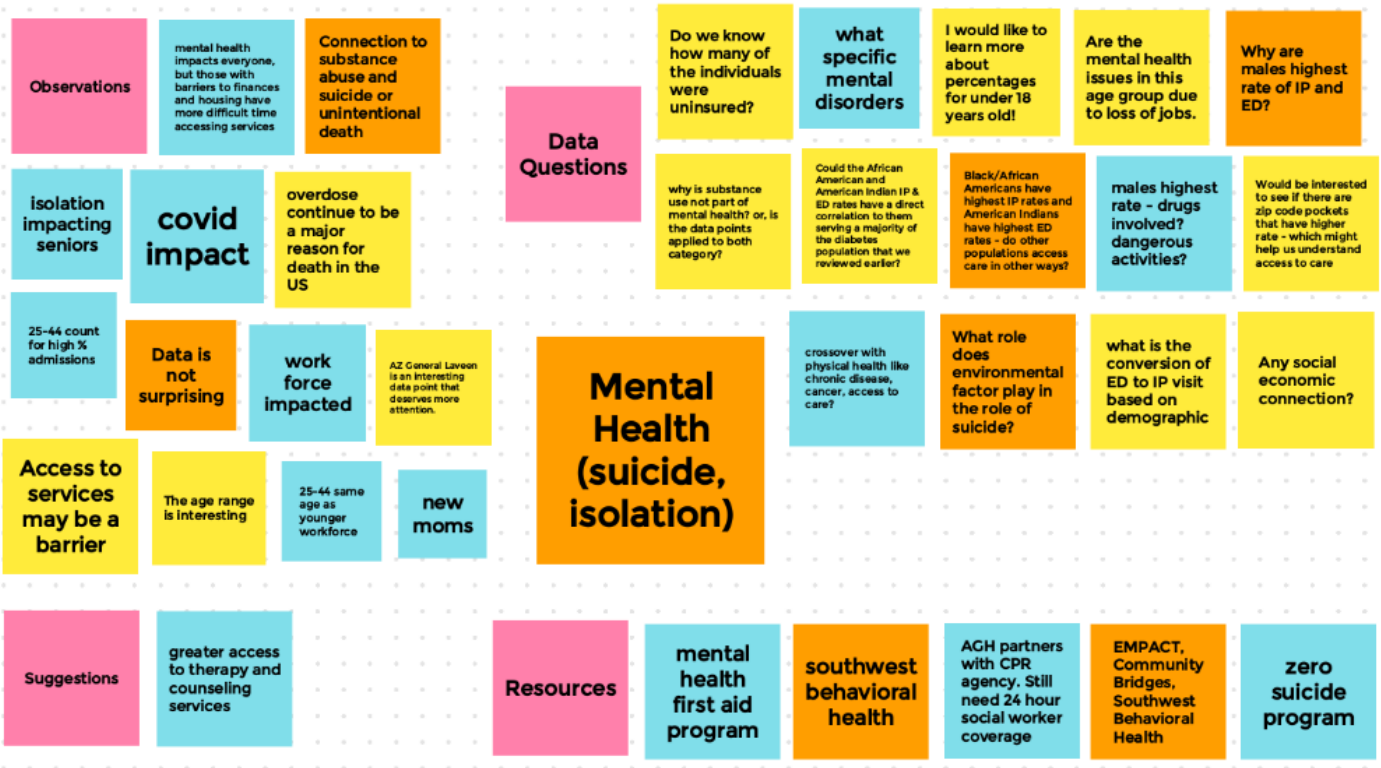
- What do you consider the most important health issues related to COVID?
- What do you consider the most important social issues related to COVID?
- What are the top 3 health conditions affecting your community?
- What are the top 3 unhealthy behaviors affecting your community?
- What are the top 3 social issues affecting your community?

All poll responses were compiled and evaluated through a health equity lens (represented by the funnel to the right), acknowledging that health equity is an underlying factor for many health and social needs. From this process, ten priorities with several sub-priorities were identified to move to the final stage.

2. Health need prioritization discussion

On February 8, 2022, CRMC and MCDPH hosted a virtual, interactive prioritization session to discuss and come to a consensus on the final ten priorities. The meeting included an overview of the top indicator disparities that were presented in the previous session. Participants were then invited to participate in virtual breakout rooms where MCDPH staff shared in-depth data and facilitated conversation about each priority. Participants had the opportunity to write observations, questions, and available resources on the virtual whiteboard, Jamboard, Figure 3. As a large group, major themes that emerged from the Jamboards were reviewed, and participants ranked the health and social issues on a prioritization matrix which demonstrated measurements of need and feasibility.

Figure 3.



3. Resource strategy session

On February 24, 2022, CRMC hosted an in-person strategy session to gather community feedback about resources to address the prioritized health needs. During this session, with the engagement of committee members, community health staff, and in collaboration with community partners they spent time discussing each health and social priority and contributed statements, strategies, resources and programs for each priority. In the upcoming 2022 Community Health Implementation Plan, the hospital intends to deliver, fund or collaborate with others to address significant community health and social needs over the next three years.

Improving health and health care requires a focus on equity – equity of access, treatment, and outcomes. Health equity is realized when each individual has a fair opportunity to achieve their full health potential.[xxxiv] Health data shows that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts.[xxxv] Acknowledging and addressing the fairway between racial inequities and poor health outcomes is necessary to bridge the health equity gap. MCDPH and CRMC utilized a health equity lens to investigate disparities in health and wellbeing based on race, gender, age, economic status, and other social factors. These differences are detailed throughout the report, to provide a framework for next steps in addressing ways in which the social and built environments impact health.

Five top social issues were identified by community partners: access to care (including immunization), housing and homelessness, violence (including domestic violence and human trafficking), equity (including racial equity and health and social equity), and nutrition (including food access and exercise). A similar process was utilized to determine the top health issues identified by community partners. The following top health issues were identified: mental health and suicide, substance use, cancer, chronic disease (diabetes, cardiovascular disease, obesity, and oral health), and injury prevention. Based on the identified top health and social needs, approval was granted from community partners to move forward with the focus of ten significant health needs.

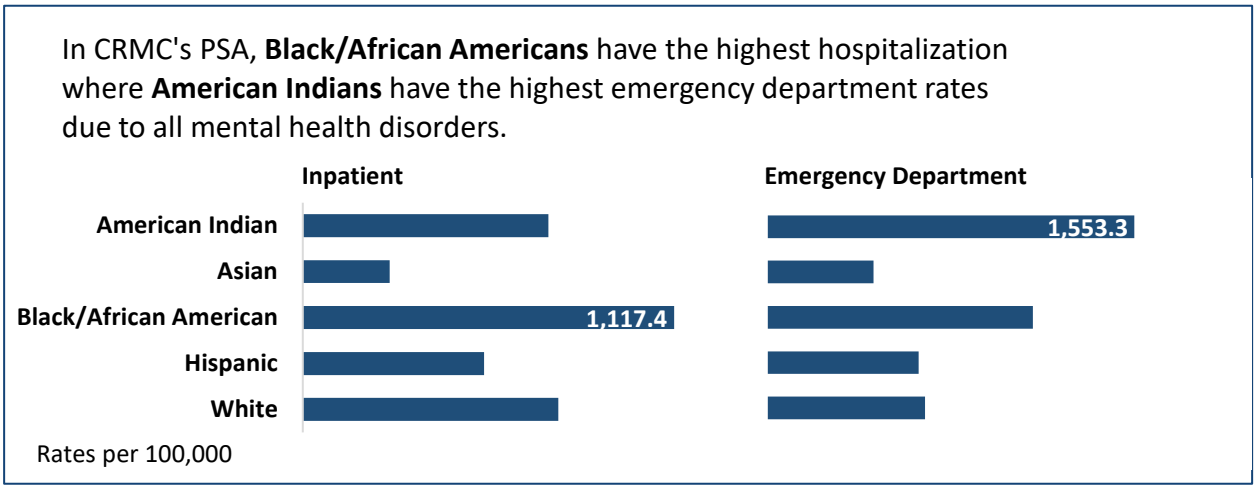
Mental Health and Suicide

Mental health and suicide was selected as a priority issue for CRMC. The prevalence and severity of mental health issues continue to be on the rise and have been exacerbated by the COVID-19 pandemic. The dynamics of working from home, temporary unemployment, losing childcare and in-person school options, and lack of physical contact with other family members, friends and colleagues, exacerbated risk factors associated with mental health and suicide for many individuals and families. In the 2019 community survey, 43.8% of residents in Maricopa County rated their mental health including mood, stress level, and the ability to think as excellent or very good. In the 2021 COVD-19 impact survey, only 32.5% of Maricopa County residents rated their mental health as excellent or very good.

In 2019, all mental health disorders ranked fifth for inpatient hospitalization visits, and eighth for emergency department visits in CRMC's PSA. Black/African Americans had the highest hospitalizations,

while American Indians had the highest all mental health disorder-related emergency department visits Figure 4.[xxxii,xxxiii]

Figure 4.



The 2021-2025 Arizona Health Improvement Plan demonstrates how the pandemic impacted mental health. In mid-2021, most Americans reported heightened stress, nearly half reported struggling with mental health and/or substance abuse, and self-reported depression increased by over 300%.[xxxvi]

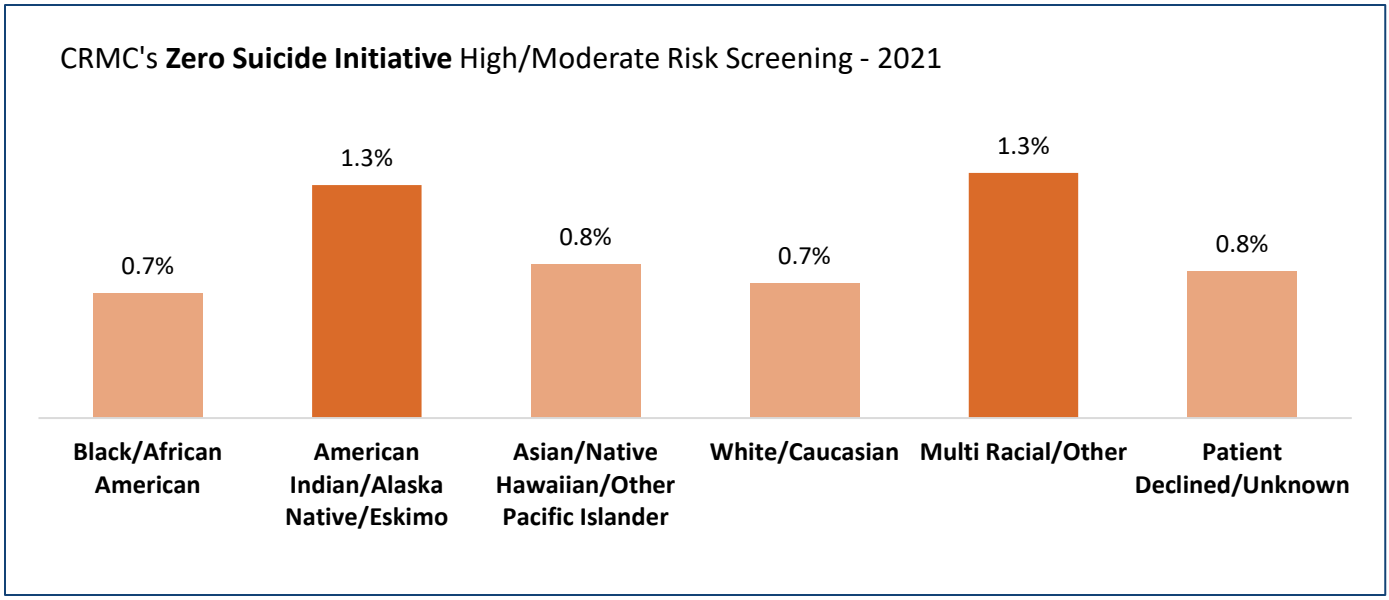
A participant from the COVID-19 impact survey reflected these trends when sharing how the pandemic impacted mental health in their community:

> "COVID created new levels of isolation and social anxiety for many and division from those who failed to take precautionary measures."
>
> *25-34 years old,*
> *COVID-19 Impact Survey*

Dignity Health is committed to providing the best suicide prevention care in the emergency rooms and throughout their hospitals by recognizing, treating, and preventing this illness. The Zero Suicide Initiative was created to provide a holistic and comprehensive approach to patient safety, to dramatically reduce patient suicides, and improve clinical staff safety through its system-wide implementation at Chandler Regional Medical Center and ultimately will be expanding to more Dignity Health hospitals.[xxxvii]

Figure 5 displays suicide-related screenings which detailed moderate and high risk between January and June of 2021. Of all CRMC's emergency department-related visits, patients who identified as American Indian/Alaska Native/Eskimo and Multi-Racial/Other had the greatest percentage of screening for high/moderate suicide risk.[xxxviii]

Figure 5.



Fear, worry, and stress are normal responses to perceived or real threats, especially when individuals are faced with uncertainty.[xxxix] The following participant from the COVID-19 impact survey shared their experience of losing a family member while battling COVID-19 themselves:

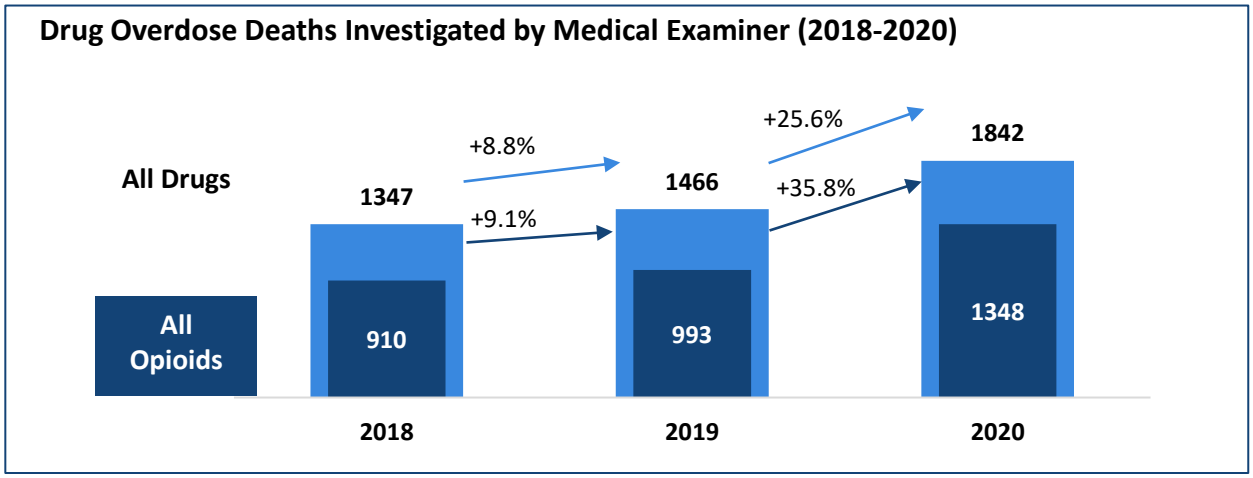
> "I feel my year was most impacted by anxiety and uncertainty and the feeling of isolation. My husband passed in Sept 2020. When I had COVID, I was alone and relied on internet for info and support. I wasn't sure who to contact for advice or support."
>
> *65-74 years old,*
> *COVID-19 Impact Survey*

Substance Use

Substance use was selected as one of CRMC's top priorities. Substance use has a major impact on individuals, families, and communities as the effects are cumulative, contributing to costly social, physical, and mental health problems.[xl]

According to drug overdose deaths investigated by Maricopa's medical examiner, from 2019 to 2020 all drug-related overdoses increased by 25.6% and opioid-related overdoses increased by 35.8%. Fentanyl became an increasingly high proportion of opioid-related overdoses Figure 6.[xli]

Figure 6.



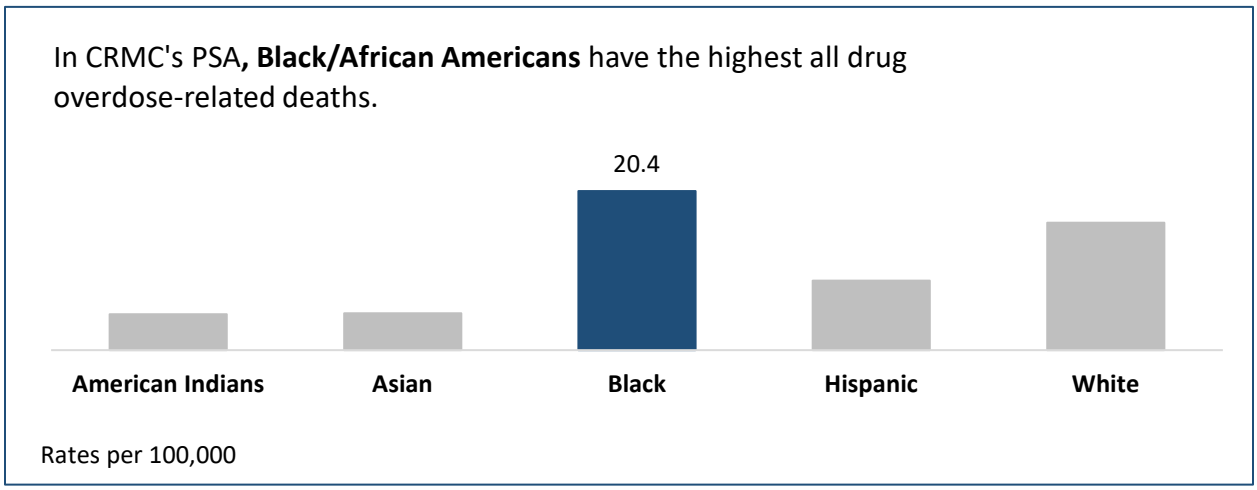
Social isolation and anxiety due to COVID-19 have likely contributed to an increase in substance use and related injuries and death.[xlii] Substance use emerged as a theme both in COVID-19 impact focus groups and the open-ended portion of the survey. One individual described the negative impact COVID-19 had on their substance use recovery:

"I have been VERY isolated and that is hard on my mental health and my long term recovery from substance abuse (28 years)."

55-64 years old, COVID-19 Impact Survey

In Figure 7, in 2019, substance overdoses ranked sixth for emergency department visits. In CRMC's PSA, Black/African Americans and adults aged 25-44 had the highest drug overdose death rate. Females experienced higher rates of hospitalization whereas males experienced higher rates of death due to all drug overdoses.[xxxii,xxxiii]

Figure 7.



Many healthcare facilities saw an increase in substance-related visits. The following survey participant shared their experience working on the frontlines of the pandemic and seeing the related health issues:

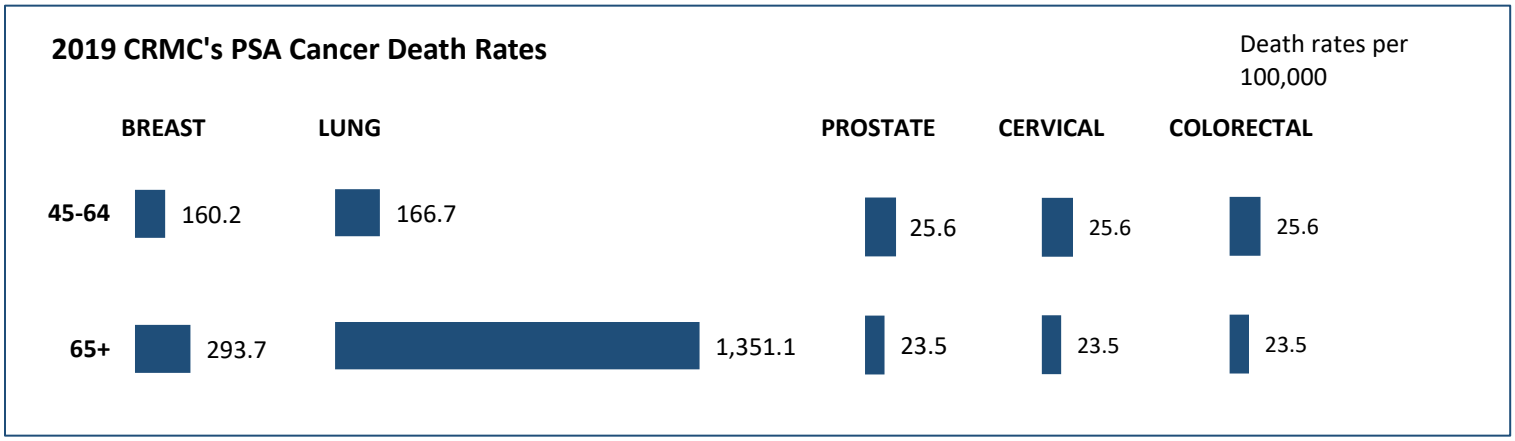
"I am an RN who was working on the COVID unit...we are seeing a lot of drug and alcohol cases- from loss: loss of jobs, families, support. I think we need more help getting people help at home- detoxing safely, outlets etc."

35-44 years old, COVID-19 Impact Survey

Cancer

Cancer is a significant health issue facing the population today. Lung cancer is the fifth leading cause of death, and breast cancer is the eleventh leading cause of death in CRMC's PSA.[xxxiii] Rates of deaths due to cancer increase with age, except for prostate, cervical, and colorectal cancer. In 2019, lung cancer was the leading type of cancer-related death for residents aged 65+ Figure 8.[xxxiii]

Figure 8.



Cancer was selected as a priority issue for CRMC due to the high rates of incidence among the primary service area population. COVID-19 has exacerbated cancer-related death and illness. According to a study conducted in 2020, the impact of the COVID-19 pandemic on cancer care in the US has resulted in decreases and delays in identifying new cancer and delivery of treatment. If unmitigated, these problems will increase cancer morbidity and mortality for years to come.[xliii] Participants in the COVID-19 impact survey shared experiences that reflected the trends seen for delayed cancer screening and care. This participant described how fear of COVID-19 infection and exposure at healthcare clinics led to a family member not receiving their cancer diagnosis early enough to pursue treatment:

"My mother died of pancreatic cancer because she was scared to go to the doctor in a timely manner. She started experiencing symptoms in March of 2020, and by the time we were able to force her to the doctor when we were finally able to see her, it was too late and she was dead by the end of September 2020."

45-54 years old, COVID-19 Impact Survey

Individuals with cancer faced even greater risk of COVID-19 infection due to their weakened immune system and underlying conditions. Furthermore, crisis standards of care across the state led to the cancellation of routine treatments and procedures that may have improved cancer patients' chances of recovery. The following participant shares their experience of losing family members both to COVID-19 and to cancer:

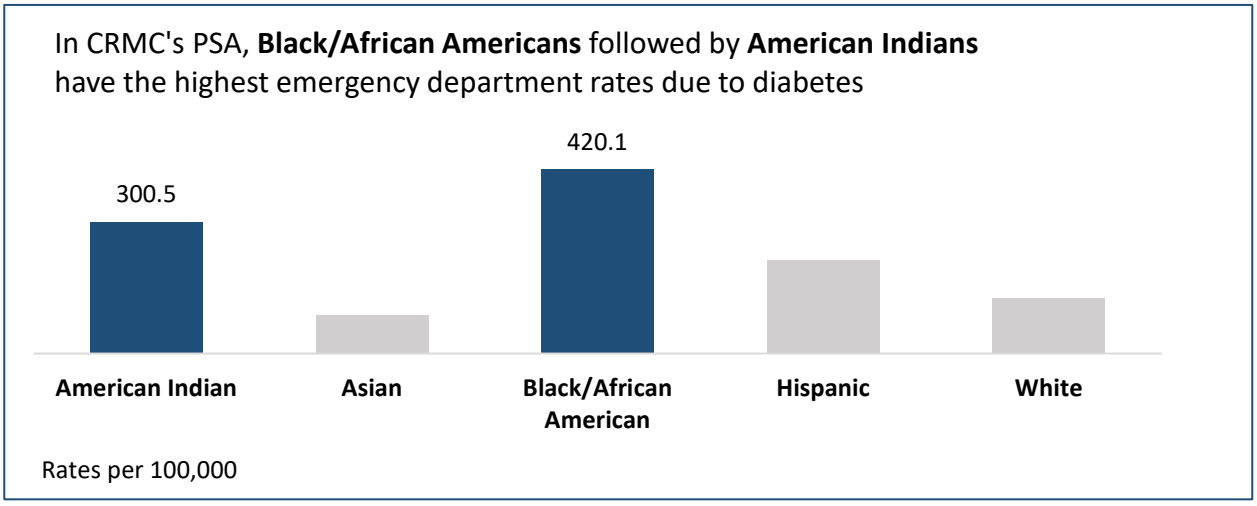
> "I had family 3 members die because of COVID. One person is dying now of cancer because they could not get cancer treatment during COVID & now it has spread to the point they can't do anything for them. We tried to be careful but work required us to meet with the public."
>
> *55-64 years old, COVID-19 Impact Survey*

Chronic Disease

Diabetes

Diabetes was selected as a priority issue for CRMC. Diabetes occurs when the body cannot produce enough insulin or cannot respond appropriately to insulin. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Diabetes affects an estimated 29.1 million people in the United States and is the 7th leading cause of death.[xliv] In 2019, diabetes was ranked fourteenth for inpatient hospitalization visits, and thirteenth for emergency department visits in CRMC's PSA.[xxxii] Black/African Americans followed by American Indians have the highest rates for emergency department visits Figure 9.[xxxii]

Figure 9.



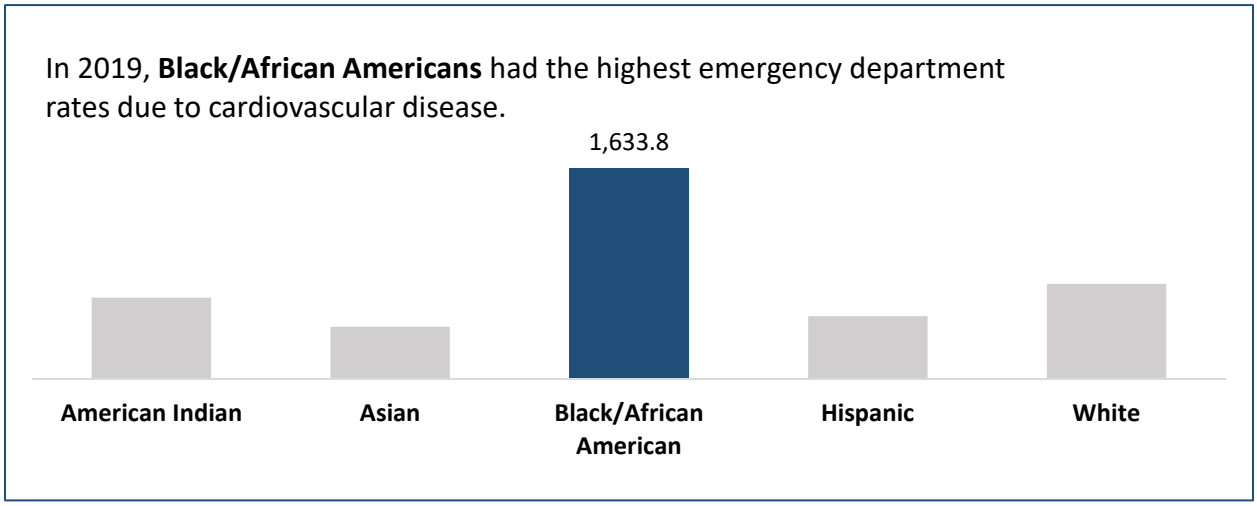
Type 2 diabetes is largely preventable through several lifestyle factors such as staying physically active, maintaining a healthy diet, and monitoring blood sugar. The following participant from the COVID-19 impact survey shared their concern on the prevalence of diabetes in Arizona:

> "…We need to focus on reinforcing healthy eating/lifestyles. Arizona has too much diabetes prone citizens. We must be healthy to ward off illness."
>
> *55-64 years old, COVID-19 Impact Survey*

- **Cardiovascular Disease (CVD)**

CVD was selected as a priority issue for CRMC. CVD is the leading cause of death in the United States. Currently more than 1 in 3 adults (85.6 million) live with 1 or more types of cardiovascular disease. The leading modifiable (controllable) risk factors for heart disease and stroke are high blood pressure, high cholesterol, cigarette smoking, diabetes, unhealthy diet, physical inactivity, and overweight and obesity. Addressing risk factors early and consistently can prevent potential complications of chronic cardiovascular disease.[xlv] In 2019, CVD was ranked first for inpatient hospitalization visits, second for emergency department visits, and first for deaths in CRMC's PSA.[xxxii,xxxiii] Black/African Americans have the highest rate for emergency department visits due to cardiovascular disease, Figure 10.[xxxii]

Figure 10.



Individuals with cardiovascular disease faced higher rates of hospitalization and death due to COVID-19. According to the American Heart Association, nearly one-fourth of those hospitalized with COVID-19 have been diagnosed with cardiovascular complications, which have been shown to contribute to roughly 40% of all COVID-19 related deaths.[xlvi]

The following participant from the COVID-19 impact survey shared their experience losing a family member due to COVID-19:

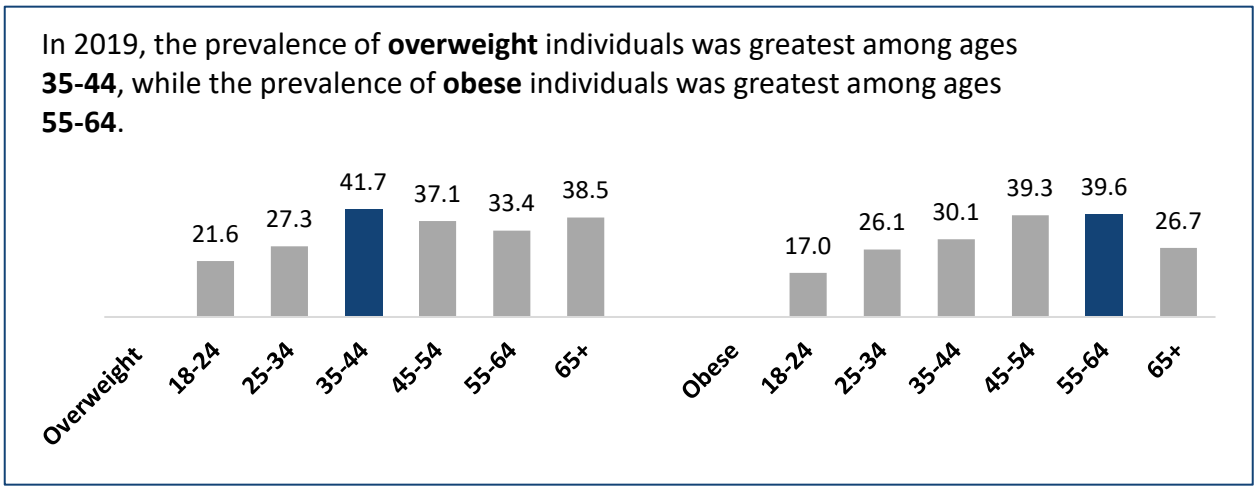
"My wife died in February, 2021, a month after she contracted COVID. The presenting cause was heart trouble which had not previously been a problem. Our cardiologist stated that COVID likely weakened her heart causing her death."

75+ years old, COVID-19 Impact Survey

- **Obesity**

Obesity was selected as a priority issue for CRMC. Obesity is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. Some contributing factors include the access to food and physical activity, education and skills, and food marketing and promotion. [xlvii] Obesity is associated with the leading causes of death in the United States and worldwide, including diabetes, heart disease, stroke, and some types of cancer. According to the Behavioral Risk Factor Surveillance System (BRFSS), in 2019 34.4% of Arizona residents were considered overweight *(BMI 25.0 - 29.9)* and 31.4% were considered obese *(BMI 30.0 - 99.8).* In Maricopa County, 34.0% of residents were considered overweight and 30.1% were considered obese in 2019. The prevalence of overweight individuals in Maricopa County was greatest among ages 35-44 while the prevalence of obese individuals was greatest among ages 55-64, Figure 11.[xlix]

Figure 11.



Stress and anxiety levels can lead to challenges maintaining a healthy weight, especially when access to gyms, public spaces, and other recreational facilities are reduced.[l] Access to safe and clean outdoor space is poignant area of disparity for many communities.

Some participants in the COVID-19 impact survey highlighted benefitting from outdoor activities in their neighborhoods and local parks. Other individuals reported not having access to quality outdoor spaces due to neighborhood design, safety concerns, lack of walkable paths, and other factors often related to socio-economic status.

A participant from the COVID-19 impact survey shared how the pandemic impacted their health and ability to stay physically active:

"I gained weight overall through COVID because I wasn't able to go outside and exercise."

55-64 years old, COVID-19 Impact Survey

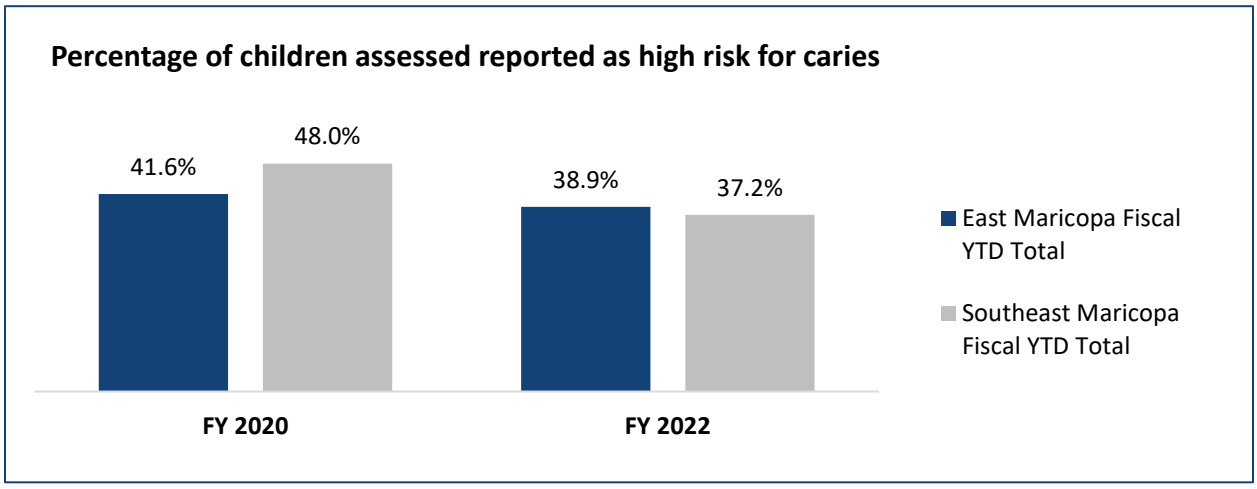
- **Oral Health**

Oral health was selected as a priority issue for CRMC. The health of the teeth, the mouth, and the surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being.[li] There have been significant enhancements to the nation's oral health, but still not all communities have equal access to these improvements. Some racial/ethnic and socioeconomic groups face poor oral health as a result of the social determinants of health. For instance, some individuals and communities can't afford to pay out of pocket for dental care, do not have private or public dental insurance, or can't get time off from work to get dental care.[lii]

Maricopa County's Office of Oral Health administers First Teeth First in partnership with First Things First and Dignity Health. Basic oral screenings, education, and referrals are provided at no cost to expectant mothers and children 0 through age 5, not enrolled in kindergarten.[liii] Preventative practices such as oral screenings, education and referrals are crucial to prevent tooth decay known as caries or cavities.[liv]

Figure 12 displays the percentage of children assessed that were reported as high risk for caries in the East and Southeast Maricopa during the fiscal year (FY) of 2020 and 2022.[lv]

Figure 12.



The following participant from the COVID-19 impact survey shared their experience of sacrificing dental care due to high expenses:

"The expense of healthcare, even with insurance, was significant for me. I chose not to go to the dentist for both the concern over getting COVID but also how expensive it would be."

45-54 years old, COVID-19 Impact Survey

The CRMC Children's Dental Clinic, hosted by the Chandler CARE Center, increases access to preventive dental health services by providing preventive clinical services to low-income children using Affiliated Practice Registered Dental Hygienists, increasing awareness and improving children's oral and overall health through education of children and parents in community locations.

The clinic serves children up to 18 years of age (22 years of age if patient is established), parents and pregnant women, caregivers of young children, community partners, educators and advocates which are eligible to receive oral health education and dental supplies. At the age of 21, the adult or expectant mother only receives $1,000 of emergency benefits through Medicaid. Some of the services that are offered are dental screenings/assessments, dental cleanings, sealants, radiographic imaging, oral health education, interim therapeutic restoration, silver diamine applications and more. From January 2019 – December 2021, the CRMC Children's Dental Clinic provided 3,893 dental appointments to children, 1,280 of which included restorative services. During this same time period, 8.7% of appointments for children with dental need were emergency-related. Among the population served by CRMC Children's Dental Clinic, 86.7% were considered as low-income.[lvi]

A regular dental checkup is crucial in keeping healthy teeth and gums. Table 10 provides 2018 data from BRFSS on adults aged 18+ who have visited a dentist or dental clinic in the past year, and adults aged 65+ who have lost all of their natural teeth due to tooth decay or gum disease in Arizona compared to the U.S.[lvii]

Table 10.

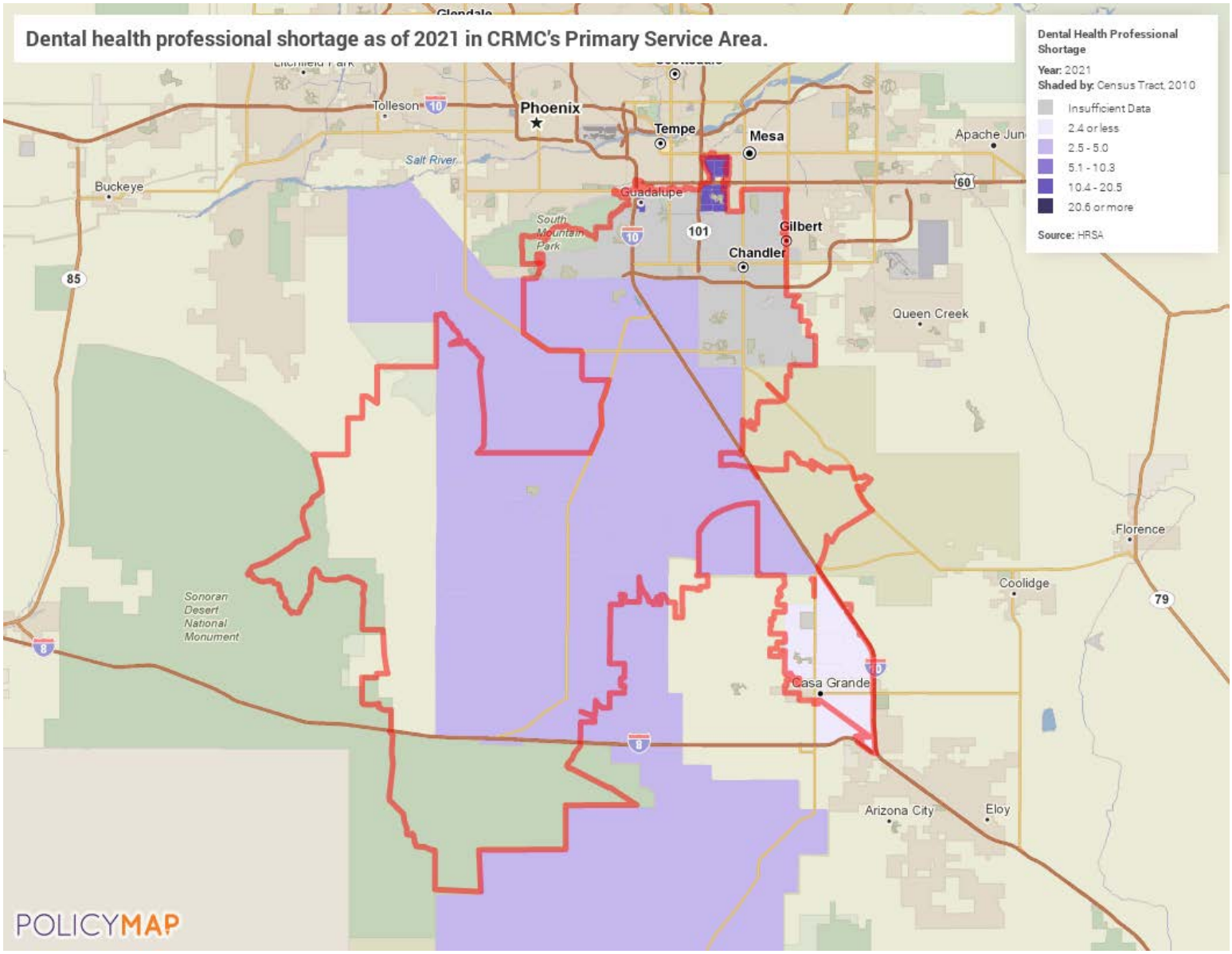
	Arizona	United States
Adults aged 18+ who have visited a dentist or dental clinic in the past year	62.3%	67.6%
Adults 65+ who have lost all of their natural teeth due to tooth decay or gum disease	11.6%	13.6%

In 2019, the average dollars spent out of pocket per person on dental care in Maricopa County was $190, $200 in Arizona, and $190 in the city of Chandler. This includes visits to dentists, dental hygienists, orthodontists, and other dental care providers. This includes only the amount paid for by the patient or the patient's family. It does not include any payments made by private or public insurance.[lxviiilxviii] Another participant from the COVID-19 impact survey described how their dental health was impaired:

> "I thought I was doing ok physically and mentally, but then went to the dentist – my health was manifested in my teeth, with grinding and worsening of my dental health."
>
> *45-54 years old, COVID-19 Impact Survey*

Figure 13 displays dental health professional shortage areas in CRMC's PSA in 2021. Health Professional Shortage Areas (HPSAs) are defined by the Health Resources and Services Administration (HRSA) as areas that need more health providers in primary care, dental health, or mental health. All HPSAs are defined on the basis of three basic criteria: the ratio of population to health providers, percent of population below the federal poverty level, and travel time to the nearest source of care outside the HPSA area.[lxviii]

Figure 13.

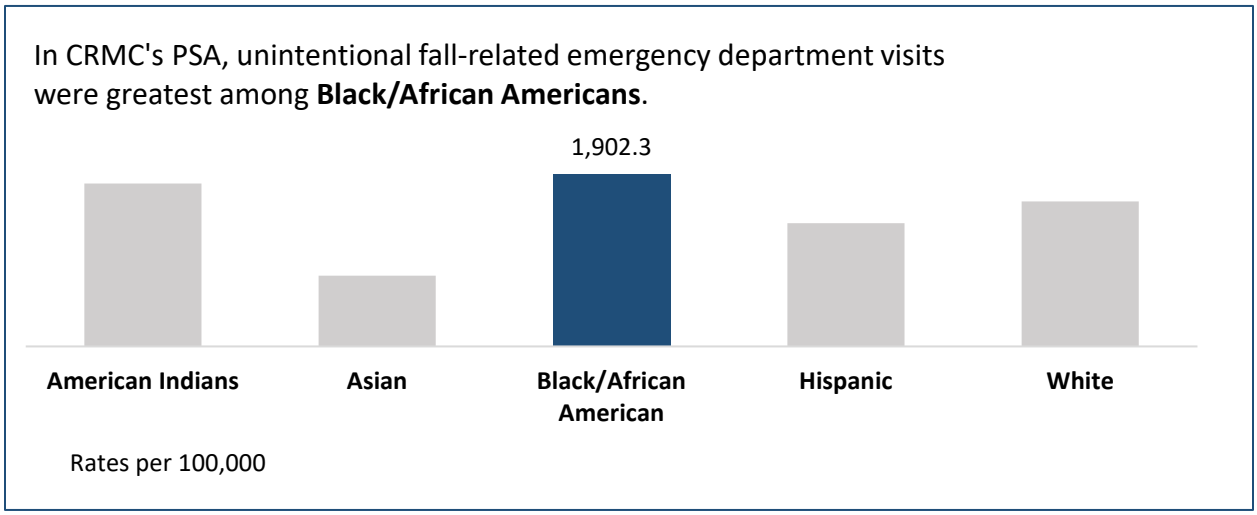


Injury Prevention

Injury prevention was selected as a priority issue for CRMC. Unintentional injuries are among the top leading causes of death of all ages. Most events resulting in injury, disability, or death are predictable and preventable. Beyond their immediate health consequences, injuries have a significant impact on the long-term well-being of individuals, contributing to premature death, disability, poor mental health, high medical expenses, and lost productivity. The effects of injuries extend beyond the injured person to family members, friends, coworkers, employers, and communities.[lviii] Unintentional falls was ranked second in inpatient hospitalizations, first in emergency department visits and eighth in deaths.[xxxii, xxxiii]

In 2019, unintentional falls-related emergency department visits were highest among Black/African Americans in CRMC's PSA, Figure 14.[xxxii]

Figure 14.



Unintentional injuries, such as falls and motor vehicle crashes, are a major issue in many communities. Accidental injuries can affect anyone, regardless of age, sex, race or socioeconomic background – but can be exacerbated by disparities in safe housing or transportation. Effective recovery often depends on appropriate access to care. Recognizing the social and economic contributors to and burdens of is critical to determine the appropriate level of intervention and investment into prevention activities.[lix] In 2019, rates of emergency department visits due to a motor vehicle crash were highest among teenagers and young adults between the ages of 15-24 in CRMC's PSA.[xxxii]

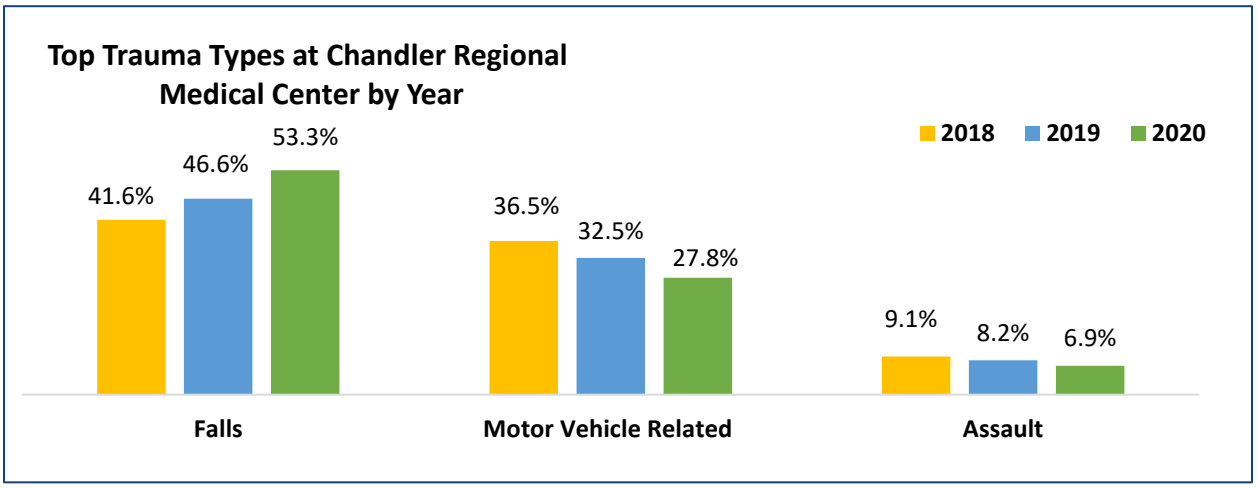
COVID-19 has impacted many communities far beyond the obvious physical implications of the disease, and the connections between COVID-19 and injury have become increasingly clear. Social distancing precautions, new sources of stress, and disruptions to daily routines can also take a toll on risk and protective factors related to injury and violence.[lx]

A participant in the COVID-19 impact survey shared their family experience that reflected the trends seen for unintentional injuries:

> "My father fell and was in a rehab facility where they had COVID -19 patients on a different floor. He got COVID-19 and died. He was healthy in general despite a muscular injury to his thigh."
>
> *75+ years old, COVID-19 Impact Survey*

Figure 15 displays the top trauma types at CRMC from 2018-2020.[lxi]

Figure 15.



Throughout the pandemic, in addition to the soaring rates of unintentional injuries there has also been an increase in crime and violence. The following participant shared their experience of increased local gang violence and crime in their neighborhood:

> "In the last 3 months, local gang violence and crime has increased in our neighborhood. People drive crazy and there have been several accidents. We have had shootings as well. The area around 83 Ave and Indian School/ Camelback is very concerning."
>
> *45-54 years old, COVID-19 Impact Survey*

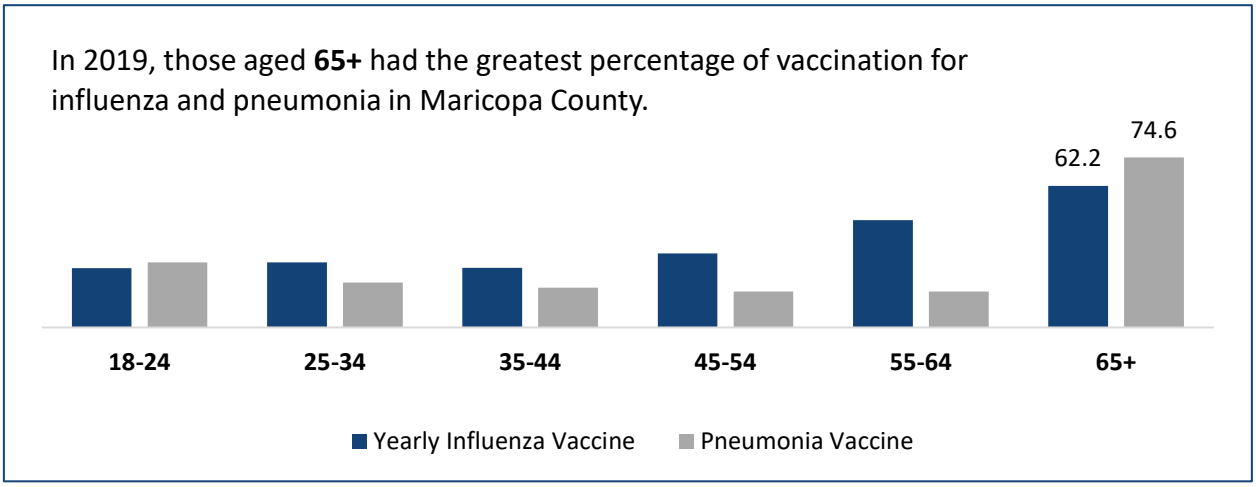
Access to Care

Access to care was selected as a priority issue for CRMC. Access to care has been a longstanding challenge for many communities, and the current COVID-19 pandemic has only exacerbated this issue. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met. Access to affordable, quality health care is important to physical, social, and mental health. Health insurance helps individuals and families access needed primary care, specialists, and emergency care, but does not necessarily ensure access – providers are needed to offer available and affordable care within adequate proximity to patients.[lxii]

Immunization

Immunization was selected as a priority issue for CRMC. Infectious diseases remain a major cause of illness, disability, and death. Viral hepatitis, influenza, and tuberculosis remain among the leading causes of illness and death in the U.S. and account for substantial spending on the related consequences of infection. Having an awareness of disease and completing prevention and treatment practices such as getting an immunization remain essential components for reducing infectious disease transmission.[lxiii] In 2019, Maricopa County residents aged 65+ had the greatest percentage of vaccination for influenza and pneumonia, Figure 16.[xlix]

Figure 16.



- **Financial Security**

Those without insurance, and even those with insurance, have higher out of pocket expenses which can quickly accumulate for individuals with chronic conditions. Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities. Inadequate health insurance coverage is one of the largest barriers to health care access. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications), and medical debt is common among both insured and uninsured individuals.[lxiv] In the 2021 COVID impact survey, only 46% of respondents reported that they had not experienced any barriers accessing health care.

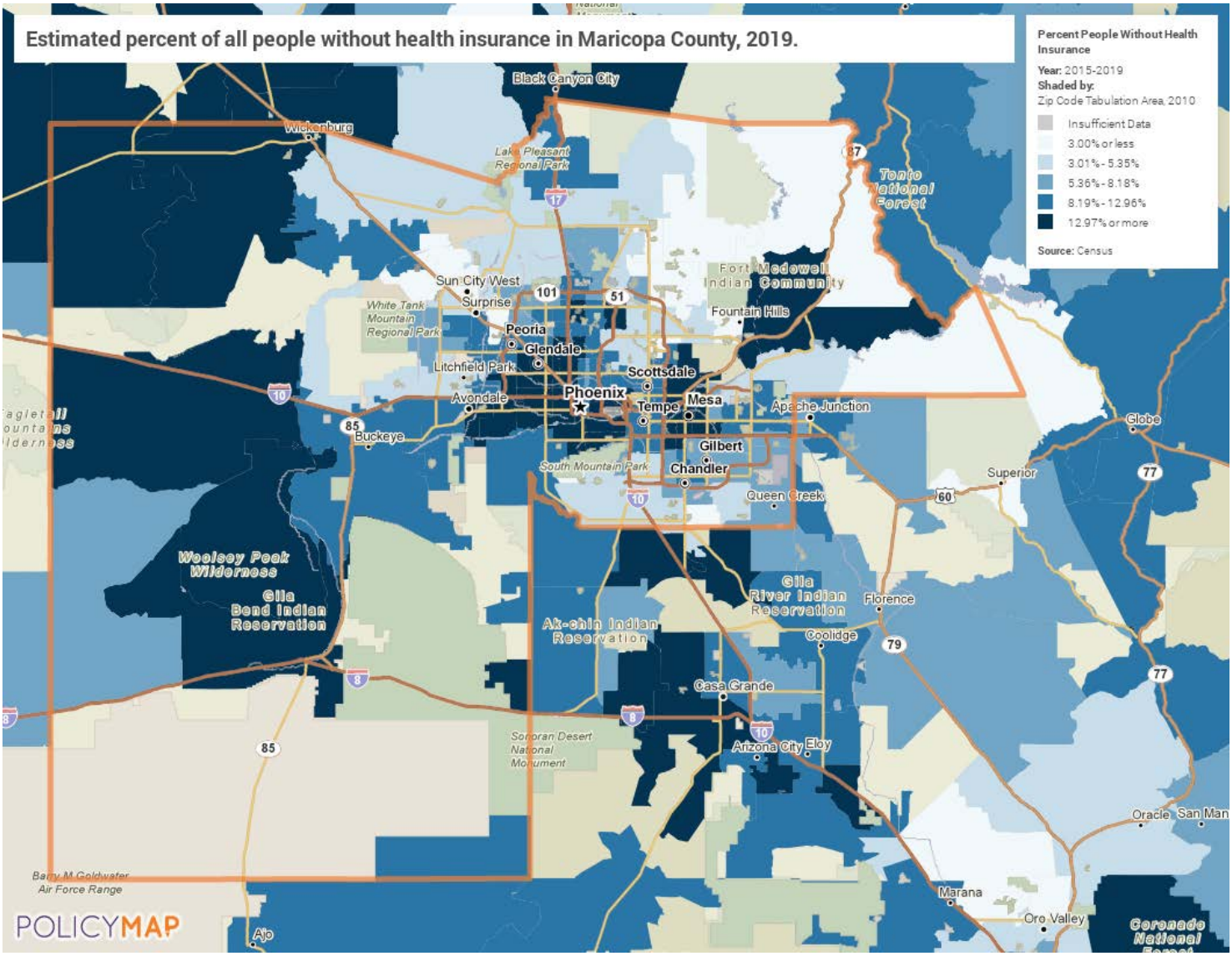
The COVID-19 pandemic has shocked the health care system. Since the beginning of the pandemic, visits to primary care physicians and outpatient specialists have declined, and many hospitals have postponed or cancelled elective procedures. Meanwhile, some hospitals have seen a surge in patients and have had to expand capacity and purchase expensive personal protective equipment. These trends have compounded problems in a fragmented health care system that has persistent gaps in access to affordable coverage and care, especially for people of color.[lxv] According to the CDC's Research and Development Survey (RANDS), nearly 40% of people have reduced access to medical care due to COVID-19, with the largest age range of 45-64 years to report not receiving planned care.[lxvi] Affordability of health care has been and continues to be a long-standing problem faced by many communities.

A participant from the COVID-19 impact survey shared their experience with healthcare affordability:

> "Even as someone who has remained employed, at an above average salary, I cannot afford the copays required for frequent doctor visits, let alone dental care and mental health care. I have had many chronic symptoms for months that sound like long COVID but just can't afford to get thoroughly checked out."
>
> *35-44 years old, COVID-19 Impact Survey*

Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. In 2019, **almost 11% of residents in Maricopa County** were without health insurance Figure 17.[lxix]

Figure 17.



Another participant from the COVID-19 impact survey shared their positive experience with access to health insurance throughout their unemployment period:

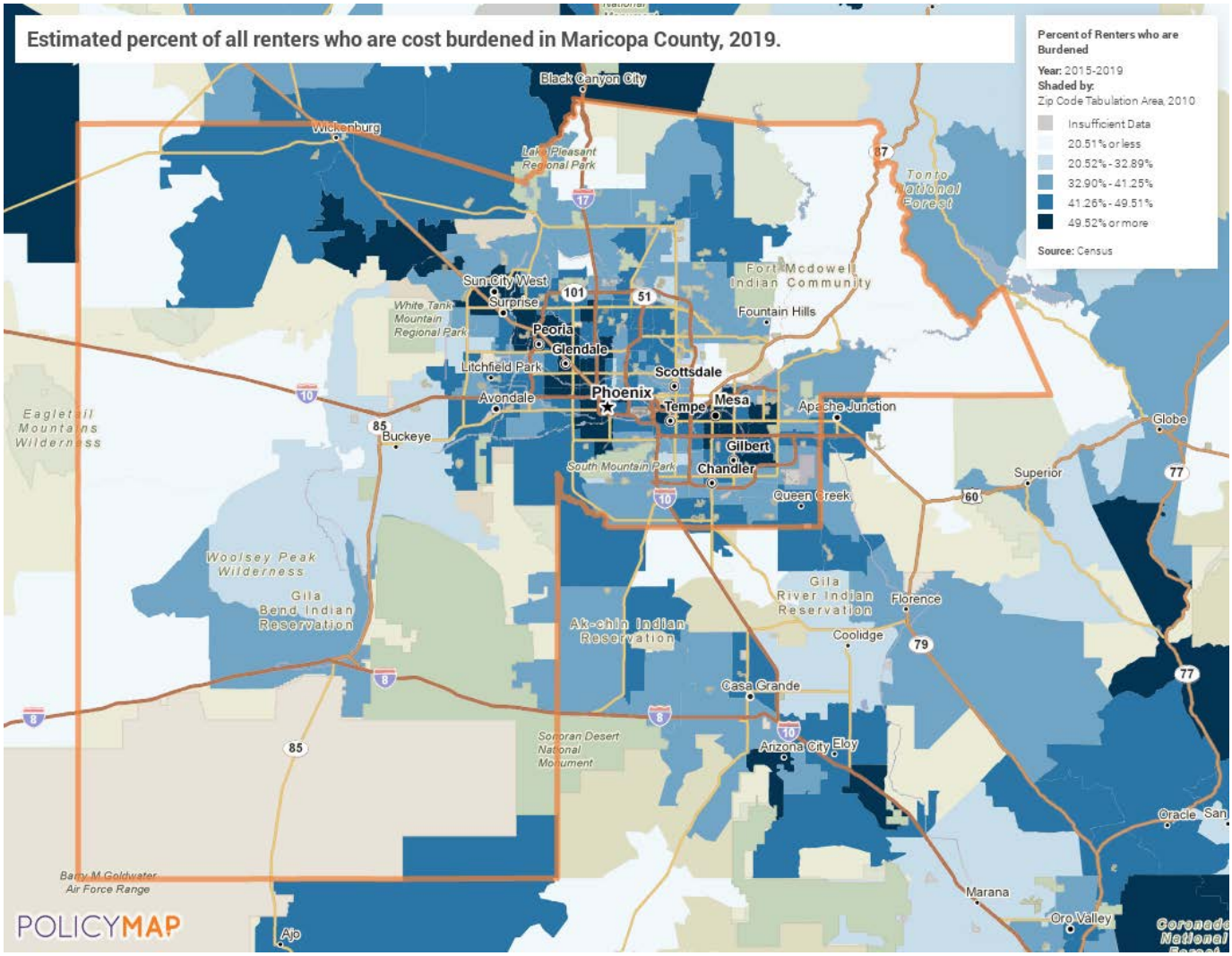
> "I am very grateful for the access to health insurance that I was given when I went on unemployment. That was a lifesaver for me, especially when I contracted COVID. I wish Phoenix would create a universal healthcare system with this wonderful insurance."
>
> *35-44 years old, COVID-19 Impact Survey*

Housing and Homelessness

Housing and homelessness was selected as a priority issue for CRMC. The lack of affordable housing and the limited scale of housing assistance programs contributes to the current housing crisis and to homelessness. High rent burdens, overcrowding, and substandard housing, has increased the number of people without housing and at risk of losing housing.[lxvii] In the 2019 community survey, 21.1% of participants indicated lack of affordable housing as one of the issues that had the greatest impact on their community's health and wellness. In the 2021 COVD-19 impact survey, affordable housing was deemed as a more prominent issue with 24.6% of respondents indicating this concern.

Housing and homelessness are issues that have been exacerbated by the pandemic. COVID-19 is widening the racial and economic gaps in access to safe, affordable, and stable housing. In 2019, **almost half (45.1%) of renters in Maricopa County were considered cost-burdened**, meaning that gross rent is 30% or more of household income, Figure 18.[lxviii]

Figure 18.

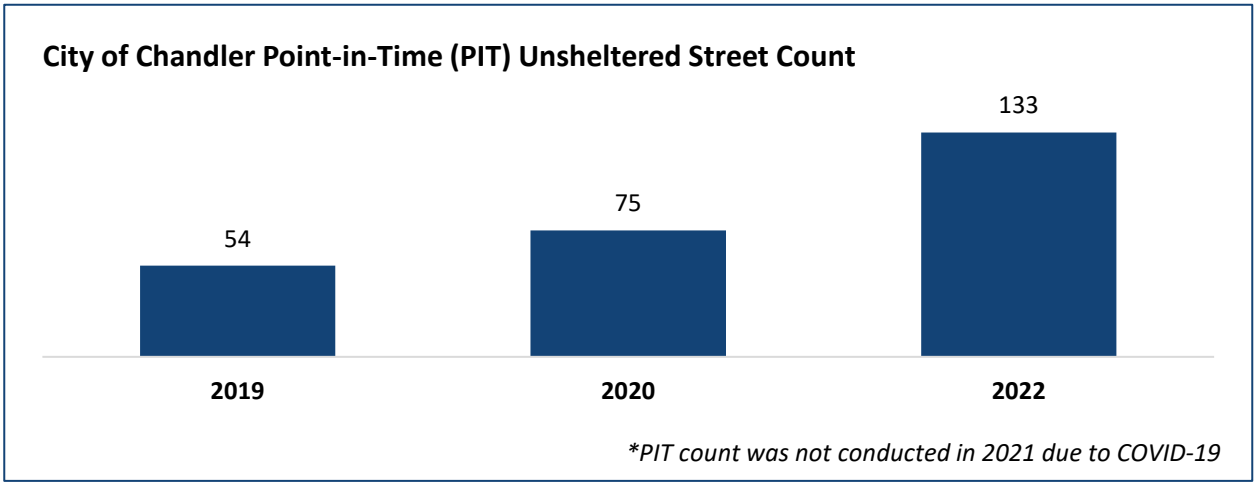


Affordable housing was an issue before COVID-19 and was greatly exacerbated by the pandemic. A participant from the COVID-19 impact survey shared their experience of struggling to pay for rent as a single parent:

> "We need more affordable housing in the valley...I have seen too many people lose their jobs as even before the pandemic they were barely able to pay rent. Rent is way too high even in certain affordable housing apartments. My rent has increase 3 times in 3 years and I live in an affordable housing apartment. Rent is over $900 now and that is tough for a single parent."
>
> *25-34 years old, COVID-19 Impact Survey*

The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experienced homelessness on a single night in January.[lxix] Numbers for participating communities are a direct census of individuals interviewed by volunteers, law enforcement, and outreach workers. The city of Phoenix conducts a survey using an extrapolation method by which areas are designated "high density" or "low density" areas. Direct counts in those areas are then extrapolated to estimate the number of individuals experiencing homelessness in unsheltered situations within the city of Phoenix geographic boundaries.[lxx] Figure 19 displays the PIT unsheltered street count for the city of Chandler from 2019-2022.[lxx]

Figure 19.



Along with the many other burdens of the pandemic, many families had to navigate losing their homes unexpectedly. This participant described their homelessness experience due to the lack of affordable housing on the market:

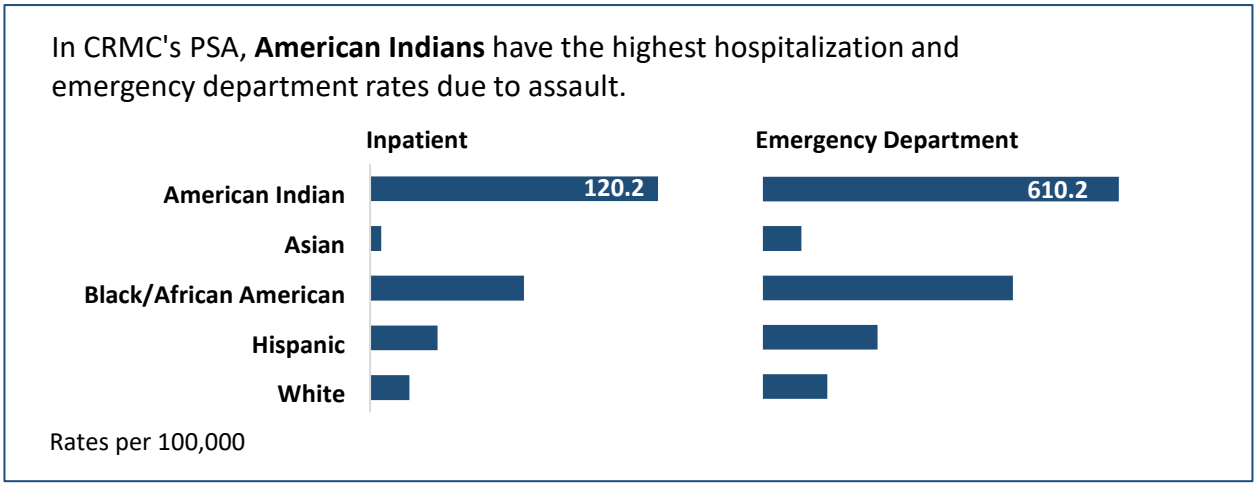
> "I am currently homeless with my disabled veteran husband and our 7 children because affordable homes are unavailable. We lost our home because our landlord decided to sell while prices were high, and we had no protections because we paid our rent in full and on time. We have been looking for 2 months, and have had no luck. This isn't right."
>
> *25-34 years old, COVID-19 Impact Survey*

Violence

Domestic Violence

Domestic violence was selected as a priority issue for CRMC. Domestic violence or intimate partner violence can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. Anyone can be a victim of domestic violence, regardless of age, race, gender, sexual orientation, faith, or class.[lxxi] The detrimental impacts of domestic violence don't just affect individuals and families, but also society. Some societal consequences may be associated with medical services for domestic violence-related injuries, lost productivity from paid work, and criminal justice.[lxxii] In 2019, American Indians had the highest hospitalization and emergency department rates due to assault, Figure 20.[xxxii]

Figure 20.



Human Trafficking

Human trafficking was selected as a priority issue for CRMC. Human trafficking is the recruitment, transportation, transfer, harboring or receipt of people through force, fraud, or deception, with the aim of exploiting them for profit. Men, women, and children of all ages and from all backgrounds can become victims of this crime.[lxxiii] At-risk populations can face deceitful recruitment practices by those bent on exploiting them for labor. Human trafficking deprives millions worldwide of their dignity and freedom.[lxxiv] The National Human Trafficking Hotline (NHTH) works closely with service providers, law enforcement, and other professionals in Arizona to serve victims and survivors of trafficking, respond to human trafficking cases, and share information and resources.[lxxv] In 2019, there were 696 contacts (phone calls, texts, online chats, emails, and webforms) received by the NHTH and 233 human trafficking cases reported in Arizona.[lxxv]

Human Trafficking is a priority concern for Dignity Health. Each hospital has a human trafficking taskforce and policies and procedures to ensure effective training of staff, identification of possible victims and support to victims. Cases are reviewed and shared across the system to ensure best practice.

Table 11 below demonstrates the impact of improved education, awareness, and processes.

Table 11.

Fiscal Year	**All 40 Dignity Health Hospitals** Numbers of patients identified as possible human trafficking victims	**Arizona Hospitals** Number of patients identified as possible human trafficking victims	**All Dignity Health Hospitals** Patients identified as moderate to high risk for labor or sex trafficking victimization	**Arizona Hospitals** Patients identified as moderate to high risk for labor or sex trafficking victimization
FY 16	38	2	31	1
FY 17	79	8	76	8
FY 18	96	9	95	9
FY16 and FY18 there was an increase of nearly 50 identified patients.				

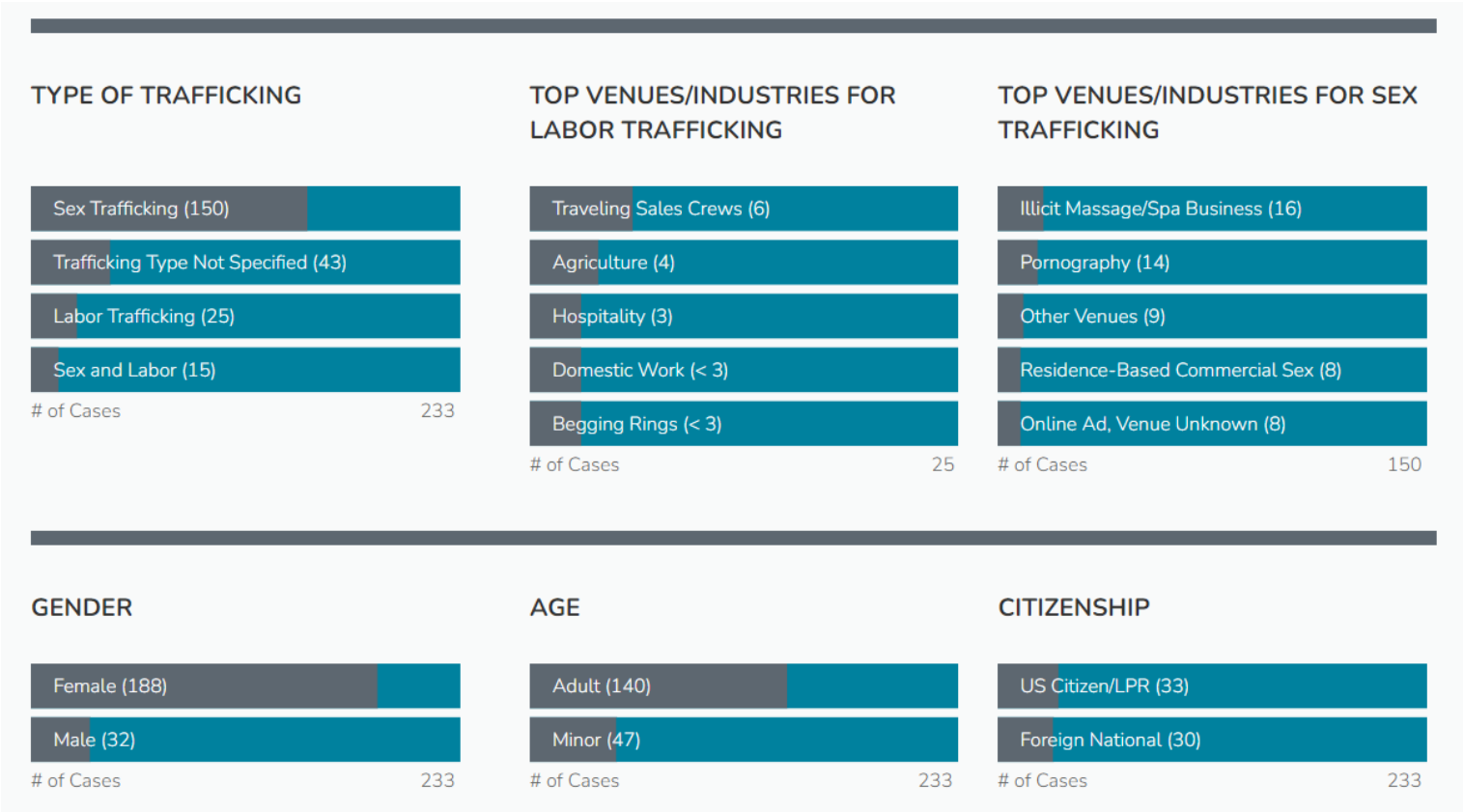
Table 12 displays a top 3 summary of Dignity Health's Human Trafficking 101 session: Dispelling the Myths.[lxxvi] Please refer to Appendix F for the TOP 10 MYTHS and FACTS of Human Trafficking.

Table 12.

MYTH	FACT
1. Human trafficking only happens overseas.	Every country is affected by human trafficking, including the United States. The USA passed federal legislation **to outlaw two common forms of human trafficking**: sex trafficking and labor trafficking. According to federal law, human trafficking means **forcing or coercing a person to perform commercial sex or labor/services**. Commercial sex is any sex act in which money or something of value is exchanged. Under federal law, anyone under age 18 involved in commercial sex is automatically a victim of human trafficking – no force or coercion is required.
2. Only foreign nationals/immigrants are trafficked in the United States.	In 2018, nearly 11,000 tips of human trafficking were reported and **at least 1,237 of these tips involved U.S. citizens or lawful permanent residents**.
3. Human trafficking and human smuggling are the same crime.	Human trafficking is **NOT** the same crime as human smuggling. Human trafficking is a violation of someone's human rights. Human smuggling is a violation of a country's immigration laws. A person can consent to being smuggled into the country; however, if that person is forced or coerced into commercial sex or labor/services, then they are a victim of human trafficking.

Figure 21 displays the top types of trafficking, venues/industries for labor and sex trafficking, and demographic information of Arizona victims in 2019.[lxxv]

Figure 21.



Equity

- **Racial Equity**

Racial equity was selected as a priority issue for CRMC. Racial equity is achieved when race no longer factors into or determines one's socioeconomic outcomes. It is when everyone has what they need to thrive, no matter where they live or how they identify. Working toward racial equity is one of the main pathways to achieving racial justice. Racial justice is defined as the systematic fair treatment of people of all races that results in all people – regardless of their race, ethnicity or the community in which they live – having equal access to opportunities.[lxxvii] The Racial Equity Index is a data tool designed to help communities identify priority areas for advancing racial equity, track progress over time, and set specific goals for closing racial gaps.

Figure 22 displays the City of Chandler's Racial Equity Index ranking in 2019 based on the inclusion score and prosperity scores.[lxxviii]

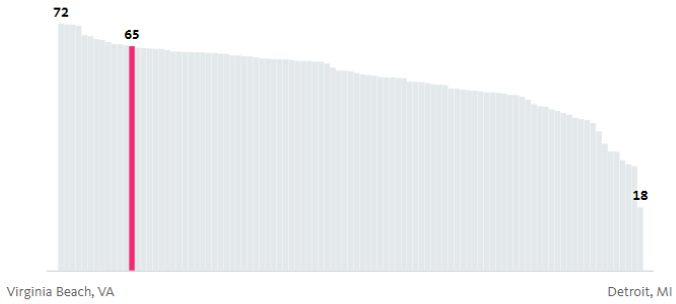
Figure 22.

Racial Equity Index ranking

Chandler, AZ ranks #13 out of 99 on the Racial Equity Index at the city level. In 2019, Virginia Beach, VA had the highest Racial Equity Index value of 72 and Detroit, MI had the lowest value of 18.

The Racial Equity Index value is based on the Inclusion score and the prosperity score, shown below.

Racial Equity Index, ranked: Chandler, AZ; 2019



Data source: National Equity Atlas

Inclusion score ranking

In 2019, Hialeah, FL had the highest Inclusion score value of 89 and Scottsdale, AZ had the lowest value of 29.

The overall Inclusion score is based on racial gaps in equity indicators from three categories: Economic Vitality, Readiness and Connectedness. See where Chandler, AZ ranks in the chart shown.

Inclusion score, ranked: Chandler, AZ; 2019

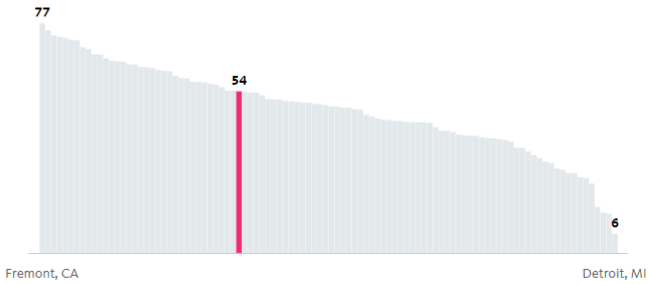
Data source: National Equity Atlas

Prosperity score ranking

In 2019, Fremont, CA had the highest Prosperity score value of 77 and Detroit, MI had the lowest value of 6. The overall Prosperity score is based on levels of equity indicators for the overall population from three categories: Economic Vitality, Readiness, and Connectedness.

See where Chandler, AZ ranks in the chart shown.

Prosperity score, ranked: Chandler, AZ; 2019



Data source: National Equity Atlas

- **Health Equity**

Health equity was selected as a priority issue for CRMC. According to the Robert Wood Johnson Foundation, "health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[xix] CommonSpirit leaders, clinicians and staff share a collective commitment to lead the nation in health equity.[lxxix] The Five Health Equity Priorities are designed to inspire, inform and enhance their work to:

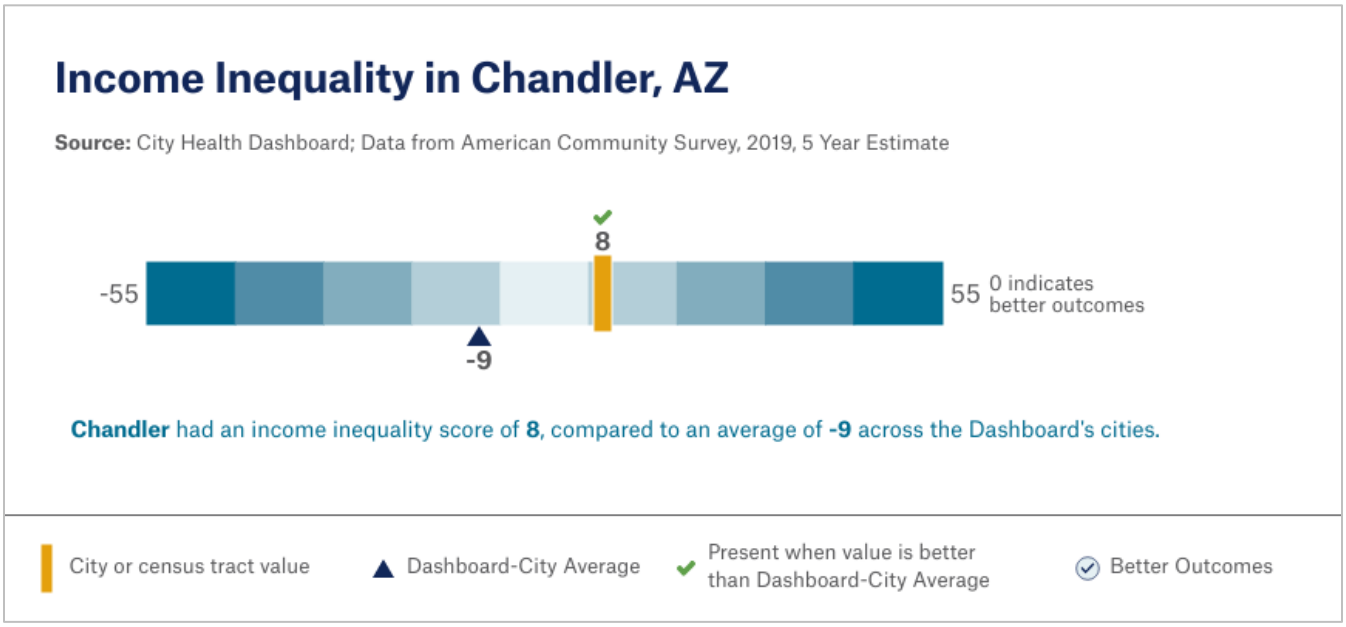
- **Transform from within.** Our purpose is to ensure that everyone belongs. We prioritize self-reflection and seek to radiate equity outward from our core. We practice inclusion, instill cultural competency, and train employees to recognize social determinants in diagnosis and treatment.
- **Build insights.** We prioritize designing interoperable data and analytics systems that measure health inequity and disparities and allow us to derive provable insights that will result in more equitable health outcomes for our patients.
- **Heal the whole person.** We prioritize adoption of existing and new clinical protocols focused on delivering equitable care and leveraging our size and scale to realize health equity within our own ministry and across the nation.
- **Partner with others.** We prioritize collaborating with like-minded partners to improve health and welfare for entire communities by developing joint programs with clear metrics for outcomes.
- **Advocate for justice.** As individuals and as a ministry, we prioritize working to enact meaningful policy and organizational actions that address health equity, social determinants of health and diversity issues.

Economic inequality has been growing and this trend has taken on a geographic dimension in the form of growing economic segregation – people who are economically privileged tend to reside in communities that are almost exclusively wealthy, while those who are deprived tend to reside in communities that are almost exclusively poor.[lxxx]

The City Health Dashboard measures income inequality through the Index of Concentration at the Extremes. For a given city or census tract, it compares the number of households in the bottom 20 percent of national household income to the number of households that fall in the top 20 percent of national household income. This number then describes the mix of household incomes in the area, ranging from -100 (all of the households are in the deprived category) to +100 (all of the households are in the privileged category), with 0 signifying that both income groups are present in equal numbers, or that none of the households fall somewhere in the middle.[lxxx]

Figure 23 shows the 2019 city value for income inequality in the City of Chandler.[lxxxi]

Figure 23.



A COVID-19 impact survey participant shared how the lack of equity in many areas has been challenging to watch:

> "The lack of equity in so many areas (health, safety, access to healthcare, housing access, education funding, wage equity, experiences with law enforcement, etc.) has been hard to watch."
>
> *45-54 years old, COVID-19 Impact Survey*

- **Social Equity**

Social equity was selected as a priority issue for CRMC. Social equity refers to all people experiencing impartiality, fairness, and justice in their daily lives. Social equity takes into account systemic inequalities to ensure everyone in a community has access to the same opportunities and outcomes. Policies promoting social equity address factors such as education, policing, welfare, housing, and transportation. Social equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.[xx]

A participant from the COVID-19 impact survey shared their insight regarding social justice issues throughout the pandemic:

> "…The social justice issues have been taxing. And now we have to push forward as if COVID never happened."
>
> *45-54 years old, COVID-19 Impact Survey*

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Reducing social vulnerability can decrease both human suffering and economic loss. The CDC/ATSDR Social Vulnerability Index (SVI) uses U.S. Census data to determine the social vulnerability of every census tract. Each census tract is ranked on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and grouped them into four related themes (socioeconomic status, household composition/disability, minority/language, and housing/transportation). Figures 24-27 display SVI maps of the four themes for the city of Chandler.[lxxxii]

Figure 24. Socioeconomic Status

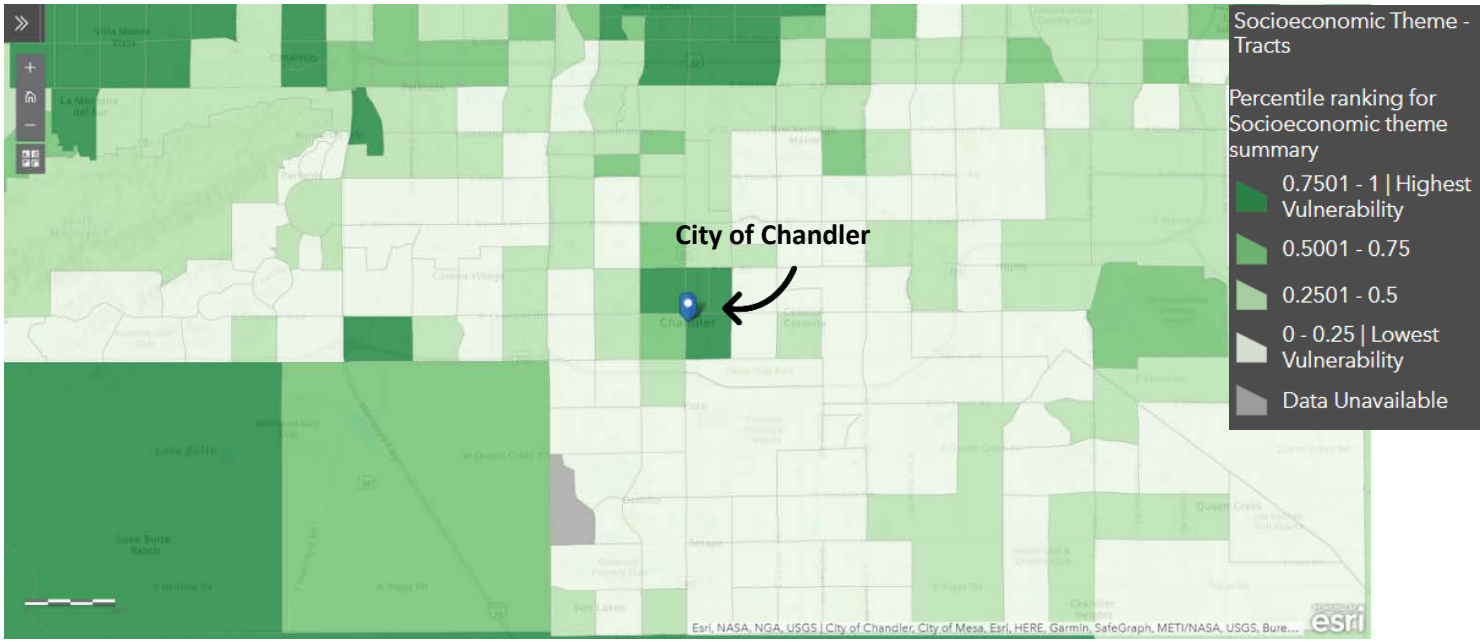


Figure 25. Household Composition/Disability

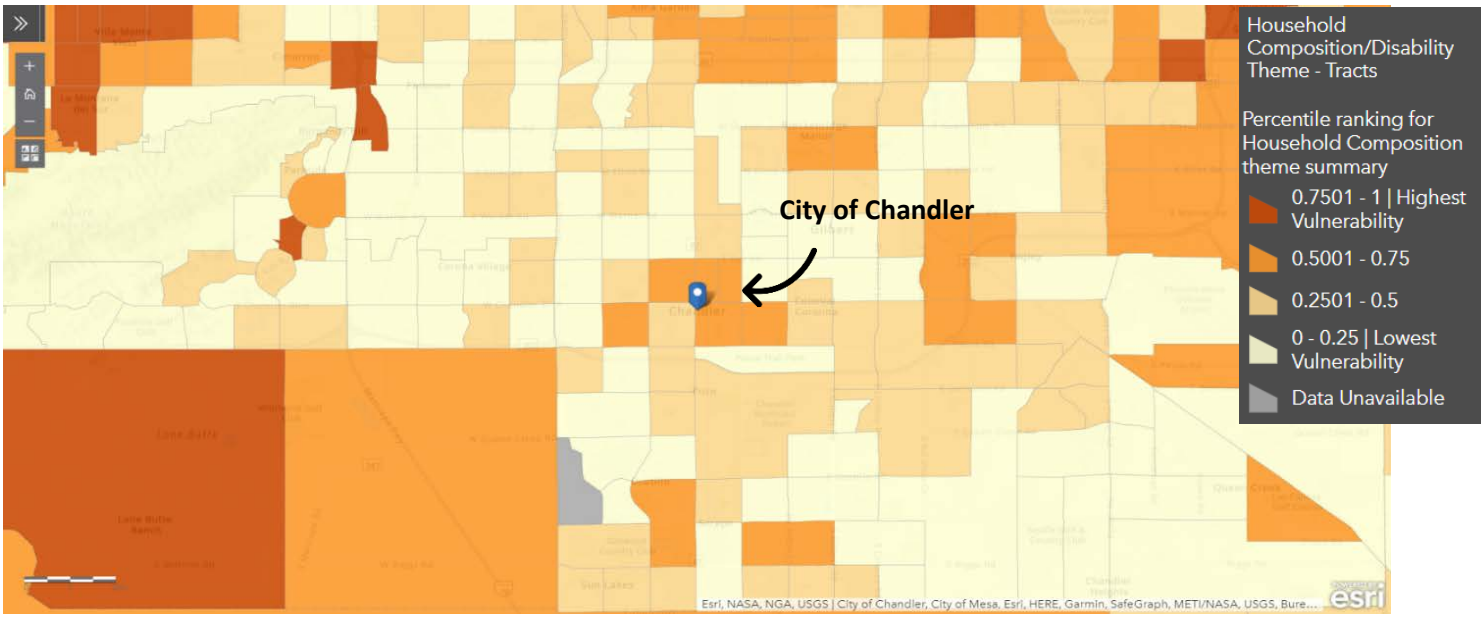


Figure 26. Minority/Language

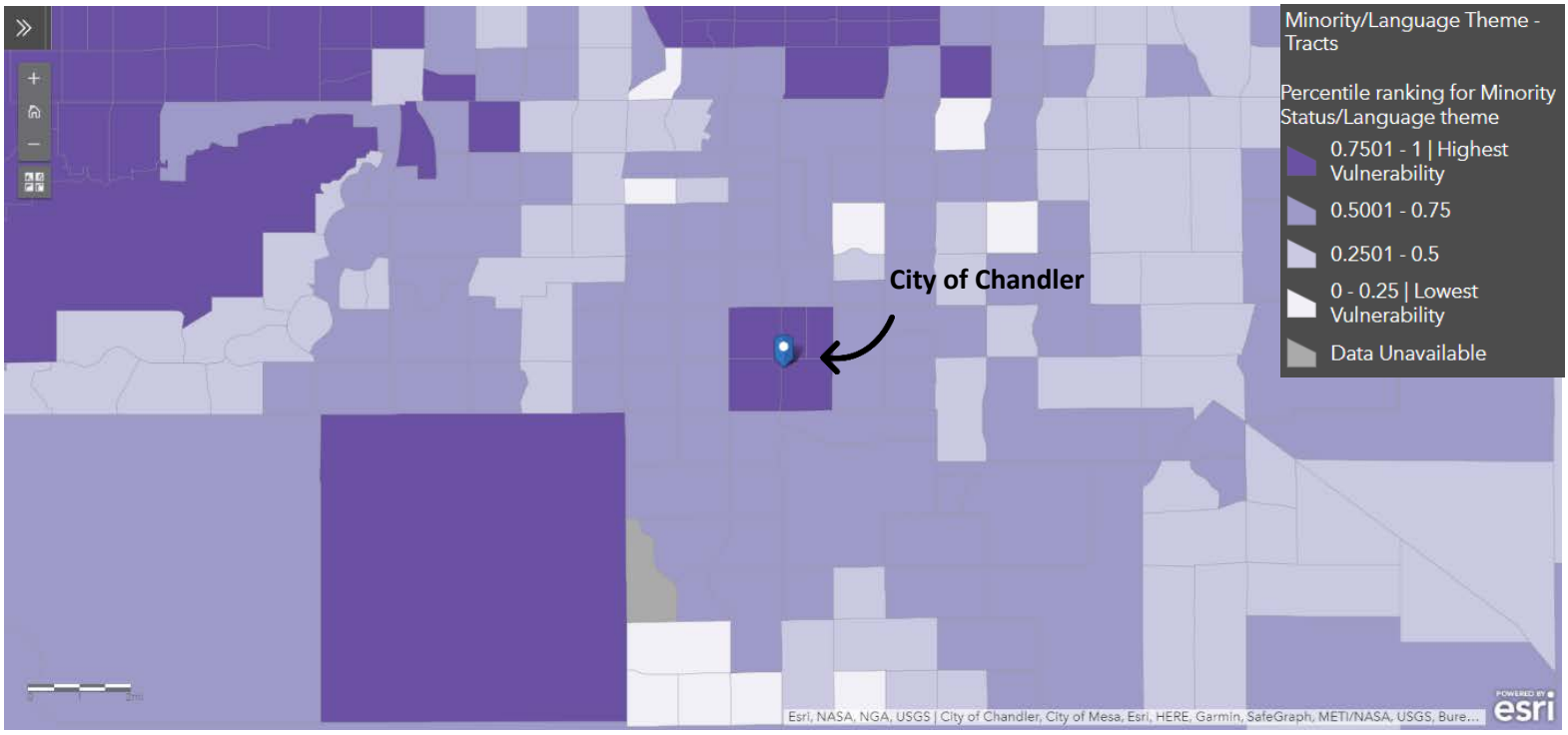
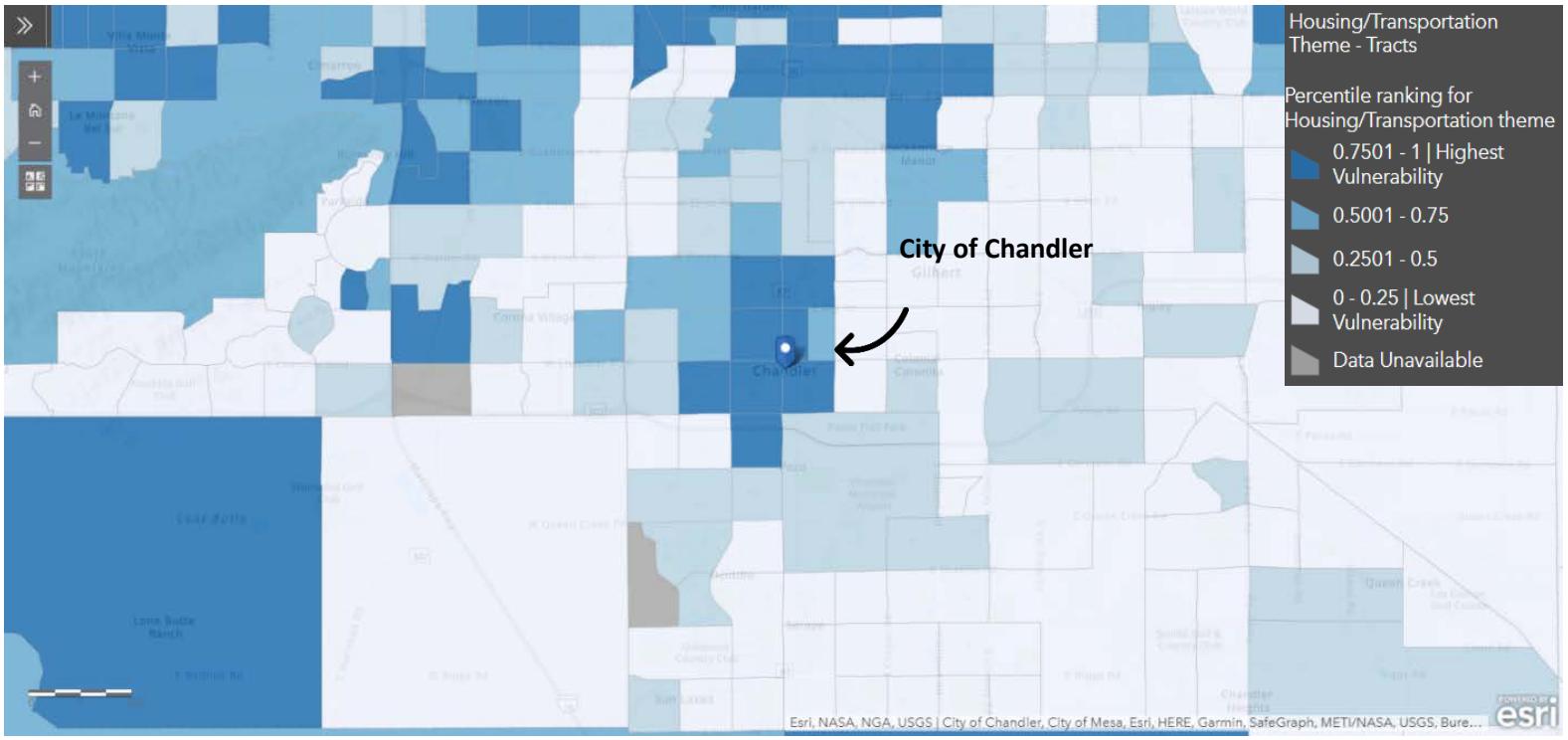


Figure 27. Housing/Transportation



Nutrition

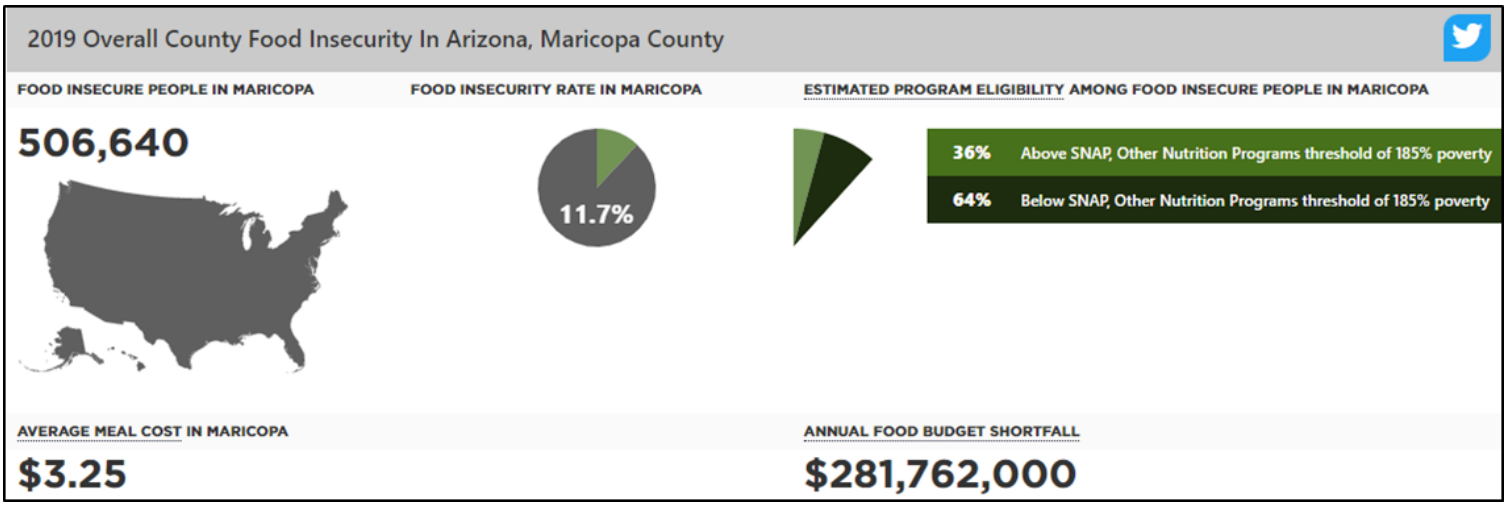
Food Access

Food access was selected as a priority issue for CRMC, as it continues to be a long-standing concern among many communities. Food insecurity does not exist in isolation, as low-income families are affected by multiple overlapping issues like affordable housing, economic/social disadvantage resulting from structural racism, chronic/acute health problems, high medical expenses, and low wages. COVID-19 has exposed and exacerbated serious disparities in food security due to employment issues, inflated prices, and food system interruptions.

In collaboration with the National Food Access and COVID-19 Research Team, Arizona State University's College of Health Solutions surveyed more than 600 households in Arizona from July 1 to August 10, 2020, to get a better understanding of the impact of COVID-19 on food insecurity in Arizona. Some key findings include that almost 1 in 3 (32%) of Arizona households experienced food insecurity since COVID-19 – a 28% increase from the year prior, when the food insecurity rate was 25%. Additionally, about 1 in 8 households bought food on credit (14%), borrowed money from friends and family for food (12%), and/or received food from food pantries (13%) during the pandemic.[lxxxiii] In summary, the percentage of households experiencing food insecurity increased by 7% during the pandemic, rising from 25% of households pre-pandemic to 32% of households during COVID-19.

In the 2021 COVD-19 impact survey, almost one-fifth (16.0%) of Maricopa County residents indicated that they sometimes or never had enough money to pay for essentials such as food since March of 2020. To assist with the essential cost of living expenses such as food, several Maricopa County residents indicated that since March of 2020 they applied for financial assistance such as Women, Infant, and Children (WIC) (2.0%) and SNAP food stamps (6.4%). Figure 28 displays the number of food insecure people, food insecurity rate, and the estimated program eligibility among food insecure people in Maricopa County. In 2019, the food insecurity rate in Maricopa County was 11.7% compared to Arizona's rate of 12.6%.[lxxxiv]

Figure 28.



Food hardships became very evident among many communities, especially throughout the pandemic. The following participant from the COVID-19 impact survey shared their experience about their financial struggle in attaining groceries:

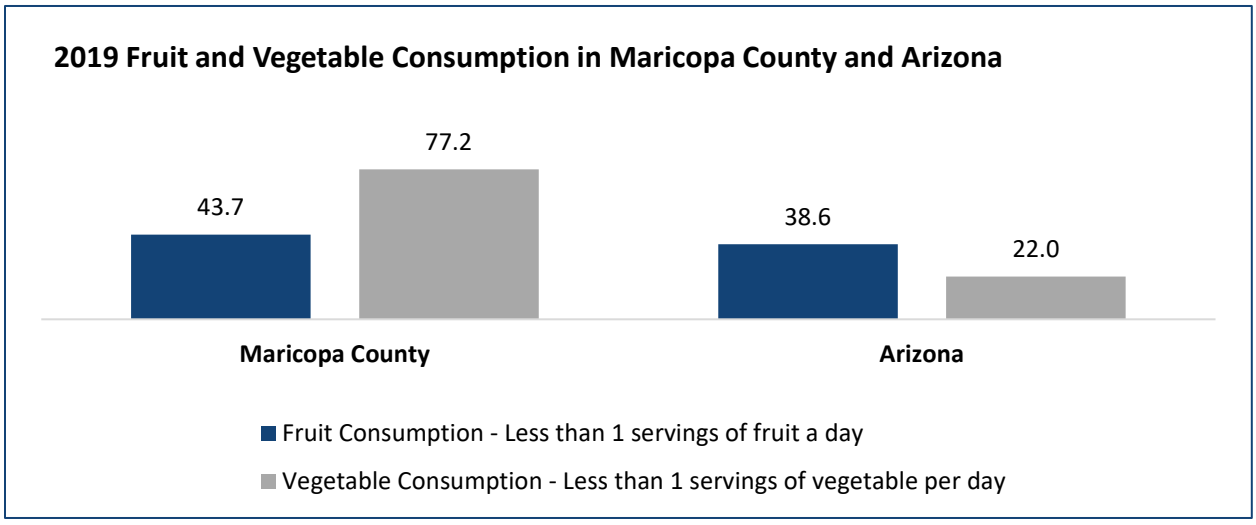
"During the pandemic due to the lack of money it was difficult to get food in stores, but I want to take a moment to say thank you to the people that donated food to food banks because thanks to them, my family was able to have meals and be able to stretch the money from the food stamps benefits. Thanks very much."

25-34 years old, COVID-19 Impact Survey

The consumption of a diet rich in fruits and vegetables can lower blood pressure, reduce the risk of heart disease and stroke, prevent some types of cancer, lower risk of eye and digestive problems, and have a positive effect upon blood sugar.[lxxxv]

Figure 29 displays fruit and vegetable consumption (less than 1 serving per day) in Maricopa County and Arizona.[xlix]

Figure 29.



Nutrition assistance also became a barrier for individuals and families as many programs failed to accommodate their needs.

This COVID-19 impact survey participant described their challenges in seeking nutrition assistance for their mother:

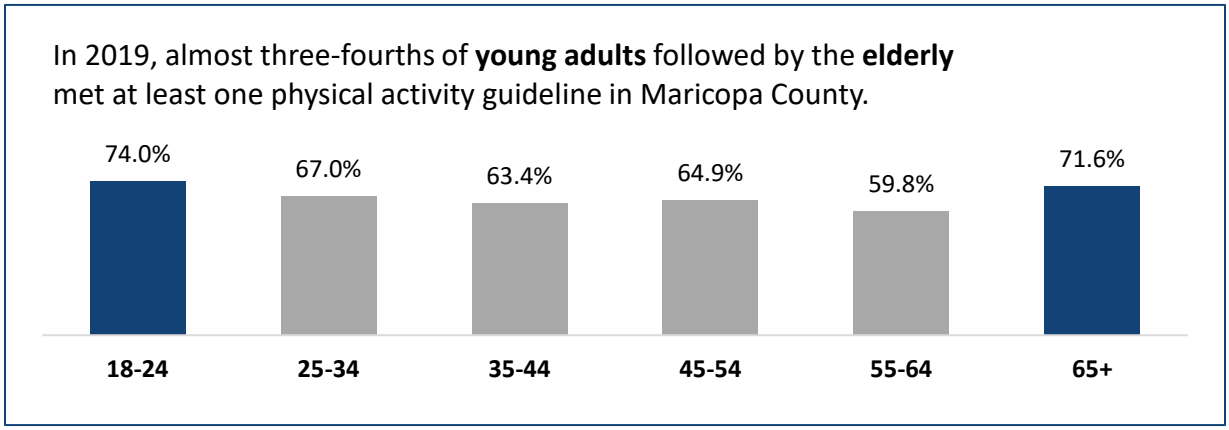
"The difficulty I have had trying to get government assistance for my elderly mother (82yrs old)… She needs SNAP but doesn't qualify and continually doesn't have money for food at the end of the month."

35-44 years old,
COVID-19 Impact Survey

- **Exercise**

Exercise was selected as a priority issue for CRMC. The evidence is clear - being physically active fosters healthy growth and development, improves overall health and well-being, and can reduce the burden of chronic diseases like heart disease, type 2 diabetes, obesity, and some cancers. For individuals with chronic disease, physical activity can help manage these conditions and complications. While it may be challenging to remain physically active while adhering to the COVID-19 pandemic precautions, it is possible and important.[lxxxvi] In 2019, Maricopa County residents aged 18-24 years followed by 65+ years had the greatest percentage of meeting at least one physical activity guideline, Figure 30.[xlix]

Figure 30.



In mid-2019, Vitalyst Health Foundation and Pinnacle Prevention partnered on a Rural Active Living Assessment with a desire to gain a better understanding of how rural communities support active lifestyles, what challenges and needs they are facing, and how philanthropic, nonprofit and government agencies can work alongside rural communities to strengthen their active living work. As part of a three phased approach, an online survey was disseminated through active living coalitions, key rural planning and transportation agencies, rural town leaders, and public health agencies.[lxxxvii]

Based on the 40 responses that were analyzed, respondents shared some top barriers to active living in rural Arizona:

- *Widespread and remote community members are hard to reach and serve.*
- *Local schools do not open their outdoor spaces to the community on evenings and weekends.*
- *People are not aware of the programs and services that support active living.*

This COVID-19 impact survey participant expressed how exercise became a challenge during the pandemic.

"The lack of exercise has weakened me. It has set me back years physically. Just started to go back feeling safe."

75+ years old,
COVID-19 Impact Survey

Resources Potentially Available to Address Needs

Resources potentially available to address identified needs include services and program available through hospital, government agencies, and community-based organizations. Resources include access to hospitals and hospital systems providing emergency care, acute care, outpatient services, and community programs:

- Dignity Health Chandler Regional Medical Center
- Dignity Health Mercy Gilbert Medical Center
- Dignity Health St. Joseph's Hospital and Medical Center
- Dignity Health St. Joseph's Westgate Medical Center
- Dignity Health Arizona General Hospital - Mesa
- Dignity Health Arizona General Hospital - Laveen
- Dignity Health Urgent Care(s)
- Dignity Health Arizona General Hospital - Emergency Room (13 Valley wide)
- Dignity Health Arizona Specialty Hospital
- Dignity Health Norton Thoracic Institute
- Dignity Health Heart Arrhythmia Center
- Dignity Health East Valley Rehabilitation Hospital
- OASIS Hospital
- Barrow Neurological Institute
- Banner Health
- HonorHealth
- Ironwood Cancer & Research Centers
- Mayo Clinic
- Phoenix Children’s Hospital
- Valleywise
- Abrazo

Impact of Actions Taken since the Preceding CHNA

From fiscal year 2019 through the fiscal year 2021, Dignity Health, Chandler Regional Medical Center provided $145,876,189 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other benefits. The hospital also incurred $108,553,551 in unreimbursed costs of caring for patients covered by Medicare. The number of persons served through financial assistance and other community health and benefit services over the last three years further demonstrates the impact Chandler Regional Medical Center has had in the community. Over 23,783 people received financial assistance and 116,119 people received care resulting in unreimbursed costs of Medicaid. In addition, approximately 257,065 people were served through other community health services.

Below is a listing of key community partners, Dignity Health Community of Care grantee recipients, and Dignity Health East Valley Community Health Outreach Programs that also had impact since the preceding CHNA.

A.T. Still University
About Care
ACZEND
Amanda Hope Rainbow Angels
Arizona Diabetes Foundation
Arizona Recovers
Aster Aging, Inc.
AZCEND
Biblical Counseling of Arizona
Big Brothers Big Sisters of Central Arizona (BBBSAZ)
Bring Change to Mind
CeCe's Hope Center
Chandler CARE Center
Chandler Coalition on Youth Substance Abuse
Chandler Education Foundation
Chandler I AM
Child Crisis Arizona
City of Chandler
City of Mesa
Dignity Health's Center for Diabetes Management
Dignity Health's Community Education
Dignity Health's Community Oral Health programs
Dignity Health's Community Wellness
East Valley Resource Coalition
Faithful City
FANS Across America Charitable Foundation
Foundation for Senior Living (FSL) – ACTIVATE
Haven 107
Homeward Bound
Hope for Addiction
Hope Women's Center
Horses Help
Hush-a-bye Nursery
ICAN: Positive Programs for Youth
Jesus Cares Ministries
Lalo Boy Foundation
Lutheran Social Services of the Southwest
Mesa Prevention Alliance
Mission of Mercy of AZ
Neighbors Who Care
notMYkid, Inc.
Pappas Kids Schoolhouse Foundation
Pregnancy Care Center of Arizona
Project25
One Small Step/ dba Clothes Cabin
Rebuilding Together Valley of the Sun
Sonoran Prevention Works
Southwest Behavioral and Health Services
Tempe Community Action Agency
Town of Gilbert
Town of Queen Creek
Women's Health Innovations of Az.
Y OPAS - Ahwatukee Foothills YMCA Outreach Program for Ahwatukee Seniors

Hospital Resources

The following hospital programs have resources potentially available to address the identified significant health needs. CRMC partners with various hospital departments to provide connected care to the Maricopa County community. Chandler Regional Medical Center's grants and investment programs provide funding to qualifying nonprofits in the local community, resulting in an expanded capacity to address health and social priorities.

Significant Health Needs	Dignity Health East Valley Programs

Mental Health and Suicide	• Community Health/ Education department programs:
	  o Support Group - Pregnancy and Postpartum
	  o Let's Talk (Perinatal Mood Disorder Therapy Group)
	  o Chandler Children's Medical Clinic
	• Support Group - Heaven's Hummingbirds, Maternal Child Health, Perinatal Bereavement Services (Remote and in – person available)
	• Chandler Regional Medical Center Emergency department:
	  o Zero Suicide - Prevention Program (hospital navigator)
	  o BRAVE Connections - Peer support for behavioral/ mental health ER patients
	• Care Coordination department - (NaviHealth (nH) referrals)
	  ACTIVATE program - (transitional care)

Substance Use	• BRAVE Connections - Peer support for substance use disorder ER patients • Care Coordination Department - (NaviHealth (nH) referrals) • ACTIVATE program - (transitional care) • Chandler Children's Medical Clinic • Collaborative partnership - Hushabye Nursery

Cancer	• Collaborative partnership - Amanda Hope Rainbow Angels (AHRA)
	• Collaborative partnership - Ironwood Cancer Center:
	  o Cancer Support Groups
	  o Breast Cancer Support Group, Caregiver Support Group, Look Good Feel Better Class, Prostate Cancer Support Group (US Too), Metastatic Cancer
	  o Integrative Services /Therapies
	  o Tai Chi Class, Chair Yoga Class, Massage Therapy
	  o Bra Fittings
	  o Wig Styling
	• Care Coordination department - (NaviHealth (nH) referrals)
	• ACTIVATE program- (transitional care)

	• Collaborative partnership - Mission of Mercy of Az. Mobile medical clinic • Chandler Children's Medical Clinic • Desert Cancer Foundation of Arizona • Chandler Regional Women's Imaging Center
Chronic Disease - Diabetes - Cardiovascular disease (CVD) - Obesity - Oral health	• Center for Diabetes Management: o 'A Sweet Life 'Outreach Group - meeting remotely o 'Pumpers' Support Group - meeting remotely o Type I, Type II, Gestational diabetes and Insulin management classes group and remote meetings o Healthy Easting, Active Living program (H.E.A.L) • Community Health department: o Chandler Children's Dental Clinics o Gilbert Children's Dental Clinics o First Teeth First program o Chandler Children's Medical Clinic • Yoga of the Heart • Chandler Regional Medical Center, Trauma Services department: Cardio Cerebral Resuscitation (CCR) program • Mission Integration - Faith Health Partnerships • Community Wellness department: o Healthier Living program o Diabetes Empowerment Education Program (DEEP) • Care Coordination department - (NaviHealth (nH) referrals) • ACTIVATE- (transitional care) • Collaborative partnership - Mission of Mercy of Az. Mobile medical clinic
Injury Prevention	• Chandler Regional Medical Center, Trauma Services department: o Car Seat Clinics o Distracted Driving program o First Aid Services o Matter of Balance o Stop The Bleed • Car Seat donation program • Care Coordination department - (NaviHealth (nH) referrals) • ACTIVATE - (transitional care) • Community Health department: o Chandler Children's Medical Clinic o Healthier Living program

Access to Care
- Immunization
	• Community Wellness department:
	  o Building Blocks for Children- Hearing and Vision screening
	  o Hearing and Vision screening adults
	  o Immunization program - children and adults
	• Community Health/ Education department programs:
	  o Support Group - Pregnancy and Postpartum
	  o Let's Talk (Perinatal Mood Disorder Therapy Group)
	• Care Coordination department:
	  o NaviHealth (nH) referrals
	  o Healthy Families program
	  o Taxi vouchers (patients discharge to home)
	• Center for Diabetes Management:
	  o 'A Sweet Life 'Outreach Group - meeting remotely
	  o 'Pumpers' Support Group - meeting remotely
	  o Type I, Type II, Gestational diabetes and Insulin management classes group and remote meetings
	  o Healthy Easting, Active Living program (H.E.A.L)
	• Community Health department:
	  o Chandler Children's Dental Clinics
	  o Gilbert Children's Dental Clinics
	  o First Teeth First program
	  o Chandler Children's Medical Clinic
	• Chandler Regional Medical Center Emergency department:
	  o Zero Suicide - Prevention Program (hospital navigator)
	  o BRAVE Connections - Peer support for behavioral/ mental health ER patients
	• Patient Financial Assistance Policy
	• ACTIVATE - (transitional care)
	• Homelessness patient transportation (Lyft ride voucher)
	• Collaborative partnership - Mission of Mercy of Az. Mobile medical clinic

Housing and Homelessness	• Care Coordination department:
	  o NaviHealth (nH) referrals
	  o Healthy Families program
	  o Taxi vouchers (patients discharge to home)
	• Collaborative partnership - House of Refuge
	• Collaborative partnership - AZCEND, Tempe Community Action Agency (TCAA) and Lutheran Social Services of the Southwest
	• Collaborative partnership - Chandler CARE Center (services and food bank)
	• ACTIVATE - (transitional care)
	• Homelessness patient transportation (Lyft ride voucher)

	• Collaborative partnership - Mission of Mercy of Az. Mobile medical clinic
Violence - Domestic violence - Human trafficking	• Care Coordination department: o NaviHealth (nH) referrals o Healthy Families program • Collaborative Partnership - Maricopa Family Advocacy Center • ACTIVATE - (transitional care) • Chandler Children's Medical Clinic • Human Trafficking Taskforce program • Community Health department: o Chandler and Gilbert Children's Dental Clinics o Chandler Children's Medical Clinic
Equity - Racial equity - Health equity - Social equity	• Care Coordination department - (NaviHealth (nH) referrals) • Community Grants Program • Community Investment Program • Community Sponsorships Program • East Valley Community Outreach Programs • Collaborative partnership - Mission of Mercy of Az. • Community Health department: o Chandler and Gilbert Children's Dental Clinics o Chandler Children's Medical Clinic
Nutrition - Food access - Exercise	• Community Health department: o Pregnancy and Postpartum Mommy Fit Camps o Healthy Easting, Active Living program H.E.A.L. o Chandler Children's Medical Clinic • Yoga of the Heart • Care Coordination department - (NaviHealth (nH) referrals) • ACTIVATE – (transitional care)

Community Resources

The following community organizations have resources potentially available to address the identified significant health needs. CRMC partners with several of these organizations to provide connected care to the Maricopa County community. Chandler Regional Medical Center's grants and investment programs provide funding to qualifying nonprofits in the local community, resulting in an expanded capacity to address health and social priorities.

Significant Health Needs	Resources

Mental Health and Suicide	• A New Leaf
	• Aris Foundation, Inc.
	• Arizona Recovers: BRAVE Connections & Zero Suicide
	• AZ Teen Crisis Solutions
	• AZCEND
	• Biblical Counseling of Arizona
	• Community Bridges, Inc.
	• Copper Springs East
	• CRISIS Line
	• East Valley Perinatal Network
	  o Women's Health Innovation
	  o Hushabye Nursery
	  o New Women's Center
	• East Valley Resource Coalition
	• EMPACT
	• Faithful City
	• Family Service Agency Counseling
	• GLSEN
	• Hope for Addiction
	• Jesus Cares Ministries
	• Jewish Family & Children's Services
	• Life Force Community Services
	• Lutheran Social Services of the Southwest
	• Maricopa Family Advocacy Center
	• Mercy Care
	• Mesa Prevention Alliance
	• Mission of Mercy of Az. Mobile medical clinic
	• NAMI Valley of the Sun
	• One- n –ten
	• Phoenix Children's Hospital
	• Southwest Behavioral and Health Services
	• Teen Lifeline, Inc.
	• Trevor Project

	• Tumbleweed.org
	• Youth Mental Health Collective
	  o notMYkid, Inc.
	  o Bring Change to Mind
	  o Lalo Boy Foundation

Substance Use	• A New Leaf • Aris Foundation, Inc. • Arizona Recovers • Biblical Counseling of Arizona • Bring Change to Mind • Chandler I AM • East Valley Resource Coalition • Hope for Addiction, Inc. • Hushabye Nursery • Jesus Cares Ministries • Mercy Care • Mesa Prevention Alliance • notMYkid, Inc. • Phoenix Children's Hospital • Valley of Hope
Cancer	• Amanda Hope Rainbow Angels (AHRA) • American Cancer Society • Cancer Support Community Arizona • Desert Cancer Foundation of Arizona • East Valley Resource Coalition • Mercy Care • Native Health Mesa • Phoenix Children's Hospital
Chronic Disease - Diabetes - Cardiovascular disease - Obesity - Oral health	• Arizona Diabetes Foundation • AZCEND • Brighter Way Institute • Chandler CARE Center • East Valley Resource Coalition • Heritage Center - Wellness, Education, and Resource Center • Mercy Care • Mission of Mercy of Az. • Phoenix Children's Hospital • Pan de Vida Foundation • Native Health Mesa • A.T. Still University School of Dentistry and Oral Health • St. Vincent de Paul

	• Adelante Healthcare • Mountain Park Health Center • NOAH Dental Clinics • Oakwood Creative Care
Injury Prevention	• About Care • Aster Aging, Inc. • Chandler Senior Center • City of Chandler Fire and Rescue Home Safety Evals • City of Mesa Fire and Rescue Home Safety Evals • City of Tempe Fire and Rescue Home Safety Evals • Compassion Connect AZ • East Valley Resource Coalition • Gilbert Community Center - Senior Center • Oakwood Creative Care • Partnership to Rebuild • Safe at Home • Town of Gilbert Fire and Rescue Home Safety Evals • Town of Queen Creek Fire and Rescue Home Safety Evals • Y-OPAS • Native Health Mesa • Ability 360 • Area Agency on Aging
Access to Care - Immunization	• Adelante Health Center, Mesa • Adelante Healthcare • AZCEND • Chandler CARE Center • Compassion Connect AZ • East Valley Resource Coalition • Heritage Center - Wellness, Education, and Resource Center • Lutheran Social Services of the Southwest (LSSSW) • Mission of Mercy • Mission of Mercy of Az. • Mountain Park Health Center • Mountain Park Health Center, Mesa • Native Health Mesa • Pan de Vida Foundation • St. Vincent de Paul • Tempe Community Action Agency (TCAA)

Housing and Homelessness	• A New Leaf • Aris Foundation • AZCEND • Chicanos Por La Causa, Inc. • Circle the City • Compassion Care Center • East Valley Resource Coalition • FANS Across America • Freedom House • House of Refuge • I-HELP • Lutheran Social Services of the Southwest (LSSSW) • Maggie's Place, Mesa & Tempe • Matthew's Crossing Food Bank • One Small Step | Clothes Cabin • Pan de Vida Foundation • SNAP Double up bucks • Sunshine Acres • Tempe Community Action Agency (TCAA) • Trellis
Violence - Domestic violence - Human trafficking	• A New Leaf • Adelante Healthcare • Bikers Against Child Abuse • CeCe's Hope Center • Chicanos Por La Causa, Inc. • Child Crisis Arizona • Compassion Connect • East Valley Resource Coalition • Freedom House • Maggie's Place • Maricopa Family Advocacy Center • Mercy Care • Mountain Park Health Center • St. Vincent de Paul • Trauma Informed Nutrition Initiative
Equity - Racial equity - Health equity - Social equity	• Boys To Men Mentoring Phoenix • Chandler Pride • City of Chandler, For Our City • East Valley Resource Coalition • Mercy Care • Mission of Mercy of Az.

	• one-n-ten • Teen Unity Board • Town of Gilbert Community Engagement Taskforce
Nutrition - Food access - Exercise	• About Care • Area Agency on Aging - Home Delivered Meals • Aster Aging • AZCEND • Chandler CARE Center • Chandler Senior Center • Compassion Care Center • East Valley Resource Coalition • Gilbert Senior Center • Heritage Center - Wellness, Education, and Resource Center • I-HELP • Matthew's Crossing Food Bank • Mercy Care - Farm Express • Oakwood Creative Care • Pan de Vida Foundation • Pinnacle Prevention o Active Living in Arizona's Rural Communities o SNAP Double Up Food Buck o Arizona Farmers Market Nutrition Program o Trauma Informed Nutrition Initiative

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