2021 COMMUNITY HEALTH NEEDS ASSESSMENT

TPMC Service Area Service Area

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HonorHealth Scottsdale Thompson Peak Medical Center

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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of HonorHealth Scottsdale Thompson Peak Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of HonorHealth Scottsdale Thompson Peak Medical Center by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

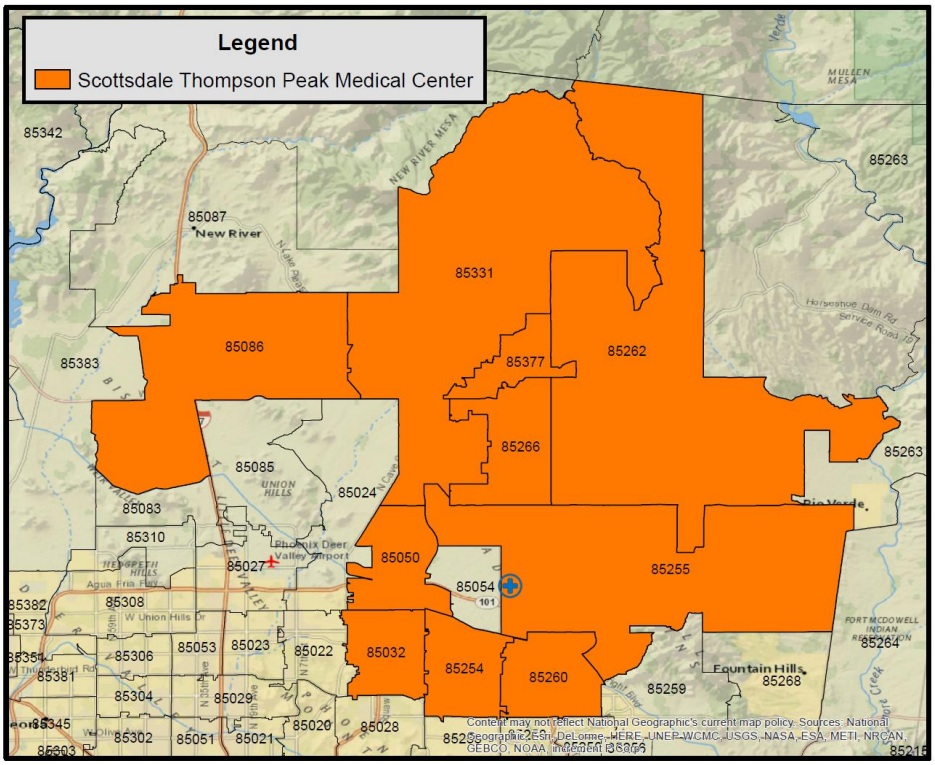
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by HonorHealth Scottsdale Thompson Peak Medical Center and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “TPMC Service Area” in this report) was determined based on the top 10 residential ZIP Codes contributing to 2018-2019 inpatient admissions and is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 357 individuals age 18 and older in the TPMC Service Area. This strata of surveys was part of a broader effort by HonorHealth to measure the various communities served by all of its hospitals throughout the greater Phoenix area.

Once the TPMC Service Area interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the service area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

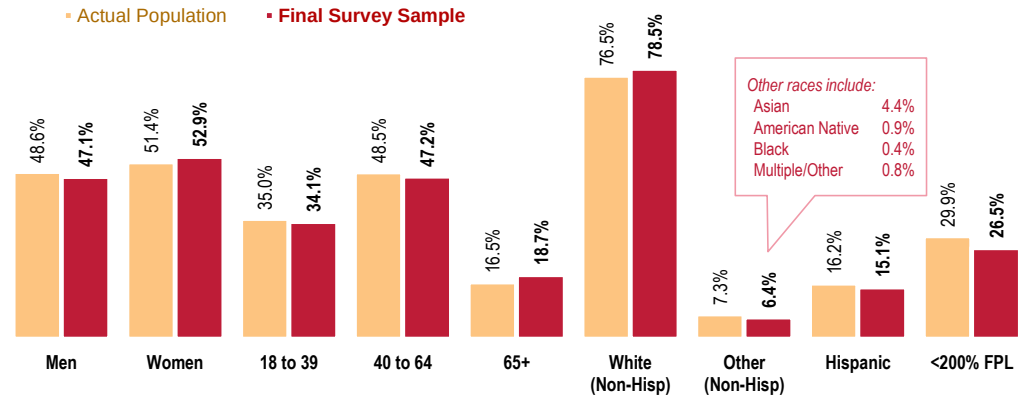
For statistical purposes, the maximum rate of error associated with a sample size of 357 respondents is ±5.2% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the TPMC Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(TPMC Service Area, 2021)



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2021 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2020 guidelines place the poverty threshold for a family of four at $26,200 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. The sample size of this study allows for two race/ethnicity segments. "White" reflects non-Hispanic White respondents; all other respondents (including Hispanic and non-White race groups) are grouped as "Communities of Color."

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by HonorHealth; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 150 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	35
Public Health Representatives	6
Other Health Providers	45
Social Services Providers	25
Other Community Leaders	39

Final participation included representatives of the organizations outlined below.

- A Place for Mom
- Ability 360
- Acacia Health Center
- Advanced Health Care of Mesa
- Advanced Health Care of Scottsdale
- AHMA
- Alliance of Arizona Nonprofits
- AM Nutrition Services
- American Heart Association, Greater Phoenix Division
- Arizona ACEs Consortium
- Arizona Alliance for Community Health Centers
- Arizona Association for the Education of Young Children
- Arizona Community Foundation
- Arizona Food Bank Network
- Arizona Home Care
- Arizona Housing Coalition
- Arizona State University
- Arizona Technology Council
- Aspen Infusion
- Assisteo Home Health
- AZ Partnership for Healthy Communities
- Camelback Fiduciary
- Canyon Home Care
- Centrix–Doves at Home Senior Care
- Chicanos Por La Causa
- Christian Health Care Center
- City of Scottsdale
- Community Bridges (CBI)
- Congregation Beth Israel
- Crossing Hospice Care (Thema)
- Curahealth
- Department of Economic Security
- Desert Mission
- Dispatch Health
- Duet: Partners In Health & Aging
- Elite Senior Services
- Empower Physical Therapy
- Encompass Health Valley of the Sun Rehabilitation Hospital
- ENSIGN–Bella Vita Health & Rehab Center
- ENSIGN–Coronado Care Center
- External Physician
- First Things First
- Foothills Caring Corps
- Free Arts Arizona
- Friendly House
- Girl Scouts Cactus Pine Council
- Global Rehab (DBA Honor Health Acute Rehab)
- Greater Phoenix Urban League
- Helios Foundation
- Hero Life Network
- Hickey Family Foundation
- Home Watch Caregivers
- Hospice Family Care (Kindred at Home)
- Hospice of the Valley

- Hospice of the Valley Geriatric Solutions
- Human Services Campus
- Innovation Care Partners
- Jewish Family & Children's Service
- Jewish Federation of Greater Phoenix
- Justa Center
- Kindred at Home
- Maricopa County Public Fiduciary Office
- NAACP of the Phoenix Region
- Native American Solutions
- Neighborhood Outreach Access Health
- Nina Pulliam Trust
- Paradise Valley Unified School District
- Phoenix Chamber of Commerce
- Providence Place (Glencroft)
- Quail Run Behavioral Health
- Read Arizona
- Read Better Be Better
- Reveille Foundation
- Saint Joseph the Worker
- Salt River Fire Department
- Salt River Police Department
- Salvation Army
- Savior Hospice & Palliative Care
- Scottsdale Community College
- Scottsdale Eye Surgery Center
- Scottsdale Leadership
- Seasons Hospice and Palliative
- Select Specialty Hospital–Phoenix Downtown
- Southland Geriatric & Palliative
- Southland Hospice
- Steele Foundation
- The Center at Arrowhead
- The Rehabilitation Center at The Palazzo
- The Scottsdale Charros and The Charro Foundaton
- The Terraces of Phoenix
- Traditions Health
- Traditions Hospice of Arizona (I,II,III)
- Upward Arizona
- Valle Del Sol (FQHC)
- Valley of the Sun United Way
- Valleywise Health
- Vi at Grayhawk
- Virginia G. Piper Charitable Trust
- Virtis Health
- Vitaylst Health Foundation
- Waste Not Arizona
- Wells Fargo Bank
- YWCA

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE ► These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the TPMC Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Arizona Department of Health Services
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect Maricopa County data.

Benchmark Data

Arizona Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

HonorHealth Scottsdale Thompson Peak Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, HonorHealth Scottsdale Thompson Peak Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. HonorHealth Scottsdale Thompson Peak Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	28
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	129
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	12
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	13
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	138

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Appointment Availability – Finding a Physician ▪ Routine Medical Care
CANCER	▪ Leading Cause of Death
DIABETES	▪ Kidney Disease Deaths ▪ Prevalence of Borderline/Pre-Diabetes
HEART DISEASE & STROKE	▪ Leading Cause of Death
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Falls [Age 65+] Deaths
MENTAL HEALTH	▪ “Fair/Poor” Mental Health ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Overweight & Obesity ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
POTENTIALLY DISABLING CONDITIONS	▪ Alzheimer’s Disease Deaths
RESPIRATORY DISEASE	▪ Pneumonia/Influenza Deaths ▪ Key Informants: COVID-19 ranked as a top concern.
SUBSTANCE ABUSE	▪ Unintentional Drug-Related Deaths ▪ Key Informants: Substance abuse ranked as a top concern.

Prioritization of Health Needs

On May 11, 2021, the HonorHealth CHNA Steering Committee (representing HonorHealth Scottsdale Thompson Peak Medical Center and other HonorHealth hospitals) held an online meeting to review, evaluate, and discuss the significant health issues identified for each of the hospital service areas and for the region overall, based on findings of this Community Health Needs Assessment (CHNA). The committee also considered community feedback on prioritization received from community stakeholders in the Online Key Informant Survey process. Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA. Following the data review, PRC answered any questions and participated in a discussion of the issues raised.

On May 25, 2021, the committee reconvened a second online meeting to take part in a process to prioritize identified health issues based on the data review and input from community stakeholders. In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting platform was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- SCOPE & SEVERITY ► The first rating was to gauge the magnitude of the problem in consideration of the following:
    - *How many people are affected?*
    - *How does the local community data compare to state or national levels, or Healthy People 2030 targets?*
    - *To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?*

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).
- ABILITY TO IMPACT ► A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. For HonorHealth Scottsdale Thompson Peak Medical Center, this process yielded the following prioritized list of community health needs:

1. Mental Health
2. Access to Health Care Services
3. Substance Abuse
4. Heart Disease & Stroke
5. Diabetes
6. Nutrition, Physical Activity & Weight
7. Respiratory Disease
8. Cancer
9. Injury & Violence
10. Potentially Disabling Conditions

Hospital Implementation Strategy

HonorHealth Scottsdale Thompson Peak Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the TPMC Service Area. These data are grouped by health topic.

Reading the Summary Tables

- In the following tables, TPMC Service Area results are shown in the larger, gray column.
- The columns to the right of the TPMC Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Trends for secondary data indicators are also shown (trends are not available for survey-derived indicators). Symbols indicate whether the TPMC Service Area compares favorably (🌞), unfavorably (🌺), or comparably (☁) to these external data.

SECONDARY DATA INDICATORS:

Trends for secondary data indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that secondary data reflect county-level data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	3.7	3.6	4.3		
Population in Poverty (Percent)	13.8	15.2	13.4	8.0	
Children in Poverty (Percent)	19.8	21.5	18.5	8.0	
No High School Diploma (Age 25+, Percent)	12.3	12.9	12.0		
% Unable to Pay Cash for a $400 Emergency Expense	16.7		24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	30.9		32.2		
% Worry/Stress Over Utility Bills in Past Year	26.8				
% Transportation Prevented Access to Work or Appointment/Past Yr	8.3				
% Unhealthy/Unsafe Housing Conditions	11.6		12.2		
% Food Insecure	22.9		34.1		
% 4+ Adverse Childhood Experiences (High ACEs Score)	21.1		16.3		

better similar worse

OVERALL HEALTH	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	10.0	19.0	12.6		

better similar worse

ACCESS TO HEALTH CARE	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**6.7**	18.7	8.7	7.9	
% Difficulty Accessing Health Care in Past Year (Composite)	**43.9**		35.0		
% Cost Prevented Physician Visit in Past Year	**12.6**	13.9	12.9		
% Cost Prevented Getting Prescription in Past Year	**10.0**		12.8		
% Difficulty Getting Appointment in Past Year	**23.8**		14.5		
% Inconvenient Hrs Prevented Dr Visit in Past Year	**11.1**		12.5		
% Difficulty Finding Physician in Past Year	**13.5**		9.4		
% Transportation Hindered Dr Visit in Past Year	**6.0**		8.9		
% Language/Culture Prevented Care in Past Year	**1.4**		2.8		
% Skipped Prescription Doses to Save Costs	**9.0**		12.7		
Primary Care Doctors per 100,000	**70.0**	66.2	76.6		
% Have a Specific Source of Ongoing Care	**75.5**		74.2	84.0	
% Have Had Routine Checkup in Past Year	**59.5**	73.8	70.5		
% Two or More ER Visits in Past Year	**7.2**		10.1		
% Eye Exam in Past 2 Years	**57.3**		61.0	61.1	
% Rate Local Health Care “Fair/Poor”	**8.8**		8.0		

better similar worse

CANCER	TPMC	TPMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	130.3	132.9	149.3	122.7	147.8
Lung Cancer (Age-Adjusted Death Rate)	27.0	27.9	34.9	25.1	
Prostate Cancer (Age-Adjusted Death Rate)	16.3	16.7	18.6	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)	18.4	17.9	19.7	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)	12.4	12.5	13.4	8.9	
Cancer Incidence Rate (All Sites)	394.2	386.7	448.7		
Female Breast Cancer Incidence Rate	121.5	114.4	125.9		
Prostate Cancer Incidence Rate	84.9	79.2	104.5		
Lung Cancer Incidence Rate	46.4	46.8	58.3		
Colorectal Cancer Incidence Rate	32.8	32.6	38.4		
% Cancer	9.3	14.0	10.0		
% [Women 50-74] Mammogram in Past 2 Years	82.1	73.1	76.1	77.1	
% [Women 21-65] Cervical Cancer Screening	86.8	78.0	73.8	84.3	
% [Age 50-75] Colorectal Cancer Screening	74.9	67.0	77.4	74.4	
		better	similar	worse	

DIABETES	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	22.2	23.2	21.5		22.8
% Diabetes/High Blood Sugar	8.3	10.9	13.8		
% Borderline/Pre-Diabetes	15.7		9.7		
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	46.7		43.3		

better similar worse

HEART DISEASE & STROKE	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	134.0	137.4	163.4	127.4	138.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	2.7	6.4	6.1		
Stroke (Age-Adjusted Death Rate)	30.4	30.7	37.2	33.4	29.1
% Stroke	2.8	3.5	4.3		
% Told Have High Blood Pressure	29.3	32.5	36.9	27.7	
% Told Have High Cholesterol	33.8		32.7		
% 1+ Cardiovascular Risk Factor	75.6		84.6		

better similar worse

INFANT HEALTH & FAMILY PLANNING	TPMC	TPMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent)	25.1	27.8	22.5		23.8
Low Birthweight Births (Percent)	7.5	7.6	8.3		7.0
Infant Death Rate	5.1	5.4	5.6	5.0	5.9
Births to Adolescents Age 15 to 19 (Rate per 1,000)	26.0	27.4	22.7	31.4	
		better	similar	worse	

INJURY & VIOLENCE	TPMC	TPMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	54.6	56.8	48.9	43.2	42.7
Motor Vehicle Crashes (Age-Adjusted Death Rate)	11.1	13.3	11.3	10.1	
[65+] Falls (Age-Adjusted Death Rate)	91.4	84.5	65.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)	13.8	15.4	11.9	10.7	
Homicide (Age-Adjusted Death Rate)	6.0	6.2	6.1	5.5	5.9
Violent Crime Rate	447.8	482.6	416.0		
% Victim of Violent Crime in Past 5 Years	1.7		6.2		
% Victim of Intimate Partner Violence	17.0		13.7		
% Threatened with Physical Violence by Member of HH	6.8				
		better	similar	worse	

KIDNEY DISEASE	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	5.8	7.3	12.9		3.3
% Kidney Disease	3.1	4.2	5.0		

better similar worse

MENTAL HEALTH	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	20.9		13.4		
% Diagnosed Depression	24.0	16.8	20.6		
% Symptoms of Chronic Depression (2+ Years)	35.3		30.3		
% Typical Day Is "Extremely/Very" Stressful	20.5		16.1		
% Felt Out of Control Over the Important Things/Past Year	34.8				
% "Sometimes/Rarely/Never" Have Someone To Turn To	25.8				
Suicide (Age-Adjusted Death Rate)	15.7	18.7	14.0	12.8	15.4
Mental Health Providers per 100,000	46.4	22.1	42.6		
% Taking Rx/Receiving Mental Health Trtmt	15.1		16.8		
% Unable to Get Mental Health Svcs in Past Yr	6.9		7.8		
% 4+ Adverse Childhood Experiences (High ACEs Score)	21.1		16.3		

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	TPMC	TPMC vs. BENCHMARKS			TREND
		vs. AZ	vs. US	vs. HP2030	
Population With Low Food Access (Percent)	**19.8**	26.2	22.4		
% “Very/Somewhat” Difficult to Buy Fresh Produce	**14.6**		21.1		
% 5+ Servings of Fruits/Vegetables per Day	**28.2**		32.7		
% No Leisure-Time Physical Activity	**15.3**	24.1	31.3	21.2	
% Meeting Physical Activity Guidelines	**32.2**	25.5	21.4	28.4	
% Overweight (BMI 25+)	**57.3**	65.7	61.0		
% Obese (BMI 30+)	**21.4**	31.4	31.3	36.0	
		better	similar	worse	

ORAL HEALTH	TPMC	TPMC vs. BENCHMARKS			TREND
		vs. AZ	vs. US	vs. HP2030	
% Have Dental Insurance	**70.7**		68.7	59.8	
% [Age 18+] Dental Visit in Past Year	**65.7**	62.3	62.0	45.0	
		better	similar	worse	

POTENTIALLY DISABLING CONDITIONS	TPMC	TPMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	23.6		32.5		
% Activity Limitations	22.1		24.0		
% With High-Impact Chronic Pain	15.8		14.1	7.0	
Alzheimer's Disease (Age-Adjusted Death Rate)	37.1	33.5	30.4		43.2
% Caregiver to a Friend/Family Member	19.0		22.6		
		better	similar	worse	

RESPIRATORY DISEASE	TPMC	TPMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)	38.0	40.7	39.6		42.5
Pneumonia/Influenza (Age-Adjusted Death Rate)	10.0	10.9	13.8		6.9
% [Age 65+] Flu Vaccine in Past Year	82.4	60.9	71.0		
% Would Accept a COVID-19 Vaccination	74.5				
% [Adult] Asthma	9.4	9.7	12.9		
% COPD (Lung Disease)	5.2	6.7	6.4		
		better	similar	worse	

SEXUAL HEALTH	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
HIV/AIDS (Age-Adjusted Death Rate)	1.5	1.4	1.9		
HIV Prevalence Rate	310.3	276.9	372.8		
Chlamydia Incidence Rate	614.4	581.6	539.9		
Gonorrhea Incidence Rate	206.4	183.4	179.1		
		better	similar	worse	

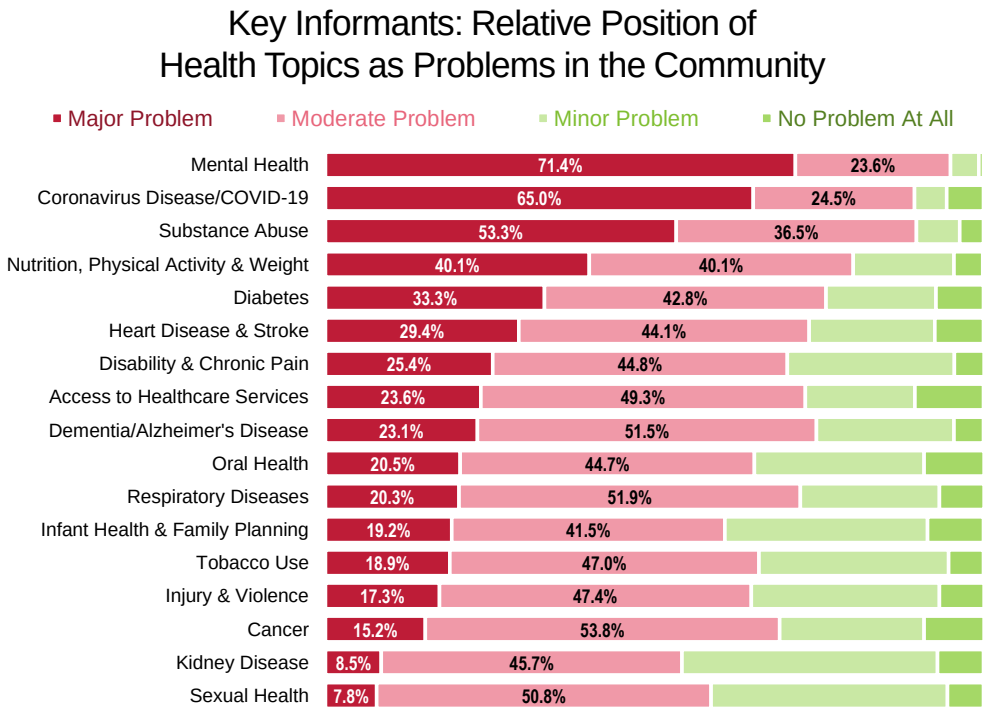
SUBSTANCE ABUSE	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	11.5	14.3	11.1	10.9	10.9
% Excessive Drinker	25.9	16.5	27.2		
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	22.2	21.3	18.8		12.1
% Illicit Drug Use in Past Month	0.6		2.0	12.0	
% Used a Prescription Opioid in Past Year	13.8		12.9		
% Ever Sought Help for Alcohol or Drug Problem	7.1		5.4		
% Personally Impacted by Substance Abuse	38.3		35.8		
		better	similar	worse	

TOBACCO USE	TPMC	TPMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
% Current Smoker	**11.5**	14.9	17.4	5.0	
% Someone Smokes at Home	**7.7**		14.6		
% Currently Use Vaping Products	**8.6**	5.3	8.9		

better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density, [COUNTY-LEVEL DATA]

Total Population
(Estimated Population, 2015-2019)

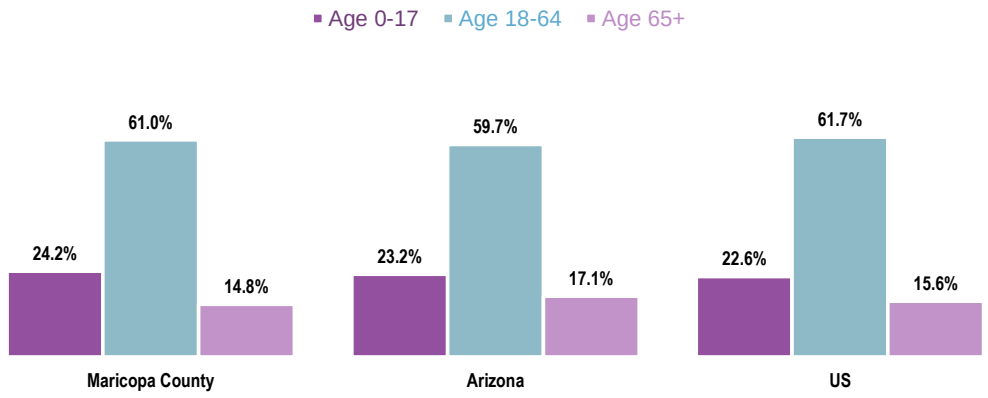
	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Maricopa County	4,328,810	9,199.25	470.56
Arizona	7,050,299	113,590.70	62.07
United States	324,697,795	3,532,068.58	91.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]

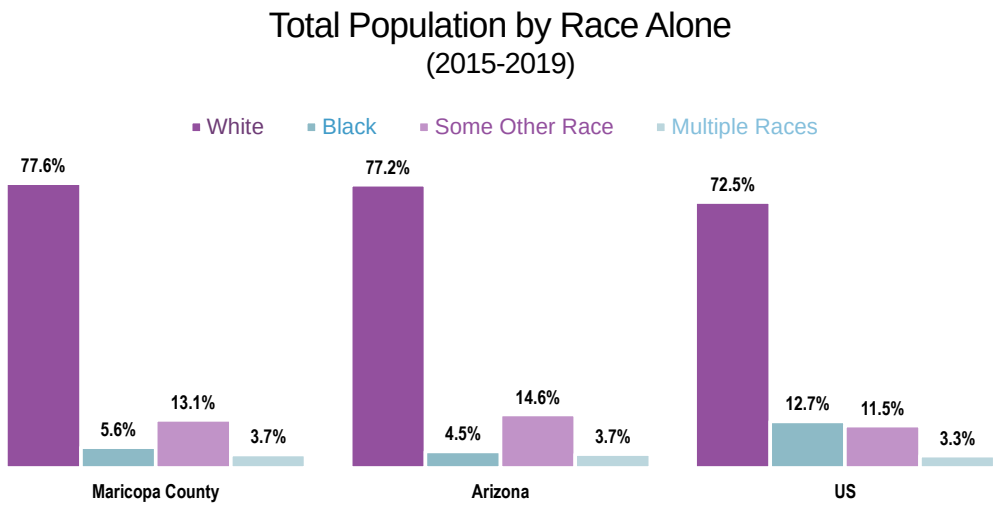
Total Population by Age Groups
(2015-2019)



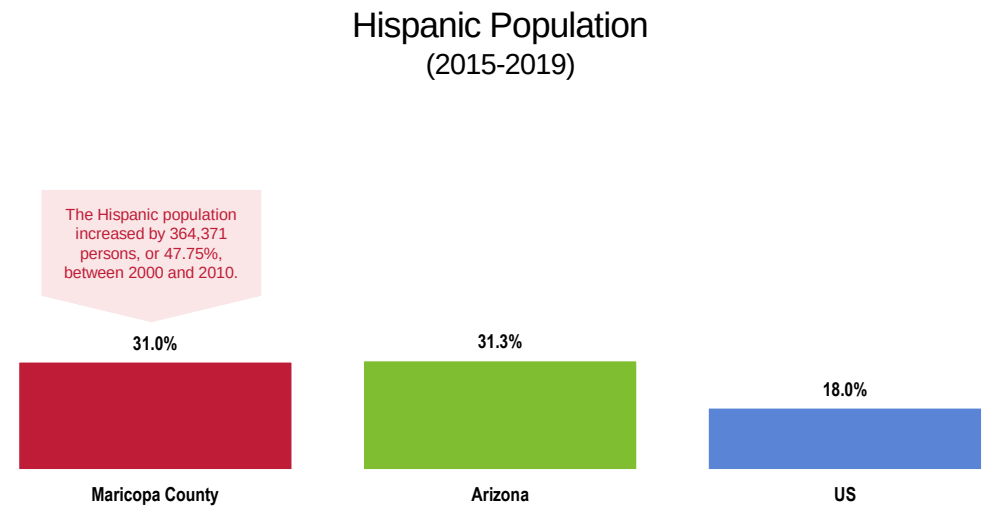
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

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.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

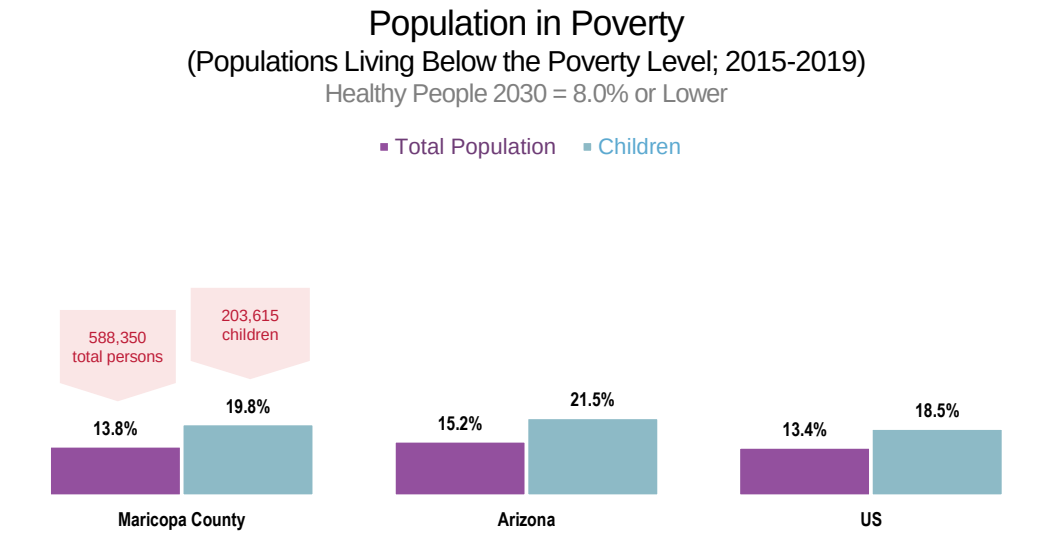
Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



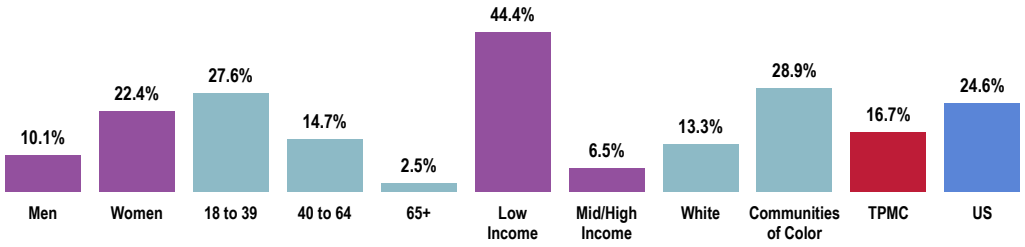
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(TPMC Service Area, 2021)



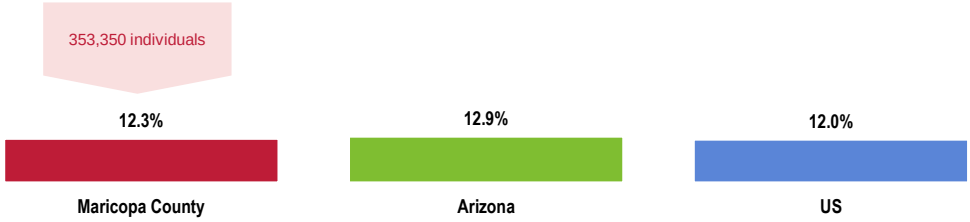
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Education

Education levels are reflected in the proportion of our population without a high school diploma. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

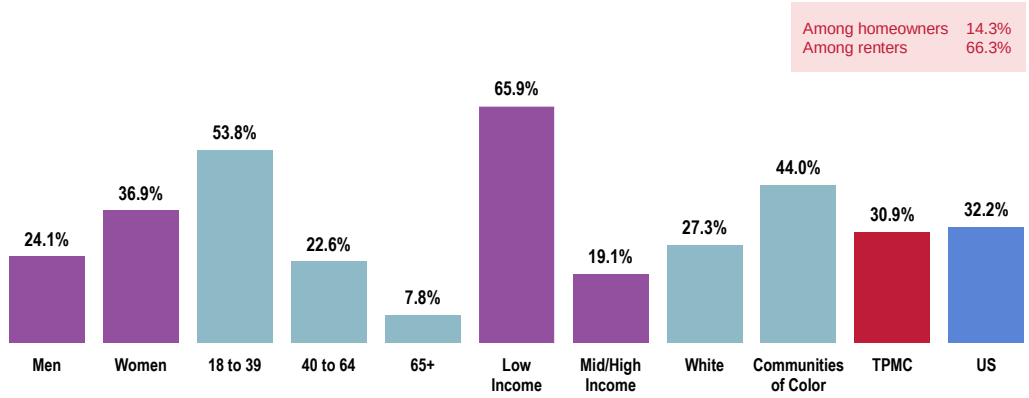
Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

Housing

Housing Insecurity

"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

"Always/Usually/Sometimes" Worried
About Paying for Rent or Mortgage in the Past Year
(TPMC Service Area, 2021)

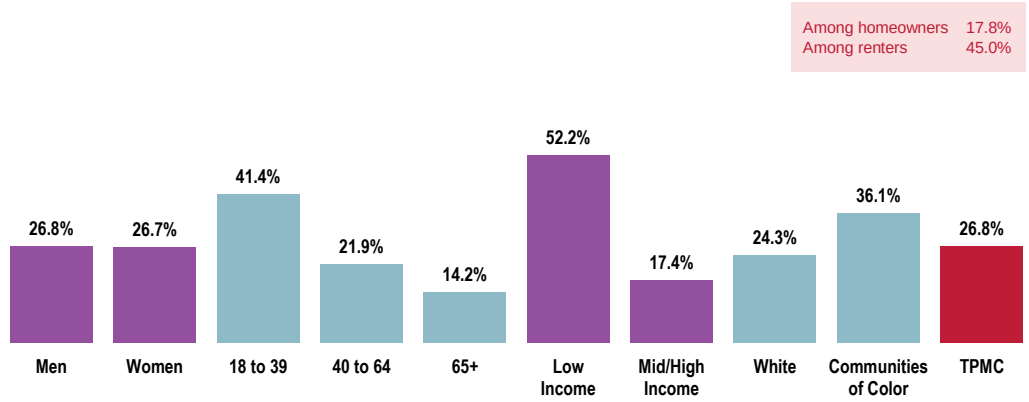


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Utilities

"In the past 12 months, how often were you worried or stressed about having enough money to pay your utility bills, such as water, electric, gas, etc.? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

"Always/Usually/Sometimes" Worried
About Paying for Utilities in the Past Year
(TPMC Service Area, 2021)

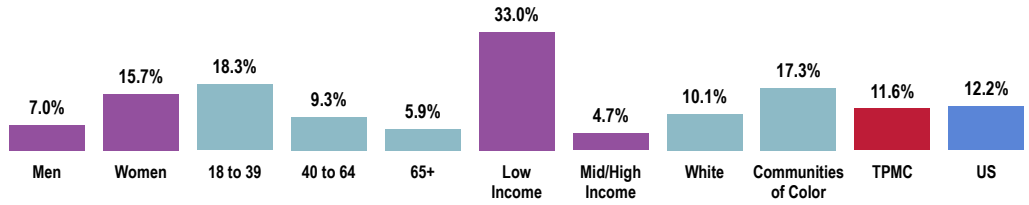


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: • Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(TPMC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

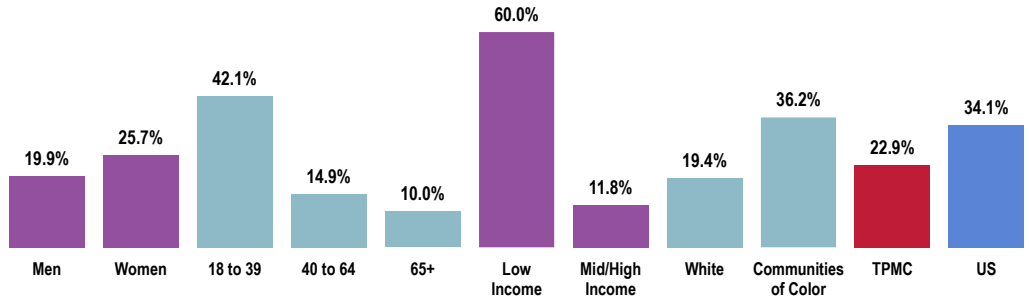
Food Insecurity

"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity
(TPMC Service Area, 2021)



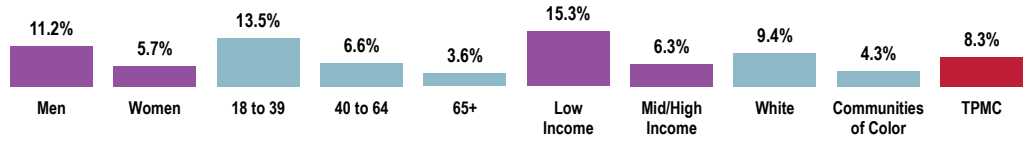
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Transportation

"Was there a time during the past 12 months when a lack of transportation made it difficult or prevented you from going to work or getting to a scheduled appointment?"

Lack of Transportation Prevented Going to Work or Getting to a Scheduled Appointment in the Past Year
(TPMC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 304]

Notes:
- Asked of all respondents.

Adverse Childhood Experiences (ACEs)

ABOUT ACEs

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They are a significant risk factor for substance abuse disorders and can impact prevention efforts. ACEs include:

- Physical abuse or neglect
- Emotional abuse or neglect
- Sexual abuse
- Intimate partner violence
- Household substance misuse
- Household mental illness
- Parental separation/divorce
- Incarcerated household member

A series of 11 survey questions was used to identify adults' experiences of adverse childhood events prior to the age of 18 years. These 11 questions align with eight ACEs categories.

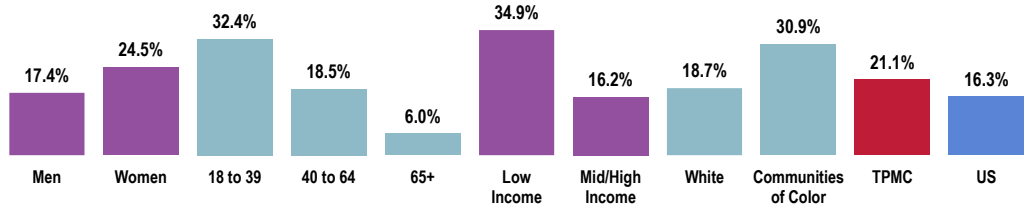
Adverse Childhood Experiences (ACEs)

CATEGORY	QUESTION
HOUSEHOLD MENTAL ILLNESS	Before you were 18 years of age, did you live with anyone who was depressed, mentally ill, or suicidal?
HOUSEHOLD SUBSTANCE ABUSE	Before you were 18 years of age, did you live with anyone who was a problem drinker or alcoholic?
	Before you were 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?
INCARCERATED HOUSEHOLD MEMBER	Before you were 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?
PARENTAL SEPARATION OR DIVORCE	Before you were 18 years of age, were your parents separated or divorced?
INTIMATE PARTNER VIOLENCE	Before age 18, how often did your parents or adults in your home slap, hit, kick, punch or beat each other up?
PHYSICAL ABUSE	Before age 18, how often did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking.
EMOTIONAL ABUSE	Before age 18, how often did a parent or adult in your home swear at you, insult you, or put you down?
SEXUAL ABUSE	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you touch you sexually?
	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you try to make you touch them sexually?
	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you force you to have sex?

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 308-318]
Notes: ● Reflects the total sample of respondents.

The impact of ACEs on future health and well-being are cumulative. PRC looks at these compounding issues by scoring the ACE series — survey respondents receive one "point" for each of the eight ACEs categories containing an affirmative response; a score of four or higher is determined to be a "high" ACE score.

Prevalence of High ACE Scores (Four or More ACEs)
(TPMC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 336]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Adults who report four or more ACEs is categorized as having a high ACE score.

Key Informant Input: Social Determinants of Health

The following related comments were captured during the administration of the online key informant survey:

Housing

> Housing. Housing instability is about to disrupt health and every SDoH. The eviction rate and financial impact through judgements placed on evicted renters is going to push thousands of people over the edge. It's going to disrupt their natural support networks, it's going to place a burden on their family/friends that help them, it's going to exhaust everyone. Experiencing homelessness for the first time is traumatic, many go into survival mode, only safety/shelter/food matter, and everything gets pushed to the side and some will self-medicate to deal with the stress. If we already have physical/mental health declining - the pending eviction tsunami is going to amplify that. Over 4k people were evicted in Maricopa County in December in the middle of the holidays and the middle of a pandemic with an eviction moratorium in place. This is a major problem that needs to concern the health industries. – Social Services Provider (Maricopa County)
>
> Housing is healthcare and there is not enough low income housing in Phoenix and not enough shelter space for those who are experiencing homelessness that have health issues. Housing is the first step in getting people healthier because if someone is unsheltered they are not concerned about their health issues - Social Services Provider (Phoenix)
>
> Housing. The healthcare sector has yet to consider housing as a "health need" yet it is often the core of all issues. Housing costs are so high in many areas that people opt to pay for housing over health - this creates chronic issues, compounds existing problems, or forces a person to choose shelter over their body. Affordable housing is limited in Arizona and this impacts many populations including those living in poverty, older adults, and marginalized communities. The formal system of healthcare could be more involved in shelter, housing check-ups (like during a telemedicine appointment can the doctor view the housing conditions in the back of the video and use that as a health check point), and referrals from hospital to housing. – Community Leader (Maricopa County)

Social Determinants

> Lack of connection of health outcomes with the social determinants of health. So much of what impacts health happens outside of a medical care setting, but as a community, we do not think of housing and other SDOH factors as contributing to "health." Until we focus on these underlying factors, many in our community will not be able to be healthy and thrive. – Public Health Representative (Maricopa County)
>
> Social determinants of health. Affordable housing, access to healthy foods and a living wage. – Community Leader (Maricopa County)
>
> Social determinants of health are starting to be assessed/evaluated but there is much work to be done in this space. – Community Leader (Maricopa County)

Homelessness

> Homelessness, it exacerbates pre-existing physical and emotional conditions, as well as can cause them. – Public Health Representative (Maricopa County)
>
> Homelessness. Homelessness is a health issue. We need robust services and that are affordable to ensure the 6,000+ people living on the streets, with major health issues, are housed rapidly. – Social Services Provider (Maricopa County)
>
> There is a lack of long term supportive housing units; not just shelters, but units that provide wrap around services. – Social Services Provider (Phoenix)

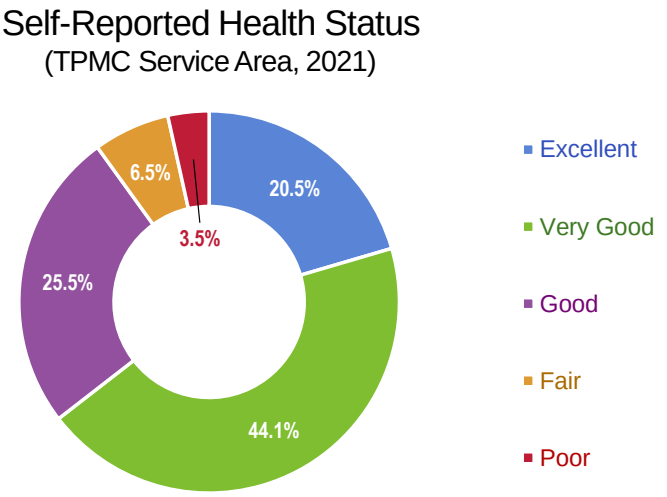
Childhood Trauma

> Childhood trauma, it predicts heart disease, cancer, mental health issues, substance use disorder, obesity, etc. Arizona ranks among the worst states for the rate of adults who have experienced childhood trauma. – Community Leader (Maricopa County)

HEALTH STATUS

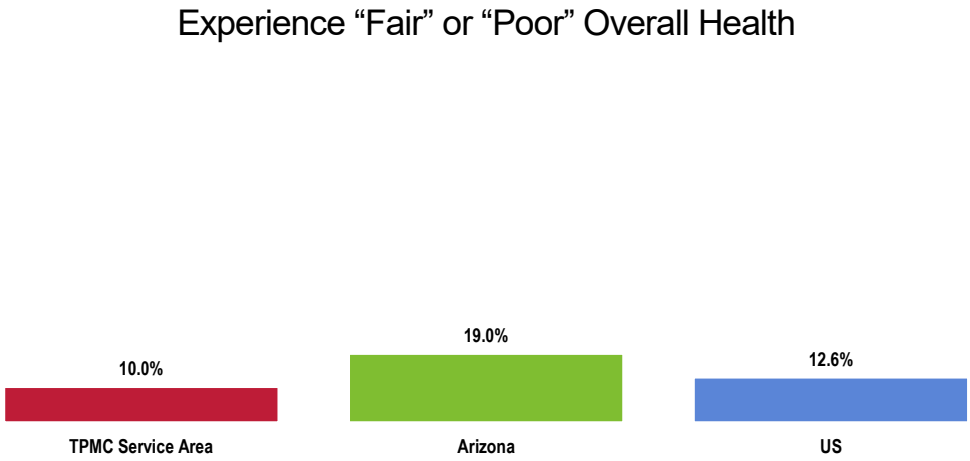
Overall Health

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"



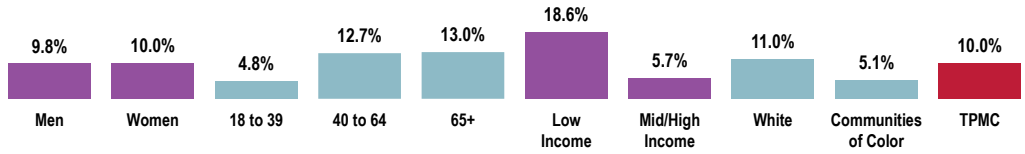
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in the TPMC Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, income [based on poverty status], and race/ethnicity).



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(TPMC Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

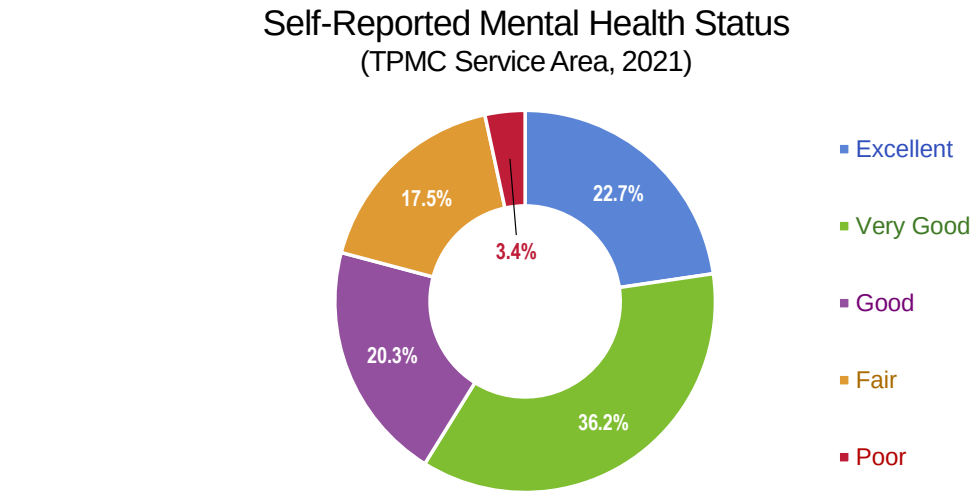
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

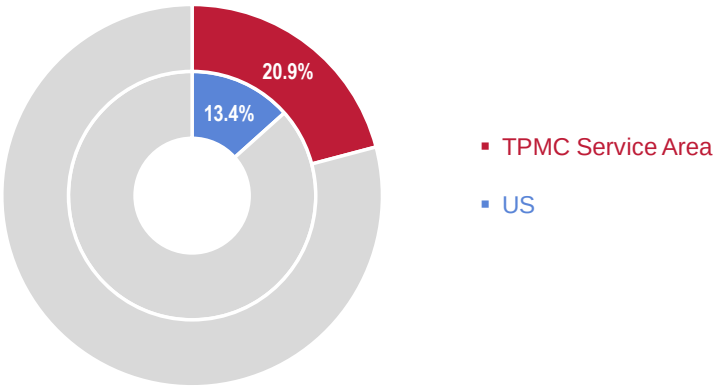
Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health



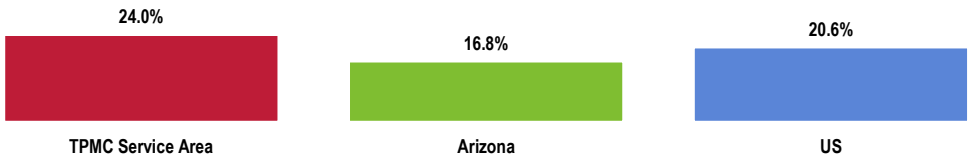
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

DIAGNOSED DEPRESSION ► **“Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”**

Have Been Diagnosed With a Depressive Disorder

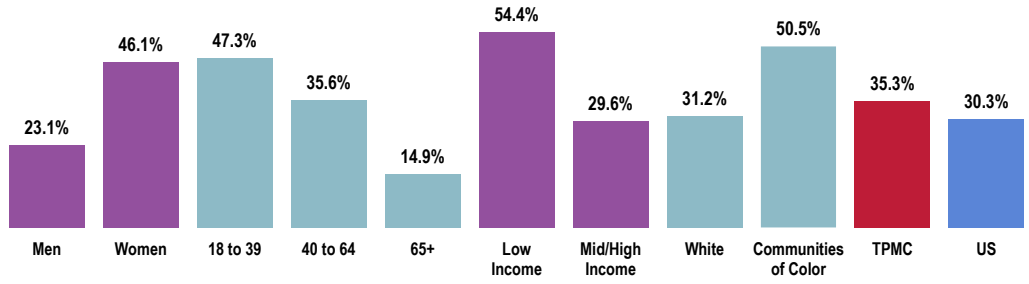


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

SYMPTOMS OF CHRONIC DEPRESSION ► **"Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"**

Have Experienced Symptoms of Chronic Depression
(TPMC Service Area, 2021)



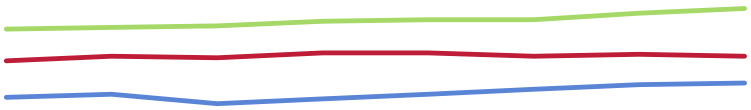
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population (refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates). [COUNTY-LEVEL DATA]

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

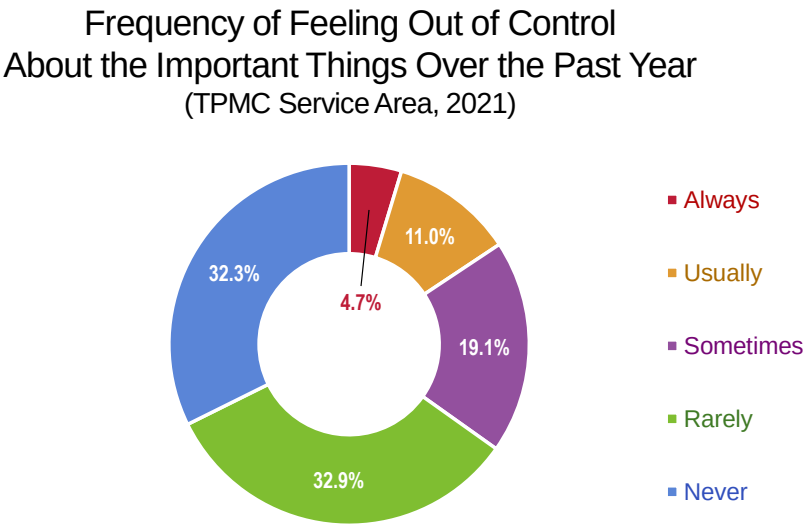


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	15.4	15.7	15.6	15.9	15.9	15.7	15.8	15.7
AZ	17.4	17.5	17.6	17.9	18.0	18.0	18.4	18.7
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

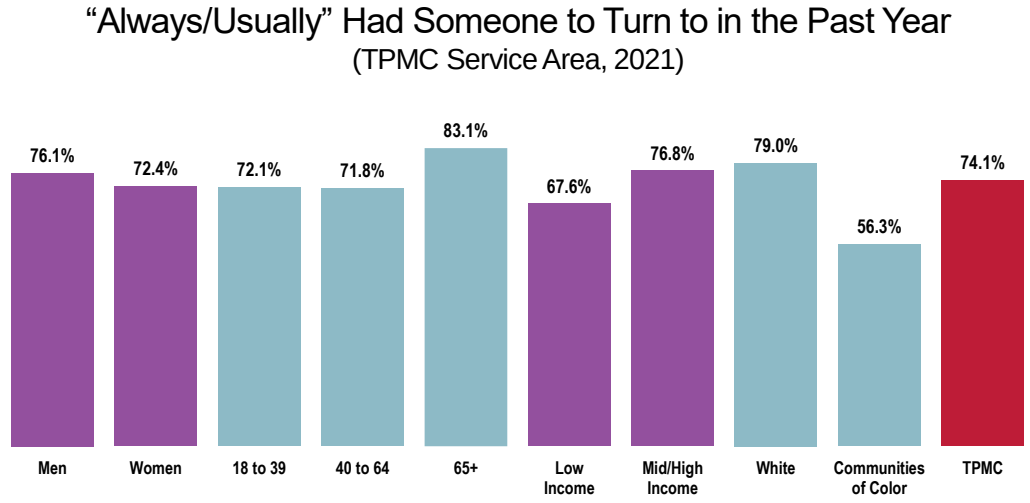
Coping and Support

"In the past 12 months, how often have you felt that you were NOT able to control the important things in your life?"



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.

"In the past 12 months, how often have you had someone you could turn to if you needed or wanted help?"

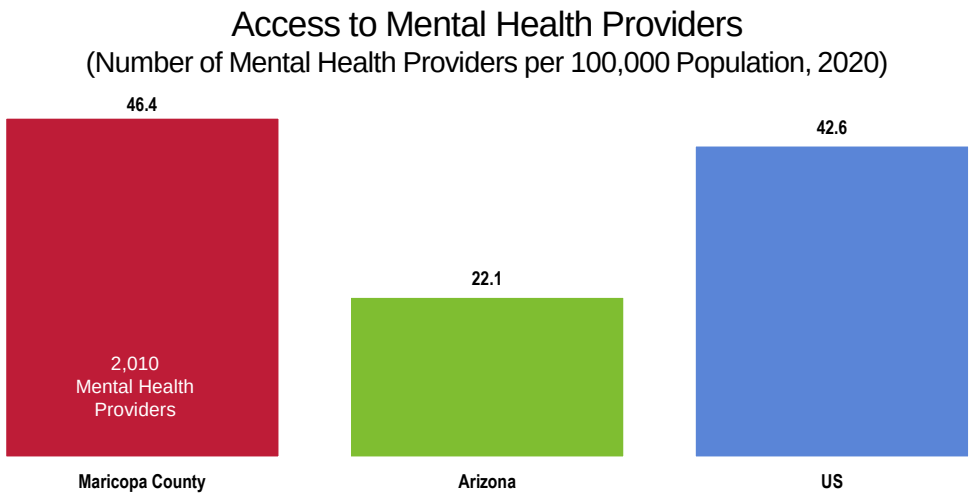


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: • Asked of all respondents.

Mental Health Treatment

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the TPMC Service Area and residents in the TPMC Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

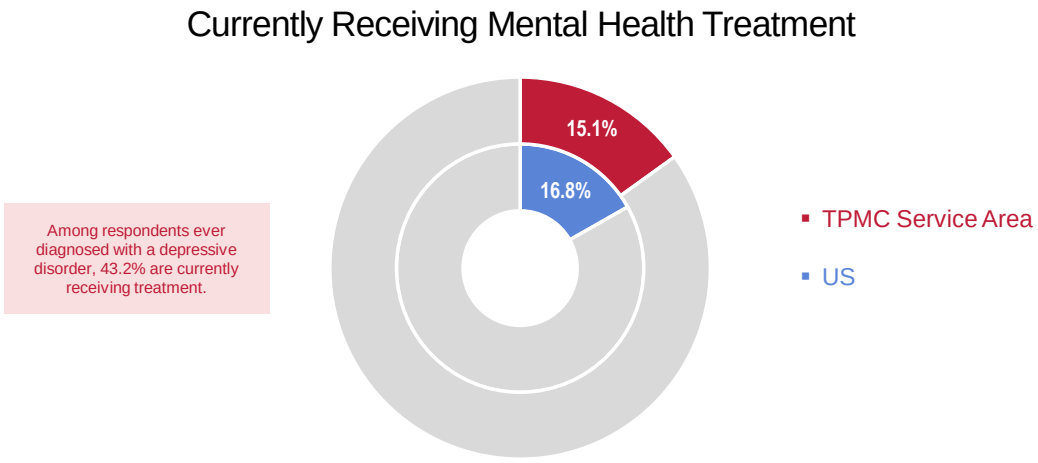
The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services
When Needed in the Past Year
(TPMC Service Area, 2021)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health
as a Problem in the Community
(Key Informants, 2021)

Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of treatment options or inpatient units. – Other Health Provider (Maricopa County)
>
> Lack of resources. – Public Health Representative (Maricopa County)
>
> Hiring and keeping qualified staff to meet the needs of our clients. – Social Services Provider (Maricopa County)
>
> Social determinants of health are a major issue in our community's access to mental health resources are challenging. – Physician (Maricopa County)
>
> Maricopa County has very few mental health facilities per capita. There is also a large homeless population, many have mental illness. – Physician (Maricopa County)
>
> Poor access. Few therapists and counselors. – Physician (Scottsdale)

Not a lot of resources for inpatient care and step down services. – Physician (Maricopa County)

Lack of both inpatient and outpatient resources for the mentally ill. Patients transferred from the Emergency Department will often have waits of two to three days before an appropriate bed becomes available. – Physician (Maricopa County)

Not enough staff available to meet the needs and better pay is needed to hire and retain quality staff. Too much turnover does not provide for consistency in quality services. We need to do better. – Other Health Provider (Maricopa County)

Not enough psychiatric services. – Physician (Maricopa County)

Access to care and lack of inpatient facilities. – Physician (Maricopa County)

Access to care and limited resources that take too long to access during a crisis situation. – Other Health Provider (Scottsdale)

Access to mental health care. – Other Health Provider (Phoenix)

Once again, easy, simple access to mental health resources. Secondly, the poor response to mental health emergencies by law enforcement agencies. – Social Services Provider (Maricopa County)

Access to mental health services with trained and effective providers. More integrated behavioral health services needed in clinics and urgent care facilities. – Physician (Maricopa County)

Access to care. There are so few programs available. I tried to get a counselor for my child and was never able to find someone that would accept our insurance and had openings. It was so frustrating, and I have the privilege and resources to try and find help. I can't imagine what it would be like for a family who does not have the same things I do. Mental health is stigmatized and many fear asking for that kind of help. – Community Leader (Maricopa County)

Access to appropriate continued care. – Community Leader (Phoenix)

The ability to get hospitalized in a safe and warm space in order to stabilize (and understanding for families on how to do this). Being able to stay somewhere affordably for longer than 72 hours. The ability to connect to quality therapists in one-on-one settings and quickly. Grief counseling related to COVID deaths. – Social Services Provider (Maricopa County)

Accessing Behavioral Health Care and navigating the confusing system for care. – Community Leader (Phoenix)

Access to providers. – Physician (Maricopa County)

Access to mental health services and follow up care. – Public Health Representative (Maricopa County)

Lack of services. – Other Health Provider (Maricopa County)

Finding a place that will take them and getting the authorization from the provider to cover it. – Other Health Provider (Maricopa County)

Lack of resources for mental health patients/homelessness. – Other Health Provider (Maricopa County)

Access to quality mental health services for the severely mentally ill. Connecting with services is very difficult for this population and the number of options for most Americans is limited. – Social Services Provider (Maricopa County)

Lack of access to care. – Community Leader (Maricopa County)

There are not enough facilities that provide this service and often people go untreated due to the lack of resources. – Physician (Scottsdale)

The Reba continues to change and appears to not be meeting the needs of those who require services in Arizona. Limited supply of day services and resources for a member to aid in recovery, other than medication. High dual diagnosis population. – Other Health Provider (Maricopa County)

Community resources and placement for patients with limited insurance. – Other Health Provider (Maricopa County)

Lack of services, quality, poor access. – Social Services Provider (Maricopa County)

Access to care and support services. – Other Health Provider (Maricopa County)

Lack of access to services. – Social Services Provider (Maricopa County)

Contributing Factors

Integrated care that cares for the whole person: primary care, behavioral health and mental health. Mental health still has a stigma around it. Insurance for talk therapy or other mental health support is limited. – Community Leader (Maricopa County)

Mental health is complicated, complex and not something that can be addressed with a band-aid. Some insurance plans do not cover adequate coverage for mental health services forcing those who may need it most from seeking or receiving the services they desperately need. There continues to be a stigma - whether real or based on perceptions - associated with mental health challenges that also prevents those who may need it most from seeking the service/support they need. As an industry, mental health providers (counselors, social workers, etc.) are often at the lower end of the pay scale which contributes to a revolving door of practitioners. Many of those imprisoned within our State's system suffer from some degree of mental health challenge - and yet if wraparound support and services were available and appropriately provided, recidivism may be positively impacted! This is an extremely complex systemic issue that currently addresses symptoms instead of root causes... – Community Leader (Maricopa County)

Language barrier, access to care and stigma around mental health. – Social Services Provider (Phoenix)

People are pushing themselves to the limits, trying to handle everything they can as they can. But some are bottling it up, some are adopting unhealthy coping mechanisms, and some don't realize that they're just one crisis/stressful event from no longer being able to hold it together. There needs to be outreach to encourage people to voluntarily engage in therapy services to help manage it, it's free under AHCCCS but many AHCCCS recipients don't seek MH services or don't know where to go, or want more client choice options in their therapist and telehealth. Some would engage through telehealth but there's a digital divide. – Social Services Provider (Maricopa County)

Stress in the home environment. Level of education and information leading to downward spirals without intervention. Access to care is very underdeveloped given amount of need. – Community Leader (Maricopa County)

Diagnosed mental health, compounded with illicit drugs. No ability for long-term residential care. No comprehensive system. Just a variety of profit-driven companies. – Community Leader (Phoenix)

Homelessness, drug abuse and domestic violence. – Social Services Provider (Maricopa County)

Housing. Sufficient funding. Enough programs. – Other Health Provider (Maricopa County)

Lack of health care coverage, lack of diagnostics, affordable medication, and homelessness. – Social Services Provider (Maricopa County)

Lack of available services even for insured patients. Stigma. Lack of diverse, culturally competent mental health providers. – Community Leader (Maricopa County)

Lack of access to services, high poverty rate, high unemployment rate. – Community Leader (Phoenix)

Lack of access to quality care and the stigma associated with seeking treatment for mental health issues. – Community Leader (Scottsdale)

Access to care, housing, employment, and maintaining a safe place to live. – Social Services Provider (Phoenix)

Appropriate diagnosis, insurance benefit, financial capacity of the patient/family availability of appropriate facilities and the patient's willingness to participate. – Other Health Provider (Scottsdale)

Arizona lags across the board in support for those with mental health issues, especially serious mental illness. Most programs seem to focus on addiction issues only but are incapable of serving those with issues such as bi-polar, schizophrenia, schizoaffective disorder, or other illnesses. Those programs that do exist (such as Terros) are stretched to the limit. For those that have been found disabled and are on Medicare, Medicare pays for in-patient services but not intensive outpatiend. For those without the financial resources to pay for private care (which is most people), resources are very limited. – Community Leader (Phoenix)

Teen mental health is a major issue as kids are out of school longer. Substance abuse is increasing as ways for people to cope with the stress of the pandemic, job loss, uncertainly and not being able to be around peer groups or support groups. There are not enough mental health providers for teens and children. There are not enough mental health providers to work with those experiencing homelessness and those dealing with substance abuse on the streets - Social Services Provider (Phoenix)

Denial/Stigma

Stigma, access to care, cost of care, crisis support, and police response. – Physician (Maricopa County)

Mental health problems are often considered an embarrassment. Treatment is not widely available, particularly for those without insurance or financial resources -- and even those who have some resources, it is often a long term problem and treatment is expensive. – Community Leader (Maricopa County)

Stigma for getting treatment goes against the grain of some cultures. Lack of understanding of how to get treatment. – Public Health Representative (Maricopa County)

Stigma, access to services, where to start. Mental health issues are chronic, but manageable. Can be expensive to treat, can have other consequence. Job loss, criminalization. – Public Health Representative (Maricopa County)

There still remains such large stigma around mental health - both within our community and within our healthcare systems. Mental health services are underinsured and the lack of integrated health services at the primary care level is causes system failures every day for patients that need adequate mental health services. – Public Health Representative (Maricopa County)

> The stigma of mental health and around seeking professional health. Also, isolation due to the ongoing pandemic. – Community Leader (Maricopa County)

COVID-19

> Depression and suicide were already high in Arizona before the pandemic. I expect these to have increased. These are directly related to mental health. With the large number of COVID deaths also, there is even more mental stress and anguish in our community. – Community Leader (Maricopa County)
>
> Mental health issues are on the rise especially due to isolation and stress of Covid-19. – Other Health Provider (Maricopa County)
>
> Isolation, depression, limited access to support networks during pandemic. – Community Leader (Maricopa County)
>
> Covid has had a profound impact on the increase of anxiety, depression and suicide among youth, teens and adults. – Social Services Provider (Phoenix)

Lack of Mental Health Providers

> Difficulty gaining access to mental health/psychiatric services, not enough providers. – Physician (Maricopa County)
>
> Not enough providers, resources, or outpatient/inpatient facilities. – Community Leader (Maricopa County)
>
> Lack of providers and resources that are easily available to patients. – Social Services Provider (Scottsdale)
>
> Not enough mental health professional. Funding for mental health. – Other Health Provider (Maricopa County)
>
> Shortage of access to providers, services and facilities. – Other Health Provider (Maricopa County)

Affordable Care/Services

> Lack of affordable resources. Lack of in person support. Lack of services and awareness of services for low income people/families. – Social Services Provider (Scottsdale)
>
> Services are so hard to get. They can be costly if insurance isn't accepted by certain therapists. Diagnoses aren't taken seriously. Stigma. – Other Health Provider (Maricopa County)
>
> Access to affordable services. – Community Leader (Maricopa County)

Awareness/Education

> Lack of knowing what resources are out there and relying on Emergency Departments for the majority of SMI acute issues. – Physician (Maricopa County)
>
> An understanding of what access they have to care. – Other Health Provider (Maricopa County)
>
> They have no idea what is happening to them or where to go for assistance. – Social Services Provider (Maricopa County)

Incidence/Prevalence

> Arizona traditionally ranks poorly on national statistics when it comes to mental health care. I'm not as involved in Behavioral Health services so my data is dated, I think others may be able to provide better information. – Other Health Provider (Maricopa County)
>
> Maricopa County has a higher than national average rate of mental health issues due to growing population. – Social Services Provider (Phoenix)

Diagnosis/Treatment

> The amount of time that it takes to get the medications right. – Community Leader (Maricopa County)
>
> Obtaining a mental health diagnosis and following through with treatment options. – Social Services Provider (Scottsdale)

Comorbidities

> Addiction, SMI, depression, anxiety and suicide are all at very high rates. Access to good behavioral medicine and counseling is tough to find and afford. – Physician (Maricopa County)
>
> Depression and anxiety. – Community Leader (Phoenix)

Funding

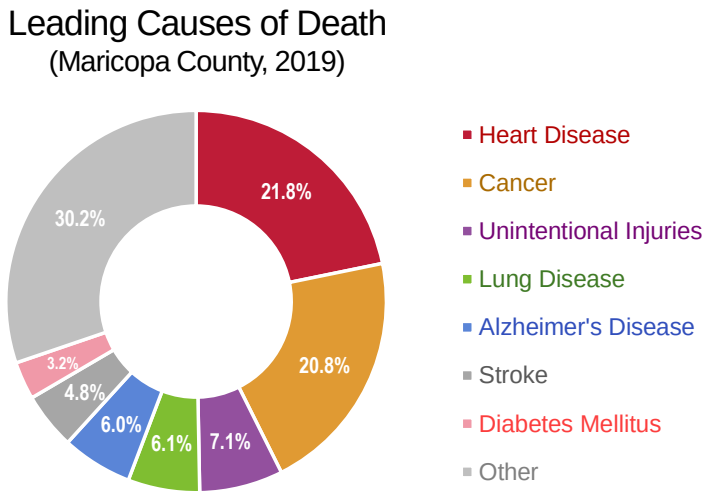
> Lack of funding and providers to address needs. – Public Health Representative (Maricopa County)

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Arizona and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the TPMC Service Area. [COUNTY-LEVEL DATA]

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2017-2019 Deaths per 100,000 Population)

	Maricopa County	Arizona	US	HP2030
Diseases of the Heart	134.0	137.4	163.4	127.4*
Malignant Neoplasms (Cancers)	130.3	132.9	149.3	122.7
Fall-Related Deaths (65+)	91.4	84.5	65.1	63.4
Unintentional Injuries	54.6	56.8	48.9	43.2
Chronic Lower Respiratory Disease (CLRD)	38.0	40.7	39.6	n/a
Alzheimer's Disease	37.1	33.5	30.4	n/a
Cerebrovascular Disease (Stroke)	30.4	30.7	37.2	33.4
Diabetes Mellitus	22.2	23.2	21.5	n/a
Drug-Induced	22.2	21.3	18.8	n/a
Intentional Self-Harm (Suicide)	15.7	18.7	14.0	12.8
Firearm-Related	13.8	15.4	11.9	10.7
Cirrhosis/Liver Disease	11.5	14.3	11.1	10.9
Motor Vehicle Deaths	11.1	13.3	11.3	10.1
Pneumonia/Influenza	10.0	10.9	13.8	n/a
Homicide	6.0	6.2	6.1	5.5
Kidney Diseases	5.8	7.3	12.9	n/a
HIV/AIDS	1.5	1.4	1.9	n/a

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	138.8	136.5	132.8	131.5	130.3	133.2	133.6	134.0
AZ	147.5	145.6	141.0	138.8	138.0	139.9	139.1	137.4
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

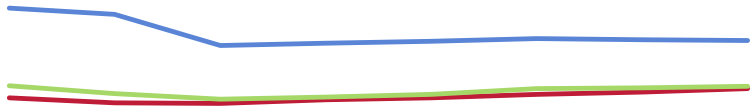
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	29.1	28.4	28.3	28.8	29.1	29.6	29.9	30.4
AZ	30.8	29.7	28.9	29.2	29.6	30.4	30.5	30.7
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

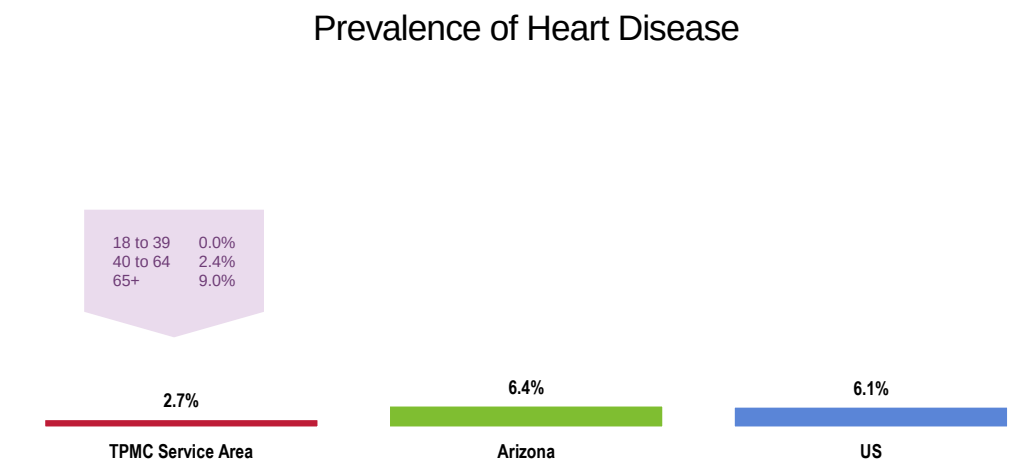
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

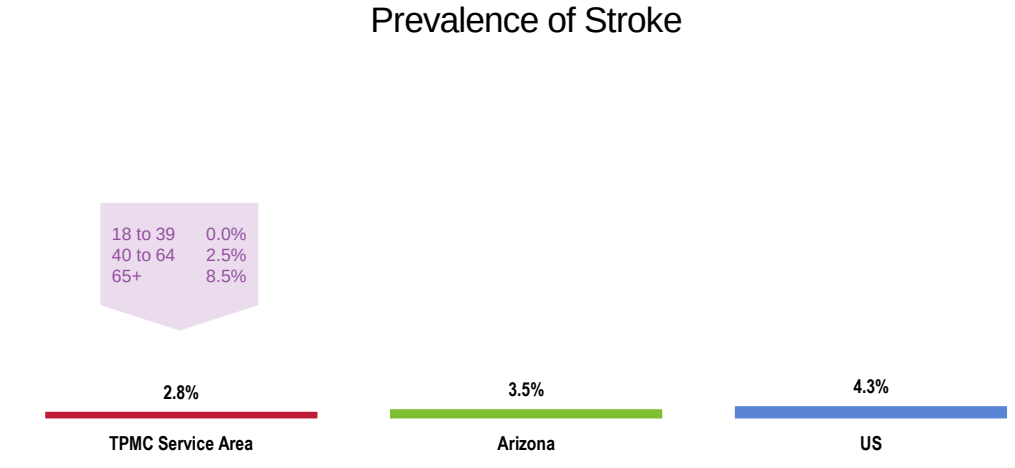
Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

"Has a doctor, nurse, or other health professional ever told you that you had a stroke?"



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

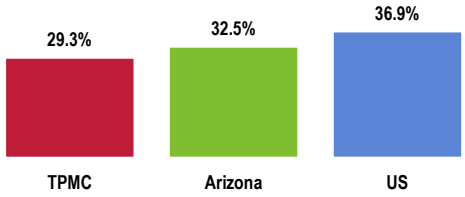
Cardiovascular Risk Factors

Blood Pressure & Cholesterol

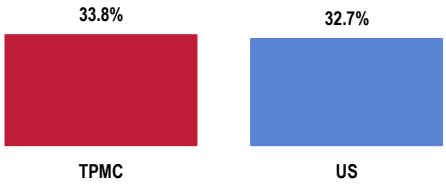
“Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?”

“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

Prevalence of
High Blood Pressure
Healthy People 2030 = 27.7% or Lower



Prevalence of
High Blood Cholesterol



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

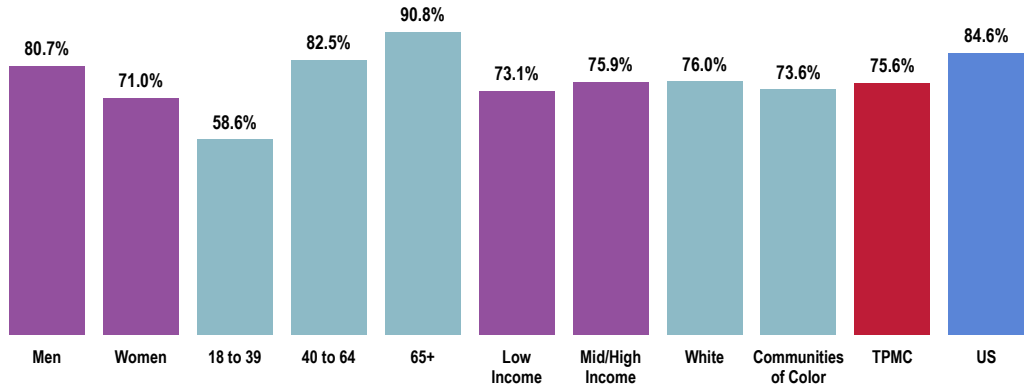
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition*, *Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

The following chart reflects the percentage of adults in the TPMC Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

Present One or More Cardiovascular Risks or Behaviors
(TPMC Service Area, 2021)



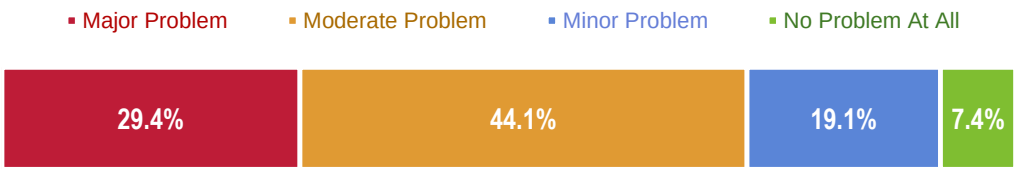
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2021)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Number one killer. – Other Health Provider (Maricopa County)
>
> Heart disease has been the No. 1 or No. 2 killer in Arizona for at least 13 years, with stroke at No. 5 or 6. Many lives are lost to these 2 diseases combined. We know that 80% of heart disease and stroke deaths are preventable; this is with early diagnosis, early intervention, and ultimately prevention through improved health behaviors. – Community Leader (Maricopa County)
>
> The Arizona Department of Health Services indicates, as does the Heart Association, that heart disease and stroke are two major issues in Arizona. – Other Health Provider (Maricopa County)
>
> One of the leading causes of death in the state among all races and ethnicities. – Community Leader (Maricopa County)
>
> It’s the number-one cause of death. – Other Health Provider (Maricopa County)
>
> The numbers of individuals dying of heart disease and strokes continues to rise. – Social Services Provider (Maricopa County)
>
> Lots of morbidity/mortality with this. – Physician (Maricopa County)
>
> I see and hear about so many deaths caused by heart disease. – Social Services Provider (Maricopa County)

Aging Population

> Our state has a large elderly population many with diagnosis of heart disease and stroke. – Other Health Provider (Maricopa County)
>
> Maricopa County has a higher than national average rate of heart disease and stroke, due to higher number of those age 65+. – Social Services Provider (Phoenix)
>
> Aging retirement population. Large Native American and Hispanic populations with diabetes and obesity. – Physician (Maricopa County)
>
> Maricopa County has a large elderly and snowbird population. – Physician (Maricopa County)
>
> We have an aging population, many of whom do not have good healthcare habits. – Community Leader (Maricopa County)
>
> Again, aging population, most with health care, but many may not, especially they if lost jobs due to Covid. – Community Leader (Scottsdale)

Access to Care/Services

> Lack of access to medical care, limited resources, lack of healthy food. – Social Services Provider (Phoenix)
>
> Long wait time to get an appointment. – Social Services Provider (Scottsdale)
>
> Access to high quality services. – Social Services Provider (Maricopa County)

Contributing Factors

> Poor diet, lack of physical activity, obesity. – Physician (Maricopa County)
>
> Heart disease and stroke are major issues across the US, not just Maricopa County. Lack of good diet, education, employment, purpose all feed into this. The cost to care for those with these diseases and the consequences are incredible. – Physician (Maricopa County)

Prevention/Screenings

> Preventative measures. – Physician (Scottsdale)
>
> Limited access to screenings and education to communities of color, low income communities and non-English speaking communities. High risk communities do not have access to testing and education when healthcare is limited to telemedicine and lack of technology is an ongoing issue. Those who are experiencing homelessness do not have access to regular health screenings - Social Services Provider (Phoenix)

Awareness/Education

> Inadequate patient education. – Other Health Provider (Maricopa County)
>
> Individuals may not recognize the signs and symptoms. Medical practitioners may not explore other aspects of the individua’ls environment to determine where stress, anxiety and/or unhealthy behavior that can reduce the possibility of heart disease and stroke - Social Services Provider (Maricopa County)

Lifestyle

> This is a chronic problem and people do little to change their lifestyles to avoid problems. I understand that heart disease is the number one cause of death. – Community Leader (Maricopa County)

Vulnerable Populations

> Inability to have medical insurance and access to medications due to undocumented status in the US. – Physician (Maricopa County)

Obesity

> High percentage of individuals with obesity have a higher risk of heart disease. – Other Health Provider (Phoenix)

Cancer

ABOUT CANCER

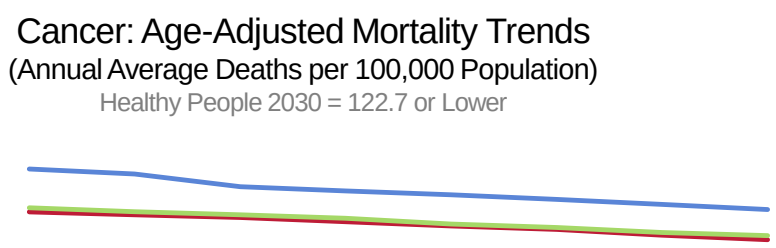
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in the TPMC Service Area. [COUNTY-LEVEL DATA]



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	147.8	145.9	144.2	141.7	139.0	136.9	133.1	130.3
AZ	150.4	148.0	146.1	143.7	140.3	138.0	134.8	132.9
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Lung cancer is by far the leading cause of cancer deaths in the TPMC Service Area. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2017-2019 Annual Average Deaths per 100,000 Population)

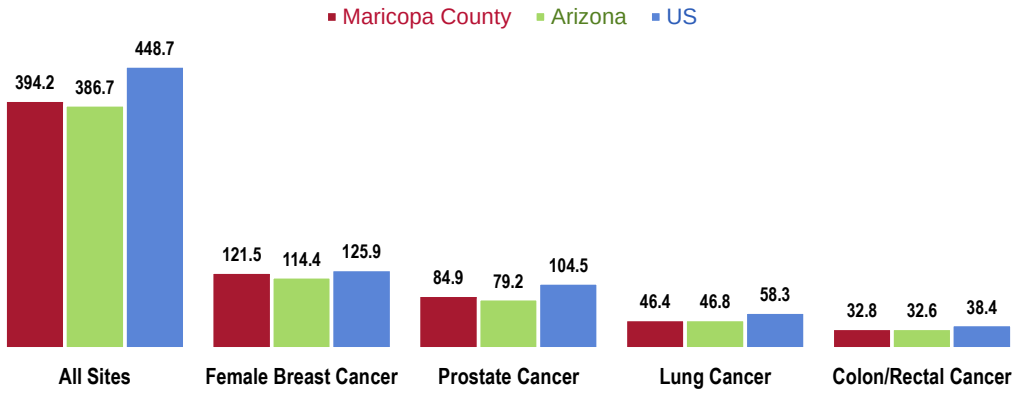
	Maricopa County	Arizona	US	HP2030
ALL CANCERS	130.3	132.9	149.3	122.7
Lung Cancer	27.0	27.9	34.9	25.1
Female Breast Cancer	18.4	17.9	19.7	15.3
Prostate Cancer	16.3	16.7	18.6	16.9
Colorectal Cancer	12.4	12.5	13.4	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2013-2017)



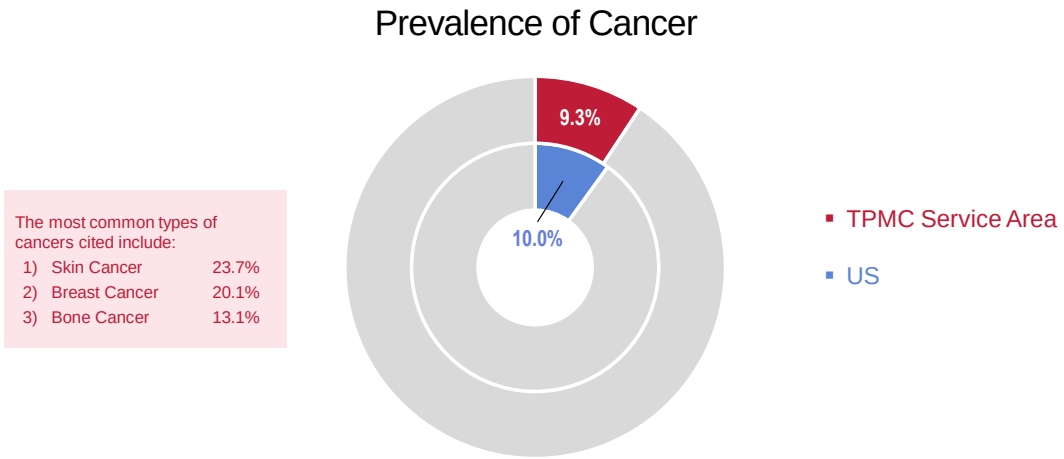
Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

“Have you ever suffered from or been diagnosed with cancer?”

“Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)



The most common types of cancers cited include:

1)	Skin Cancer	23.7%
2)	Breast Cancer	20.1%
3)	Bone Cancer	13.1%

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition*, *Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation’s cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

BREAST CANCER SCREENING ► **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

CERVICAL CANCER SCREENING ► **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"**

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

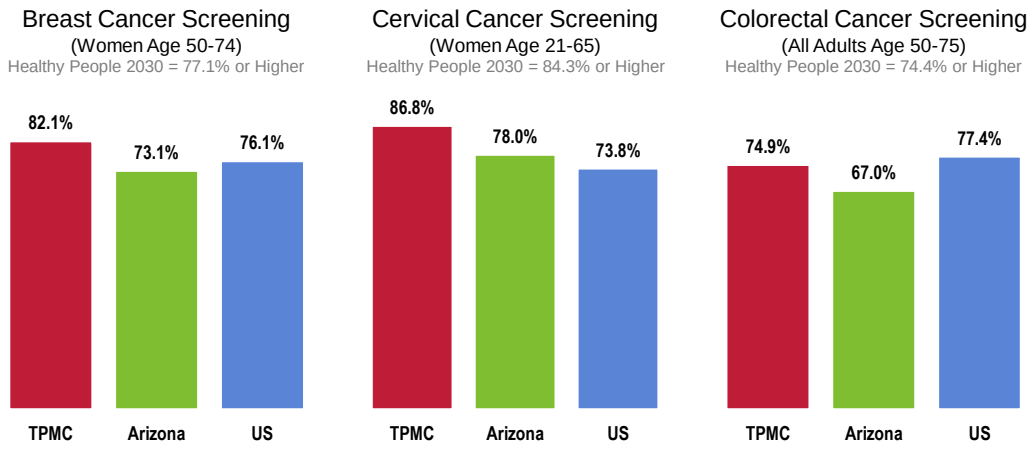
"Have you ever had a hysterectomy?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

COLORECTAL CANCER SCREENING ► **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"**

"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

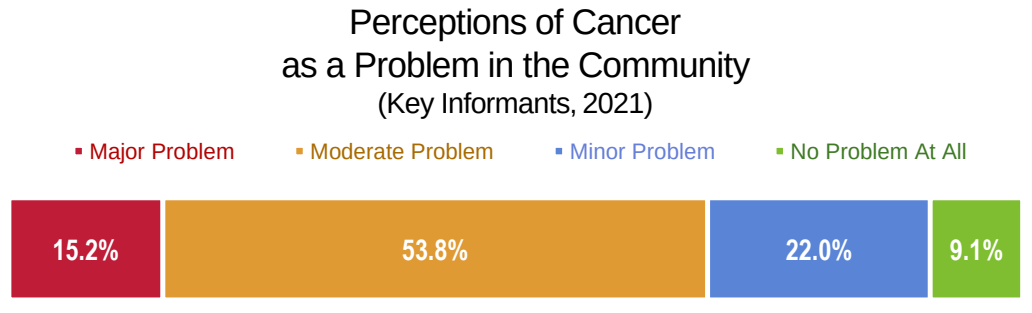


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Many patients I have cared for have cancer or have a family member with cancer. When referring patients to an oncologist it is often difficult to get in. – Physician (Maricopa County)
>
> Anecdotally, I know many of our chronic pain and substance use patients often report they also have or had cancer. – Other Health Provider (Maricopa County)
>
> Prevalence is high and treatment options are not readily available to everyone, especially the under or uninsured. – Community Leader (Maricopa County)
>
> Leading cause of death. – Community Leader (Maricopa County)
>
> I believe cancer has become a major problem throughout our community based upon the current statistics of those diagnosed with cancer. Additionally access to early detection and treatment has been seriously impacted by Covid over the past year. – Other Health Provider (Maricopa County)
>
> Maricopa County has a higher than national average rate of all cancers. – Social Services Provider (Phoenix)
>
> Cancer is the second leading cause of death among American Indians. – Social Services Provider (Maricopa County)

Prevention/Screenings

> Lack of detection, access to preventative care. Vulnerable communities live in areas prone to be exposed to carcinogens due to industry and other factors. – Community Leader (Maricopa County)
>
> Some of the cancers have no screening tool. – Physician (Maricopa County)

Diagnosis/Treatment

> Delays in seeking care. – Physician (Maricopa County)
>
> Hard to diagnose, high cost, high mortality and scarce resources. – Physician (Maricopa County)

Vulnerable populations

> There is not enough education and cancer screenings for the non-English speaking community or those experiencing homelessness. During this pandemic many who do not have regular healthcare are not being seen by any doctors or have limited contact with a healthcare professional that can let them know they are due for age appropriate cancer screenings. Many of the elderly that have been quarantined at home have not been able to get regular screenings since so many doctors have gone to telemed appointments and many seniors do not have access to technology for those types of appointments. – Social Services Provider (Phoenix)

Contributing Factors

> 1) If a person is acutely ill with cancer & receiving treatments but requiring 24-hour care, there are limited options. Using the hospital resources is expensive, skilled nursing facilities can’t afford to accept due to PPS system with chemo & treatments hitting their expenses. At times “hospice” is pushed/recommended due to inadequate support systems. 2) Delay in diagnosis due to a. fear of health care system, b. no insurance, c. lack of awareness of preventative care and or signs and symptoms; thus a heavier burden on the patient and system with later diagnosis. – Other Health Provider (Maricopa County)

Awareness/Education

> I think about myself—where would I go? What doctor would I choose? It is a lot of information to navigate in a not so easy medical world. Specialist copays, financial burden—it would all add up and be very difficult to cope with in our current medical world. – Other Health Provider (Maricopa County)

Environmental Contributors

> There are communities that have high incidence of cancer based on environmental concerns for the area. – Social Services Provider (Phoenix)

Access to Care/Services

> Providers unable to meet demands to see new patients. – Social Services Provider (Scottsdale)

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

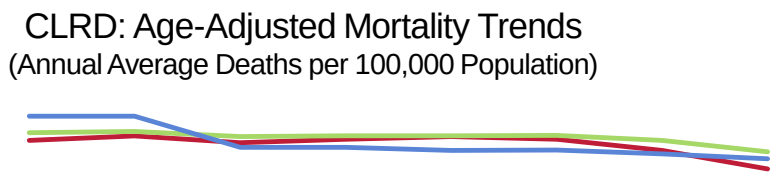
Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

Pneumonia and influenza mortality is also illustrated. [COUNTY-LEVEL DATA]

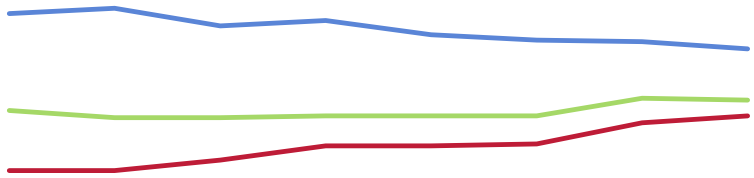


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	42.5	43.2	42.1	42.7	43.1	42.7	40.9	38.0
AZ	43.7	43.9	43.1	43.2	43.2	43.3	42.5	40.7
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

Notes: • CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	6.9	6.9	7.5	8.3	8.3	8.4	9.6	10.0
AZ	10.3	9.9	9.9	10.0	10.0	10.0	11.0	10.9
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

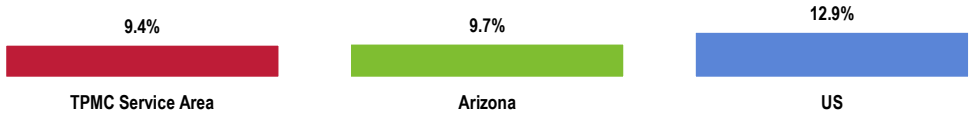
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

Prevalence of Respiratory Disease

Asthma

ADULTS ► **"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?"** (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

Prevalence of Asthma

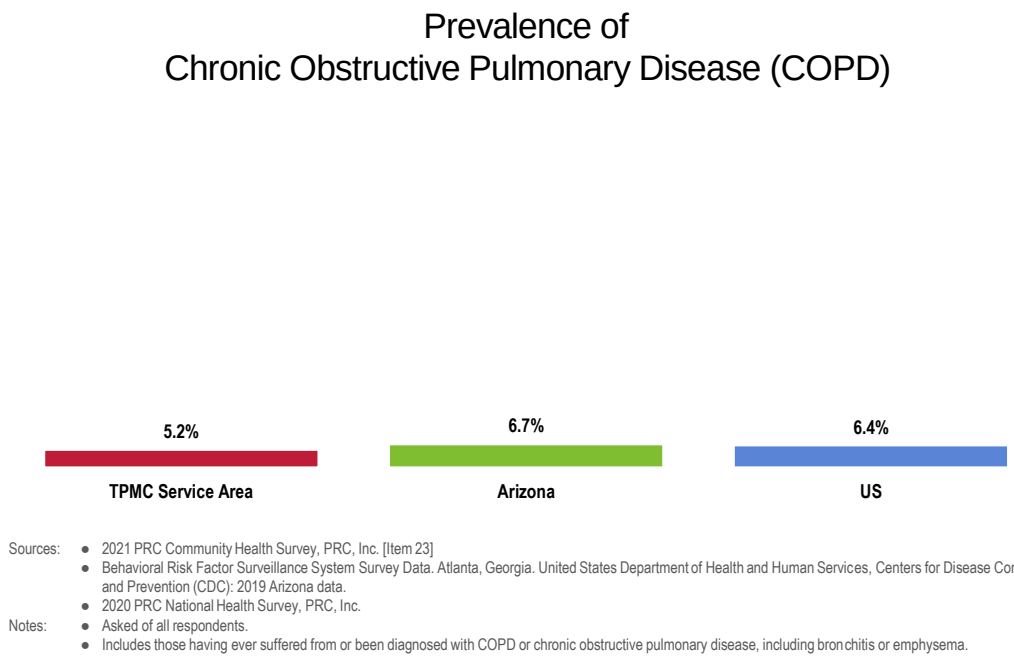


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

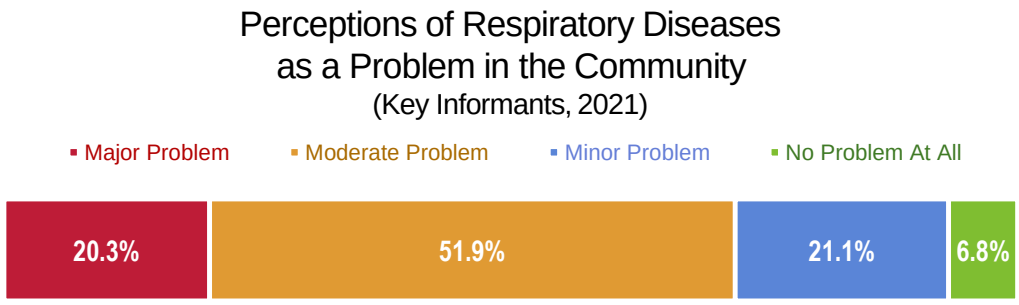


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Environmental Contributors

> Level of pollution due to lack of public transportation options, and high density population in urban areas. – Community Leader (Maricopa County)
>
> Poor air quality, unhealthy lifestyles including smoking, vaping and cannabis. – Social Services Provider (Phoenix)
>
> Too many people smoke and the effects of that are cumulative. The climate contributes to dust and dirt in the air. Construction affects the air and increases pollution. – Community Leader (Maricopa County)
>
> Air quality in our community continues to become worse. Lack of activity because of Covid has added to this issue. – Social Services Provider (Maricopa County)
>
> Maricopa County has a higher than national average rate of respiratory disease to high pollution and global warming. – Social Services Provider (Phoenix)
>
> Air quality has been an issue in Arizona. While we are not one of the worst states in the country for respiratory diseases, we certainly have a high number of asthma, COPD, chronic bronchitis. – Other Health Provider (Maricopa County)
>
> High rate of asthma, poor air quality, proximity to industry. – Community Leader (Maricopa County)

Incidence/Prevalence

> Many friends with respiratory issues. – Community Leader (Maricopa County)
>
> Reports from ADHS. – Community Leader (Maricopa County)
>
> I have seen respiratory diseases at the top of the list for causes of death in Arizona. – Community Leader (Maricopa County)

Access to Care/Services

> Lack of equipment and facility that are able to handle the rise of demand. – Social Services Provider (Scottsdale)
>
> Affordable health care. – Other Health Provider (Maricopa County)

Comorbidities

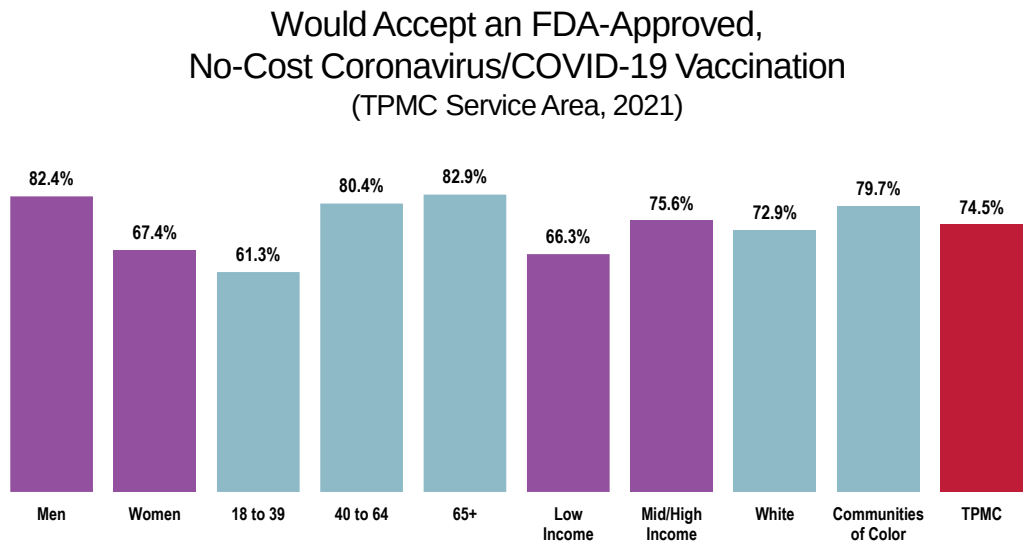
> Smoking, COPD, asthma. – Physician (Maricopa County)
>
> COVID. – Community Leader (Maricopa County)

Tobacco Use

> Tobacco use, current and past, vaping, drug use, and environmental concerns in the community. – Social Services Provider (Phoenix)

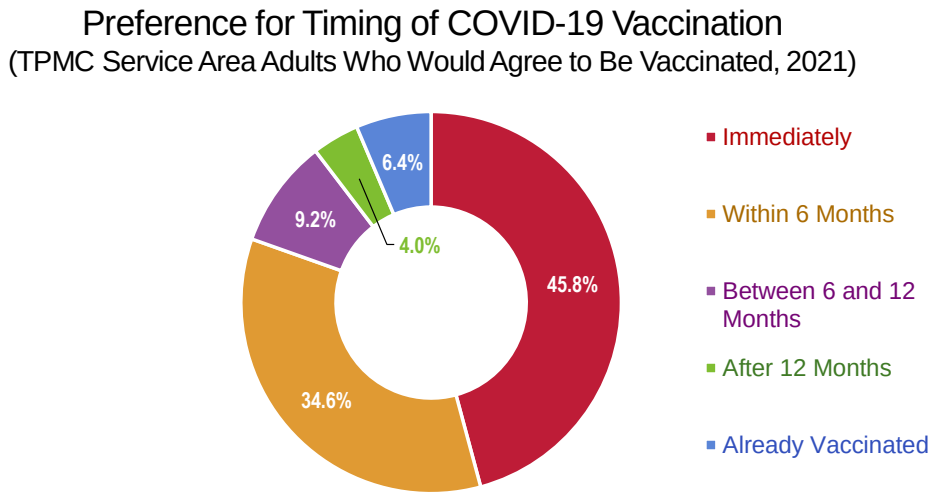
COVID-19 Vaccinations

"If an FDA-approved vaccine to prevent coronavirus/COVID-19 were available to you at no cost, would you get vaccinated?"



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: • Asked of all respondents.

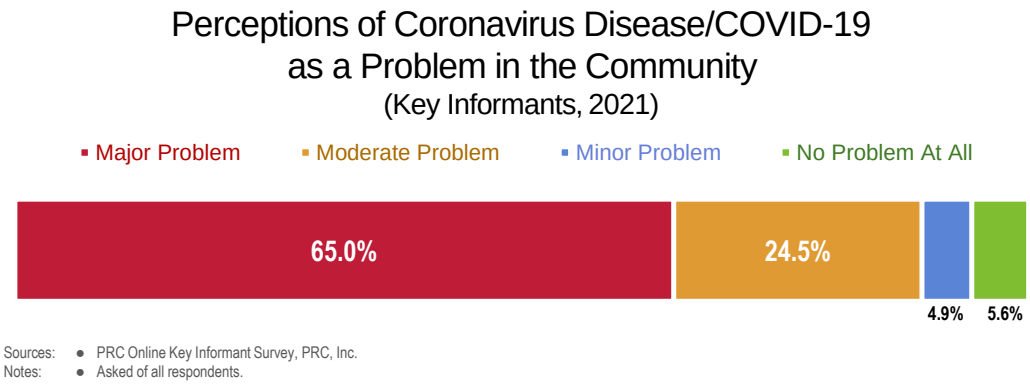
"Would you want to receive this coronavirus/COVID-19 vaccination immediately, within six months, between six months and one year, or after more than one year?"



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of those respondents who would agree to be vaccinated.

Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

Arizona has the highest rate of spread in the United States. To make things more difficult a significant part of our population does not support the mitigation strategies proposed by the CDC, some even believe it is a hoax, many of these same people will not get the vaccination not having a Statewide mask policy that is enforced is contributing to our rate of infection. – Social Services Provider (Maricopa County)

Our numbers have lead the country for a period of time. We have so many out of state and out of country visitors and COVID has become rampant. I worked in urgent care for the last 10 months and have seen the ambulatory side of testing over 40,000 individuals. – Physician (Maricopa County)

At one point Arizona was ranked number one in the country for per capita increases in cases of Covid-19. In June of 2020 and most recently in January of 2021. Arizona does not have an adequate mask policy in place. – Physician (Maricopa County)

My community has had the highest per capita incidence of HIV in the world at multiple points in the pandemic. There is no meaningful public health leadership at the county or state level, with pandemic response dictated by partisan political actors and resulting in the worst global outcomes. – Physician (Maricopa County)

A year into dealing with COVID and only finally seeing numbers trend downwards for any significant length of time. Number of deaths is alarming. Lack of resources given to school districts- mostly threats to decrease state payments as a way to make schools reopen their physical classrooms. Lack of guidance and planning from government at both state and federal levels until recently. – Community Leader (Phoenix)

Specifically due to the high rate of deaths, high numbers in the community and no real cure yet. – Other Health Provider (Maricopa County)

Still working to stop the spread. – Other Health Provider (Maricopa County)

Arizona consistently rank near the top in the world in all areas related to the coronavirus pandemic. In our work, we are consistently seeing a high number of clients and staff test positive, become hospitalized and in some cases death. Our governor has continually minimized the health risks in favor of economic growth. Our vaccine rollout has been challenging to say the least. – Other Health Provider (Maricopa County)

Arizona continues to rank at the top of the list for Covid-19 cases and death. – Other Health Provider (Maricopa County)

Pandemic, sick patients and staffing issues. – Physician (Maricopa County)

High rates of infection, illness and death. – Community Leader (Maricopa County)

Number of positive cases/deaths; impact on ICU/ER availability in hospitals; people not accessing healthcare for other issues because they are scared; burnout of healthcare workers; impact on mental health/isolation; inability to visit nursing homes, hospitals; impact on public transportation; increased costs to businesses; closing of many small businesses; unsure of long-term impact of having disease. – Public Health Representative (Maricopa County)

Arizona has one of the worst, if not the worst Covid-19 numbers in the USA. – Public Health Representative (Maricopa County)

Stats for Maricopa County infections and deaths have been extremely high throughout the pandemic, including in assisted living facilities. – Community Leader (Maricopa County)

Greatest pandemic of our lifetime, responsible for more than 500,000 deaths in United States so far. – Community Leader (Maricopa County)

The rates of infection in Arizona are some of the highest in the world. More people here are contracting the disease, having complications from it, and dying from it. As time goes on we will have a clearer picture as to the long term side-effects of having COVID 19. To this end, Arizona is going to face a larger health burden in the future as well since so many have/had the disease. – Community Leader (Maricopa County)

The community spread is high and resources are limited as well as vaccines. – Other Health Provider (Maricopa County)

The number of Covid cases and access to the Covid vaccine is challenging. There needs to be more support in this area. – Social Services Provider (Maricopa County)

Substantial death, substantial spread, many people are not getting access to needed health resources after having the virus. Still not wanting the vaccine. A lot of work to do the get the community and nation through this. – Other Health Provider (Maricopa County)

Infection rates remain high and many people are not adopting good practices. – Community Leader (Maricopa County)

We are in a pandemic. – Other Health Provider (Maricopa County)

The numbers are increasing. – Social Services Provider (Scottsdale)

Because it is a pandemic. – Social Services Provider (Maricopa County)

Lack of Local Leadership

The community leaders have not managed the risk factors well and this laxity has put Arizona in the higher Covid states. – Other Health Provider (Maricopa County)

Maricopa County has a higher than national average rate of Covid-19 due to a lack of a statewide coordinated public health plan and poorly coordinated vaccination plan. – Social Services Provider (Phoenix)

I do not believe that our leadership, Governor and Legislators, have prioritized the right things in managing this health crisis. They have focused on keeping business and the economy going, and not looking at the impacts on low income and communities of color. These communities are disproportionately impacted, economically, and worse health outcomes due to Covid-19. Even after Covid-19 is ‘gone’ the impacts will stay in those communities. – Community Leader (Maricopa County)

State leadership has not taken it seriously enough and spread of the disease is greater than it might have been with a better response. – Community Leader (Maricopa County)

Again, the governor continues to be a weak leader not actively promoting CDC guidelines, and now the vaccine roll out is poorly done. The buck stops at his desk yet he has been AWOL in leadership. Very poor communication to the state. – Other Health Provider (Maricopa County)

Lack of any leadership at the state level to address the crisis. – Public Health Representative (Maricopa County)

Poor governmental management of balancing economic needs versus measures to slow the spread. A lack of community awareness or concern for others. – Other Health Provider (Maricopa County)

Because the state government has not taken any responsibility to assist in mitigation. Our numbers are high. There is no mask mandate. Our vaccination plan is very slow. – Community Leader (Maricopa County)

It is out of control. There is no oversight and no leadership in the state addressing what has to be done to contain the virus and protect the population. The amount of cases and associated deaths is devastating and 100% preventable. – Public Health Representative (Maricopa County)

Our state did a poor job of implementing necessary restrictions to mitigate the spread of COVID-19 from day 1. Unfortunately this lack of direction continues. I do not feel that our state is doing a thorough job educating citizens to the benefits of receiving the vaccine nor is our state providing enough education to dispel misinformation pertaining to the vaccination. – Other Health Provider (Maricopa County)

Rates of Covid are still extremely high in Maricopa County, with limited state and county mandates on safety measures. – Community Leader (Maricopa County)

Noncompliance with Masks/Social Distancing

Lack of statewide enforcement of known preventative measures, such as masks; inequitable access to testing and vaccines; inequitable protection of vulnerable/low income employees, front line employees; lack of statewide employer requirements regarding sick employees working. – Social Services Provider (Maricopa County)

Lack of statewide mitigation measures. No mask mandate, lack of bars/restaurant closures, have led to widespread community transmission, overwhelming our hospital system. – Public Health Representative (Maricopa County)

People in my community do not wear masks. Many view it as a political stance. I have talked to a few who think it’s a conspiracy of some sort. Additionally, I have older patients who are not able to register for a vaccine. One person who was trying to register at a HUB online said every time he saw an available appointment, his hands would shake so bad he couldn’t manipulate the mouse to register. by the time he was able to complete the steps, the appointment was gone. - lack of understanding, lack of vaccine and poor methods to distribute vaccine. – Physician (Maricopa County)

Noncompliance with social distancing and masking by many; older people are isolated and frightened; testing is not widely advertised even though it is available; people with symptoms are afraid to go to the ER so symptoms get worse. The vaccination effort is abysmal -- most older people aren't even trying to get vaccinated but are waiting for the shots at their local CVS or Walgreens. The response by the state and county health departments has been in adequate. Clear and concise directions to the public on what to do has been inadequate. – Community Leader (Maricopa County)

Lack of acceptance on the part of some individuals, and as a result, there is a lack of concern for mitigating measures. People don't wear masks and they do not socially distance themselves. – Other Health Provider (Maricopa County)

The increase in positive cases and the observation that some people still do not wear masks. I fear that as the pandemic numbers decrease, that more people will feel no need to remain cautious. – Public Health Representative (Maricopa County)

People do not care about other's health/wellbeing. Are tired of social distancing and not being able to do normal things. Not having a mask mandate/people not wearing masks. Poor leadership from governor regarding Covid public health safety. – Physician (Maricopa County)

Vaccinations

The lack access to the Covid-19 vaccines for the vulnerable population. The senior population is having a difficult time getting an appointment to get the vaccine. The long term care facilities and GH are having difficult getting access to the COVID 19 vaccine as well. – Physician (Scottsdale)

Not enough vaccines or appointments, so people are feeling panicked. Deaths caused by COVID-19 are still high, even as the positive cases drop. The inability to be with loved ones when they are dying or to attend services/view the body is complicating grief and mental health issues. Deaths caused by COVID-19 are still high, even as the positive cases drop. The focus of the vaccine phased rollout hasn't included people with complicated health issues, leaving many still in fear of death. It feels like the last two are related - vulnerable are not vaccinated yet and death rates still high. – Social Services Provider (Maricopa County)

Although rates are declining, infectivity rates are still very high. Our vaccine rate response is inadequate. – Physician (Maricopa County)

Due to the low vaccination rate and high number of essential workers that are in the community that we serve, there is a higher probability that they will get infected and not have the resources to survive the disease. – Social Services Provider (Maricopa County)

Cannot get vaccine. – Community Leader (Maricopa County)

Individuals are not able to get the vaccine. – Other Health Provider (Maricopa County)

Awareness/Education

Many do not believe it is a serious issue. Some are skeptical about the level of danger. – Social Services Provider (Phoenix)

There's an abundance of information, including misinformation. People are overwhelmed in trying to separate good from bad info. It's impacting every area of SDoH, it has impacted access to food, need for food, education, health, transportation, and especially mental health. There is also a large economic impact, creating financial instability and housing instability. It's also impacting housing to the extent that there is bad information out there, people think they won't get evicted but they still get sent to court and judgements are placed against them. The future financial impact on housing instability is being underestimated. People are already overwhelmed in trying to navigate each system/resource and adding more steps and changing processes adds to the confusion. – Social Services Provider (Maricopa County)

Lack of information. – Social Services Provider (Maricopa County)

Clear guidance from CDC and Leadership. Lack of education and resources. Testing and how it spreads. Cultural, family gatherings, celebrations. Lack of tracing system. Lack of transportation to testing and vaccination sites. – Community Leader (Maricopa County)

Lack of up to date correct information regarding how best to protect yourself and those in your family from COVID 19 and the spread of COVID-19. Lack of information and supplies in receiving the COVID injections. Lack of government interaction as to educating and supporting health officials and their recommendations as per the CDC to protect those in the community. – Other Health Provider (Maricopa County)

Impact on Quality of Life

Covid-19 has impacted all sectors of life. Arizona has had difficulties with the population complying with the standards of infection control. Due to the lack of control, Arizona has become number one in incidence and death. – Other Health Provider (Maricopa County)

Mental health and the increased isolation, loss of jobs and family members. – Physician (Maricopa County)

Loneliness. High levels of social disconnection. – Community Leader (Maricopa County) People are dying, now we know people that are dying. We are still masked and can't travel freely. People are getting sick, it is impacting the economy, jobs and lives. – Other Health Provider (Maricopa County)

The effects of the COVID-19 pandemic are being disproportionately born by families with fewer resources (i.e., parents who cannot work from home, families that rely on public transportation, children who get free or reduced cost meals from their schools, etc.). In addition, the COVID-19 pandemic has been particularly harmful to individuals who have experienced historical or childhood trauma. The isolation, the uncertainty, the stress, etc., are especially dangerous to these individuals. – Community Leader (Maricopa County)

Emotional/psychological toll of isolation from Covid on populations. – Physician (Maricopa County)

High cost for the whole society, businesses closing, family loss, health post-COVID, Sequela. Expensive to mitigate the spread of Covid-19 from day one. Unfortunately this lack of direction continues. I do not feel that our state is doing a thorough job educating citizens to the testing, separation from elderly/family and kids out of school. – Physician (Maricopa County)

It makes people sick and can cause death. – Social Services Provider (Maricopa County)

The pandemic has created an atmosphere of fear and isolation. Many people have chosen not to take care of their physical and mental issues because of the fear of contracting Covid. Even refusing the vaccine. – Social Services Provider (Maricopa County)

Major life impact, and hospital utilization. – Other Health Provider (Maricopa County)

Access to Care/Services

Access to vaccine will continue to be an issue, and community compliance with guidelines set out to protect them are not being followed. – Other Health Provider (Scottsdale)

There are limited resources for families to stay and shelter at home without the worry of losing their homes. This includes rental and mortgage assistance but also includes modifications to home to help maintain the home healthy and safe for families. There is also a need for a greater supply of rapid tests higher supply of vaccines. – Social Services Provider (Phoenix)

Not enough resources. – Social Services Provider (Scottsdale)

Access to testing and to vaccines. Physical locations of care, familiarity and presentation of information. Multi-generational households, making it easier for virus to spread, harder to quarantine. – Community Leader (Maricopa County)

During peak simply run short of beds and staff. – Other Health Provider (Maricopa County)

Cancer treatments, I originally marked as a moderate concern, however it is an issue. If residents develop Covid they are unable to see their specialist or resume treatment until they are off Covid Unit, which could be 14 days up to 30 plus days. – Other Health Provider (Maricopa County)

Pandemic and finding resources to provide care for Covid patients. – Other Health Provider (Maricopa County)

Vulnerable Populations

COVID-19 disproportionately kills Black, Brown, and Indigenous Americans at a rate of 3x higher than white Americans according to a CDC analysis. In order to address these inequities, communities must provide equitable access to the vaccine, and work to dismantle the systemic racism embedded within health care systems which creates low levels of trust in healthcare by marginalized communities. If these inequities aren't addressed at local, County, and state levels, COVID-19 will continue to be a major problem. – Community Leader (Maricopa County)

Older population and many are not computer-friendly. A percentage of low SES and Hispanic population who may be hesitant to take the vaccine. Many people are still vacationing here and have not had the vaccine young and old, Healthcare workers who are running on little sleep and no end in sight. – Community Leader (Scottsdale)

We have numerous Latino families, multigenerational families who live in crowded situations and are less likely to seek medical care until they are very ill. – Physician (Maricopa County)

Rate of infection is extremely high in Maricopa County. Large proportion of Native Americans adversely impacted by this virus. In addition, the mental health issues surrounding this are excessive. – Other Health Provider (Phoenix)

The stats around infection of women and people of color are staggering and access to the vaccine for this population is currently very inefficient. The delay in providing vaccines for front line workers and folks who need to report to their job site may continue the spread. The other impacts of COVID-19 such as economic, education, housing, access to technology are expanding the gaps in these communities. – Social Services Provider (Maricopa County)

Communities of color are not receiving the vaccine and/or testing as much as those who identify as Caucasian. Low income and those without access to transportation and technology also do not have easy access to testing sites and vaccines. Information is not being shared regularly with non-English speaking communities and those communities also have a distrust of government so are more likely to be hesitant to get a vaccine. – Social Services Provider (Phoenix)

Testing

Slow access to testing, limited vaccines. – Other Health Provider (Maricopa County)

> We are not treating people when they initially get COVID or educating people on how to deal with COVID once they get it. While it has 'only' been a year, there are no established protocols on how a person who gets COVID should treat it and for what to watch as concerning signs. For example, a COVID patient, especially elderly and those with underlying conditions, should monitor their oxygen levels and understand at what level to go to the doctor, hospital, or call 911. In a country where people pride themselves on 'sucking it up' and going to school or work even when we feel ill, it is time for a reeducation on taking care of ourselves and not delaying our health. – Community Leader (Phoenix)
>
> Not enough rapid testing. – Social Services Provider (Phoenix)
>
> Lack of testing, contact retracing and vaccines. – Social Services Provider (Maricopa County)

Essential Workers

> A large part of the workforce in the community are service workers and are very exposed. – Social Services Provider (Phoenix)
>
> Many are front line and essential employees. They have lost jobs and support through the pandemic. This is especially difficult in communities of color and low income neighborhoods, where families live in multi-generational housing. – Social Services Provider (Phoenix)

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	42.7	42.3	42.0	43.5	46.1	49.4	52.8	54.6
AZ	46.2	46.8	46.9	48.3	50.1	53.2	55.3	56.8
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

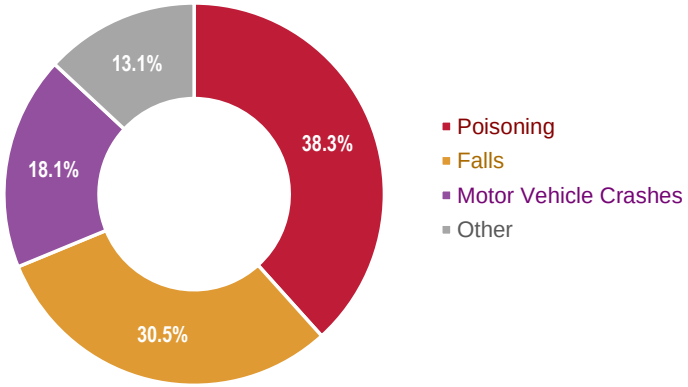
Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in the area include the following: [COUNTY-LEVEL DATA]

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading Causes of Unintentional Injury Deaths

(Maricopa County, 2017-2019)



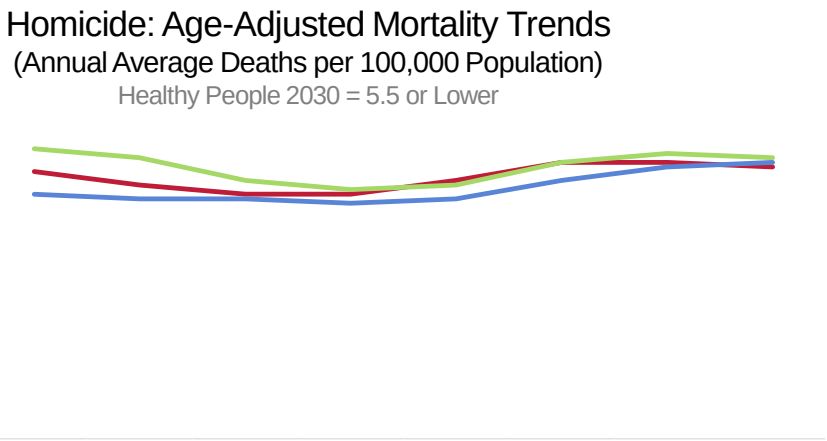
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]



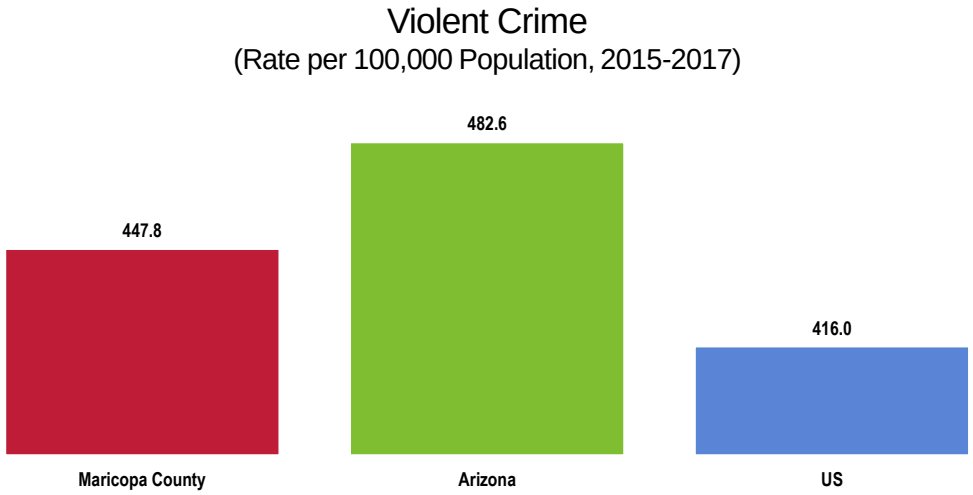
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	5.9	5.6	5.4	5.4	5.7	6.1	6.1	6.0
AZ	6.4	6.2	5.7	5.5	5.6	6.1	6.3	6.2
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]

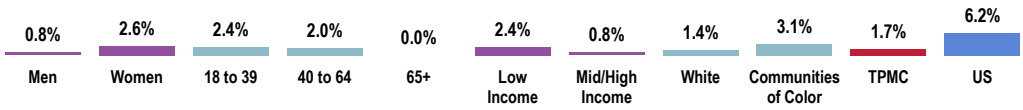


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

VIOLENT CRIME EXPERIENCE ► **"Have you been the victim of a violent crime in your area in the past 5 years?"**

Victim of a Violent Crime in the Past Five Years
(TPMC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

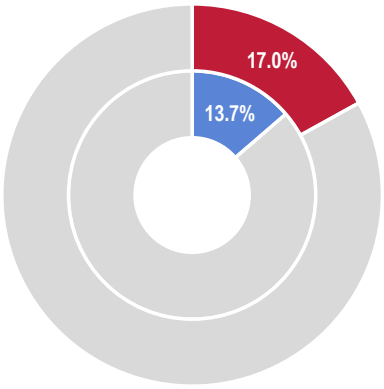
Notes:
- Asked of all respondents.

INTIMATE PARTNER VIOLENCE ► **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**

"During the past 12 months, has anyone THREATENED you or another member of your household with physical violence? This includes threatening to hit, slap, push, kick, or physically hurt them in any way."

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

Another 6.8% of adults have been threatened with physical violence by a member of the household in the past year.



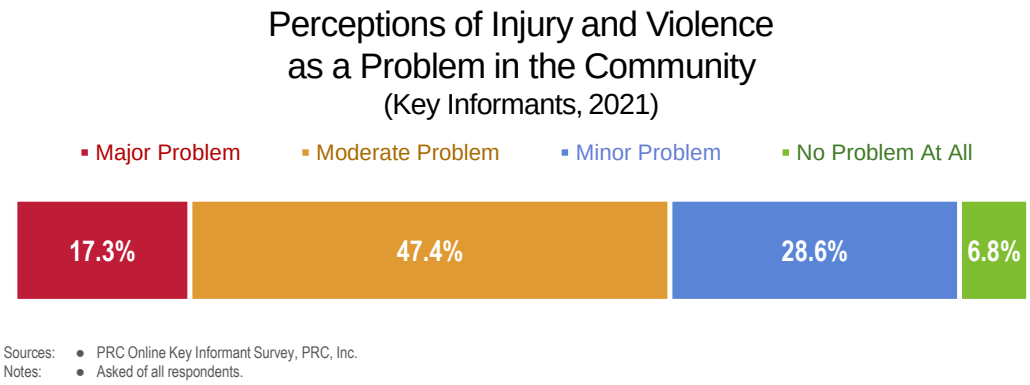
- TPMC Service Area
- US

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 39, 301]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> One of the leading causes of morbidity and mortality. – Other Health Provider (Phoenix)
>
> Lots of violent crimes happening in our city. – Physician (Maricopa County)
>
> Domestic violence and gang activity are on the rise since the pandemic. – Social Services Provider (Maricopa County)
>
> Domestic violence is on the rise. I oversee a domestic violence shelter and injury and violence is prevalent. – Social Services Provider (Maricopa County)

COVID-19

> Crime rates are high in the Maryvale Area and other areas. They've risen during the pandemic. Public spaces for play and exercise are less utilized if perceived as less safe. – Social Services Provider (Maricopa County)
>
> Domestic violence, injury, child abuse have increased greatly during COVID-19. – Other Health Provider (Maricopa County)
>
> Suicide and domestic violence rates continue to rise, especially during the pandemic. More police reports involving escalated physical violence in domestic violence situations. – Community Leader (Maricopa County)
>
> DV is on the rise as more people have to deal with the stress of job loss, economic insecurity, loss of healthcare that sometimes comes from job loss, being at home and school insecurity with their children. – Social Services Provider (Phoenix)

Contributing Factors

> Environment lived in, including higher rates of crime and violence, and type of work done. Given higher rate of injury with physical labor. – Community Leader (Maricopa County)
>
> No prevention efforts. – Social Services Provider (Maricopa County)
>
> Lack of support for individuals and families on resolving conflict. – Social Services Provider (Phoenix)

Income/Poverty

> Domestic violence and child abuse are prevalent in low income communities. – Social Services Provider (Phoenix)

Law Enforcement

> Lack of support for the police department, as well as not enough officers. – Other Health Provider (Maricopa County)

Youth Suicide

> Suicide rates for youth are very high and higher than previous years. – Community Leader (Maricopa County)

Diabetes

ABOUT DIABETES

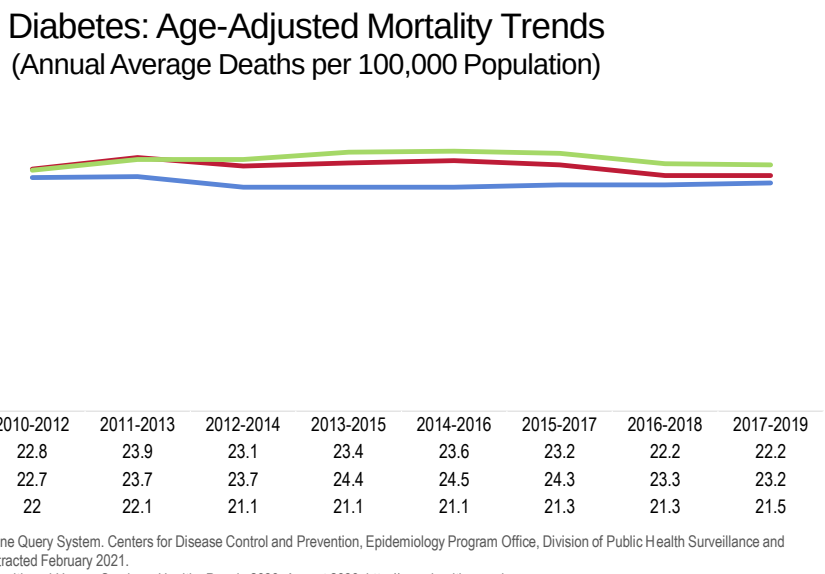
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	22.8	23.9	23.1	23.4	23.6	23.2	22.2	22.2
AZ	22.7	23.7	23.7	24.4	24.5	24.3	23.3	23.2
US	22	22.1	21.1	21.1	21.1	21.3	21.3	21.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Prevalence of Diabetes

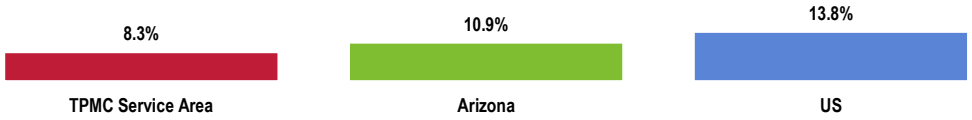
"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)**"**

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)**"**

[Adults who do not have diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**

Prevalence of Diabetes

Another 15.7% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

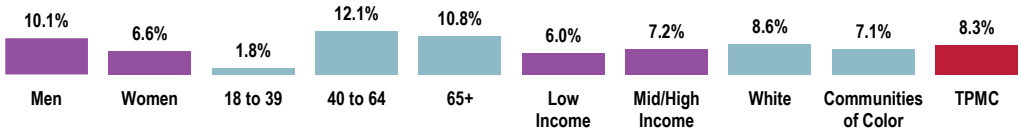


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 121]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(TPMC Service Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 46.7% report having had their blood sugar level tested within the past three years.

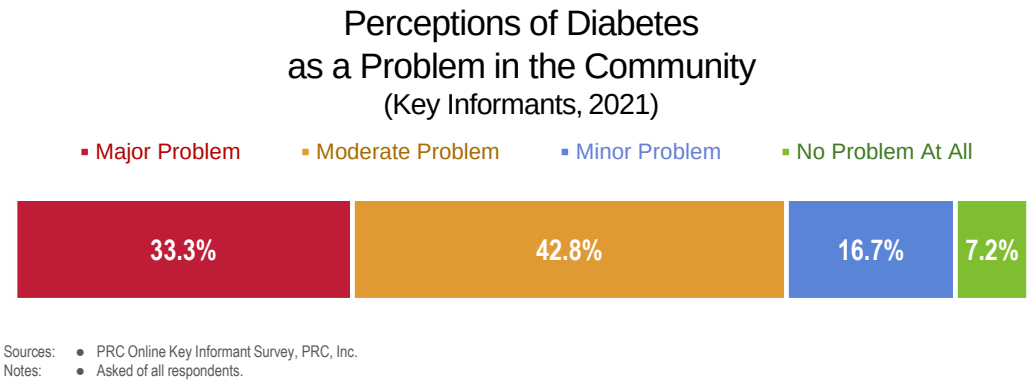


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 33, 121]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> Lack of fresh and healthy food in the inner city. – Community Leader (Phoenix)
>
> Access to affordable, healthy food in a food desert. Educational support on adjusting life style as an aid in caring for the disease. – Social Services Provider (Maricopa County)
>
> Food deserts. – Community Leader (Maricopa County)
>
> Access to health food and medication. Lack of safe and available outside spaces for daily exercise. Multiple competing daily priorities. – Community Leader (Maricopa County)
>
> Eating healthy food that is readily available and less expensive than unhealthy, processed foods. – Physician (Maricopa County)
>
> Affordable healthy food. – Other Health Provider (Maricopa County)
>
> Poor access to healthy food. Poor health from diet and lack of physical activities. – Social Services Provider (Phoenix)
>
> Access and affordability of healthy food, inability to find affordable medications such as insulin. – Physician (Maricopa County)
>
> Poor diet due to food deserts and lack of funds, poor exercise. – Physician (Maricopa County)

Awareness/Education

> Many people are obese and likely to develop diabetes, but don't know the symptoms. Type II is and has been on the rise, particularly in young people, but many go untreated. – Community Leader (Maricopa County)
>
> Education and adherence. – Other Health Provider (Maricopa County)
>
> Lack of information and access to medical attention, one stop center for all. – Social Services Provider (Maricopa County)
>
> Lack of supportive follow-up, resulting in lesser compliance. – Other Health Provider (Phoenix)
>
> Access to diabetic education classes. – Physician (Scottsdale)
>
> Understanding nutrition, understanding carbs, meal planning, affording the healthier foods and sugar alternatives, access to healthy food. There are affordable healthy fast food options in the county like Salad and Go but not in neighborhoods where it's most needed. – Social Services Provider (Maricopa County)
>
> Issues with education and low income affording food that is health for them. – Physician (Maricopa County)
>
> Lack of understanding of the severity of the issue. – Social Services Provider (Maricopa County)
>
> Access to appropriate knowledge, nutrition, exercise and support. – Other Health Provider (Maricopa County)
>
> Education, appropriate referrals to specialists, diet, cost of supplies and medications. – Other Health Provider (Maricopa County)

Contributing Factors

> Maintaining health diets, food, nutrition. Lack of education on importance of regular visits, compliance with medical plan. – Physician (Maricopa County)

> Cost of supplies, lack of motivation. – Physician (Maricopa County)
>
> Lack of public transportation to health care, poor diet due to high cost of living. – Social Services Provider (Phoenix)

Affordable Care/Services

> Too many of us have it in the first place, myself included. Adequate healthcare coverage faces a financial divide between those who can afford access and those who cannot do not have adequate services available to them. – Other Health Provider (Maricopa County)
>
> Access to effective and often high cost medical management for poor community members. Adequate access to healthy diet. – Physician (Maricopa County)

Lifestyle

> Getting them to engage in and take responsibility for their health care. – Social Services Provider (Maricopa County)

Affordable Medications/Supplies

> Access to insulin and affordable insulin; access to affordable equipment, like pumps, test strips and medical care. – Social Services Provider (Maricopa County)

Transportation

> Access to existing resources due to limited transportation. – Social Services Provider (Maricopa County)

Comorbidities

> The most common illness that causes so many health problems. Immunity low, wounds, infections, dementia, cancer and obesity. – Physician (Maricopa County)

Incidence/Prevalence

> Arizona has about 12–14% of our population living with diabetes. Additionally a high percentage of Arizonans have prediabetes. – Other Health Provider (Maricopa County)

Language Barriers

> Access to information in other languages other than English. Access to testing, screenings and education to low income communities and non-English speaking communities. Education that takes into consideration community culture and lifestyles along with high risk aspects of some cultures. – Social Services Provider (Phoenix)

Nutrition

> Poor nutrition. – Physician (Maricopa County)

Kidney Disease

ABOUT KIDNEY DISEASE

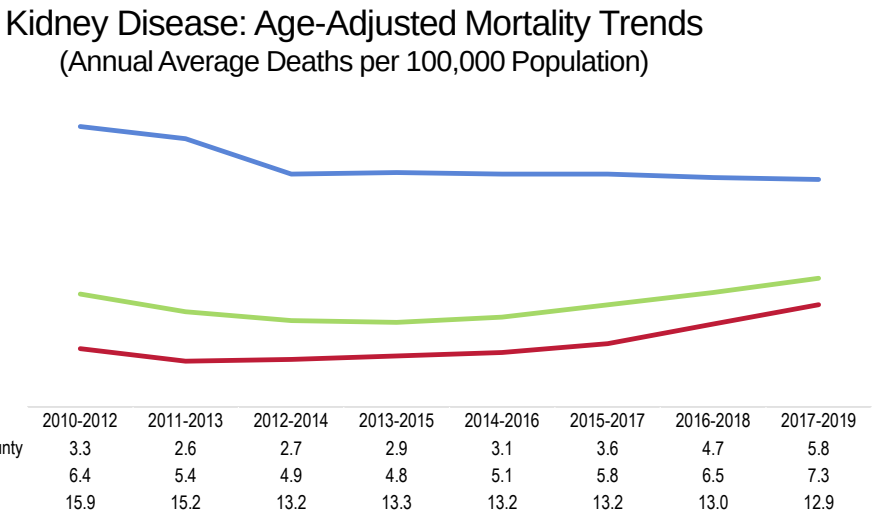
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart. [COUNTY-LEVEL DATA]

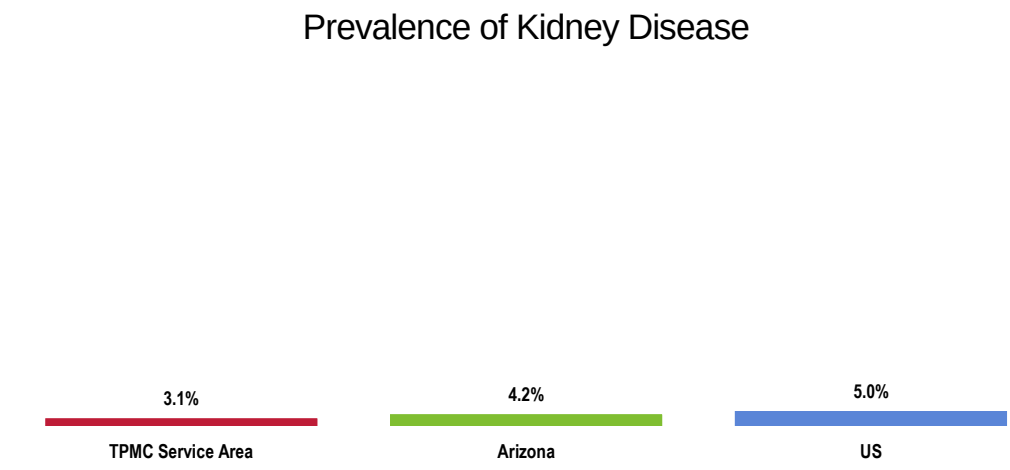


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	3.3	2.6	2.7	2.9	3.1	3.6	4.7	5.8
AZ	6.4	5.4	4.9	4.8	5.1	5.8	6.5	7.3
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

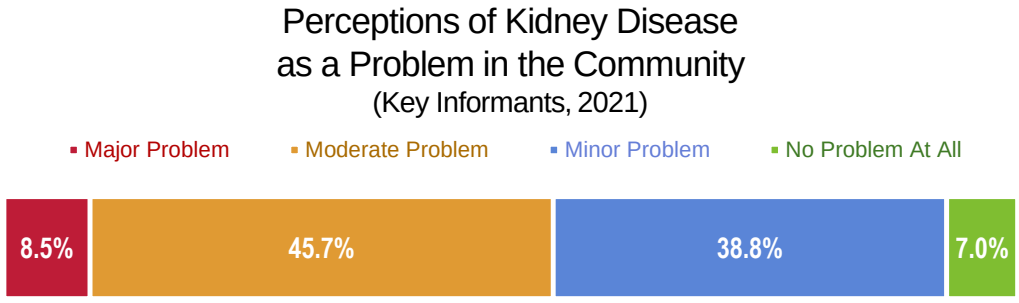


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Kidney Disease* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Comorbidities

> Uncontrolled diabetes. – Physician (Maricopa County)
>
> Increased rate of chronic conditions like hypertension, diabetes mellitus that contribute to chronic kidney disease. – Physician (Maricopa County)
>
> Kidney disease is a consequence of uncontrolled hypertension and diabetes mellitus and heart disease. Cost for this disease is very high, especially when involving dialysis. – Physician (Maricopa County)

Access to Care/Services

> Hemodialysis patients continually use the emergency department for dialysis. Patients who are not compliant or have behaviors are kicked out of their clinics and forced to use the hospital for dialysis. The hospital attempts to DC and has no accepted dialysis clinic. – Other Health Provider (Phoenix)

Affordable Care/Services

> Affordable health care. – Other Health Provider (Maricopa County)

Awareness/Education

> Poor public awareness of preventative health care decisions. – Other Health Provider (Maricopa County)

Nutrition

> Overall poor health driven by lack of nutrition and healthy lifestyle options. – Community Leader (Maricopa County)

Potentially Disabling Conditions

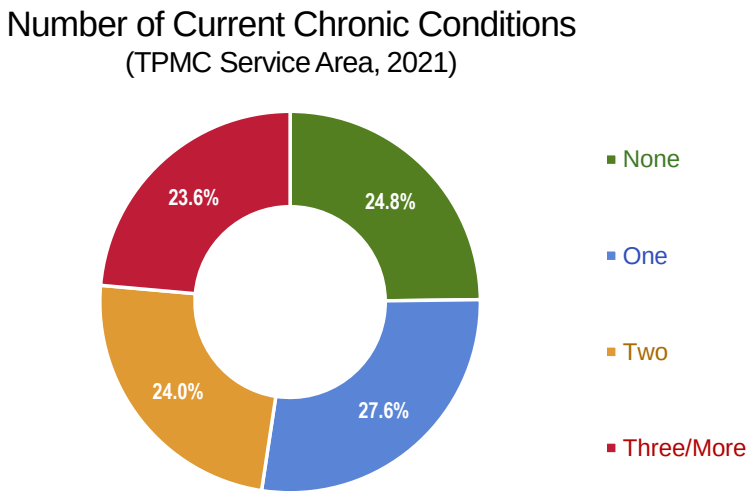
For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

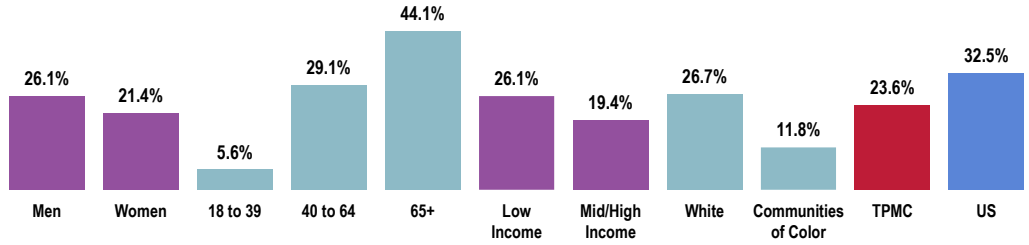
Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(TPMC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

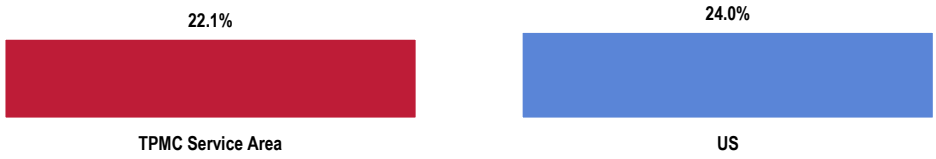
– Healthy People 2030 (https://health.gov/healthypeople)

"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

[Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

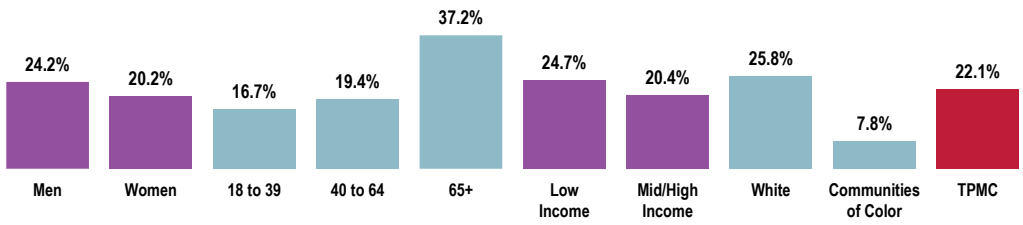
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

Most common conditions:
- Back/neck problems
- Arthritis
- Mental health
- Lung/breathing problem
- Diabetes
- Difficulty walking



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

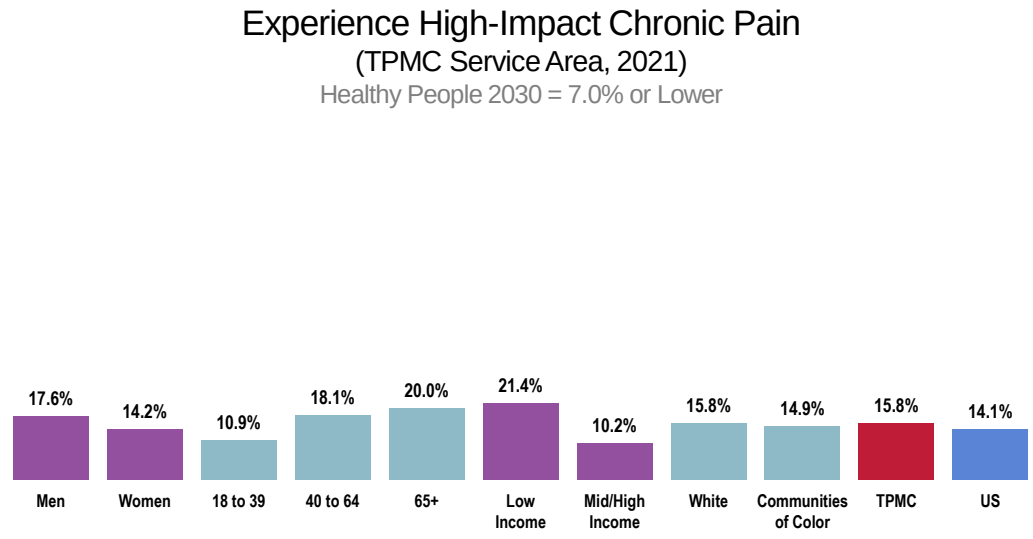
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(TPMC Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: Asked of all respondents.

High-Impact Chronic Pain

"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

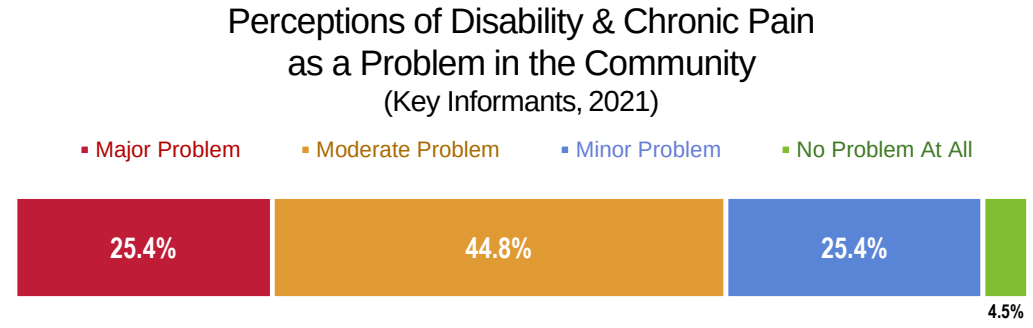


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective MICH-8.1]

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of services and supports for all people with disabilities and in particular very young children. – Social Services Provider (Maricopa County)

> Limited accommodations for people with disabilities. Lack of alternatives to opioid chronic pain management. – Community Leader (Maricopa County)
>
> There are just few outpatient resources for this. – Physician (Scottsdale)

Affordable Care/Services

> Affordable health care. – Other Health Provider (Maricopa County)
>
> Disability and chronic pain are expensive to treat and have no cure (generally); access is complicated and difficult (technology and physically); public benefits are sometimes involved; difficult to hold employment these conditions; impact on family/caregivers; often lowers lifespan or causes other chronic conditions; not enough specialists - Public Health Representative (Maricopa County)

Incidence/Prevalence

> Multiple patients seek assistance with managing their pain. – Other Health Provider (Phoenix)
>
> I hear and see a lot of individuals always sharing their stories. – Social Services Provider (Maricopa County)

Opioid Crisis

> There are many, many people with chronic pain now addicted to opiates and not holding employment. They lack resources for addition, financial help for rent/food, lack jobs. Depression and suicide are added on. – Physician (Maricopa County)
>
> Having worked on the opioid epidemic in Arizona and Maricopa, we quickly learned how many people were utilizing pain meds for chronic pain. Quick and affordable access to physical therapy, massage, accupuncture, trauma therapy is limited, expensive or unavailable and reliance on medication is one of the only ways people can deal with pain. – Social Services Provider (Maricopa County)

Contributing Factors

> Workplace. Most jobs available are very physical. Stressors in home environment, damaging behavioral/emotional health. – Community Leader (Maricopa County)
>
> Past life issues of substance abuse or past injuries that went untreated. Poor nutrition and no easy access to Medicare or healthy food. – Social Services Provider (Phoenix)

Aging Population

> Maricopa County has a higher than national average rate of disabilities and chronic pain due to higher number of those age 65+. – Social Services Provider (Phoenix)
>
> There is a large elderly population in Maricopa County, many have disabilities and chronic pain. – Physician (Maricopa County)

Co-Occurrences

> Chronic pain is very difficult to treat. We see the fallout from previous decades of prescribing opioids, we know that anxiety, depression, and trauma are tied into chronic pain. Treating in a silo does not work, you must treat the whole person through behavioral health modalities, medical services (including MAT), and physical therapy with a focus on overall function. – Other Health Provider (Maricopa County)
>
> ALS. – Social Services Provider (Scottsdale)

Reliance on Medication

> People rely on medications to treat their pain. They do not want to do physical therapy, weight loss, exercise, etc. to help their chronic pain. – Physician (Maricopa County)
>
> Medication abuse. – Other Health Provider (Maricopa County)

Diagnosis/Treatment

> ED visits and hospital admissions are noted for acute on chronic pain rather than other medical conditions. Inpatient care for chronic pain is suboptimal, and there are few options for transitioning patients to outpatient care of chronic pain. – Physician (Maricopa County)

Impact on Quality of Life

> Many of my patients have gait limitations and chronic pain that limits their ability to work. – Physician (Maricopa County)

Insurance Issues

> Most medical insurance will not cover natural pain management, AHCCS does not cover it. – Other Health Provider (Scottsdale)

Lack of Providers

> Lack of providers. – Social Services Provider (Scottsdale)

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

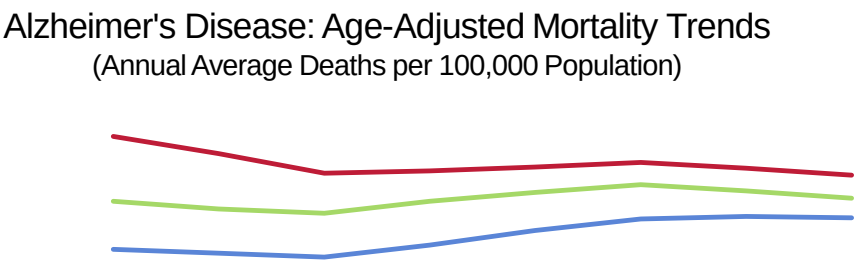
Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]

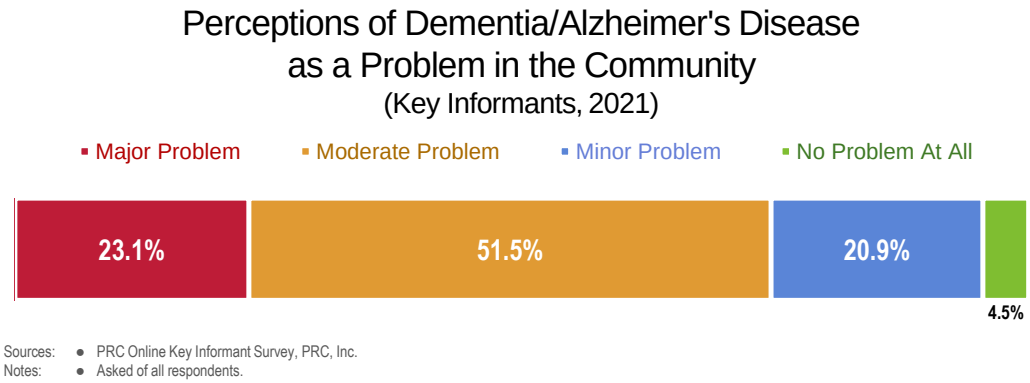


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	43.2	40.5	37.4	37.8	38.4	39.1	38.2	37.1
AZ	33.0	31.8	31.1	33.0	34.4	35.6	34.6	33.5
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> We are a state with a large elderly population. – Other Health Provider (Maricopa County)
>
> Our aging population in Arizona. – Public Health Representative (Maricopa County)
>
> Arizona has an older population as a retirement destination, we have a high number of people over the age of 65 liviing with Alzheimers and dementia in our state. There is a tremendous burden on family caregivers to bear the burden of caring for their loved ones. There are hundreds of millions of hours of unpaid care that is provided by family caregivers. There are limited funds available for professional caregivers, and there is a workforce shortage of people willing to do the work of a caregiver at the low wages that can be paid. – Other Health Provider (Maricopa County)
>
> Aging population, lack of long-term care options. – Physician (Maricopa County)
>
> Elderly population is increasing and there are not any services for caregivers and dementia patients. – Physician (Maricopa County)
>
> Elderly with low income, placement in group home and lack of therapy. Cost of medical care and hard to diagnose. – Physician (Maricopa County)
>
> Scottsdale has an older/retired population and will need more memory care housing. – Community Leader (Scottsdale)

Access to Care/Services

> I used to work in Senior Living and I saw firsthand how there is a major need for dementia care. We are even seeing more early onset than ever before. – Other Health Provider (Maricopa County)
>
> Undiagnosed due to lack of access to care. Attempts to treat it at home. – Community Leader (Maricopa County)
>
> Services for families with a family member experiencing dementia or Alzheimer's are quite challenging to find. Even the hospital staff don't really seem to know how to manage a patient with these diseases so it is more challenging to get care for such patients. This can be addressed through better staff training and expansion of support services. – Community Leader (Phoenix)
>
> Limited resources available to the community to address dementia/Alzheimer's. – Physician (Scottsdale)
>
> The slowing of in-person health care has left this population without access to needed care. – Other Health Provider (Maricopa County)

Incidence/Prevalence

> It is a growing problem across the USA. Arizona has the one of the highest rates of increase in new diagnoses due to its age demographics. There has been approximately a 60% increase in the number of cases in 2020 compared to 2009. – Public Health Representative (Maricopa County)
>
> Maricopa County has a higher than national average rate of dementia/Alzheimer's. – Social Services Provider (Phoenix)
>
> Arizona has the largest growth of population with dementia, and specifically Alzheimer's dementia, in the United States. – Physician (Maricopa County)

COVID-19

> Because I believe the pandemic has escalated dementia in our community. – Other Health Provider (Phoenix)
>
> The increasing number of cases in our community coupled with isolation from Covid and the limited services in our Senior Centers. – Social Services Provider (Maricopa County)

Environmental Contributors

> Environmental concerns in the community, past life issues such as substance abuse and violence. – Social Services Provider (Phoenix)
>
> It is growing and evidence suggests that it is connected to air quality, Mayo research. With an increasing urban heat island and no plan or urban planning for tree planting, it will only get worse. – Community Leader (Maricopa County)

Contributing Factors

> Dementia and the ability to care for these people that are homeless and or don't have family. – Other Health Provider (Maricopa County)
>
> Growth in older adults in Arizona. Lack of end of life planning. Low social security or retirement dollars. Limited health insurance support. – Community Leader (Maricopa County)

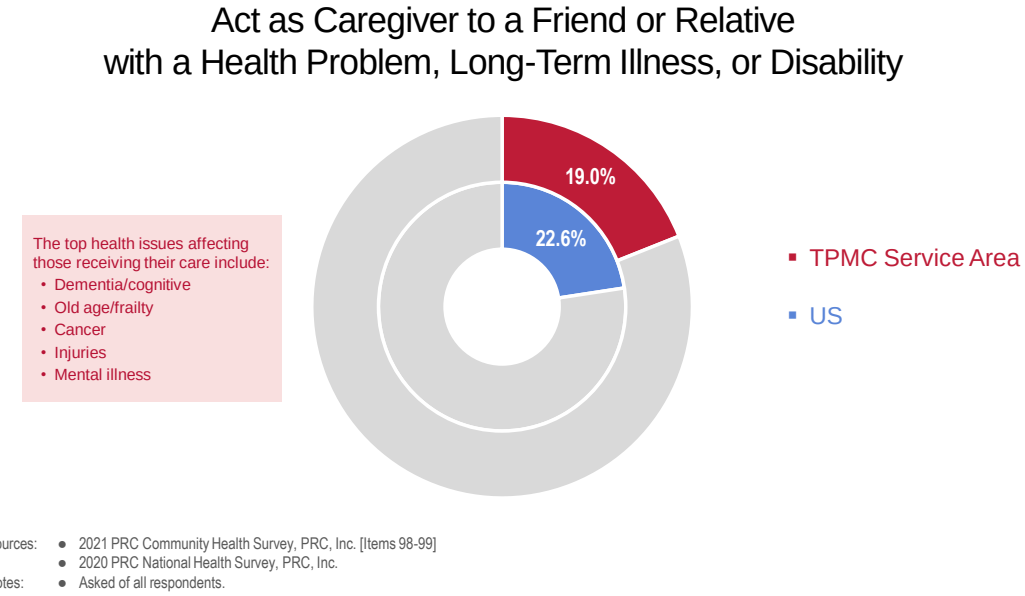
Vulnerable Populations

> Communities of color do not have regular access to screenings or information is limited in other languages besides English. Low income communities also do not have regular access to information, screenings or testing especially when so much is through telemedicine currently. – Social Services Provider (Phoenix)

Caregiving

"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

[Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 98-99]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

BIRTHS

ABOUT INFANT HEALTH

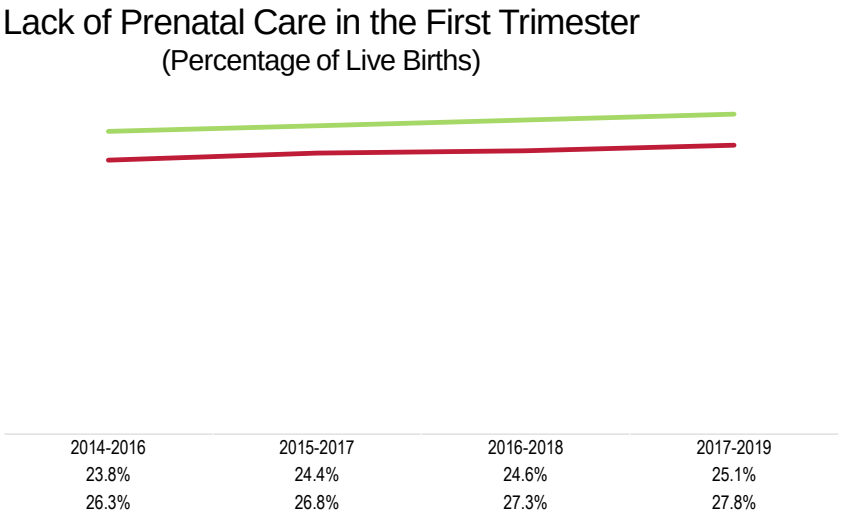
Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Lack of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following chart. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	23.8%	24.4%	24.6%	25.1%
AZ	26.3%	26.8%	27.3%	27.8%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.

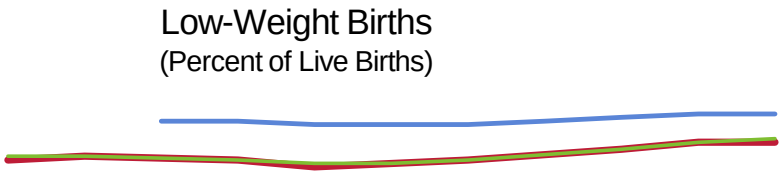
Note: ● This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

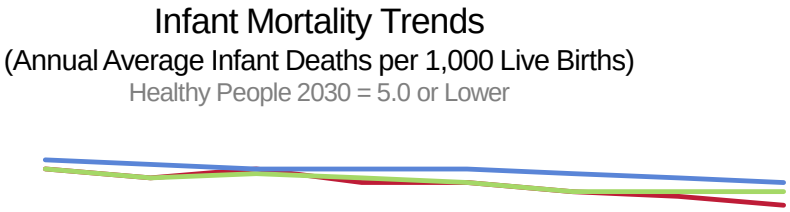


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Maricopa County	7.0%	7.1%		7.0%	6.8%	6.9%	7.0%		7.3%	7.5%	7.5%
AZ	7.1%	7.1%		7.0%	6.9%	6.9%	7.0%		7.3%	7.5%	7.6%
US			8.1%	8.1%	8.0%	8.0%	8.0%	8.1%	8.2%	8.3%	8.3%

Sources: ● Arizona Health and Vital Statistics, Bureau of Public Health Statistics, Various Health Statistics, Births Section. Sourced from Kidscount.org.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart. [COUNTY-LEVEL DATA]



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	5.9	5.7	5.9	5.6	5.6	5.4	5.3	5.1
AZ	5.9	5.7	5.8	5.7	5.6	5.4	5.4	5.4
US	6.1	6.0	5.9	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

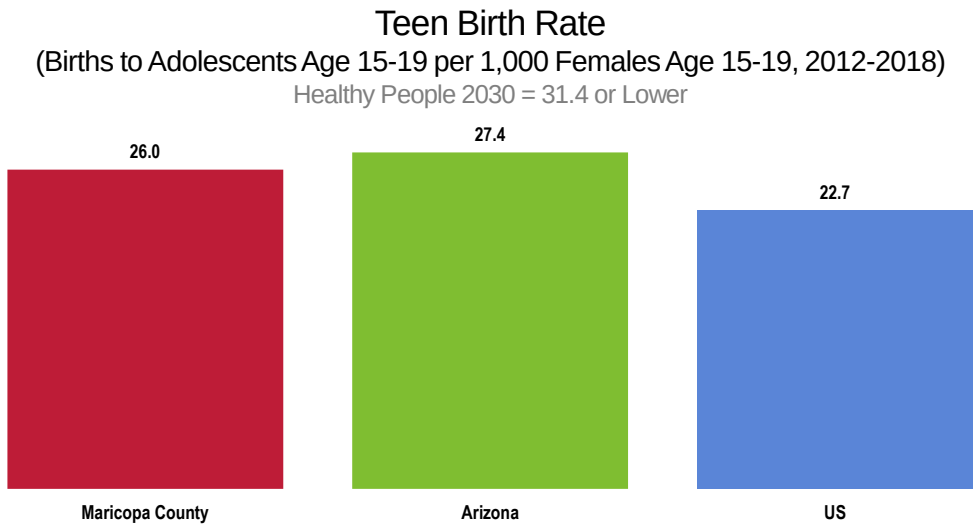
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years. [COUNTY-LEVEL DATA]

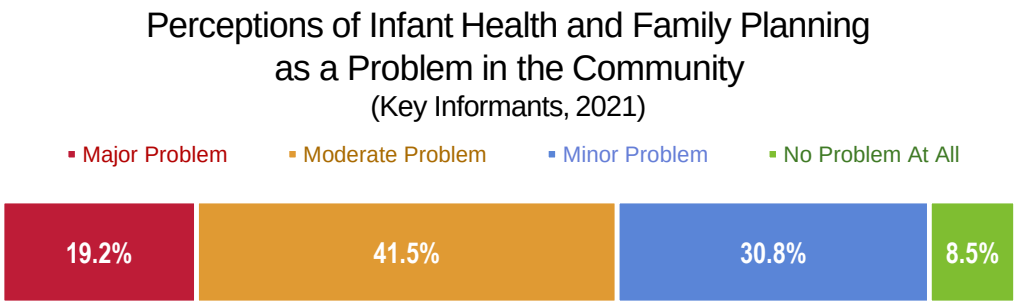


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved 2E-DATE via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

> There is a lack of family planning centers and resources. There is a lack of education on the subject of family planning. – Social Services Provider (Phoenix)
>
> We have a large underserved population that includes women and children. Many women do not have access to family planning. – Other Health Provider (Maricopa County)
>
> Infant health and family planning is an area that organizations like First Things First, which focuses on early childhood development and family support combat challenges in this area. Covid has added additional stress on the system and our families. – Social Services Provider (Maricopa County)
>
> Lack of services and politics. – Social Services Provider (Maricopa County)
>
> There is inadequate access to LARC for young mothers. Prenatal care can be difficult to access and patients are often lost to follow-up prior to their delivery. There is not regular communication between the delivering provider and newborn provider. – Other Health Provider (Phoenix)

Government/Politics

> Due to political and religious ideology, access to family planning is limited and under attack by conservatives, particularly for lower income families that would benefit the most from access to counseling and family planning support. Access to healthcare in general for lower income families is limited. – Community Leader (Maricopa County)
>
> Planned Parenthood has taken an unfair financial hit. They have been a huge, positive contributor to our communities for decades. Thousands of individuals need it to be fully funded and supported by the community. Quit playing politics with them. – Other Health Provider (Maricopa County)
>
> Health care disparities, dysfunctional state government. – Public Health Representative (Maricopa County)
>
> Family Planning has been limited through recent actions at the state and federal level. Early intervention with family planning, parent education, pre-natal care, and then early childhood help don’t appear to be a focus of our Arizona government. Instead, money gets shifted to putting children into foster care. Primary support for these services is offered by several non-profits but I am not aware of those focusing on the North Central/Sunnyslope area. – Community Leader (Phoenix)

Vulnerable Populations

> Rural communities, low income and non-English speaking communities do not have adequate access to infant health care, prenatal care and family planning especially now when many doctors are only available by telemedicine. Access to family planning is also not available to teens when kids are not in person at school. – Social Services Provider (Phoenix)
>
> WIC office would have approximately 1,200 contacts per month. We are a Title 1 school with 89% free meals. As a nurse case manager, I deal with many of our families as well as home visits. We also have two Head Start classes. – Community Leader (Phoenix)
>
> High immortality rate in the black community, WIC offices have been closed or have minimal services due to staff cuts. – Community Leader (Maricopa County)
>
> Maternal mortality is much higher for women of color than white women; that needs to be addressed. – Community Leader (Maricopa County)

Affordable Care/Services

> Arizona has a high number of low income families that have little or no access, other than via their AHCCCS plans to seek assistance with family planning and infant care. Shortage of pediatric physicians and specialists in Arizona. – Other Health Provider (Maricopa County)
>
> Lack of affordable health care, discrimination against minority populations and immigrant communities to access support and resources. – Social Services Provider (Maricopa County)

Awareness/Education

> Efforts to restrict family planning and comprehensive sex education in schools, including Planned Parenthood, etc. – Community Leader (Maricopa County)
>
> Lack of information and access to care. – Social Services Provider (Phoenix)

Income/Poverty

> Poverty rate, average income, poorly ranked public educational and support system. – Physician (Maricopa County)

Infant Mortality

> High rates of infant mortality, lack of access to care. – Community Leader (Maricopa County)

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

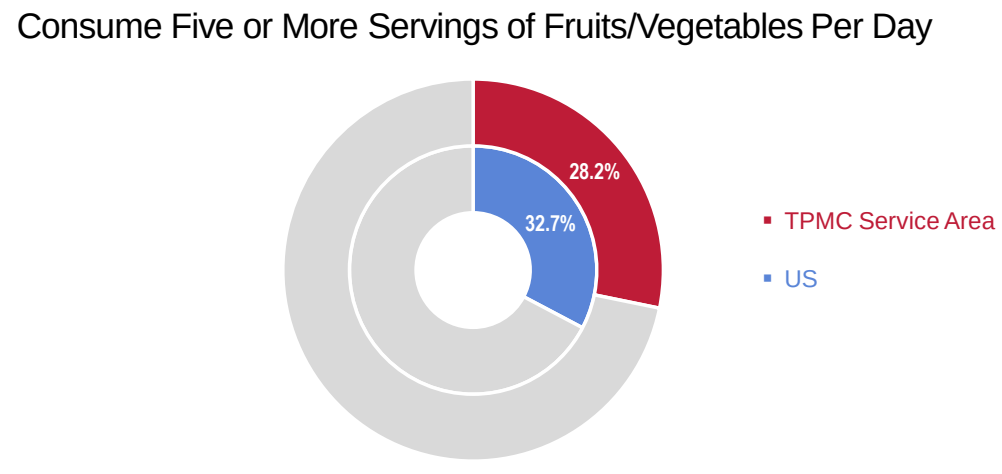
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

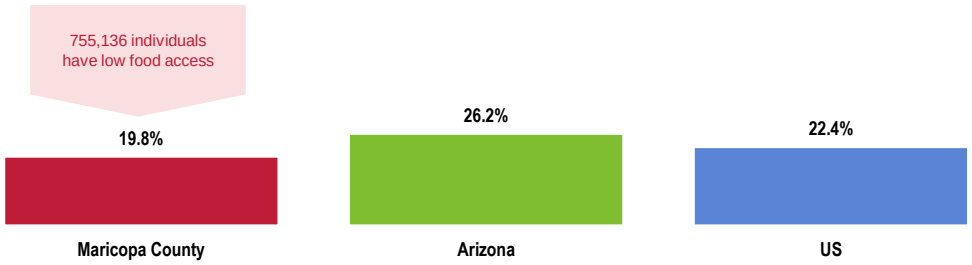
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(TPMC Service Area, 2021)

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

ABOUT PHYSICAL ACTIVITY

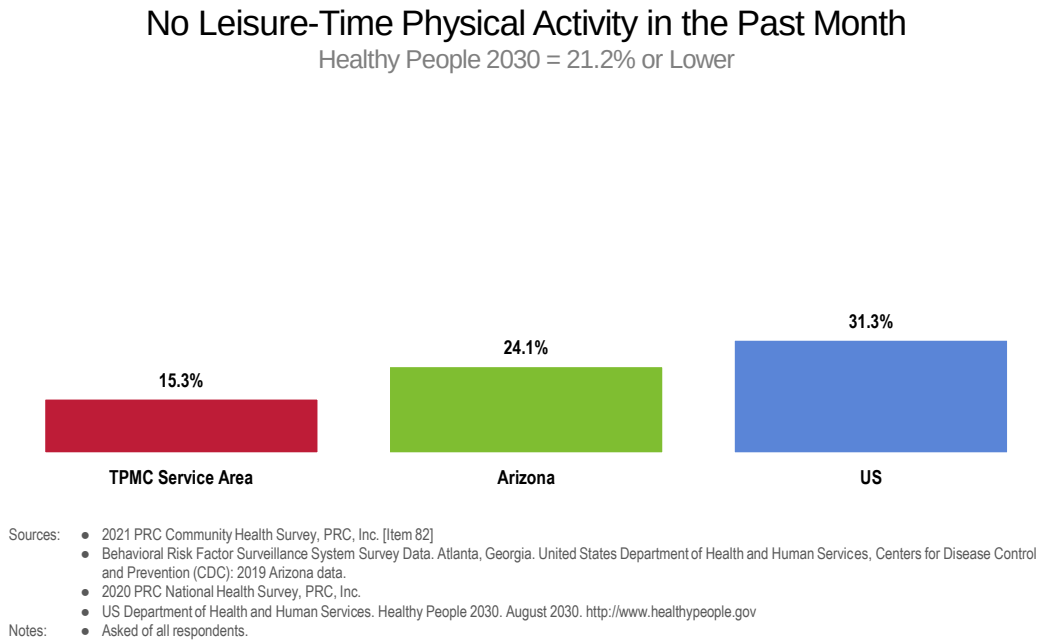
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

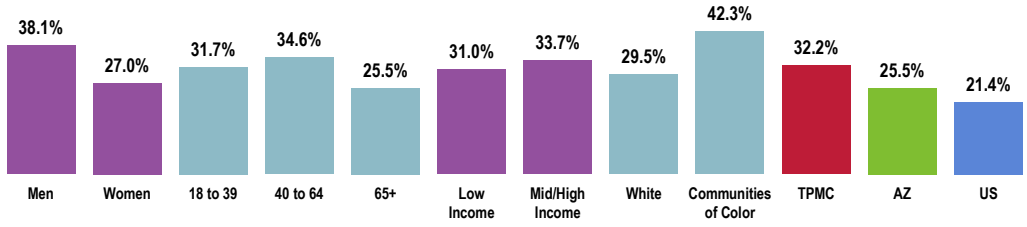
"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations

(TPMC Service Area, 2021)

Healthy People 2030 = 28.4% or Higher



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

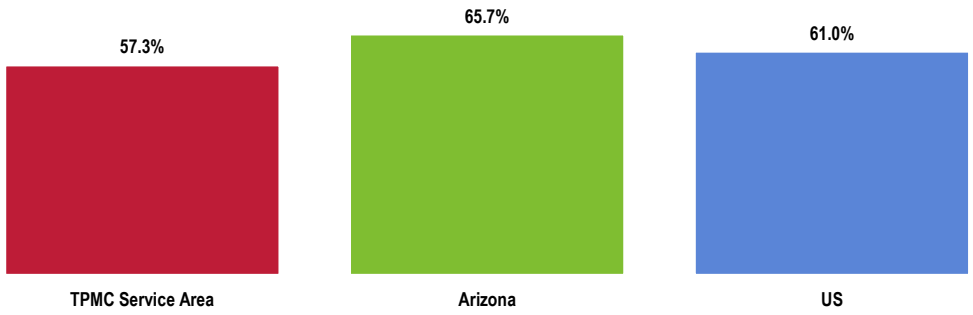
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

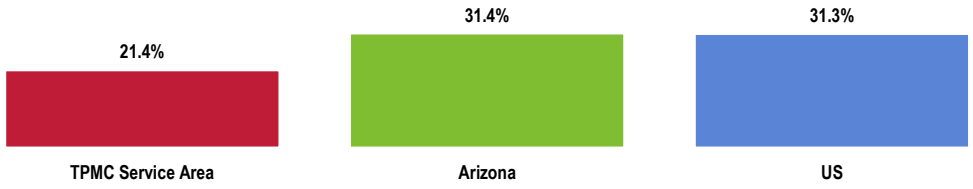


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

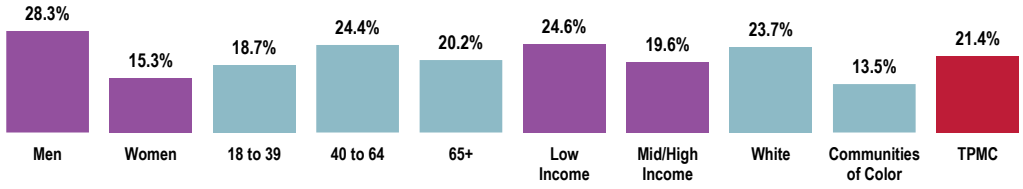
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(TPMC Service Area, 2021)
Healthy People 2030 = 36.0% or Lower



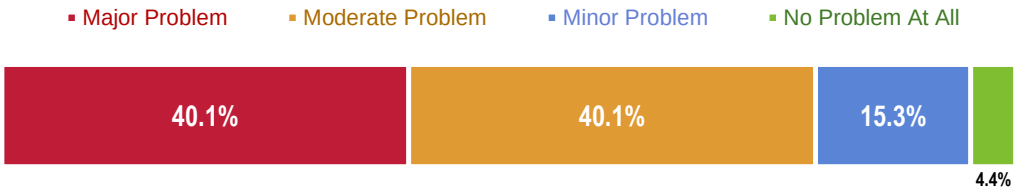
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2021)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Ignoring good health advice and the traditional eating habits of some populations. – Community Leader (Maricopa County)
>
> A public health campaign to encourage healthy nutrition, exercise and losing weight. Lower income families feel they can't afford to eat healthy, even if they wanted to do so. It is more expensive to eat healthy. Family budgets are tight and fast food, sodium filled frozen dinners etc. are often the foods of choice. – Other Health Provider (Maricopa County)
>
> Many in Arizona are obese and overweight - this is directly related to nutrition and physical activity. We have some of the highest child poverty rates in the country, which leads to lack of healthy food for families. We have streets that are not maintained and are dangerous for walking or biking, making being active even harder - this is particularly true for specific neighborhoods like South Phoenix and Maryvale. – Community Leader (Maricopa County)

Food deserts in many poorer neighborhoods. Lack of physical activities in schools other than paid sports programs. – Community Leader (Maricopa County)

Access to fresh and affordable food, information about physical activity and its importance, and poverty. – Social Services Provider (Maricopa County)

Maricopa County has a higher than national average rate of poor nutrition, and high weight due to Phoenix being a driving city, rather than being able to walk to amenities. – Social Services Provider (Phoenix)

Access to healthy food, minimal exercise education and opportunities in the schools. – Other Health Provider (Phoenix)

Lack of healthy food options. Lack of safe and available outside space for physical activity. – Community Leader (Maricopa County)

Food insecurity, access to equipment or a safe neighborhood to walk, education about diet and nutrition. – Other Health Provider (Maricopa County)

Access to healthy food and exercise programs, affordability, isolation and the stress of the pandemic. – Community Leader (Maricopa County)

Cost of healthy food, access to healthy food, smoking, kids not being in school, so no PE or activity. – Social Services Provider (Phoenix)

High rate of obesity, lack of understanding of healthy diet, lack of adequate resources to obtain a healthy diet. – Community Leader (Maricopa County)

Lack of information. Too much down time spent on technology. Healthy food is more expensive. – Social Services Provider (Maricopa County)

Built Environment

Safe places to engage, affordable, low/no cost options for healthy food. Overall needing to feel less stressed about crisis management so they can focus proactively on adopting healthier habits. – Social Services Provider (Maricopa County)

Lack of access to parks and open space. Lack of affordable healthy food in the community. – Public Health Representative (Maricopa County)

Access to parks, nutritional food for our populations. – Social Services Provider (Maricopa County)

Physical environment. Lack of space/opportunity for physical activity. – Community Leader (Maricopa County)

Lack of community resources and the nature of the communities design lends to an inability to live a naturally active lifestyle, i.e. walking, biking, running, etc. Food deserts in certain areas create barriers to access healthy, affordable foods. – Public Health Representative (Maricopa County)

Access to Affordable Healthy Food

Food deserts. Many people do not have access to fresh foods or they cannot afford quality foods. Families in poverty do not get to make the same choices about food and exercised that others can. – Community Leader (Maricopa County)

Access to healthy, affordable food. – Community Leader (Maricopa County)

The low to moderate income families do not have access to affordable healthy food choices in their communities. Physical activities need to be increased in schools. – Social Services Provider (Phoenix)

Food insecurity and cost of healthy food choices. – Physician (Maricopa County)

Food access. – Social Services Provider (Maricopa County)

Obesity

Obesity is widespread. Eating healthy is expensive and takes time to cook and plan. People don't seem to exercise enough. – Physician (Maricopa County)

Obesity, food deserts in low income areas. – Physician (Maricopa County)

AZ ranked 34th nationally in regards to percentage of adults who are obese, and we rank 25th in childhood obesity. We have numerous challenges related to this, access to nutritious food, safe places to play for children in many neighborhoods. In Phoenix, we are not a walkable city. – Other Health Provider (Maricopa County)

Obesity. – Social Services Provider (Maricopa County)

Specifically, obesity should be addressed as a topic on its own. – Public Health Representative (Maricopa County)

COVID-19

We are blessed to live in an environment where outside activities are possible 365 days a year. Unfortunately, fear of contracting the Covid-19 virus has kept many people sequestered in their homes. The American diet leaves much room for improvement. – Other Health Provider (Maricopa County)

Covid has caused many people to limit their physical activities while staying at home. – Social Services Provider (Maricopa County)

> Being in quarantine, easy access to cheap, unhealthy foods, lack of support by primary care; “you’re fat, you need to lose weight,” instead of real help. Weight-insensitive talk in the medical field, shame. – Other Health Provider (Maricopa County)
>
> The pandemic. Too many fast food places in health food insufficient areas. Grocery stores within walking distance. – Other Health Provider (Maricopa County)

Access to Care/Services

> Access to disability exercise programs, such as water aerobics, gentle yoga, and low-impact options that are affordable and accessible. Access to nutritionists, particularly those who help with chronic health conditions. – Social Services Provider (Maricopa County)
>
> Nutrition experts are not easy to access, nor readily available to patients coming in to treatment. – Physician (Maricopa County)

Awareness/Education

> Access to education, healthy foods, and breaking habits. – Other Health Provider (Maricopa County)
>
> Lack of education of children about healthy diets and exercise. Lack of motivation of society as a whole to live healthful lives. – Physician (Maricopa County)

Lifestyle

> Laziness, lack of motivation to eat healthy and lose weight. Stress. – Physician (Maricopa County)
>
> People don’t take responsibility for their lifestyle and many are obese. – Community Leader (Maricopa County)

Vulnerable Populations

> Communities of color, low income and non-English speaking communities do not have enough education, information, screenings and health assessments in their native language that also take into consideration their cultural differences. Rural communities do not have access to nutrition education especially when classes are online only and technology is a challenge. Activities for low income children are closed when schools are not in person and PE classes are limited to online learning. – Social Services Provider (Phoenix)

Cultural/Personal Beliefs

> Cultural foods, lack of access to healthy foods, lack of financial resources for recreational activities and families. – Social Services Provider (Phoenix)

Health Disparities

> Health care disparities and lack of services. – Public Health Representative (Maricopa County)

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

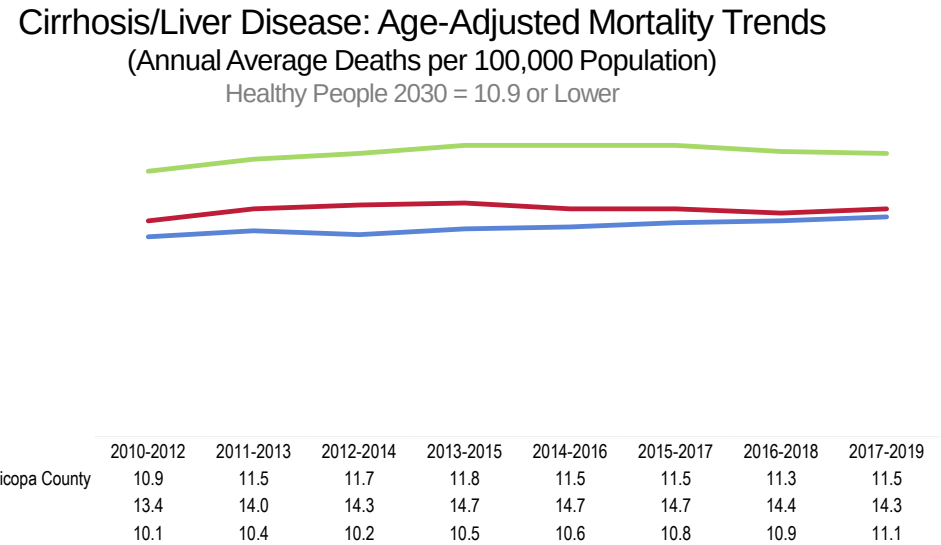
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the area. [COUNTY-LEVEL DATA]



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	10.9	11.5	11.7	11.8	11.5	11.5	11.3	11.5
AZ	13.4	14.0	14.3	14.7	14.7	14.7	14.4	14.3
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

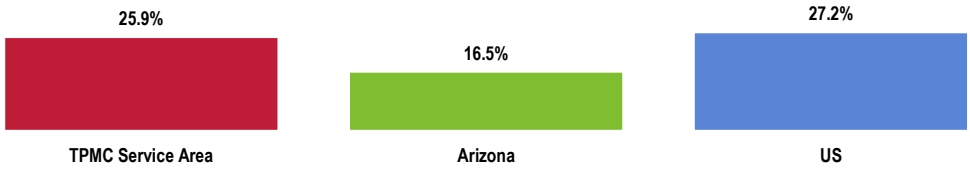
- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive Drinkers



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

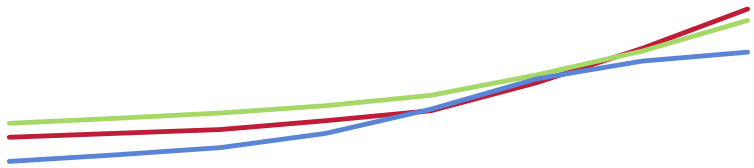
Drugs

Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-related deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Maricopa County	12.1	12.4	12.7	13.4	14.2	16.4	19.1	22.2
AZ	13.2	13.6	14.0	14.6	15.4	17.0	18.9	21.3
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.

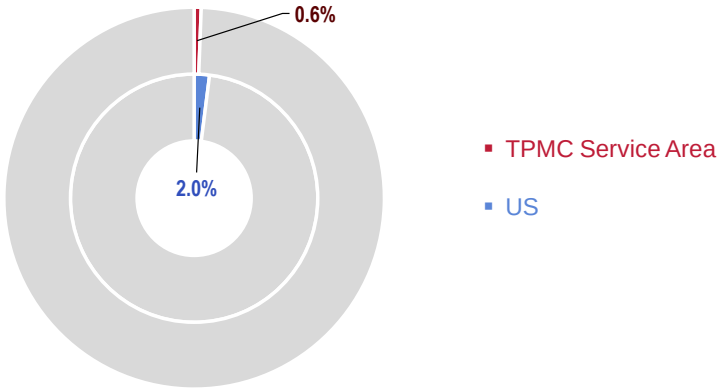
Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(TPMC Service Area, 2021)

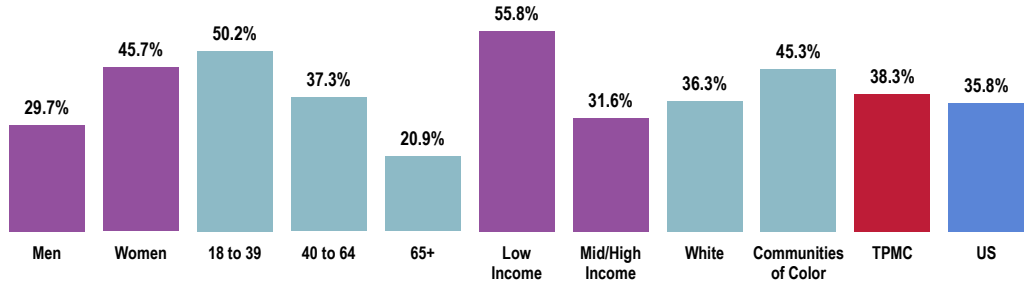
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(TPMC Service Area, 2021)

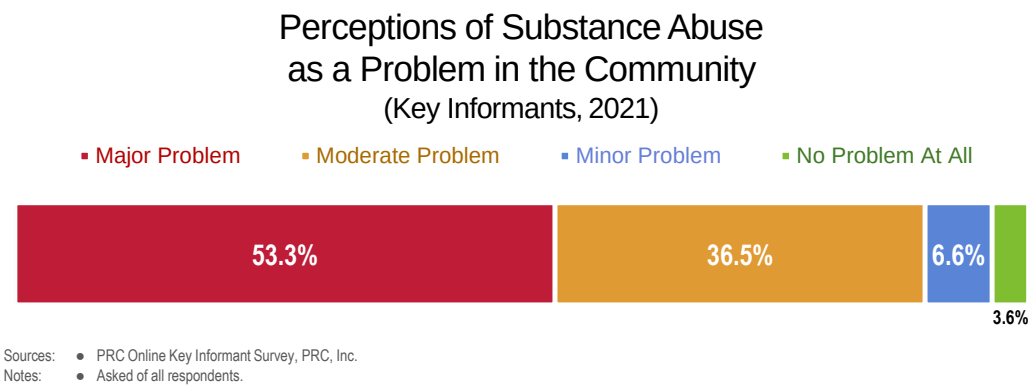


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of pain management and MAT options, counseling resources and social stigma associated with opiate overuse. – Physician (Maricopa County)
>
> Not enough substance abuse facilities. – Physician (Maricopa County)
>
> Capacity, access, lack of parity between public and private sector. – Social Services Provider (Maricopa County)
>
> Comprehensive SA treatment centers that address barriers to sobriety. – Physician (Maricopa County)
>
> Not enough resources. Our substance use rates are much higher. Go to the Arizona State Health Assessment for all this data on AZDHS.gov. – Community Leader (Maricopa County)
>
> Lack of access. – Public Health Representative (Maricopa County)
>
> There are not enough facilities offering this care. – Other Health Provider (Phoenix)
>
> More rehabs, more training for primary care providers to help treat them. – Physician (Maricopa County)
>
> Limited number of mental health and supportive services with sustainable housing options. – Social Services Provider (Phoenix)
>
> There is a lack of resources and immediate opening when a patient is ready to address these issues. – Physician (Maricopa County)
>
> Access to MAT resources. – Physician (Scottsdale)
>
> Connections to resources. – Community Leader (Maricopa County)
>
> Lack of available resources, difficulty getting appointments, transportation, and lack of insurance. – Community Leader (Maricopa County)
>
> Limited services available and lack of awareness of existing programs. Stigma. – Community Leader (Maricopa County)
>
> Lack of available programs to access. – Other Health Provider (Maricopa County)
>
> Community resources. – Other Health Provider (Maricopa County)
>
> Location of clinics. More clean needle programs. – Other Health Provider (Maricopa County)
>
> Access to MAT clinics, syringe access, safe use information, harm-reduction kits, particularly for Fentanyl, access to affordable or free inpatient services for detox and treatment. – Social Services Provider (Maricopa County)
>
> Lack of access to quality treatment. Stigma both in the community and in healthcare. Overprescribing of addictive medications such as opioids, Adderall, etc. – Public Health Representative (Maricopa County)
>
> Lack of agencies that provide this service in the Scottsdale area. – Physician (Scottsdale)

Affordable Care/Services

> Affordable treatment. – Community Leader (Maricopa County)
>
> Cost, lack of funding by the state. – Other Health Provider (Maricopa County)

Costly care. – Other Health Provider (Maricopa County)

Cost to patient. – Physician (Maricopa County)

Affordability, family support, re-entry process, employment and mentorship. – Social Services Provider (Scottsdale)

Cost of services, quality, lack of diversity in approaches and staff. – Social Services Provider (Maricopa County)

Cost. – Other Health Provider (Maricopa County)

Financial, and admitting they have an issue. – Social Services Provider (Maricopa County)

Contributing Factors

Like mental health services access to quality substance abuse treatment is limited. Also, the stigma around the disease causes people to not take action. Covid has increased this issue as well. – Social Services Provider (Maricopa County)

Affordable and easy access to services. Limited stay in detox, fear of detox and limited. – Social Services Provider (Phoenix)

Stigma, long term issue, even after treatment there are lifelong triggers. Insurance or AHCCCS coverage; location of treatment centers. Expensive. – Public Health Representative (Maricopa County)

Social stigma and access to resources, transportation and cost. – Social Services Provider (Maricopa County)

Denial/Stigma

There is still a stigma attached to substance abuse disorder that prevents individuals from acknowledging their disorders or accessing help. This stigmatization is perpetuated, in part, by some elected members of the criminal justice system who actively seek to prosecute rather than treat and who erroneously attribute substance abuse disorder to personal weakness. – Community Leader (Maricopa County)

Stigma, timing of services. Offered only during the day when services might be needed at night. – Community Leader (Maricopa County)

Stigma. – Social Services Provider (Maricopa County)

Stigma. – Community Leader (Phoenix)

The addict wanting to receive help. – Other Health Provider (Maricopa County)

Criminality of substance abuse keeping individuals from seeking help. Stigma/mental health resources, or lack thereof. – Community Leader (Maricopa County)

Awareness/Education

Awareness of resources, language barriers, stigma around substance abuse and access to care. – Social Services Provider (Phoenix)

I don't think access is the issue, I think it's outreach and information that's needed. Hardly anyone has the stamina/resolve right now to call multiple places to find eligibility criteria, program design details, commitments/costs/expectations. It's even harder in crisis. There has to be more done to consolidate information on providers, detailed information. – Social Services Provider (Maricopa County)

Knowing where to call, navigating insurances, etc. – Other Health Provider (Maricopa County)

Access to Care for Uninsured/Underinsured

People with substance abuse can't get into rehab without health care it is a vicious cycle. – Other Health Provider (Maricopa County)

Lack of insurance coverage and placement opportunities. – Other Health Provider (Scottsdale)

Access to detox, rehab, and outpatient services if you don't have insurance. – Physician (Maricopa County)

Incidence/Prevalence

High rates of heroin and meth use. – Community Leader (Maricopa County)

There were high rates of alcoholism in Arizona before the pandemic. I assume these have only worsened. – Community Leader (Maricopa County)

Continues to be a chronic issue in our community. It can sometimes be the underlying issue of an individual's chronic health problems. Getting people substance abuse care when and how they want to receive it is not yet a wide-spread thought. – Community Leader (Maricopa County)

Funding

Lack of funding and connection to academic researchers. – Public Health Representative (Maricopa County)

Ability to have more funding within the community for education, family resources for assistance. – Community Leader (Scottsdale)

Diagnosis/Treatment

> No profit in cure. Profit is in treatment. Methadone is a great example. – Community Leader (Phoenix)
>
> Patient often do no come for care until very late. Often they do not know what is available. Inpatient detox and addiction medicine is unaffordable. – Physician (Maricopa County)

COVID-19

> Substance abuse has increased as people are isolated from support systems and stress from the pandemic has worn people weary. Teens do not have school to help them address substance abuse use and are feeling isolated from peers. The issue of substance abuse among the homeless population is not being addressed as it is one of the many ways they look to address their mental health issues. – Social Services Provider (Phoenix)

Easy Access

> Drugs are easy get, and denial. – Social Services Provider (Maricopa County)

Aging Population

> Maricopa County has a higher than national average rate of substance abuse to higher number of those age 65+. – Social Services Provider (Phoenix)

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

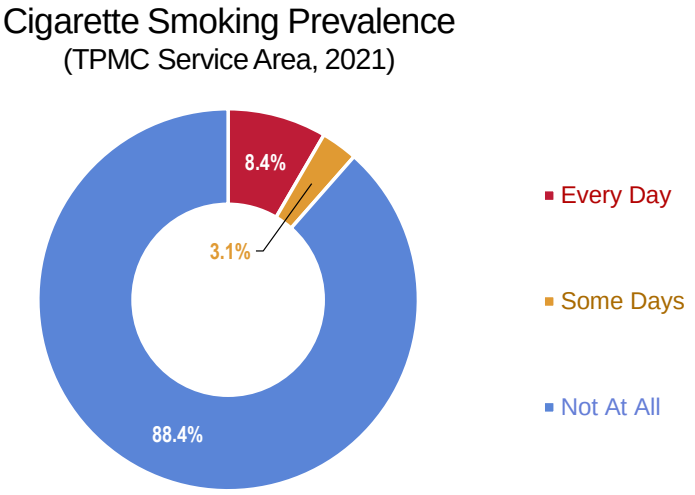
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

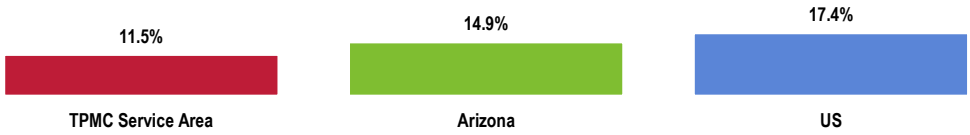
Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?" ("Current smokers" include those smoking "every day" or on "some days.")



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40]

Notes:
- Asked of all respondents.



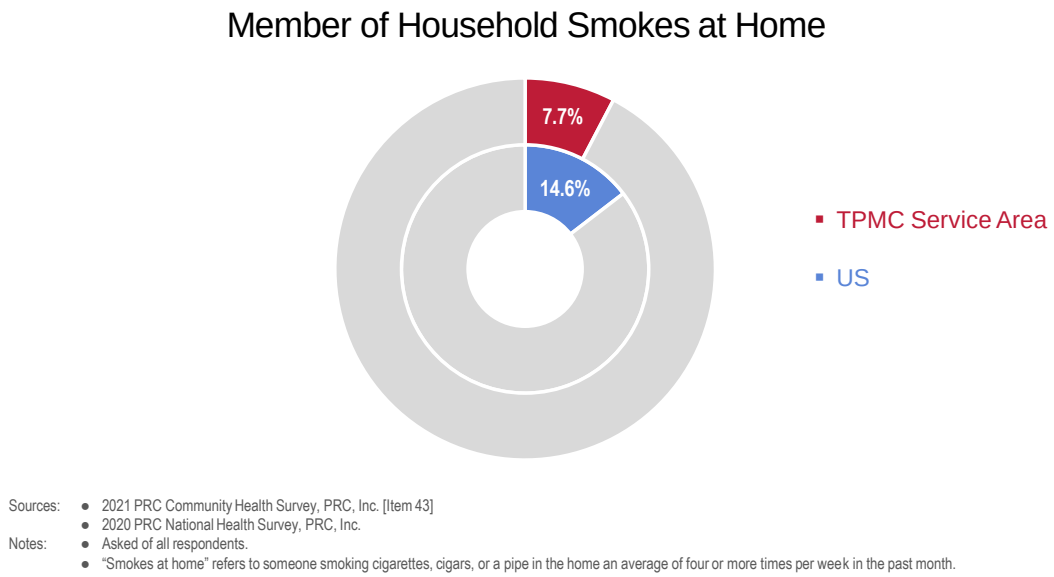
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

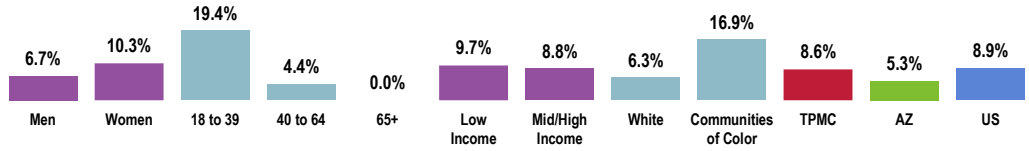
Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?"

"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(TPMC Service Area, 2021)



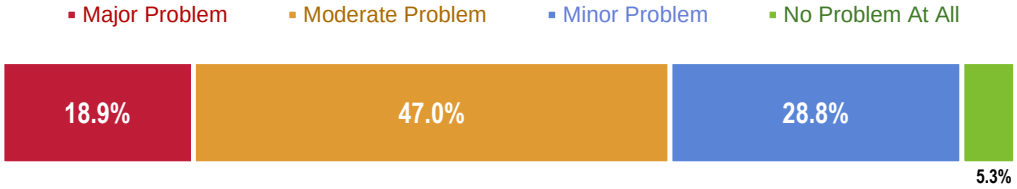
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2021)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Most patients smoke. – Physician (Maricopa County)
>
> Many people use tobacco and it kills people. – Physician (Maricopa County)
>
> Continues to be sold and used, still creating health issues. Although traditional tobacco is used less, now vaping has its own side effects. – Other Health Provider (Maricopa County)
>
> I was hasty to stay major. I believe it is a minor problem. – Social Services Provider (Scottsdale)
>
> The Phoenix Rescue Mission serves a large population of people in recovery and or experiencing homelessness. Tobacco use is highly accepted by this community. – Social Services Provider (Phoenix)
>
> I observe many smokers. – Public Health Representative (Maricopa County)

Impact on Quality of Life

> Still an issues with patient that have severe medical issues as a result of long time tobacco use. – Physician (Maricopa County)

> Any amount of tobacco use is too much. It causes all manner of disease and is expensive, draining resources from patients and the health care system. – Physician (Maricopa County)

Vaping

> I include nicotine with tobacco which may not be your intent. However, for a long time we did a great job of educating kids about tobacco and drugs. We got complacent and e-cigarettes are now infiltrating our young people. It is time to stand up against tobacco, nicotine, and drugs again. I am also concerned about the new problems that legalized marijuana will bring the City of Phoenix. – Community Leader (Phoenix)

> Vaping and chew are problems among our younger population. – Other Health Provider (Maricopa County)

Vulnerable Populations

> Low income communities and communities of color are often the target areas for smoke shops, liquor stores and Vape shops. There is not enough education to non-English speaking communities in their native languages. Children and teens are still being targeted by tobacco companies through flavored Vape and flavored tobacco products - Social Services Provider (Phoenix)

Awareness/Education

> Lack of education and motivational interviewing for behavior change. – Physician (Maricopa County)

Addiction

> Very difficult to quit. – Physician (Scottsdale)

Comorbidities

> High rates of emphysema. – Community Leader (Maricopa County)

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

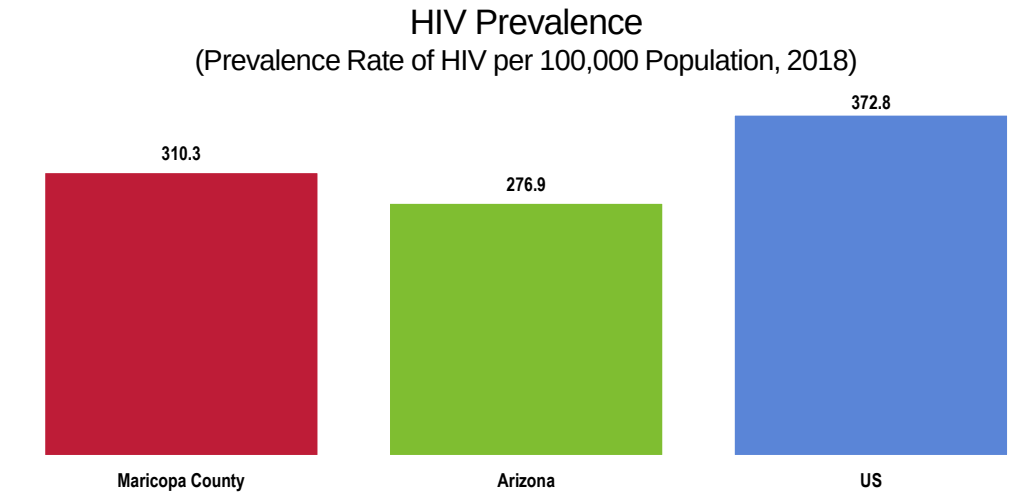
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

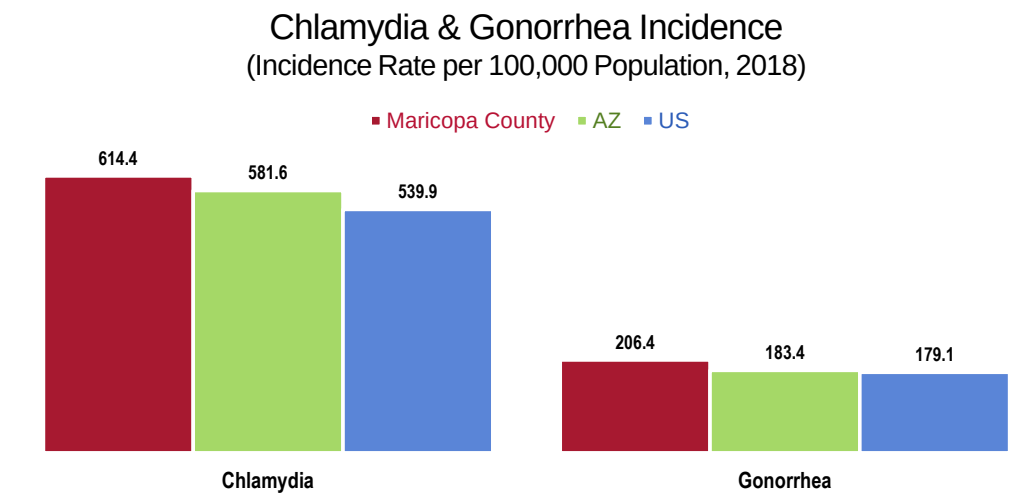
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

CHLAMYDIA ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]

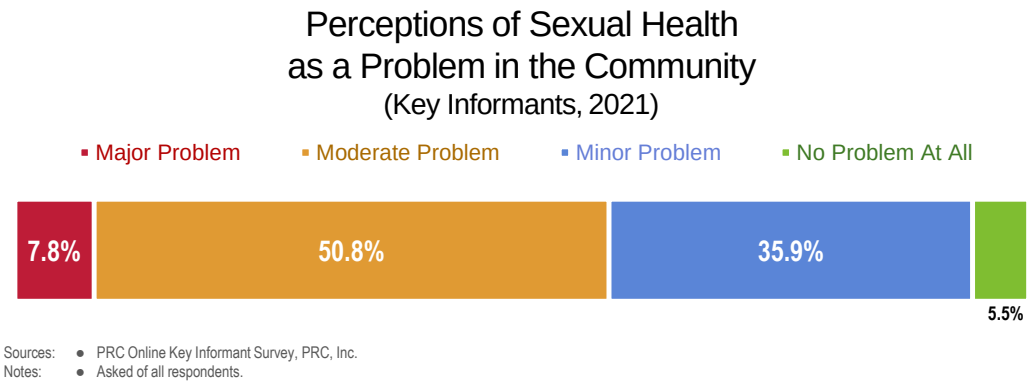


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Not a lot of pro-sexual health advertising or organizations. We're constantly seeing programs that help women lose their funding or facing threats that they will lose their funding. – Social Services Provider (Maricopa County)
>
> Lack of comprehensive sex education in schools. Maricopa County has one of the highest rates of HIV in the nation. – Community Leader (Maricopa County)

Incidence/Prevalence

> High rates of HIV, lack of access to care. – Community Leader (Maricopa County)
>
> Lots of STDs, multiple partners/dating sites. – Physician (Maricopa County)

Vulnerable Populations

> Low income communities, those experiencing homelessness, communities of color and LGBTQ youth do not have access to education, screenings and information in native languages. Access to information when online is limited when technology is an issue. – Social Services Provider (Phoenix)

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

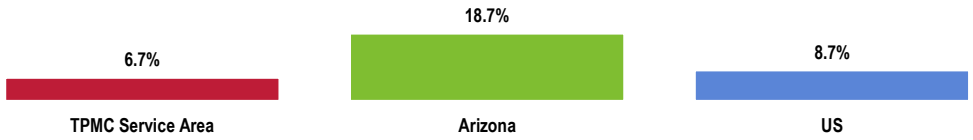
Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program)**, or VA/military benefits?"**

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

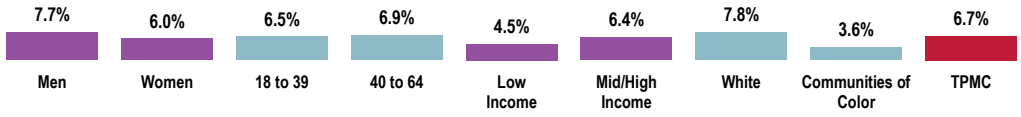
Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage
(Adults Age 18-64; TPMC Service Area, 2021)
Healthy People 2030 = 7.9% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

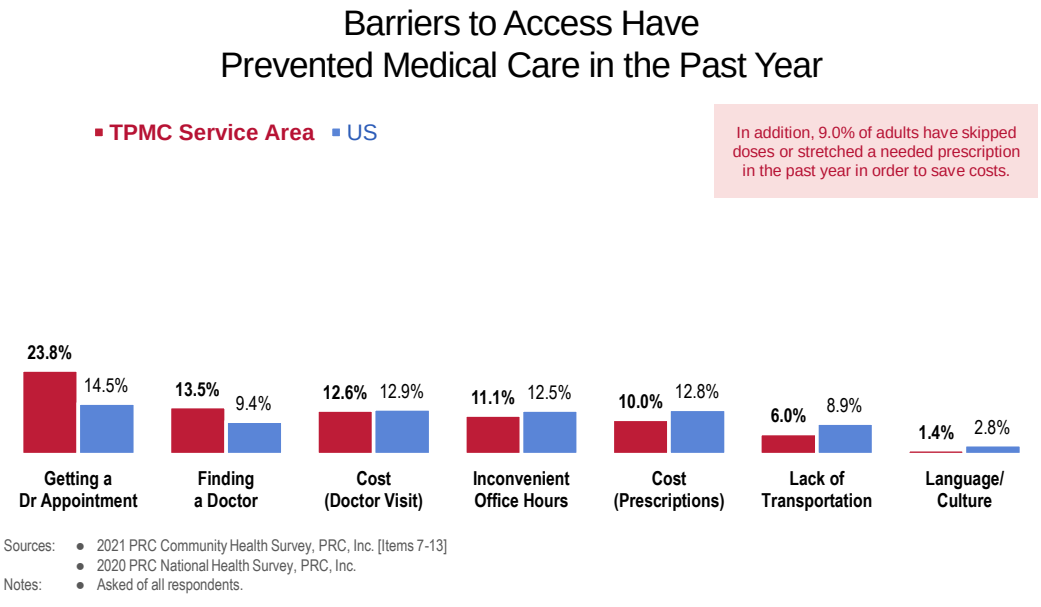
"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

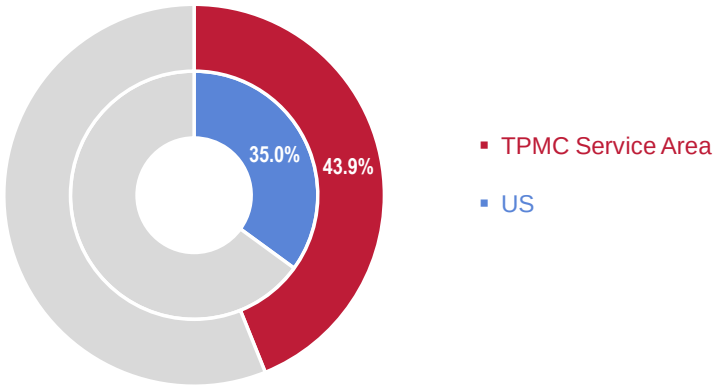


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 7-13]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

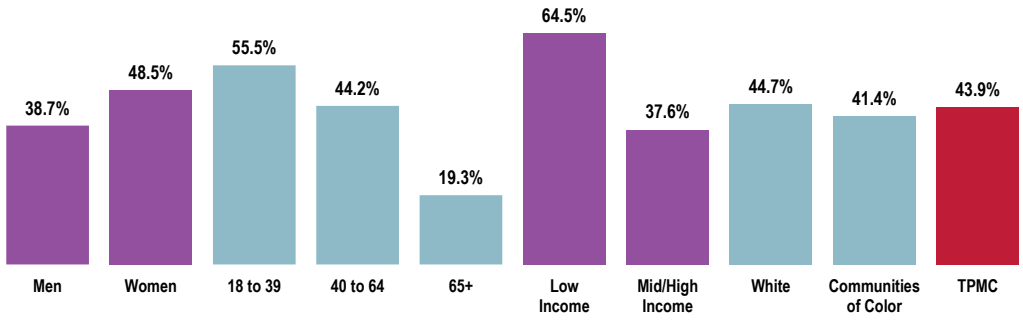
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(TPMC Service Area, 2021)

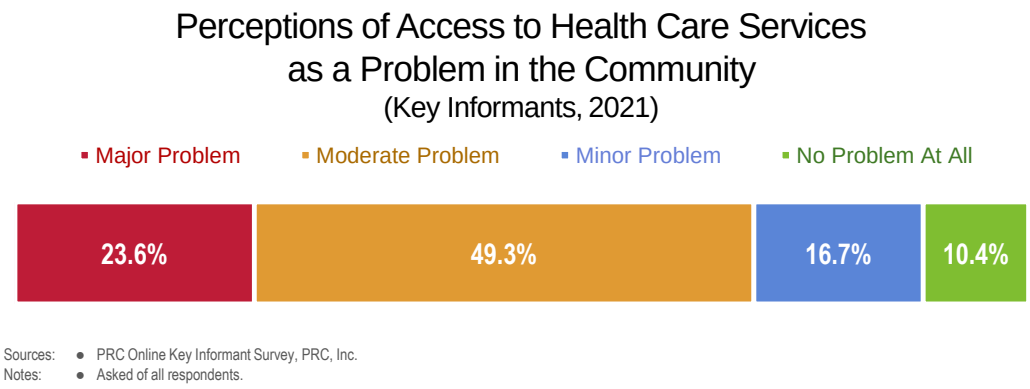


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 140]

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

Barriers to health care. For example, those who HAVE healthcare and unable to get to their doctor due to transportation or mobility issues. On the other hand, those who DO NOT HAVE healthcare due to lack of funds, undocumented status, homelessness, or lack of trust for healthcare system due to culture. – Social Services Provider (Scottsdale)

Many in our community are unable to afford health care. Many lack transportation to access health care and many with behavioral health issues are simply too ill to seek out medical care. – Other Health Provider (Maricopa County)

Our city is so spread out that many low income individuals do not have transportation to adequate health care. Health care is not readily available in the rural areas of Phoenix. Healthcare is also not affordable to low income or mid income families, those that may be the working poor who make too much to qualify for AHCCCS but they cannot participate in an employer supported health care system. Low income families have limited access to healthcare and especially telemedicine when they do not have access to technology. Access is also a barrier to non-English speakers and those that are experiencing homelessness. There is only one major health care provider that works with the homeless and Circle of the City cannot do it all as we are seeing during this pandemic. – Social Services Provider (Phoenix)

Transportation, receiving follow-up care after hospitalization. Locating medical care that is covered by the specific insurance plan the person has, whether public or private. Navigating websites to make appropriate appointments or requesting advice. – Community Leader (Phoenix)

General trust in the provider and system are big challenges, this includes cultural competencies, language barriers, systems that are one dimensional i.e. don't take into account the other environmental aspects of the patient's health history. Transportation and ease of appointments are also challenges - Social Services Provider (Maricopa County)

Access to care is an issue due to poor public transportation, the availability of services for medical and Mental health issues is a capacity issue, we have them but never enough of them, health care inequity is also an issue for our medicaid populations. Safe stable affordable housing is a huge issue, food security is also a problem and reliable transportation. Many of our populations do not have ongoing relationships with a primary care physician and get their health care at the ED. This is not optimal for treating chronic health conditions. Culturally appropriate healthcare is also needed. A great example is the COVID vaccine. Communities of color are not receiving it at the same rate as those who are white. There must be public campaigns aimed at our non-white populations to help engage them in these health care practices. – Social Services Provider (Maricopa County)

Cost of service for non-under insured, health disparity and language barrier. – Physician (Maricopa County)

Underlying factors (lack of transportation, unstable housing, working 2+ jobs and unable to prioritize medical care, etc.). Lack of mental health care access and service providers. Cultural barriers (language other than English spoken, lack of trust in healthcare system) - Public Health Representative (Maricopa County)

> Navigating the process and understanding the process. Trust among providers - fear of deportation or immigration status. Fear of green-card eligibility if on public health insurance. Transportation to and from health clinics prohibits access to a health provider. Technology or internet access prohibits access to telemedicine. Growth in unemployment means growth in under-insured. Small-scale safety net with limited specialists for the homeless and poverty. Lack of medical home for vulnerable populations. Housing and other basic needs not seen as connected to health. – Community Leader (Maricopa County)
>
> Specialists are backlogged; transportation/location. Covid issues make all access complicated. People are afraid to access services especially preventative. – Public Health Representative (Maricopa County)
>
> I think affordability and fear of costs creates barriers for people to even start the process. Long wait times. Quality of care - finding medical professionals that have the time to listen. We receive a lot of calls from median income people who have acquired a great deal of debt from medical bills. So they don't fit into the AHCCCS bracket but they can't afford the thousands of dollars of bills they're receiving. – Social Services Provider (Maricopa County)
>
> Affordability, lack of insurance coverage among vulnerable communities, inequitable distribution and access for individuals and families of color. – Social Services Provider (Maricopa County)

Affordable Care/Services

> Health care access to lower income neighborhoods/populations. – Other Health Provider (Maricopa County)
>
> The cost of health care and prescription drugs. – Social Services Provider (Maricopa County)
>
> Many in our community are unable to afford health care. Many lack transportation to access health care and many with behavioral health issues are simply too ill to seek out medical care. – Other Health Provider (Maricopa County)
>
> Cost and access to appointments. – Community Leader (Maricopa County)
>
> The variance in access seen across the community depending upon individual circumstance. Cost of care is an incredibly large issue that must be addressed. – Public Health Representative (Maricopa County)
>
> High cost for services and medication and lack of locations in low income communities. – Social Services Provider (Phoenix)
>
> Lack of insurance making it difficult for patients to see specialists and get care beyond primary care. Transportation difficulties -- patients do not have rides to/from doctor, lab appts, imaging appts, etc. Financial difficulties that people have. Insurance & prior authorizations creating barriers for patients to get Rx. – Physician (Maricopa County)
>
> Lack of insurance, lack of affordable sliding scale options. – Physician (Maricopa County)
>
> Lack of insurance (or underinsured), which leads to the next issue - financial barriers (causing people to avoid accessing service due to the fears of the costs that will be associated with usage), for specific fields there is a lack of providers available making specialty care hard to get due to increased travel and expense required. – Community Leader (Maricopa County)

Insurance Issues

> Frequently we have families that have come from out of state or AHCCCS has expired. These families need to go through the AHCCCS process to get Health care. We need a quick more efficient process then long phone options. When we had an outreach person from NOAH on our campus, everything flowed much easier for our families. The current systems, and families' lack of knowledge and transportation are the biggest barriers. – Community Leader (Phoenix)
>
> Coverage eligibility -- much of the challenge is not being eligible for coverage that's affordable; lack of navigational support -- systematic barriers that prevent people from accessing care, such as limited access to COVID testing and vaccines for elderly and low-income individuals. – Community Leader (Maricopa County)
>
> Patients that do not qualify for medical insurance secondary to undocumented status in the US. – Physician (Maricopa County)

Vulnerable Populations

> Disparity in access to health care that leaves behind vulnerable populations, while people with money and connections are able to receive top level treatment. – Community Leader (Phoenix)
>
> Lower income families struggle and vulnerable populations like elderly. – Public Health Representative (Maricopa County)
>
> Immigration status. – Social Services Provider (Phoenix)
>
> There is a large veteran population that are not being identified and resources not being sought out for them which causes additional costs to the healthcare system. – Social Services Provider (Scottsdale)

Racial Inequities

> Structural racism and lack of a national plan for primary care for all and health care as a human right. – Public Health Representative (Maricopa County)

> There is a lack of access based on racial inequities. – Social Services Provider (Maricopa County)
>
> Systemic racism. The American Public Health Association recently declared racism as a public health crisis. We need to understand how communities of color are more severely impacted by all health challenges because of all the other barriers they face. – Community Leader (Maricopa County)

Access to Care/Services

> Access to natural pain management services. – Other Health Provider (Scottsdale)

Awareness/Education

> There is a lack of awareness of the free health and mental health services available in the community. – Community Leader (Maricopa County)

Lack of Providers

> We don't have enough culturally competent primary care doctors in lower income neighborhoods. – Community Leader (Maricopa County)

Coordination of Care

> Assessment of needs and coordination of services. – Social Services Provider (Maricopa County)

COVID-19

> Due to Coronavirus, it's been difficult for providers to see their patients because of facility lockdown. – Social Services Provider (Scottsdale)

Transportation

> Transportation to appointments. Time from work, if appointments need to be between 9:00 AM and 5:00 PM. Affordable insurance. – Community Leader (Maricopa County)

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

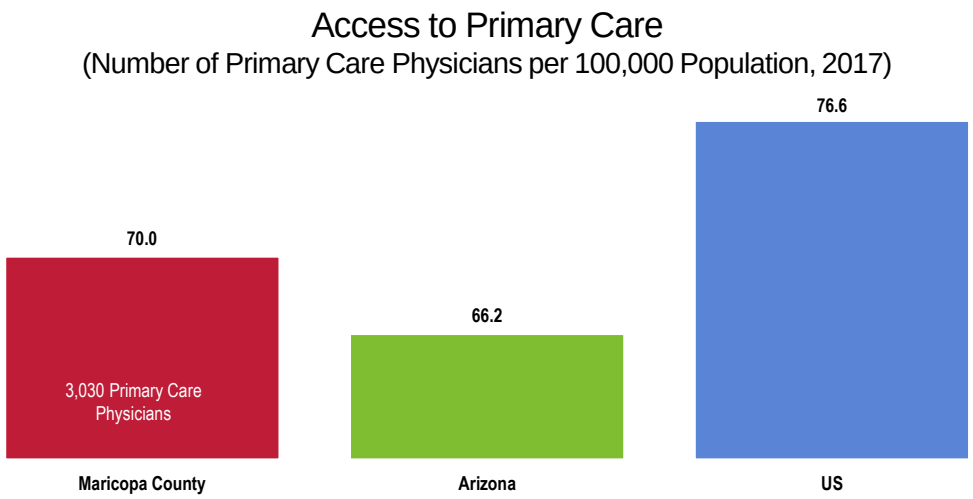
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

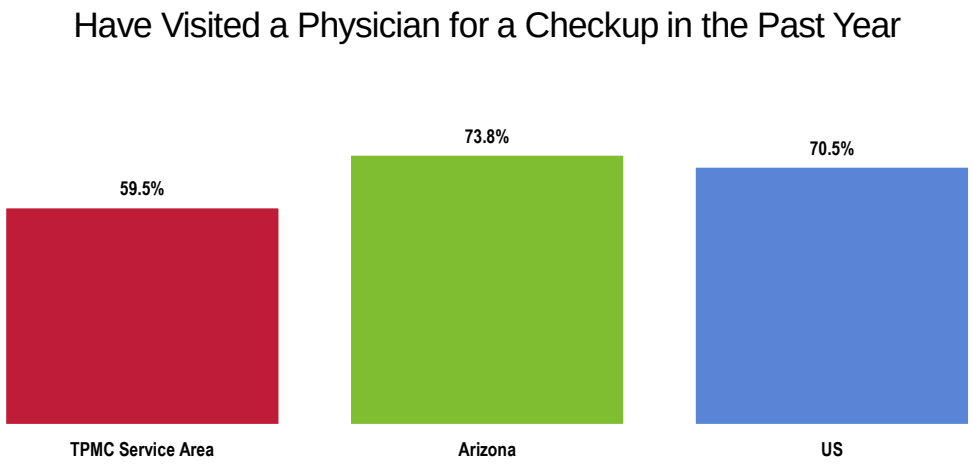


Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

ADULTS ▶ **"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"**



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Oral Health

ABOUT ORAL HEALTH

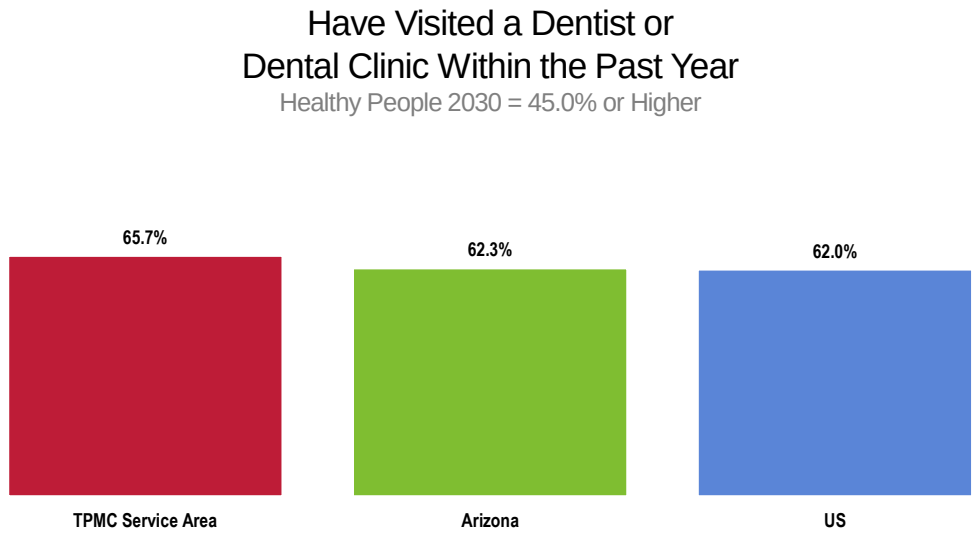
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

ADULTS ▶ **"About how long has it been since you last visited a dentist or a dental clinic for any reason?"**

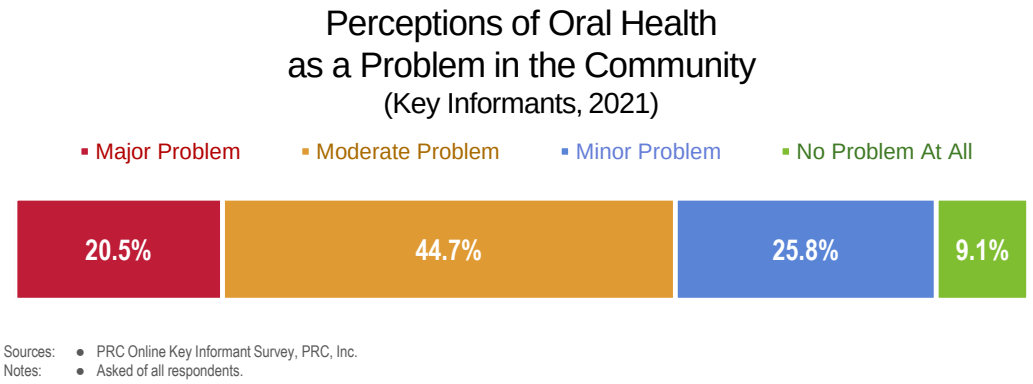


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Arizona data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> Dental care is expensive. Many people avoid it to the detriment of their overall wellbeing. It isn't promoted as a major factor in personal health even though it has a huge benefit if addressed routinely. – Community Leader (Maricopa County)
>
> Low income families are not getting the necessary screenings due to job loss, dental health care costs are too expensive or employer provided dental insurance is not an option. Dental care for those experiencing homelessness do not have access to enough care. Those in rural areas do not have access close to home especially when they are limited in their transportation - Social Services Provider (Phoenix)
>
> Access to affordable dental care, care is limited to the most affluent. Dental plans are limited and the out of pocket cost continues to rise. – Social Services Provider (Maricopa County)
>
> High cost of care and lack of access to dentists or dental specialists. – Social Services Provider (Phoenix)
>
> Families not able to pay for service. – Community Leader (Phoenix)
>
> Cost. – Other Health Provider (Maricopa County)
>
> Lack of access to affordable dental care. – Social Services Provider (Maricopa County)
>
> Arizona has little assistance to help community members with oral care unless the person is able to pay for services. Often times, they are told they cannot afford costs. Limited to no AHCCCS assistance with oral health. – Other Health Provider (Maricopa County)
>
> Dental needs are not addressed by Medicaid, so adults with dental concerns go untreated, which leads to other health related concerns. Dental care needs to be addressed as a part of ongoing medical care. – Social Services Provider (Phoenix)

Contributing Factors

> Past life issues with substance abuse has led to poor dental health. AHCCCS provides extremely limited access to dental. – Social Services Provider (Phoenix)
>
> Coverage barriers, knowledge of quality providers, fear of the unknown if oral health has never been a focus/habit. Not knowing where to start, what to expect, feeling overwhelmed or unmotivated to do the research. – Social Services Provider (Maricopa County)
>
> There are a few factors: Altcs coverage has changed for some of the long-term residents, where they aren't approved for certain dental care. Routine appointments or elective appointments have been an issue when COVID outbreak is in the SNF. Hesitant to send resident out to the community, some offices hesitant. etc. Dental providers reluctant to come out to the SNF to provide services due to COVID in facility or facility is hesitant to allow non-urgent providers to enter the facility and go room to room, during a COVID outbreak or risk of outbreak. – Other Health Provider (Maricopa County)

Access to Care for Uninsured/Underinsured

> It is not a coverage for adults and not a cultural priority for some families. – Community Leader (Maricopa County)
>
> Lack of dental insurance and access to affordable dental care. – Physician (Maricopa County)

> Lack of insurance, lack of funding for dentures. – Community Leader (Maricopa County)
>
> Many in Maricopa County do not have dental insurance or have money for a dentist. – Physician (Maricopa County)
>
> Lack of coverage for adults under Arizona Medicaid. – Community Leader (Maricopa County)

Access to Care/Services

> Access to dental care for adults is poor. – Other Health Provider (Phoenix)
>
> Lack of access to care. – Community Leader (Maricopa County)

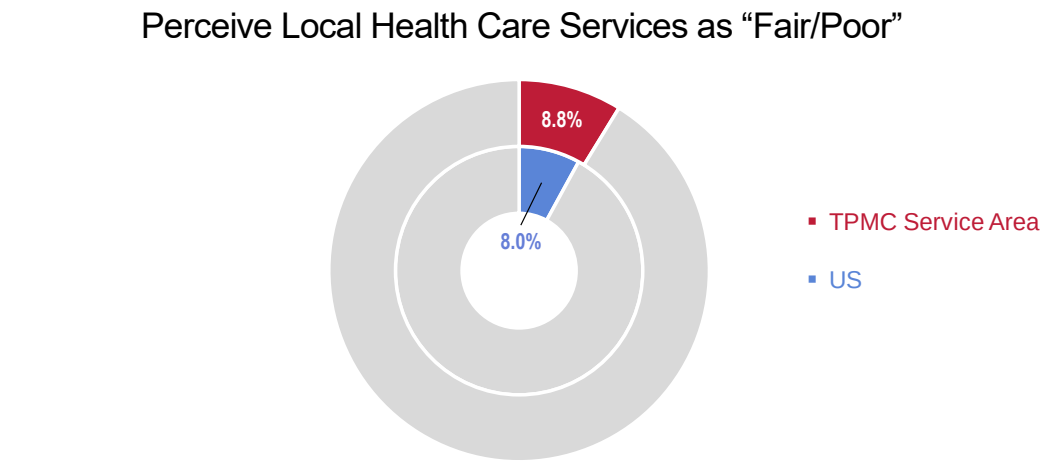
Aging Population

> Maricopa County has a higher than national average rate of poor oral health due to higher number of those age 65+. – Social Services Provider (Phoenix)

LOCAL RESOURCES

Perceptions of Local Health Care Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- 211
- 24/7 Crisis Line and Mobile Teams
- A New Leaf
- Adelante Healthcare
- AHCCCS
- Arizona Complete Health
- ASU
- Banner Health Clinic
- Bayless Healthcare
- Breath Mobile
- Brighter Way
- CARES Dollars
- Catholic Social Services
- Central Arizona Shelter Services
- Chicanos Por La Causa
- Circle the City
- City of Phoenix
- Community Clinics
- Community Health Centers
- COVID-19 Hotline
- Department of Child Safety Rapid Response and CSS
- Dignity Health
- Door Ways
- Elaine
- Equality Health
- Federally Qualified Health Centers
- GoodRx
- Government
- Helping Families in Need
- Home Health
- Hospice
- Hospitals
- Human Services Campus
- Innovation Care Partners
- Jewish Family and Children's Services
- Maricopa County Public Health
- Maricopa Integrated Health System
- Mission of Mercy
- Mobile Physician Group
- Mountain Park Health Center
- Native Health
- Neighborhood Outreach Access to Health
- Non-Profit Organizations
- Olive Branch
- On-Site Community Resource Team
- Phoenix Day
- School System
- St. Mary's Food Bank
- St. Vincent de Paul
- Substance Use Disorder Treatment Services
- Terros Health
- UPC
- Urgent Care
- Vaccination Sites
- Valle del Sol
- Valley Metro
- Valleywise
- Veteran Alliance
- Vitalyst Foundation
- WIC

Cancer

- AHCCCS
- American Cancer Society
- Arizona Oncology
- Arizona Self Help
- Arizona Veterans Program
- Banner Health
- Banner MD Anderson Cancer Center
- Cancer Treatment Centers of America
- Dignity Health
- Dignity St. Joseph Hospital
- Doctor's Offices
- Food Banks
- Home Health
- HonorHealth
- Hospice
- Hospitals
- Inpatient Acute Care
- Ironwood Cancer and Resource Center
- Mayo Clinic
- Mobile Physician Group
- Palliative Care Programs
- Post Acute Facilities
- Social Security and Economics

University of Arizona Cancer Center
Valleywise
Veteran Alliance
Virginia G. Piper Cancer Center

Coronavirus

211
ACO Partnerships
Adelante Healthcare
AHCCCS
Arizona Association for the Education of Young Children
Arizona Department of Health Services
Arizona Housing Coalition
Arizona Hubs
Arizona Public Health Department
Arizona Republic Newspaper
Arizona State Dashboard
ASU
AzCHER
Banner Health
Banner Health Covid Line and Website
Behavioral Health Services
Boys and Girls Club
CARES Dollars
Center for Disease Control
Chicanos Por La Causa
Child Care Programs
Circle the City
City of Phoenix
City of Phoenix Mobile Testing
Community Health Centers
Covenant Health Network
Crisis Response Network
CVS
Department of Health Services
Department of Homeland Security Employment Assistance
Desert Mission
Doctor's Offices
Embry Women's Health
Equality Health
Eviction Prevention App
Fastmed
Federally Qualified Health Centers
FEMA
First Things First
Food Banks
Foundations
Grand Canyon University
Health Care Services Advisory Group
Health Care Systems
Home Health
HonorHealth
Hospital and Insurance Committee of Greater Phoenix Leadership
Hospice
Hospitals
Internal Task Force
Johns Hopkins
Leading Age
Lifestream Cook and Beatitudes
Local Government
Maricopa County
Maricopa County Department of Health
Maricopa County Government
Maricopa County Public Health
Maricopa County Vaccine
Mayo Clinic
Media
Medical Professionals
Mesa Community College
Mobile Physician Group
Mountain Park Health Center
Neighborhood Outreach Access to Health
NHW Community Health Center
Non-Profit Organizations
Paradigm Labs
Pharmacies
Phoenix Municipal Stadium
Prestamos
Promotoras
Public Health
QIO (Medicare Quality Improvement)
Savior Hospice
Scottsdale Physicians Group Virtual Care
Select Home Health Care
Shea Parc SNF
Sonora Quest
South Mountain Post Acute and Alta Mesa
State Farm Stadium
State of Arizona
Sunnyslope Family Health Center
Testing Blitz
Testing Sites
The Universities
University of Arizona
Urgent Care
Vaccination Sites
Vaccines
Valle del Sol
Valley Leadership
Valley of the Sun United Way
Walgreens
www.hhs.gov

Dementia/Alzheimer's Disease

- AARP
- Adult Protection Service
- Alzheimer's Association
- Area Agency on Aging
- Arizona Alzheimer's Consortium
- Arizona Elderly Care
- Arizona Veterans Program
- Banner Alzheimer's Institute
- Barrow Neurological Institute
- Beatitudes Campus
- Center to Advance Palliative Care
- Circle the City
- City Governments
- Dementia Caregivers Alliance
- Dementia Friendly America
- DES
- Desert Mission Adult Day Health Care
- Duet's Finding Meaning and Health Program
- Foundation for Senior Living
- Hospice
- Hospice of the Valley
- Lyft/Uber
- Mayo Clinic
- None
- Non-Profit Organizations
- Palliative Care Programs
- Parkinson and Dementia Groups
- Retirement Communities
- Shadow Mountain Memory Care
- Support Groups
- The Nature Conservancy
- The Universities
- Trees Matter
- University of Arizona Medical School
- Vitalyst Foundation

Diabetes

- ACO Partnerships
- American Diabetes Association
- Chicanos Por La Causa
- Circle the City
- City of Phoenix
- Community Gardens
- Community Health Centers
- County Health
- Diabetes Education
- Doctor's Offices
- Education Books
- Federally Qualified Health Centers
- First Arizona
- Food Banks
- Food Shelves
- Fresh Express
- Grand Canyon University
- Gregory's Fresh Market
- Grocery Stores
- HonorHealth
- Hospitals
- Mountain Park Health Center
- Native Health
- Neighborhood Outreach Access to Health
- Nutrition Services
- Parks and Recreation
- QIO (Medicare Quality Improvement)
- School System
- Shopping Malls
- St. Mary's Food Bank
- St. Vincent de Paul
- Sun Produce Co-op
- Support Groups for Education
- The Universities
- Valleywise
- Vitalyst Foundation
- YMCA

Disabilities

- Ability 360
- Abrazo Health
- Access to Medical/Recreational Marijuana
- Arizona Department of Health Services
- Backfit Spine
- Chandler Pain Clinic
- Circle the City
- Community Health Centers
- Community Medical Services
- DES DDD
- Doctor's Offices
- Home Health
- HonorHealth
- Hospice
- Hospitals
- Mayo Clinic
- Mental Health Services
- Mobile Physician Group
- Neighborhood Outreach Access to Health
- Olive Branch
- Pain Clinics
- Recovia
- School System
- Southwest Behavioral Health
- Southwest College of Naturopathic Medicine
- Southwest Human Development
- St. Luke's Medical Center
- The CORE Institute of Arizona
- United Cerebral Palsy
- Veterans Administration
- Valleywise

- Veteran Alliance
- www.arizonapain.com
- www.belbuca.com
- www.phusionwellness.com

Heart Disease & Stroke

- AARP
- American Heart Association
- Arizona Alliance for Community Health Centers
- Arizona Heart Association
- Arizona Heart Hospital
- arizona.myresourcedirectory.com
- Banner Health
- Banner Heart Hospital
- Barrow Neurological Institute
- Circle the City
- Community Health Centers
- Dignity St. Joseph Hospital
- Doctor's Offices
- Federally Qualified Health Centers
- Fitness Centers/Gyms
- Grand Canyon University
- Grannynannies.com
- Home Health
- HonorHealth
- Hospice
- Hospitals
- Local Health Organizations
- Maricopa County Medical Resources
- Mayo Clinic
- Mobile Physician Group
- Neighborhood Outreach Access to Health
- Neurological Institute at HonorHealth Osborn Campus
- North Phoenix Heart Center
- Parks and Recreation
- Southwest College of Naturopathic Medicine
- Stroke Education Campaigns
- VA
- Veteran Alliance

Infant Health & Family Planning

- AHCCCS
- Arizona Complete Health
- Arizona Department of Health Services
- Arizona Family Health Partnership
- Babies Beyond One Zone
- Banner Health
- Birth to 5 Hotline
- Catholic Social Services
- Child Crisis Arizona
- Community Clinics
- Community Health Centers
- Doctor's Offices
- First Things First
- Healthy Families Arizona
- Helping Hands
- HIE
- Home Health
- KidsCare
- Maricopa County Health Service
- Mountain Park Health Center
- Neighborhood Outreach Access to Health
- Phoenix Children's Hospital
- Planned Parenthood
- School System
- Title X Funding
- WIC
- Women's Health Coalition

Injury & Violence

- A New Leaf
- American Academy of Pediatrics
- Arizona Child Abuse Information Center
- Arizona Coalition to End Sexual and Domestic Violence
- Arizona Department of Health Services
- Arizona Injury Prevention Coalition
- Arizona Teen Lifeline
- Boys and Girls Club
- Cass
- Child Abuse Hotline
- Child Crisis Arizona
- City of Phoenix - Maryvale Community Center
- City of Phoenix Fire Station
- City of Phoenix Police Department
- Community Health Centers
- Community Health Organizations
- Domestic Violence Shelters
- Hospitals
- Maricopa County Adult Probation Office
- Maricopa County Domestic Violence Resources
- Neighborhood Watch Programs
- Non-Profit Organizations
- Phoenix Children's Hospital
- Phoenix Rescue Mission
- Police Department
- School System
- Seatbelt Laws, Pool Fence Laws
- Shelter Without Walls
- Sojourner Center
- Southwest Human Development
- St. Vincent de Paul
- UMOM Centers
- Valle del Sol
- YMCA

Kidney Disease

- Doctor's Offices

Mental Health

- 211
- 4th Trimester
- AHCCCS
- Alzheimer's/Memory Care Facilities
- Arizona Behavioral Health and Crisis Line
- Aurora Behavioral Health
- Banner Behavioral Health
- Banner Health
- Banner Mental Health Center
- Bayless Healthcare
- Behavioral Health Services
- Brain Injury Alliance of Arizona
- Catholic Charities
- CBI
- Chicanos Por La Causa
- Circle the City
- City of Phoenix
- Community Bridges
- Community Bridges
- Community Health Centers
- Community Health Organizations
- Community Health Workers
- Counseling Services
- County Mental Health Hotline
- CPR
- Crisis Hotline/Suicide Hotline
- Crisis Response Network
- Crossroads
- dcs.az.gov
- Department of Child Safety Rapid Response and CSS
- Desert Mission
- Doctor's Offices
- Door Ways
- EPI Center
- Federally Qualified Health Centers
- HonorHealth
- Hospitals
- Housing
- HSAG
- Insurance Company Behavioral Health Line
- Jewish Family and Children's Services
- Life Well
- Magellan Website
- Marc Community Resources
- Maricopa County
- Maricopa County Crisis Line
- Maricopa County Health Service
- Maricopa Medical Center
- Marketing/Education
- Marley House
- Mayo Clinic
- Medicaid
- Mental Health America of Arizona
- Mental Health Services
- Mental Mercy Care
- Mercy Maricopa Integrated Care
- Mobile Crisis Unit
- Mountain Park Health Center
- NAMI
- Neighborhood Outreach Access to Health
- NHW Community Health Center
- Non-Profit Organizations
- Nurse Case Management
- Outpatient Mental Health Clinic
- Private Therapists
- Quail Run
- Recovia
- Social Services Agencies
- Southwest Behavioral Health
- Southwest College of Behavior Health
- Southwest Human Development
- St. Luke's Behavioral Health
- St. Luke's Medical Center
- St. Vincent de Paul
- State of Arizona
- Suicide Help Lines
- TBI Programs/Facilities
- Tempe St. Luke
- Terros Health
- The Meadows
- Thunderbird Samaritan Hospital
- Touchstone Health Services
- Tragedy Support Line
- University of Arizona Pharmacogenomics
- UPC
- VA
- Valle del Sol
- Valley Hospital
- Valleywise
- Veterans Hospital
- Vista del Camino
- Warm Line
- Wrap Around Support Services
- www.rtor.org

Nutrition, Physical Activity & Weight

- American Heart Association
- Arizona Department of Health Services
- Arizona DES
- Arizona Health Zone
- Boys and Girls Club
- Circle the City
- City Community Centers

- Community Gardens
- Community Health Centers
- Community Health Organizations
- Doctor's Offices
- F.I.T. Training
- Farmer's Markets
- Federally Qualified Health Centers
- Fitness Centers/Gyms
- FitPHX
- Food Banks
- Food City
- Food Shelves
- Food Stamps
- Grocery Stores
- Healthy Choice Arizona
- Medical Professionals
- None
- Nutrition Services
- Parks and Recreation
- Pinnacle Prevention
- Private Treatment Providers
- Salvation Army
- School System
- Silver Sneakers
- SNAP
- St. Mary's Food Bank
- St. Vincent de Paul
- Tiger Mountain Foundation
- Weight Watchers
- WIC
- YMCA

Oral Health

- AHCCCS
- ALTCS Case Manager
- Arizona Department of Health Services
- Boys and Girls Club
- Brighter Way
- Community Health Centers
- Hopefest
- Human Services Campus
- Maricopa County Department of Health
- Midwestern University Dental Clinics
- Mobile Dentists
- Neighborhood Outreach Access to Health
- New Horizons
- School System
- Smiles and Beyond
- St. Vincent de Paul
- Valleywise
- www.deltadentalaz.com
- www.freedentalcare.us
- www.smileaz.com

Respiratory Disease

- AA/NA
- Arizona Lung Association
- Circle the City
- Community Health Centers
- DME
- Doctor's Offices
- Home Health
- Hospice
- Hospitals
- Long-Term Care Facilities
- Maricopa County Public Health
- No Burn Days
- Norton Thoracic Center
- Parks and Recreation
- The Universities
- Urban Planners
- VA
- Vitalyst Foundation

Sexual Health

- Aunt Rita's
- Circle the City
- Community Health Centers
- One n Ten
- Planned Parenthood
- Public Health
- Ryan White
- Sonoran Prevention Works
- Southwest Center for HIV/AIDS

Substance Abuse

- 12 Step Programs
- 19th Avenue and Dunlap Methadone Clinic
- 211
- 23rd Avenue and Northern Methadone Clinic
- 28th Drive Cactus Methadone Clinic
- AA/NA
- AAA
- Arizona Adverse Childhood Experiences Consortium
- Arizona Department of Health Services
- ASU
- Aurora Behavioral Health
- Banner Behavioral Health
- Banner Hospital Addiction Program
- CBI
- Chandler Valley Hope
- Child Services
- Churches
- Circle the City
- City of Scottsdale Human Services
- Community Bridges
- Community Health Centers
- Community Medical Services

- Copper Springs
- Doctor's Offices
- First Responders
- First Things First
- HOM Inc.
- Horizon Human Services Substance Abuse Treatment
- Human Services Campus
- IHS
- Inpatient Treatment Centers
- Insurance Company Behavioral Health Line
- LARC
- Marketing/Education
- MAT Clinics
- Mercy Care
- Native American Connections
- Native Health
- Neighborhood Outreach Access to Health
- New Arizona Family
- Non-Profit Organizations
- Outpatient Treatment Centers
- Oxford House
- Parents of Addictive Loved Ones
- Patina
- Phoenix Rescue Mission
- Private Substance Abuse Services
- Recovia
- RiverSource
- Salvation Army
- Scottsdale Fellowship
- Sonoran Prevention Works
- Southwest Behavioral Health
- Southwest Recovery Alliance
- State of Arizona
- SUSD
- Terros Health
- Treatment Homes
- UArizona
- UMOM
- Valle del Sol
- Valley Hope
- Valleywise

Tobacco Use

- AA/NA
- American Cancer Society
- Ash Line
- Center for Disease Control
- City of Phoenix
- Doctor's Offices
- Flavorhookkids.org
- Hospitals
- Maricopa County Government
- Neighborhood Outreach Access to Health
- Phoenix Rescue Mission
- Quit Lines
- School System
- smokefree.gov
- tobaccofreekids.org

APPENDIX

EVALUATION OF PAST ACTIVITIES

HonorHealth

You want healthcare focused on you – your unique needs, your schedule, your goals. You want a network of experts connected to each other, with everyone focused on your well-being. HonorHealth provides that focus. The HonorHealth health system:

- Provides care for individuals and families with a variety of medical needs.
- Encompasses more than 2,800 expert physicians, 12,800 dedicated employees, and 3,100 caring volunteers working in partnership.
- Is committed to wellness management.
- Has nearly 150 years of combined experience serving communities in greater Phoenix

HonorHealth is both a name and call to action. It emphasizes trustworthiness and integrity while demonstrating respect and dedication to delivering the highest quality care in a personal and easy manner.

The brand promise of making healthy personal reflects HonorHealth's mission — to improve the health and well-being of our community.

Community Benefit

Over the past three years, HonorHealth has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $268 million in community benefit, excluding uncompensated Medicare.
- More than $176 million in charity care and other financial assistance programs.

HonorHealth offers an integrated system of care to bring highly coordinated, more accessible healthcare to patients and our communities. Caring for our community extends beyond HonorHealth's medical centers, it also includes the community programs of HonorHealth Desert Mission and the HonorHealth Military Partnership Program. In addition, HonorHealth's affiliation with Neighborhood Outreach Access to Health (NOAH) adds to HonorHealth's extensive integrated care network by providing behavioral health services and dental care as well as addressing social needs. All of these various pieces help us deliver on our mission to improve the health and well-being of those we serve.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

HonorHealth conducted its last CHNA in 2018 and reviewed the health priorities identified through that assessment performed on behalf of the following hospitals:

- Deer Valley Medical Center
- Greenbaum Specialty Surgery Hospital
- HonorHealth Rehabilitation Hospital
- John C. Lincoln Medical Center
- Scottsdale Osborn Medical Center
- Scottsdale Shea Medical Center
- Scottsdale Thompson Peak Medical Center

We collaborated on the CHNA with internal stakeholders and as well as external key informants. Working together, taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that HonorHealth would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Health Care Services
- Access to Healthy Food
- Mental Health including homelessness and substance abuse
- Chronic Disease Management
- Maternal and Infant Health

Strategies for addressing these needs were outlined in the 2019 HonorHealth Implementation Plans. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by HonorHealth to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Access to Health Care Services	
Community Health Need	**Improve access to primary care services**
Goal(s)	• **Increase integration and referrals to Neighborhood Outreach Access to Healthcare and FQHC ("NOAH")** • **Remove barriers to care**

Strategy 1: Build the capacity of local community clinics to provide primary and preventive healthcare services.	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents, all service areas
Partnering Organization(s)	Internal: Hospital inpatient, outpatient, and HonorHealth Medical Group External: NOAH, Neighborhood Outreach Access to Healthcare
Results/Impact	• NOAH experienced 21% increase in patients served in 2019 from 2018: 36,948 individuals (up from 30,417 in 2018). • In 2019 there were 89,416 medical visits, 1,331 substance abuse visits, 9,743 dental visits, 11,880 (public benefit) eligibility visits, 3,471 nutrition visits and 28,443 counseling visits • In 2020, NOAH provided navigation assistance to Community Based Organizations for 13,749 individuals

Strategy 2: Address economic barriers to accessing care	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents, all service areas
Partnering Organization(s)	Internal: HonorHealth Desert Mission External: St. Joseph the Worker
Results/Impact	• Number of individuals who received "Living Well" services (including a financial, career and home success course) 106 in 2019, 164 in 2018 • 206 in 2019 obtained employment, 162 in 2018 • 63% of participant screened for public assistance eligibility in 2019. 22 participants were approved for at least one public benefit in 2018 • 58 individuals experienced higher income in 2019 and 2018

Strategy 3: Increase number of urgent care locations	
Strategy Was Implemented?	Yes
Target Population(s)	All service areas
Partnering Organization(s)	Internal: Corporate Office External: FastMed
Results/Impact	• Acquired 30 FastMed locations in 2020 • FastMed volumes and potential impact on Emergency Department low-acuity volumes is unknown at this time

Strategy 4: Increase number of HonorHealth Medical Group locations	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals with limited access to care, Underserved geographies, all service areas
Partnering Organization(s)	Internal: Corporate Office External: HonorHealth Medical Group
Results/Impact	Opened one new HonorHealth Medical Group location in Fountain Hills, Arizona

Strategy 5: Increase number of telemedicine capabilities and access	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals with limited access to care, Underserved geographies, all service areas
Partnering Organization(s)	Internal: External: FastMed, NOAH
Results/Impact	• Acquired 30 FastMed locations in 2020, FastMed offers telehealth • Referrals accepted at NOAH from inpatient, outpatient and HonorHealth Medical Group, NOAH offers telehealth

Strategy 6: Increase access to behavioral health services	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals with limited access to care, Underserved geographies including the Salt River Pima Reservation, all service areas
Partnering Organization(s)	Internal: Corporate Office and Care Management External: UHS
Results/Impact	• Planning ongoing in 2018-2021, opening in 2022 • 157 beds planned

Priority Area: Mental Health, including homelessness and substance abuse	
Community Health Need	**Improve access to mental health services**
Goal(s)	• **Improve access to behavioral health services for vulnerable populations** • **Improve navigation to community based organizations**

Strategy 1: Increase access to behavioral health services	
Strategy Was Implemented?	Yes
Target Population(s)	Underserved, all service areas
Partnering Organization(s)	Internal: Corporate Office and Care Management External: UHS
Results/Impact	• Planning ongoing in 2018-2021, opening in 2022 • 157 beds planned

Strategy 2: Build the capacity of local community clinics to behavioral health	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents, all service areas
Partnering Organization(s)	Internal: Hospital inpatient and outpatient, HonorHealth Medical Group External: NOAH, Neighborhood Outreach Access to Healthcare
Results/Impact	• Referrals accepted at NOAH from inpatient, outpatient and HonorHealth Medical Group • NOAH held 28,443 counseling visits in 2019 and 23,309 in 2018

Strategy 3: Support senior adults with cognitive impairment	
Strategy Was Implemented?	Yes
Target Population(s)	Senior adults with cognitive impairment, **JCL Service Area only**
Partnering Organization(s)	Internal: HonorHealth Desert Mission Adult Day Healthcare External: None
Results/Impact	• Number of clients multiplied by number of days in attendance 8,398 in 2019. Number of individuals in Adult Day Healthcare in 2018 105. • In 2019 and 2018 67% of clients received financial support to attend program • 78% of clients have dementia in 2019, 83% in 2018

Strategy 4: Develop opioid prescription management program	
Strategy Was Implemented?	Yes
Target Population(s)	Inpatient, all service areas
Partnering Organization(s)	Internal: Opioid Stewardship Steering Committee External: None
Results/Impact	• Cross-functional team has eleven strategies to reduce opioid prescriptions for at-risk populations, monitor prescriptions and create workflows to ensure safety. 41% reduction in ADE Adverse Drug Events during 2018-2020. New Balanced Scorecard created for the 2020 2021 period.

Strategy 5: Improve discharge navigation for individuals experiencing homelessness	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals experiencing homelessness, **JCL Service Area only**
Partnering Organization(s)	Internal: JCL Emergency Department, Care Management and Government and Community Affairs External: Circle The City
Results/Impact	• Circle the City Navigator placed in emergency department starting in 2019 • Navigator places individual experiencing homelessness in respite care and coaches individuals on available follow-up care at “Street Medicine” clinics and NOAH • Navigated over 750 individuals in 2020

Strategy 6: Improve discharge outcomes for Seriously Mentally Ill patients	
Strategy Was Implemented?	Yes
Target Population(s)	Seriously Mentally Ill patients, all service areas
Partnering Organization(s)	Internal: Case Management External: Community Based Organizations, Independent Businesses, and non-hospital healthcare organizations
Results/Impact	• Social Worker dedicated to place Seriously Mentally Ill patients in care facility and/or align community-based resources for patient’s discharged home to improve outcomes

Priority Area: Access to Food	
Community Health Need	**Food insecurity**
Goal(s)	• **Screen for food insecurity and make referrals to Community Based Organizations** • **Provide greater access to healthy food**

Strategy 1: Improve access to food	
Strategy Was Implemented?	Yes
Target Population(s)	Vulnerable populations, all service areas
Partnering Organization(s)	Internal: HonorHealth Desert Mission Food Bank External: St Mary's Food Bank, federal and state agencies, corporate and private volunteers
Results/Impact	• 1,798 in 2020, 20,526 2019 and 22,981 in 2018 snack packs given to children in schools, libraries, and community centers • 10,563 2019 11,913 in 2018 children supplied with nutrition assistance including 1,043 in 2019 and 1,134 in 2018 infant food bags • 20,965 in 2020, 37,584 in 2019 and 34,945 in 2018 food boxes provided to Food Bank clients • Commodity Supplement Food Program (CSFP) for seniors 60 years old and older 3,717 senior boxes provided in 2020

Strategy 2: Launch pilots to begin screening patients for food insecurity	
Strategy Was Implemented?	Yes
Target Population(s)	Screen vulnerable populations for food insecurity, all service areas
Partnering Organization(s)	Internal: HonorHealth Medical Group, Desert Mission, Social Determinants of Health Steering Committee External: NOAH
Results/Impact	• Three (pilot sites: Hauser, Palomino and Desert Mission locations) of nine NOAH clinics are screening patients using the Center for Disease Control "Hunger Vital Sign" two questions measuring financial constraints to access food. • March 2020 3% of patients were being screened. In March 2021 9% of NOAH patients were screened. • Referrals made to Community Based Organizations including Desert Mission.

Strategy 3: Increase home delivered meals to homebound seniors	
Strategy Was Implemented?	Yes
Target Population(s)	Homebound seniors with limited income, all service areas
Partnering Organization(s)	Internal: Food Services Thompson Peak Medical Center External: Area Agency on Aging and Foothills Corps
Results/Impact	56,000 warm and freezer ready meals prepared in 2020. Community Based Organizations pick up prepared meals from Thompson Peak Hospital and deliver to vulnerable seniors.

Strategy 4: Increase home delivered meals to homebound seniors	
Strategy Was Implemented?	Yes
Target Population(s)	Homebound seniors with limited income in the City of Scottsdale
Partnering Organization(s)	Internal: Desert Mission External: City of Scottsdale
Results/Impact	9,560 bags of food delivered to City of Scottsdale Granite Reef Senior Center.

Strategy 5: Increase availability to healthy food options at cafeterias within hospitals	
Strategy Was Implemented?	Yes
Target Population(s)	Employees and visitors, all service areas
Partnering Organization(s)	Internal: Desert Mission, hospital food service External: None
Results/Impact	During the years 2019 and 2020 there were 2,015 customers at all HonorHealth “Farm Stand” sites. 18,168 HonorHealth employee food bags were delivered in 2020

Strategy 6: Increase availability to healthy food options in Sunnyslope	
Strategy Was Implemented?	Yes
Target Population(s)	Vulnerable children in Sunnyslope, **JCL only**
Partnering Organization(s)	Internal: Government and Community Affairs External: Sunnyslope School District/Washington Elementary, Sprouts Grocers
Results/Impact	Built garden area on the campus of Washington Elementary for the purposes of providing access to healthy food and to provide education on gardening, nutrition, and cooking.

Priority Area: Chronic Disease Management	
Community Health Need	**Chronic Disease Management**
Goal(s)	• **Support patient self-care at home** • **Screen individuals for potential chronic disease risk**

Strategy 1: Deliver Diabetes education	
Strategy Was Implemented?	Yes
Target Population(s)	Newly diagnosed community members with diabetes, all service areas
Partnering Organization(s)	Internal: External: Physician practices, Endocrinologists
Results/Impact	• Class participants 613 in 2019, 580 consultations in 2019 • Class participation 76 in 2020, 364 consultations in 2020 • 65% of referrals are from community physicians and 45% referrals are from HonorHealth affiliated physicians. • Educational program meets the recognition status by the National Standards for Diabetes Self-Management Education and Support (DSMES) • Monthly Community Diabetes Lecture

Strategy 2: Provide health screenings for chronic disease	
Strategy Was Implemented?	Yes
Target Population(s)	Vulnerable populations, all service areas
Partnering Organization(s)	Internal: Referrals from HonorHealth affiliated physicians External: Referrals from community physicians
Results/Impact	• Women's Heart Health Evaluations • Cholesterol and Glucose Screenings • Bone Mineral Density Screenings • Skin Cancer Screenings

Strategy 3: Increase care coordination for Congestive Heart Failure	
Strategy Was Implemented?	Yes
Target Population(s)	Congestive Heart Failure patients
Partnering Organization(s)	Internal: Care Management, Transitional Care Team External: Community Based Organizations, Independent Businesses, and non-hospital healthcare organizations
Results/Impact	• Provide 24/7 telemedicine clinical support for patients discharged from hospital with Congestive Heart Failure. Offer medical consultation, medication management, wound care instructions, transportation, durable medical equipment, and coordination with other non-hospital healthcare organizations • Launch date: 2/18/2019: In 2019 42,066 call attempts made to 26,959 discharges that met the criteria to call. In 2020, 43,666 call attempts made to 28,685 discharges that met the criteria to call.
Strategy 4: Provide clinical and emotional support for patients with chronic disease	
Strategy Was Implemented?	Yes
Target Population(s)	Diagnosed community members with diabetes, all service areas
Partnering Organization(s)	Internal: Referrals from HonorHealth affiliated physicians External: Referrals from community physicians
Results/Impact	• Cardiac Rehab Support Group • Healthy Heart Classes • Osteoporosis Support Group

Priority Area: Maternal and Infant Health	
Community Health Need	**Fill gaps in care Maternal and Infant Health**
Goal(s)	• **Offer access to care and education in Sunnyslope** • **Provide specialized care for women experiencing trauma** • **Youth awareness of drugs and alcohol and other risky behaviors**

Strategy 1: Provide healthy environment for education and well-being in Sunnyslope neighborhood	
Strategy Was Implemented?	Yes
Target Population(s)	Vulnerable children ages six weeks to 12 years old, **JCL Service Area Only**
Partnering Organization(s)	Internal: Desert Mission/Lincoln Learning Center External: Washington School District
Results/Impact	• Number of children receiving early care and education 440 in 2019 414 in 2018 • Number of children assessed for kindergarten readiness 430 in 2019 401 in 2018 • Number of children receiving tuition assistance 127 in 2019 128 in 2018

Strategy 2: Provide specialized care for women experiencing trauma	
Strategy Was Implemented?	Yes
Target Population(s)	Maricopa County, all service areas (per contract with Maricopa County
Partnering Organization(s)	Internal: Forensic Nursing Program External: Maricopa County seven Family Advocacy Centers, all hospital emergency departments in Maricopa County
Results/Impact	• Number of forensic exams provided (for potential victims of sexual assault, sex trafficking, domestic violence, or other forms of trauma) 2018 = 2,411, 2019 = 2,284, 2020 = 2,130 • Number of mental health screenings 2018 = 1,732, 2019 = 2,057, 2020 = 2,032 • Number of screening for human trafficking 2018 = 1,889, 2019 = 2,016, 2020 = 1,993

Strategy 3: Provide youth awareness of risk behaviors	
Strategy Was Implemented?	Yes
Target Population(s)	School age youth, all service areas
Partnering Organization(s)	Internal: Military Partnership and Trauma Department External: Service Area School Districts
Results/Impact	• Over 2,000 individual students per year received awareness training on risky behavior such as driving without a seatbelt, using a bike helmet and involving the use of alcohol and drugs

Strategy 4: Add midwives to care delivery	
Strategy Was Implemented?	No
Target Population(s)	Prenatal care for vulnerable populations, all service areas
Partnering Organization(s)	Internal: Maternal and Child Health External:
Results/Impact	• Intended on adding midwives to care team to meet adapting needs of the community. Plan put on hold with leadership changes and resource constraints.