Scottsdale Healthcare
2013 Community Health Needs Assessment
Implementation Plan
Shea Medical Center
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The Scottsdale Healthcare (SHC) 2013 -2016 Community Health Needs Assessment Implementation Plan (CHNAIP) addresses priorities identified in the 2012 Community Health Needs Assessment (CHNA) and responds to other previously identified community health needs that will improve the health and well-being of our community. As required by federal law, individual CHNAs and CHNAIPs have been developed for each of the four SHC licensed hospitals: Osborn Medical Center, Greenbaum Surgical Specialty Hospital, Shea Medical Center and Thompson Peak Hospital. The CHNAIPs will be submitted with the SHC Form 990s in August 2014, following SHC Board approval in 2013.

SHC Community Health Services led the development of the 2012 CHNA and the SHC organization-wide CHNAIPs. A project Steering Committee was formed with representation across SHC. Consistent with best practice, input also was provided by an external Community Stewardship Advisory Council.

The first step in the development of the CHNAIP was to inventory the programs and services SHC organization-wide that impact the five focus areas identified in the 2012 CHNA: 1) Cardiovascular Disease 2) Heart Failure 3) Diabetes 4) Obesity and 5) Cancer. The inventory was based on a Continuum of Care framework:

```
Prevention ----> Early Screening/ Diagnosis ----> Disease State Management ----> Acute Care ----> Post-Acute Care ----> Palliative Care
```

Next, we evaluated if the inventory of programs and services for each of the five Focus Areas met the needs of the highest Priority Group and other identified key segments. This segmentation approach was designed to ensure that we maximize SHC and community resources by addressing the population segments with the greatest need and/or opportunity, especially in the areas of prevention and early screening/diagnosis.

We need to ensure that the programs and services meet the needs of each segment in two ways. First, we assessed the Continuum of Care coverage. Programs and services across the Continuum of Care must be relevant and accessible to the highest Priority Group and other key segments, sufficiently covering the Continuum of Care for each Focus Area. Second, based on the size of each segment, the relevant and accessible programs and services must have enough capacity to make a significant impact.

On an ongoing basis, SHC will reallocate resources or identify additional resources in the community to address gaps in the Continuum of Care coverage and/or capacity constraints. Internally, we will monitor program effectiveness through a combination of process and outcome measures against baseline data presented in the CHNA.
Scottsdale Healthcare Shea Medical Center
Community Health Needs Assessment Implementation Plan 2013-2016

Background

Scottsdale Healthcare is a nonprofit, community-based health system and Scottsdale’s largest employer. Founded in 1962, it is now one of the largest health systems in Arizona with 834 licensed beds, serving 275,000 total patients annually. The vision of Scottsdale Healthcare is setting the standard for excellence in personalized healthcare. Our values include integrity, caring, accountability, respect and excellence. The non-profit community-based mission is to provide the highest quality and most compassionate care for all individuals.

Scottsdale Healthcare Shea Medical Center is a 433-bed, full-service magnet designation hospital, committed to the health of the community they serve and one of four facilities in the Scottsdale Healthcare system, including Greenbaum Surgical Specialty Hospital, Osborn Medical Center and Thompson Peak Hospital.

Our 2013 Community Implementation Plan outlines our community focused programs and services and summarizes the plans for Scottsdale Healthcare Shea to sustain and develop new community benefit programs that 1) address prioritized needs from the 2012 Community Health Needs Assessment (CHNA) and 2) respond to other identified community health needs to improve the health and well-being of our community.

How the Implementation Strategy was Developed

The Shea CHNAIP was developed based on the findings from the CHNA and review of Scottsdale Healthcare’s current community benefit activities and services.

The Community Health Services (CHS) Department provided leadership for the 2012 CHNA through the SHC CHNA Steering Committee (Appendix 1). The Steering Committee responded to each of the priority needs and developed and monitored action plans and goals for each need. Additionally, a Community Stewardship Advisory Council (Appendix 2), including representatives from agencies and organizations providing services and programs in the community, had been formed in 2008 to guide community benefit activities at Scottsdale Healthcare.

Focus Areas were reviewed and approved by both the Advisory Council and the Steering Committee.
Major Needs and How Priorities Were Established

Focus Areas

Using Focus Areas selection criteria (Appendix 3) as a guide, the SHC CHNA Steering Committee established the priority community needs for Scottsdale Healthcare Shea Medical Center. Focus Areas were identified:

1) Cardiovascular Disease
2) Heart Failure
3) Diabetes
4) Obesity
5) Cancer

Description of What Scottsdale Healthcare Shea Will Do To Address Community Health Needs

Priority Groups and Key Population Segments

With the five Focus Areas identified, the next steps were to determine the highest Priority Groups and other key population segments. This segmentation approach was designed to ensure that we maximize SHC and community resources by addressing population segments with the greatest need and/or opportunity.

Priority Groups were identified for each disease state, utilizing primary and secondary data sources, and zip codes within the service area. For most Focus Areas, residents age 65 and over living in selected zip code areas and making less than $40,000/year were identified as the most in need.

To identify additional key segments of the population that would warrant a more targeted focus in our Implementation Plan, program managers, service line leaders and clinicians within Scottsdale Healthcare were queried. Through an examination of population data as well as the clinical expertise of this team, key population segments were delineated. Priority Groups and key population segments for each Focus Area can be found in Appendix 4.

Continuum of Care Coverage

The SHC CHNA Steering Committee developed a Continuum of Care framework to assess current SHC programs and services. The Steering Committee involved the service line directors, physicians and other key leaders that aligned with the five Focus Areas. Using information
obtained through departmental surveys and face-to-face interviews, programs were inventoried for each of the five Focus Areas.

The Continuum of Care aligns closely with widely used preventive medicine strategies. Prevention, screening and disease management involve the three levels of prevention—primary, secondary and tertiary. Primary prevention attempts to prevent the disease (such as counseling or immunizations). Secondary prevention involves screening and early detection (such as PAP smears and mammograms). Tertiary prevention involves managing the disease to prevent further complications.

The Continuum of Care begins with an emphasis on prevention and early screening/diagnosis:

- Prevention
- Early Screening/Diagnosis
- Disease State Management
- Acute Care
- Post-Acute Care
- Palliative Care

Early screening is a strategy used to identify an unrecognized disease in individuals without signs or symptoms. This can include individuals with pre-symptomatic or unrecognized symptomatic disease. As such, screening tests are somewhat unique in that they are performed on persons apparently in good health. Screening interventions are designed to identify disease in a community early, thus enabling earlier intervention and management in the hope to reduce mortality and suffering from a disease.

For each Focus Area, a Program/Service Inventory (Appendix 5) captured programs and services currently offered by Scottsdale Healthcare or through various community partners.

For all five Focus Areas across the Continuum of Care, strategic partnerships were identified which assist Scottsdale Healthcare Shea in meeting the healthcare needs of the community. (Appendix 6). As we move forward, Scottsdale Healthcare will expand programs which meet the identified needs and establish new partnerships in the community.

The Programs/Services Inventory was evaluated for each of the five Focus Areas to determine if they covered the needs of the highest Priority Group and other identified key population segments. Use of this framework assisted Scottsdale Healthcare to identify current programs that are relevant and accessible. Where relevant and accessible programs were not available, it was determined that a gap existed.

**Capacity Analysis**

Based on the size of each segment, the relevant and accessible programs and services must have enough capacity to make a significant impact over a three-year period. Where programs and services were determined to have enough capacity to reach the key population segments, they
were deemed to be sufficient. Where programs and services did not have the capacity or meet the population needs, services were identified as lacking in scale.

Where relevant and accessible programs/services existed, but were not currently being targeted to the identified population segment, they were identified as needing a broader range of targeted communication efforts.

Programs will be assessed on an ongoing basis to ensure that capacity needs are being met for all population segments across the Continuum of Care. In addition, this will allow the SHC Steering Committee to identify opportunities for program expansion and partnerships.

**Introduction to the Focus Area Matrices**

An analysis of Continuum of Care and capacity determined that for most High Priority groups, programs and services were sufficient. For most larger-size population segments, scale (capacity) was lacking.

With a focus on prevention and screening/diagnosis, an analysis of programs/services was conducted for each population segment across the Continuum of Care:

1. **Sufficient:** We believe that the programs/services have enough scale based on the estimated population segment size to make a significant impact on the health of our community over a three year time horizon.
2. **Gap:** There are currently no relevant and accessible programs/services in place to meet the needs of the identified population segment.
3. **Scale:** Programs/services currently exist for this population segment, however there is likely currently not enough scale (capacity) to make a significant impact.
4. **Communication:** There are relevant and accessible programs/services but they are not currently being targeted to the population segment.
5. **N/A:** Programs/services are not applicable to this key population segment.

Please review the following matrices for a detailed view by Focus Area:
1. Cardiovascular Disease Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority: Age 65+</td>
<td></td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
</tr>
<tr>
<td>• Shea ZIP: 85260,85032</td>
<td>slightly less than 5,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• And Income &lt;$40 k per year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension: untreated and uncontrolled population age 40-64</td>
<td>slightly less than 40,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
</tr>
<tr>
<td>Overweight and physical inactivity: address age group 30-64</td>
<td>slightly more than 36,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking: prevention for middle school to age 21</td>
<td>4,000</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking: cessation for adults</td>
<td>26,000</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Cardiovascular Disease Key Learnings:

• Programs/services across the Continuum of Care are sufficient for the High Priority Groups.

• There is a need to increase scale to broaden program/services for all other population segments. Focus on additional partnership development will create program expansion.
2. Heart Failure Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 65+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shea ZIP:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85258, 85263, 85268</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>And Income &lt; $40 k per</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension: untreated</td>
<td>slightly less</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
</tr>
<tr>
<td>and uncontrolled</td>
<td>than 40,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>population age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-64</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight and</td>
<td>slightly more</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>physical inactivity:</td>
<td>than 36,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>address age group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-64</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking: prevention for</td>
<td>4,000</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>middle school to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking: cessation for</td>
<td>26,000</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heart Failure Key Learnings:

- Heart Failure is a type of a Cardiovascular Disease. Progression of Heart Failure can be minimized with treatment.

- Risk factors of Heart Failure include hypertension, obesity and smoking. Increasing program capacity in prevention, screening, and disease management are needed for all population segments through partnership expansion and online services.
### 3. Diabetes Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Age 65+ (Shea: also 55-64)</td>
<td></td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Scale</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>N/A</td>
</tr>
<tr>
<td>• Shea: 85032, 85264</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• And Income &lt;$40 k per year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undiagnosed Type 2 school age children and their parents</td>
<td>less than 61,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Undiagnosed Type 2 young adults (who just turned 18 and living independently)</td>
<td>22,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetic Type 1 &amp; 2: young adults (who just turned 18 and living independently)</td>
<td>2,500</td>
<td>Communication</td>
<td>N/A</td>
<td>Communication</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetics Type 1 and 2: age 30+</td>
<td>slightly more than 18,000</td>
<td>Scale</td>
<td>N/A</td>
<td>Scale</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
</tr>
<tr>
<td>First time mothers (pre-conception)</td>
<td>less than 53,000*</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>less than 53,000*</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Women of child bearing age' statistic was used in lieu of 'first time mothers' and 'pregnant women' statistic.

**Diabetes Key Learnings:**

- Programs/services across the Continuum of Care are sufficient for the High Priority groups.
- For all other population segments, there is a need to increase scale for current programs/services. Having the opportunity to partner with Scottsdale Health Partners and Neighborhood Outreach Access to Health (NOAH) Cholla Center will allow for growth of the needed programs/services.
4. Obesity Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Former Smokers; Eat</td>
<td>slightly less</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>• Fast Food At Least</td>
<td>than 800</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Once in a Week; Do</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Not Exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Shea ZIP: 85260,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 85032 And Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &lt;$40 k per year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children (boys and girls)</td>
<td>less than 61,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>First time mothers (pre-conception)</td>
<td>less than 53,000*</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>less than 53,000*</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Women perimenopause</td>
<td>39,000</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Men age 30+</td>
<td>slightly more than 80,000</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Seniors men and women age 65+</td>
<td>36,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Obesity Key Learnings:**

- Educational and screening programs to address obesity are sufficient for the High Priority groups.

- There is a need to increase capacity of obesity prevention and screening programs for children, pregnant women, and seniors age 65+.

- Improving communication about programs/services targeted toward first time mothers (pre-conception), women perimenopause, and men age 30+ will be addressed through online education/awareness.
5. Cancer

Continuum of Care Coverage: The Virginia G. Piper Cancer Center at Scottsdale Healthcare ensures that our community has access to comprehensive cancer care which includes cancer-related information, education and support and ongoing monitoring and improvement of care. This coordinated delivery of care is provided with collaborators such as the Arizona Cancer Center, Arizona State University and the University of Arizona. Through the Cancer Center and Community Health Services, disease specific education, tobacco prevention and cessation classes and community outreach programming provide ongoing cancer prevention initiatives; however, deficiencies do exist for various programs/services. These communication and capacity issues will be addressed according to cancer site.

Lung Cancer Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/ Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Income &lt;$40k per year</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Shea ZIP:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85260, 85032</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Age 65+</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>slightly less than 5,000</td>
<td>Sufficient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking: prevention, middle school to age 21</td>
<td>4,000</td>
<td>Sufficient</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking: Cessation for adults</td>
<td>26,000</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking: secondary exposure, children and adults</td>
<td>no data</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Lung Cancer Key Learnings:

• Programs/services that address prevention for the High Priority Groups and smoking prevention for middle age school to age 21 are sufficient.

• Both adult smoking cessation and secondary exposure risk for children and adults are identified as programs needing added scale. The Maricopa County Health Department has identified lung cancer as a need to address. Scottsdale Healthcare will partner with the Maricopa County Health Department to increase awareness of additional programs focused on lung cancer prevention.
### Breast Cancer Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/ Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Income &lt;$40k per year</td>
<td></td>
<td>Sufficient</td>
<td>Scale</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
</tr>
<tr>
<td>- Shea ZIP: 85260, 85032</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Age 55+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history, all ages, first degree relatives</td>
<td></td>
<td>N/A</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Benign breast condition all ages</td>
<td></td>
<td>Communication</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women who had more menstrual cycles</td>
<td></td>
<td>Communication</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women using oral contraceptives</td>
<td></td>
<td>Communication</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women post-menopausal</td>
<td></td>
<td>Communication</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women with excessive alcohol consumption</td>
<td></td>
<td>Communication</td>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women age 50-69 (mammogram, education)</td>
<td></td>
<td>Scale</td>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Breast Cancer Key Learnings:

- Breast Cancer screenings are sufficient for the High Priority groups. Increase in scale is needed for screening/diagnosis of the low income members of our community.

- Women of all ages need improved communication about prevention efforts risk factors for breast cancer such as age of menarche, use of excessive alcohol/oral contraceptives and menopause. Increase of scale for breast cancer prevention/screening programs is necessary for women age 50-69.

- Through partnerships with community organizations or reallocation of current efforts, Scottsdale Healthcare will look at expanding screening/diagnostic services to those with lower incomes and women age 50-69.
## Skin Cancer (Melanoma) Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Income &lt;$40k per year</td>
<td></td>
<td>Scale</td>
<td>Scale</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>N/A</td>
</tr>
<tr>
<td>• Shea ZIP: 85260, 85032</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Caucasian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanning booths users</td>
<td>no data</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Fair skin, freckling, light hair</td>
<td>no data</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Have moles</td>
<td>no data</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Caucasian parents</td>
<td>93,000</td>
<td>Scale</td>
<td>scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Caucasian preteens and teens</td>
<td>9,000</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Caucasian young adults</td>
<td>18,000</td>
<td>Communication</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Skin Cancer (Melanoma) Key Learnings:**

- There is a need to increase scale for skin cancer prevention and screening programs for High Priority groups and Caucasian parents.

- There is opportunity for better communication about prevention and screening for all the other population segments.

- Additional partnerships, Primary care Providers, and awareness campaigns are ways to increase scale of needed programs/services and communication for the population segments.
Colorectal Cancer Key Learnings:

- Historically there has been a gap in screening for those with lower incomes. With health care reform, we anticipate changes that will result in closure of this gap.

- Communication about risk assessment screenings for those with a personal history (IBD, polyps, cancer), inherited gene defects, and family history is an identified need. To meet this need, additional efforts for online education and campaigns will be reviewed.

- There is a need to increase scale for prevention, disease management, and post-acute care for those with low incomes and across the Continuum of Care for adults age 50-74.

*Genetic screening, while an identified need for those with a personal/family history or inherited gene defect, and a service currently available through the Virginia G. Piper Cancer Center, will not be further addressed at this time due to allocation of resources that would be required. Resources will be directed to prevention and screening initiatives aimed at reaching a wider audience with a greater potential for risk reduction.
## Prostate Cancer Matrix

<table>
<thead>
<tr>
<th>Key Population Segments</th>
<th>Estimate of Group Size</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease Management</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Priority:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Income &lt;$40 k per year</td>
<td>slightly less than 5,500</td>
<td>Sufficient</td>
<td>scale</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Sufficient</td>
</tr>
<tr>
<td>- Shea ZIP: 85260, 85032</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Men age 50+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African Americans, all ages (make up about 2% of SHC population)</td>
<td>5,500</td>
<td>Communication</td>
<td>Communication</td>
<td>Sufficient</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Family history, all ages, first degree relatives</td>
<td>no data</td>
<td>N/A</td>
<td>Communication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking: Prevention for middle school to age 21</td>
<td>4,000</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking: Cessation for adults</td>
<td>26,000</td>
<td>Scale</td>
<td>Scale</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Prostate Cancer Key Learnings:

- Population segments age 50+ and low income are in need of greater scale for prevention and screening programs. Smoking cessation programs for adults is also an area identified as needing increased scale for prevention and screening.

- For remaining population segments, targeted communication efforts need to be directed toward African Americans and those with a family history on the importance of screening/diagnosis for prostate cancer.

- Partnership with the Scottsdale Healthcare Medical Groups and the opening of the Neighborhood Outreach Access to Health (NOAH) Cholla Center is one way for increasing prevention of, and screening for, prostate cancer by offering increased access to care.
Other Initiatives and Programs

During the program assessment process, initiatives and programs were identified which do not fall within the five Focus Areas, yet are programs which will be continued as they serve the greater needs of the community. These are identified in Appendix 5, Other Initiatives and Programs tab. The CHNA Steering Committee, nonetheless, acknowledges the importance of those other needs and plans to collaborate with community partners to address them. Programs such as childhood and adult immunizations, flu vaccinations, well-child visits, dental care, behavioral health services and assisting children with disabilities will be sustained throughout the system toward the betterment of the community’s health and well-being.

Resource Management

On an ongoing basis, SHC will reallocate resources or identify additional resources in the community to address gaps in the Continuum of Care coverage and/or capacity constraints.
# Appendix 1

## CHNA Steering Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Responsibilities</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wendy Armendariz</strong></td>
<td>Executive Director, Neighborhood Outreach Access to Health (NOAH)</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Gary Baker</strong></td>
<td>Executive Vice President, Healthcare Operations</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>David Barber</strong></td>
<td>Vice President, Marketing</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Marvin Bell, M.D., MPH</strong></td>
<td>Associate Director, Family Practice</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>James Burke, M.D., M.B.A.</strong></td>
<td>Senior Vice President, Chief Physician Executive</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Evonda Copeland, MLIS</strong></td>
<td>Supervisor, Library Services &amp; HealthConnect</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Jess DeJesus, Pharm. D., MBA/HCM</strong></td>
<td>Associate Vice President, Department of Pharmacy</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Karen Ford, RN, MSN</strong></td>
<td>Director, Case Management</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Pauline Hrenchir, BS, MSN, MSL, RNC, RNFA</strong></td>
<td>Clinical Director, Women’s Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Mary Kopp, RN, BSN, MS</strong></td>
<td>Associate Vice President, Administration</td>
<td>Scottsdale Healthcare Shea</td>
</tr>
<tr>
<td><strong>Renae Larcus, Ph.D.</strong></td>
<td>Manager, Community Health Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Diane Legum, MHA</strong></td>
<td>Director, Ambulatory Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Jim Marshall</strong></td>
<td>Director, Human Resources</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Barbara Martindale, MS-NL, RN</strong></td>
<td>Project Manager, Community Health Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Peggy Morehouse, RN, BSN, MSL</strong></td>
<td>Director, Clinical Nursing Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Marialena Murphy</strong></td>
<td>Clinical Director, Perioperative Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Chris O’Mara, MSN, RN</strong></td>
<td>Supervisor, Community Health Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Michelle Pabis</strong></td>
<td>Executive Director, Gov. &amp; Public Affairs</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Kimberly Post, DNP, MBA/HCM, RN, NEA-BC</strong></td>
<td>Vice President, Administration</td>
<td>Thompson Peak Hospital</td>
</tr>
<tr>
<td><strong>Bobbi Presser, MPH</strong></td>
<td>Executive Director, Clinical Integration</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Peggy Reiley, RN, Ed.D.</strong></td>
<td>Executive Director, Clinical Integration</td>
<td>Scottsdale Healthcare</td>
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<tr>
<td><strong>Irving M. Rollingher, M.D.</strong></td>
<td>Chief Medical Information Officer</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Lisa Sandoval, MPH</strong></td>
<td>Director, Marketing</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Tracey Schalscha, MPH</strong></td>
<td>Consultant</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Richard Silver, M.D.</strong></td>
<td>Vice President, Chief Medical Officer</td>
<td>Scottsdale Healthcare</td>
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<tr>
<td><strong>Brian Steines, CPA</strong></td>
<td>Vice President of Finance</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>James Stelzer</strong></td>
<td>Executive Director</td>
<td>Scottsdale Health Partners</td>
</tr>
<tr>
<td><strong>Dean Thomas, MBA, MHSA</strong></td>
<td>Vice President, Clinical Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td><strong>Lindsay Thomas, RN, MSN, OCN</strong></td>
<td>Director, Cancer Center</td>
<td>Scottsdale Healthcare</td>
</tr>
</tbody>
</table>
## Appendix 2

### Community Stewardship Advisory Council

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendy Armendariz</td>
<td>Executive Director</td>
<td>Neighborhood Outreach Access to Health (NOAH)</td>
</tr>
<tr>
<td>Milissa Sackos</td>
<td>Executive Director</td>
<td>Student and Community Services Scottsdale Unified School District (SUSD)</td>
</tr>
<tr>
<td>David Barber</td>
<td>Vice President, Marketing</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>Tracey Schalscha, MPH</td>
<td>Consultant</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>Marvin Bell, M.D., MPH</td>
<td>Associate Director, Family Medicine</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>Brian Steines, CPA</td>
<td>Vice President, Finance</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>James Bertz, DDS, M.D.</td>
<td>Oral/Maxillofacial Surgery</td>
<td>Brent Stockwell</td>
</tr>
<tr>
<td>Tim Bray</td>
<td>President</td>
<td>Southwest Community Resources</td>
</tr>
<tr>
<td>Trisha Stuart</td>
<td>President, Giving Solutions</td>
<td>City of Scottsdale</td>
</tr>
<tr>
<td>Evonda Copeland, MLIS</td>
<td>Supervisor, Library Services &amp; HealthConnect</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>Toby Urvater, M.S.W.</td>
<td>Administrator, Community Health Action</td>
<td>Maricopa County Health Dept. of Public Health</td>
</tr>
<tr>
<td>Jan Gehler, Ed.D.</td>
<td>President</td>
<td>Scottsdale Community College</td>
</tr>
<tr>
<td>Laura Grafman</td>
<td>Executive Vice President</td>
<td>Scottsdale Healthcare Foundation</td>
</tr>
<tr>
<td>Bruce Johnson</td>
<td>Pastor</td>
<td>Scottsdale Presbyterian Church</td>
</tr>
<tr>
<td>Virginia Korte, Chair</td>
<td>City Council Member, City of Scottsdale</td>
<td>Scottsdale Training &amp; Rehabilitation Services</td>
</tr>
<tr>
<td>Christine Kovach</td>
<td>Community Activist</td>
<td>McDowell Sonoran Conservancy</td>
</tr>
<tr>
<td>Renae Larcus, Ph.D.</td>
<td>Manager, Community Health Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>Barbara Martindale, MS-NL, RN</td>
<td>Project Manager, Community Health Services</td>
<td>Scottsdale Healthcare</td>
</tr>
<tr>
<td>Michelle Pabis</td>
<td>Director, Government Relations</td>
<td>Scottsdale Healthcare</td>
</tr>
</tbody>
</table>
Appendix 3

FOCUS AREA SELECTION CRITERIA

• Magnitude: number of people impacted
• Severity: risk of morbidity/mortality associated with the problem
• Historical trends
• Alignment of the problem with the organization's strengths and priorities
• Impact of the problem on vulnerable populations
• Importance of the problem to a community
• Existing resources addressing the problem
• Relationship of the problem to other community issues
• Feasibility of change, availability of tested approaches
• Value of immediate intervention vs. any delay, especially for long term or complex threats
## Appendix 4

### High Priority Groups & Key Population Segments

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>High Priority Group</th>
<th>Key Population Segments</th>
</tr>
</thead>
</table>
| Cardiovascular | • Age 65+<br>  o ZIP Osborn: 85256, 85257, 85281<br>  o Shea: 85260, 85032<br>  o TPK: 85022, 85027<br>  • And Income <$40 k per year | 1. Hypertension: address untreated and uncontrolled population age 40-64  
2. Overweight and physical inactivity: address age group 30-64  
3. Smoking: address prevention for junior high to age 21  
4. Smoking: address cessation for adults |
| Heart Failure | • Age 65+<br>  • ZIP<br>  o Osborn: 85256, 85257, 85251<br>  o Shea: 85258, 85263, 85268<br>  o TPK: 85022, 85054, 85262<br>  • And Income <$40 k per year | Same as CVD |
| Diabetes | • Age 65+ (Osborn: also 55-64)<br>  o Osborn: 85256, 85257<br>  o Shea: 85032, 85264<br>  o TPK: 85022, 85027<br>  • And Income <$40 k per year | 1. Prediabetic Type 2: focus on nutrition and physical activity for school age children and their parents  
2. Prediabetic Type 2: focus on nutrition and physical activity for young adults (who just turned 18 and living independently)  
3. Diabetic Type 1 & 2: focus on nutrition, physical activity, medication, and A1C level for young adults (who just turned 18 and living independently)  
4. Diabetics Type 1 and 2: education on nutrition, physical activity, A1C, medication, and blood pressure level for age 30+  
5. First time mothers (pre-conception): focus on importance nutrition and physical activity on disease prevention  
6. Pregnant women: focus on importance nutrition and physical activity on disease prevention |
| Obesity | • Former Smokers; Eat Fast Food At Least Once in a Week; Do Not Exercise<br>  • ZIP<br>  o ZIP Osborn: 85256, 85257, 85281<br>  o Shea: 85260, 85032<br>  o TPK: 85022, 85027<br>  • And Income <$40 k per year | Nutrition and Physical Activity:<br>  1. Children (boys and girls)<br>  2. First time mothers (pre-conception)<br>  3. Pregnant women<br>  4. Women perimenopause<br>  5. Men age 30+<br>  6. Seniors men and women age 65+ |
| Lung Cancer | • Income <$40 k per year<br>  • ZIP<br>  o ZIP Osborn: 85256, 85257, 85281<br>  o Shea: 85260, 85032<br>  o TPK: 85022, 85027 | 1. Smoking: address prevention for junior high to age 21  
2. Smoking: Cessation for adults  
<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Risk Factors</th>
<th>ZIP Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma Skin Cancer</td>
<td>• Income &lt;$40 k per year&lt;br&gt;• ZIP&lt;br&gt;  o ZIP Osborn: 85256, 85257, 85281&lt;br&gt;  o Shea: 85260, 85032&lt;br&gt;  o TPK: 85022, 85027</td>
<td>1. Tanning booths users&lt;br&gt;  2. Fair skin, freckling, light hair&lt;br&gt;  3. Have moles&lt;br&gt;  4. Caucasian parents&lt;br&gt;  5. Caucasian preteens and teens&lt;br&gt;  6. Caucasian young adults&lt;br&gt;  7. Caucasian other?</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>• Income &lt;$40 k per year&lt;br&gt;• ZIP&lt;br&gt;  o ZIP Osborn: 85256, 85257, 85281&lt;br&gt;  o Shea: 85260, 85032&lt;br&gt;  o TPK: 85022, 85027</td>
<td>1. Personal history (IBD, polyps, cancer)&lt;br&gt;  2. Inherited gene defects, all ages&lt;br&gt;  3. Adults age 50-74&lt;br&gt;  4. Family history, all ages, first degree relatives</td>
</tr>
<tr>
<td>Prostate</td>
<td>• Income &lt;$40 k per year&lt;br&gt;• ZIP&lt;br&gt;  o ZIP Osborn: 85256, 85257, 85281&lt;br&gt;  o Shea: 85260, 85032&lt;br&gt;  o TPK: 85022, 85027</td>
<td>1. African Americans, all ages&lt;br&gt;  2. Family history, all ages, first degree relatives&lt;br&gt;  3. Smoking: Prevention for junior high to age 21&lt;br&gt;  4. Smoking: Cessation for adults</td>
</tr>
</tbody>
</table>
## Appendix 5

### Heart Failure Initiatives/ Program Care Continuum

<table>
<thead>
<tr>
<th>Organizational Area/Dept.</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease State Management</th>
<th>Acute Treatment</th>
<th>Post-Acute</th>
<th>Palliative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Health</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
|                           | 1. Tobacco Cessation-Adults  
2. Walking club adults-TPK  
3. Heart Math  
4. Nibbles of Nutrition  
5. Tobacco Prevention-Youth  
6. CPR Heartsave, First Aid, AED Class  
7. Fitness Seniors  
8. Matter of Balance | 1. CVD and stroke Screening  
(includes BP, BMI checks)  
2. Blood Pressure Checks  
3. Cholesterol/Glucose Screenings | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Promotora | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Disease Management (in progress)  
4. Behavioral Health Education  
5. Nutrition Education and | N/A  
N/A  
N/A  
N/A | N/A  
N/A  
N/A  
N/A |
| **NOAH**                  |            |                     |                          |                |           |           |
|                           | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Promotora | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Disease Management (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Care Coordination Community Case Management | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Family Education | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Family Education | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Family Education |
| **Corporate Health**      |            |                     |                          |                |           |           |
|                           | 1. We have Path Program (Salt River Pima Rd)  
2. Silverstone Retirement Center | 1. Heart Rhythm Center  
(Sheena & Osborn)  
2. Heart Health Screening  
(Sheena)  
3. SHC Mobile Health Unit  
4. Women’s Wellness Program (Sheena) | 1. Cardiac Rehab Center  
(Sheena)  
2. Body, Mind and Spirit exercise class (Sheen, Osborn Yoga only)  
3. The Heart of a Woman Forum (Sheen)  
4. Cardiac Rehab Support Group (Sheen)  
5. TeleHealth Case Management Monitoring  
6. Cardiac Rehab Heart Healthy Education Classes (Sheen) | N/A  
N/A  
N/A  
N/A | N/A  
N/A  
N/A  
N/A |
| **Service Line**          |            |                     |                          |                |           |           |
|                           | 1. SHC Website Education-all areas  
2. Heart and Vascular Community Lectures  
3. Chest Pain Recognition-Activating 911  
4. Body, Mind and Spirit exercise class (Sheen, Osborn Yoga only)  
5. Essential Touch Workout Center (Sheen)  
6. The Heart of a Woman Forum | 1. Heart Rhythm Center  
(Sheena & Osborn)  
2. Heart Health Screening  
(Sheena)  
3. SHC Mobile Health Unit  
4. Women’s Wellness Program (Sheena) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management)  
4. TeleHealth Case Management | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) |
| **Scottsdale Health Partners** | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management)  
4. TeleHealth Case Management | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) |
| **Scottsdale Healthcare Medical Group** | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management)  
4. TeleHealth Case Management | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) |
| **Employee Wellness**     | 1. Purewellness online tracking | 1. Wellness screenings | 1. Disease Management |                |           |           |
| **CommunityOutreach/Sponsorships/Marketing** | | | | | | |
| **Sponsorships - Community Benefit** | | | | | | |
| **Community Partnerships/Alliances** | 1. Footprints Caring Corp  
3. Footprints Community Foundation  
4. School Districts  
5. Senior Centers (COB)  
6. Silverstone Community Center | 1. Fountain Hills Screening Center  
2. Senior Centers (COB)  
3. School Districts  
2. Rehab Agencies  
3. Group Homes  
4. Hospice | 1. Hospice Coordination |
<table>
<thead>
<tr>
<th>Organizational Area/Dept.</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease State Management</th>
<th>Acute Treatment</th>
<th>Post-Acute</th>
<th>Palliative Care</th>
</tr>
</thead>
</table>
| **Community Health**     | 1. Tobacco Cessation-Adults  
2. SHC Fitness (Osborn)  
3. Nutrition  
4. Tobacco Prevention-Youth  
5. Walking Club Adults-TPK  
6. Heart math  
7. Matter of Balance  
8. Fitness Seniors  
9. Early Childhood Programs  
10. Zumba Dancing | 1. CVD and Stroke Screening (Includes BP, BMI checks)  
2. Blood Pressure Checks  
3. Cholesterol/Glucose Screenings | 1. Chronic Disease Self-Management | N/A | N/A | N/A |
| **NOAH Osborn and TPK**  | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Promotora | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Disease Management (in progress)  
4. Behavioral Health Education  
5. Nutrition Education and Management | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Care Coordination  
2. Patient Centered Medical Home (in progress)  
3. Care Coordination  
4. Community Case Management |
| **Corporate Health**     | 1. Corporate Challenges  
2. Lunch and Learn | 1. WellPath Program  
(Salt River Pima-RV)  
2. Cholesterol/Glucose Screenings  
3. Silverstone Retirement Center | N/A | N/A | 1. Occupational Health Clinic | N/A |
| **Service Line**         | 1. HSH Website Education  
2. Heart and Vascular Community Lectures  
4. Body, Mind and Spirit exercise class (Shea, Osborn Yoga Only)  
5. Essential Touch Workout Center (Shea)  
6. The Heart of a Woman Forum (Shea) | 1. Heart Health Screening (Shea)  
2. Body Composition (Shea)  
3. Heart Health Bus Unit (Women’s Wellness Program (Shea)) | 1. Heart of a Woman Forum (Shea)  
2. Stroke Survivor and Caregiver Education and Support Group (Osborn)  
3. Cardiac Rehab Center (Shea)  
4. Body, Mind and Spirit Exercise Class  
5. TeleHealth Case Management Monitoring  
6. Cardiac Rehab Heart Healthy Education Classes (Shea) | 1. Chest pain Accredited Center  
2. ADHS Share program for treatment of Cardiac Arrest  
3. Structural Heart program (Osborn and Shea)  
4. SHC Inpatient Case Management Team  
5. ICA Echo Accreditation | 1. Clinical Trial Research  
2. Area Agency for Aging Region 1  
3. ED 2 Home  
4. Care coordination Community Case Management  
5. Cardiac Rehab Fitness Center (Shea) | N/A |
| **Scottsdale Health Partners** | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management |
| **Scottsdale Healthcare Medical Group** | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease Management) | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease Management) | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease Management) |
| **Employee Wellness**    | 1. Purewellness online tracking | 1. Wellness screenings  
1. Disease Management | 1. N/A | 1. N/A | 1. N/A |
| **Community Outreach/Sponsorships/Marketing** | 1. AHA “Go Red for Women”  
2. H&V Civic/Municipality Participation and Education | 1. N/A | 1. N/A | 1. N/A | 1. N/A |
| **Sponsorships - Community Benefits** | 1. American Heart Association | 1. N/A | 1. N/A | 1. N/A | 1. N/A |
| **Community Partnerships/Alliances** | 1. Foothills Caring Corp  
2. Foothills Community Foundation  
4. School Districts  
5. Senior Centers (COS)  
6. Stonegate Community Center | 1. Fountain Hills Screening Center  
2. Senior Centers (COS)  
3. School Districts  
4. Stonegate Community Center | 1. N/A | 1. N/A | 1. N/A | 1. N/A |
### Care Continuum

<table>
<thead>
<tr>
<th>Organizational Sector</th>
<th>Prevention Activities</th>
<th>Screening/Diagnosis</th>
<th>Disease State Management</th>
<th>Acute Management</th>
<th>Post-Acute Treatment</th>
<th>Palliative Care</th>
</tr>
</thead>
</table>
| **Community Health**  | 1. SHC Fitness - Osborn (Osborn)  
2. Walking club adults  
3. Nibbles of Nutrition  
4. Fitness Seniors  
5. Nutrition Classes - children & adults  
6. Grand Canyon Trekkers - children  
7. Zumba Dancing  
8. Yoga | 1. CHD and Stroke Screening  
(includes BP and glucose checks)  
2. BMI Screenings  
3. Cholesterol/Glucose Screenings | 1. Chronic Disease Self-Management | N/A | N/A | N/A |
| **NOAH**              | 1. Diabetes Center Certification Site (in progress)  
2. Promotor  
3. Access to care  
4. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Disease Management (in progress)  
4. Behavioral Health Education  
5. Nutrition Education and Management  
6. Dental Services  
7. Podiatric exams, ocular exams  
8. Diabetes Group Classes | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Diabetes Group Classes  
2. Dental Services  
3. Access to care  
4. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress)  
3. Family Education |
| **Corporate Health**  | 1. Corporate Challenges  
2. Lunch and Learn | 1. Cholesterol/Glucose Screenings  
2. WellPath Program (Salt River Pima RSV)  
3. Silverstone Retirement Center | N/A | N/A | N/A | N/A |
| **Service Line**      | 1. Pre-Diabetes Class (Shea)  
2. Gestation Diabetes Class (Shea)  
3. Essential Touch Workout Center (Shea)  
4. Early Childhood Programs (Osborn)  
5. Fit Club | 1. Body Composition Screening (Shea)  
2. Heart Health Screening (Shea)  
3. SHC Mobile Health Unit | 1. Comprehensive Diabetes Classes (Shea)  
2. The Heart of a Woman Forum (Shea)  
3. Cardiac Rehab Center (Shea)  
4. TeleHealth Case Management Monitoring  
5. Diabetic Individual Counseling and Behavioral Management (Shea) | 1. SHC inpatient Case Management Team | 1. Diabetic Individual Counseling and Behavioral Management (Shea)  
2. ED 2 Home | N/A |
| **Scottsdale Health Partners** | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management)  
4. Quality Care Coordination | 1. Access to Care  
2. Patient Centered Medical Home |
| **Scottsdale Healthcare Medical Group** | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management) | 1. Access to Care  
2. Patient Centered Medical Home  
3. Care Management (Disease management)  
4. Quality Care Coordination | 1. Access to Care  
2. Patient Centered Medical Home |
| **Employee Wellness** | 1. Purewellness online tracking | 1. Wellness Screening | 1. Disease Management | | | |
| **Community Outreach/ Sponsors/Marketing** | | | | | | |
| **Sponsorship-Community Benefit** | | | | | | |
| **Community Partnerships/Alliances** | 1. Pine Towers Senior Center  
2. Arizona Diabetes Coalition  
3. ADA  
4. JDRF  
5. School Districts  
6. Senior Centers | 1. School Districts  
2. Senior Centers | 1. ADA-Type 1 & 2  
2. JDRF-Focus on Type 1 | | | |
<table>
<thead>
<tr>
<th>Organizational Area/Dept.</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease State Management</th>
<th>Acute</th>
<th>Post-Acute</th>
<th>Palliative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health</td>
<td>1. Tobacco Cessation-Adults&lt;br&gt;2. Tobacco Prevention-Youth&lt;br&gt;3. Heart Math&lt;br&gt;4. Nibbles of Nutrition</td>
<td>1. Skin Screenings&lt;br&gt;2. BMI Screenings</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate Health</td>
<td>1. Tobacco Cessation-Adults&lt;br&gt;2. Tobacco Prevention-Youth</td>
<td>1. Skin Screenings&lt;br&gt;2. Silverstone Retirement Center</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Employee Wellness</td>
<td>1. Purewellness online</td>
<td>1. Wellness screenings</td>
<td>1. Disease Management</td>
<td></td>
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<tr>
<td>Sponsorships - Marketing</td>
<td>1. Undy 5000 (Colon Ca)&lt;br&gt;2. Parada del Sol&lt;br&gt;3. Night for Life</td>
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<tr>
<td>CommunityOutreach/ Sponsorship/Community/Benefit</td>
<td>Komen &quot;Race for the Cure&quot;,</td>
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<tr>
<td>Organizational</td>
<td>Prevention</td>
<td>Screening/Diagnosis</td>
<td>Disease State Management</td>
<td>Acute</td>
<td>Post-Acute</td>
<td>Palliative Care</td>
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</tr>
</tbody>
</table>
| Community Health | 1. SHC Fitness (Osborn)  
2. Nutrition Classes-Children  
3. Fit Club  
4. Walking Club Adults-TPK  
5. Nibbles of Nutrition  
6. Matter of Balance  
7. Grand Canyon Trekkers-Children  
8. Early Childhood Programs  
9. Fitness Seniors  
10. Zumba Dancing | 1. BMI Screenings | N/A | N/A | N/A | N/A |
| NOAH | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress) | 1. Access to care  
2. Patient Centered Medical Home (in progress) |
| Corporate Health | 1. Corporate Challenges  
2. Lunch and Learn | 1. WellPath Program (Salt River Pima REV)  
2. Silverstone Retirement Center | N/A | N/A | N/A | N/A |
| Service Line | 1. SHC Website Education  
2. Gestational Diabetes Class (Shea)  
3. Pre-Diabetes Class (Shea)  
4. Nutrition Programs-Cancer (Shea)  
5. Essential touch Workout Center (Shea)  
6. Heart and Vascular lectures  
7. The Heart of a Woman Forum (Shea) | 1. Bariatric Seminars  
2. Body Composition Screening (Shea)  
3. Heart Health Screening (Shea)  
4. Women’s Wellness Program (Shea)  
5. PMR/Bariatric Coordinator Presentations | 1. Heart of a Woman Forum (Shea)  
2. Cardiac Rehab Heart Healthy Education Classes (Shea)  
3. Cardiac Rehab Center (Shea)  
4. Comprehensive Diabetes Classes (Shea) | 1. Gastric Surgery (Shea) | 1. Cardiac Rehab Fitness Center (Shea) | N/A |
| Scottsdale Health Partners | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home |
| Scottsdale Healthcare Medical Group | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home | 1. Access to Care  
2. Patient Centered Medical Home |
| Community Outreach Sponsors/Marketing | | | | | |
| Sponsorships - Community Partnerships/Alliances | 1. AZ Dept of Education  
3. Best Pals Preschool  
4. Boys and Girls Club  
5. La Petite Child Care Center  
6. McCormick Ranch Preschool  
7. Paute Neighborhood Center (COS)  
8. Parks and Recreation (COS)  
9. City of Scottsdale  
10. School Districts  
11. Senior Centers | 1. Footprints Community Foundation  
2. Paute Neighborhood Center (COS)  
3. School Districts | | | | |
### Care Continuum

#### Other Initiatives/Programs

<table>
<thead>
<tr>
<th>Organizational Area/Dept.</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease State Management</th>
<th>Acute</th>
<th>Post-Acute</th>
<th>Palliative</th>
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<tr>
<td>Corporate Health</td>
<td></td>
<td>Occupational Health Medical Surveillance Programs 2. TB Skin Testing</td>
<td>N/A</td>
<td>1. Post exposure Follow-up for TB</td>
<td>N/A</td>
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<td>Service Line</td>
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<tr>
<td>Scottsdale Healthcare Medical Group</td>
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<tr>
<td>Employee Wellness</td>
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<tr>
<td>Community Outreach/Sponsorships/Marketing</td>
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<tr>
<td>Sponsorships - Community Benefit</td>
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### Community Partnerships/Alliances

<table>
<thead>
<tr>
<th>Organizational Area/Director</th>
<th>Prevention</th>
<th>Screening/Diagnosis</th>
<th>Disease State</th>
<th>Acute</th>
<th>Post-Acute</th>
<th>Palliative</th>
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</thead>
<tbody>
<tr>
<td>Community Health</td>
<td>COPE Emergency Preparedness Safe Sitters</td>
<td>Community Case Management</td>
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<tr>
<td>NOAH</td>
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<tr>
<td>Corporate Health</td>
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<tr>
<td>Service Line</td>
<td>Chest pain Recognition-Activating 911</td>
<td></td>
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<td>Support groups/ Bariatric</td>
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<tr>
<td>Scottsdale Healthcare Employed Medical Group</td>
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<td>Employee Wellness</td>
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<td>Community Outreach/Sponsorships/Marketing</td>
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<td>Sponsorships - Community Benefit</td>
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<td>Community Partnerships/Alliances</td>
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Appendix 6

Strategic Community Partnerships

1) Academy of Dermatology
2) American Cancer Society
3) Apria Healthcare
4) Arizona Dept. of Education
5) American Diabetes Association
6) American Heart Association
7) Arizona Diabetes Coalition
8) Arizona Living well Institute
9) Arizona Smokers’ Helpline (ASHline)
10) Arizona State University
11) AT Still University
12) Best Pals Preschool
13) Boys and Girls Club
14) Cave Creek Unified School District
15) City of Carefree
16) City of Cave Creek
17) City of Scottsdale - Human Resources (Employee benefits and wellness programs)
18) City of Scottsdale – Parks and Recreation
19) City of Scottsdale – Human Services (including Paiute Neighborhood Center, Vista del Camino, Granite Reef Senior Center, Via Linda Senior Center)
20) City of Scottsdale Public Library
21) City of Scottsdale Fire Department
22) City of Scottsdale Police Department
23) Colon Cancer Alliance
24) Community Dermatologist
25) Desert Cancer Foundation
26) Duet-Parish Nurses
27) Foothills Caring Corp
28) Foothills Community Foundation
29) Fountain Hills Screening Center
30) Fountain Hills Unified School District
31) Gateway Community College
32) Grand Canyon University
33) Institute of HeartMath
34) Jewish Family Services
35) Juvenile Diabetes Research Foundation
36) Keogh Health Connection
37) La Petite Child Care Center
38) LDS-Camelback Stake
39) Lymphoma Research Foundation
40) Leukemia & Lymphoma Society
41) Maricopa County Health Department
42) Maricopa County Smokeless Tobacco Coalition
43) McCormick Ranch Preschool
44) Mesa Fire Department
45) MOM-mammography
46) New Faces
47) Northern Arizona University
48) Nurtur
49) Our Lady of Perpetual Help Catholic Church
50) Paradise Valley Unified School District
51) Phoenix Fire Department
52) Pine Towers Senior Center
53) POP-Prostate Onsite Project (prostate education and prevention)
54) PureWellness
55) Rural Metro Fire Department
56) Scottsdale Chamber of Commerce
57) Scottsdale Community College
58) Scottsdale Unified School District
59) Scottsdale/PV Community YMCA
60) Southwest Human Development
61) Sprouts
62) St. Patrick’s Catholic Community
63) Stonegate Community Center
64) Susan G. Komen Foundation
65) The Wellness Community
66) The Mollen Foundation
67) University of Arizona
68) Valley Presbyterian
69) Women of Scottsdale

* Sponsorships are subject to change