City of Hope | PHOENIX

2024

Implementation Strategy

Contents

Executive Summary

The service area of City of Hope Phoenix is richly diverse in language, culture, religion, race, and ethnicities. With this diversity comes a large variation in factors that put individuals at risk for health issues such as cancer and diabetes. Sociocultural factors — for example, the level of education achieved, language spoken at home, racism, and cultural biases — can increase or decrease the risk of preventing and treating potentially life-threatening illness. Serving our community and providing programs and services to our residents designed to reduce risk and improve access to health care are paramount to our success as a nonprofit hospital. One way to ensure we do this is by developing a strategy to address the main opportunities identified in our 2024 Community Health Needs Assessment (CHNA).

The Internal Revenue Service, through its 1969 Revenue Ruling 69-545, describes the Community Benefit Standard for charitable tax-exempt hospitals as helping the community in a way that relieved a governmental burden and promoted general welfare. In addition, the Affordable Care Act, enacted in 2010, set forth requirements for nonprofit hospitals under § 501(r) of the Internal Revenue Code. Under this requirement, tax-exempt hospitals are directed to conduct a CHNA and develop an implementation strategy every three years. City of Hope has undertaken a CHNA as required. The CHNA is a primary tool used by City of Hope to determine our community benefit plan, which outlines how we will give back to the community in the form of health care and other services that address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the community benefit service area.

For this recent CHNA, City of Hope Phoenix collected primary data from focus groups, interviews, and surveys. Secondary data was collected on the leading causes of death, illness, social determinants of health and deeper causes of health inequality. Our Community Benefit team took this data to community stakeholders and asked them, “What does this mean to you? How do you believe that these issues are impacting you and your community? What ideas for solutions do you have for addressing these concerns?” The stakeholders engaged in lively discussion and then prioritized the issues as follows:

1. **Mental Health – Prevention and upstream programming to address access, policy and quality services that serve both the adult and youth communities**
2. **Social Determinants of Health – (for example: housing, food, economic insecurity) Addressing the root causes of poor health outcomes and disparities that are often systemic.**
3. **Cancer – Achieving health equity across the cancer continuum, we aim to work collaboratively with community partners and residents to implement strategies that can reduce the risk of cancer.**
4. **Access to Care – Cross-sectoral collaborations that increase representation in health care and promote knowledge/awareness/education that decrease barriers to care.**

Although addressing these priorities is ambitious, we believe we have formulated a realistic implementation strategy that addresses these issues in a way that makes the most sense for a new non-profit hospital building the infrastructure to grow and sustain our ongoing efforts. We will continue to seek new pathways to meet the needs of our vulnerable residents and explore innovative strategies that maximize collaborations to build sustainable programs in our local communities. Ultimately, we will provide positive contributions to the collective impact of other hospitals, organizations, schools, churches and government entities in our service area. We encourage you to take your time reading this plan. Should you have any questions regarding how we plan to implement it, please feel free to contact our Community Benefit Department. We can be reached at CommunityBenefit@coh.org.

Who We Are and Whom We Serve

City of Hope's mission is to make hope a reality for all touched by cancer and diabetes. Founded in 1913 in Los Angeles, City of Hope has grown into one of the largest and most advanced cancer research and treatment organizations in the U.S. and is one of the leading research centers for diabetes and other life-threatening illnesses. With an independent National Cancer Institute-designated comprehensive cancer center at its core, City of Hope brings a uniquely integrated model to patients that spans cancer care, research and development, academics and training, and innovative initiatives. Research and technology developed at City of Hope has been the basis for numerous breakthrough cancer medicines as well as human synthetic insulin and monoclonal antibodies. As a leader in bone marrow transplantation and immunotherapy,

such as CAR T cell therapy, City of Hope's personalized treatment protocols help advance cancer care throughout the world.

With a goal of expanding access to the latest discoveries and leading-edge care to more patients, families and communities, City of Hope's growing national system includes its main Los Angeles campus, a network of clinical care locations across Southern California, a new cancer center in Orange County, California and cancer centers and outpatient facilities in the Atlanta, Chicago and Phoenix areas. City of Hope's affiliated family of organizations include Translational Genomics Research Institute and AccessHope™. Through this national system, more patients will have access to the best of academic medicine in a community environment, including world-renowned innovation and sub-specialist expertise in hematology and bone marrow transplantation, advanced surgical oncology, clinical trials, precision medicine and cellular therapies.

Upon acquiring Cancer Treatment Centers of America in 2022, City of Hope filed for not-for-profit, tax-exempt status for the newly acquired entities, including City of Hope Atlanta. Caring for the vulnerable communities in its catchment area has been a cornerstone of City of Hope's engagement with the community. This institutional commitment fosters collaboration among local communities, City of Hope employees, and charitable organizations to benefit the residents across the Maricopa County.

Service Area

City of Hope Phoenix serves residents across Maricopa County with specialty treatment and care, therefore Maricopa County is defined as City of Hope Phoenix's Primary Service Area (PSA) (**Figure 1**). In this report, data will be provided for City of Hope Phoenix's PSA (Maricopa County) which represents the zip codes where more than 75% of City of Hope Phoenix's patients reside.

Maricopa County is the fourth most populous county in the United States. Based on the 2021 American Community Survey, Maricopa County has an estimated population of over 4.3 million, which is home to well over half of Arizona's residents.[1] Maricopa County encompasses 9,224 square miles, includes 24 cities and towns, several unincorporated communities, and 5% of Indigenous land from tribes including Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation.[2]

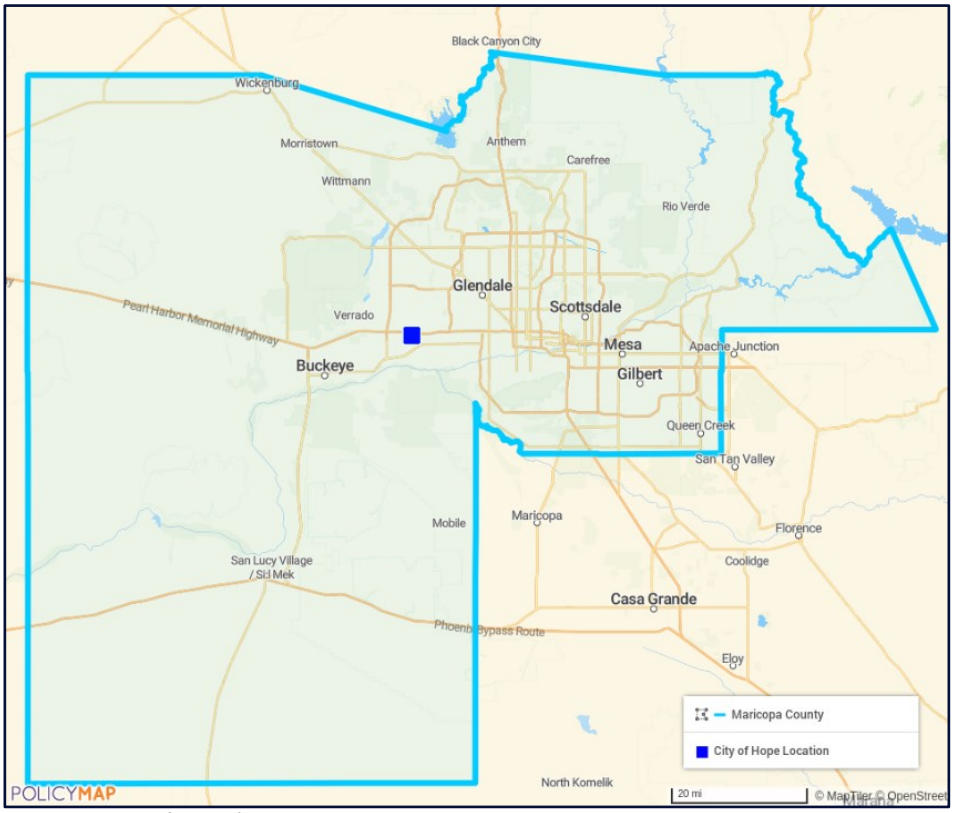


Figure 1. City of Hope's PSA in Maricopa County

[1] United States Census Bureau (2021). American Community Survey. Retrieved from https://data.census.gov/

[2] Maricopa County. Maricopa County Quick Facts. Retrieved from https://www.maricopa.gov/3598/County-Quick-Facts

Community Health Needs Assessment Findings

Secondary data analysis yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process helped validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations and ascertain community assets to address needs.

The following criteria were used to identify significant health needs:

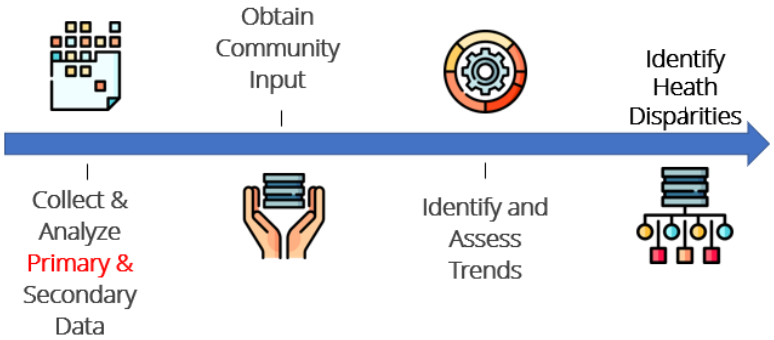
1. Size of the problem (relative portion of population afflicted by the problem)
2. Seriousness of the problem (impact on individuals, families and communities)

To determine size and seriousness, health indicators identified in the secondary data collection were measured against benchmark data, specifically California rates and Healthy People 2030 objectives, whenever available. Health indicators that performed poorly against one or more of these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources (interviews, focus groups and survey participants) were asked to identify and validate community and health issues. Information gathered from these sources helped determine significant health needs.

Significant Health Needs

Based in the secondary data collection, the following significant health needs were determined:

- **Access to Care**
- **Cancer**
- **Chronic Disease**
- **Mental and Behavioral Illness and Substance Use**
- **Health Behaviors**
- **Social Determinants of Health**



Health needs for City of Hope Phoenix were identified through the review of combined analysis, including primary and secondary data sources. **Primary data sources** include the 2019 and

2021 community surveys[3,4] and focus groups[5,6] conducted by MCDPH. The first round of community data collection occurred in the fall of 2019 and included a community survey and focus groups. In response to the severe changes in the community health landscape due to the COVID-19 pandemic, a supplemental survey and focus group cycle were conducted in the summer of 2021. In both rounds of data collection, focus groups prioritized recruitment of underrepresented and underserved populations to identify community concerns and assets. **Secondary data sources** include health and social indicators from local, state, and national sources that encompass health outcomes, economic factors, health behaviors, physical environment and health care delivery.

Resources to Address Significant Needs

Through focus groups, surveys and interviews, community stakeholders and residents identified community resources that can help address the significant health needs. These resources are presented in the appendix.

Prioritization of Needs

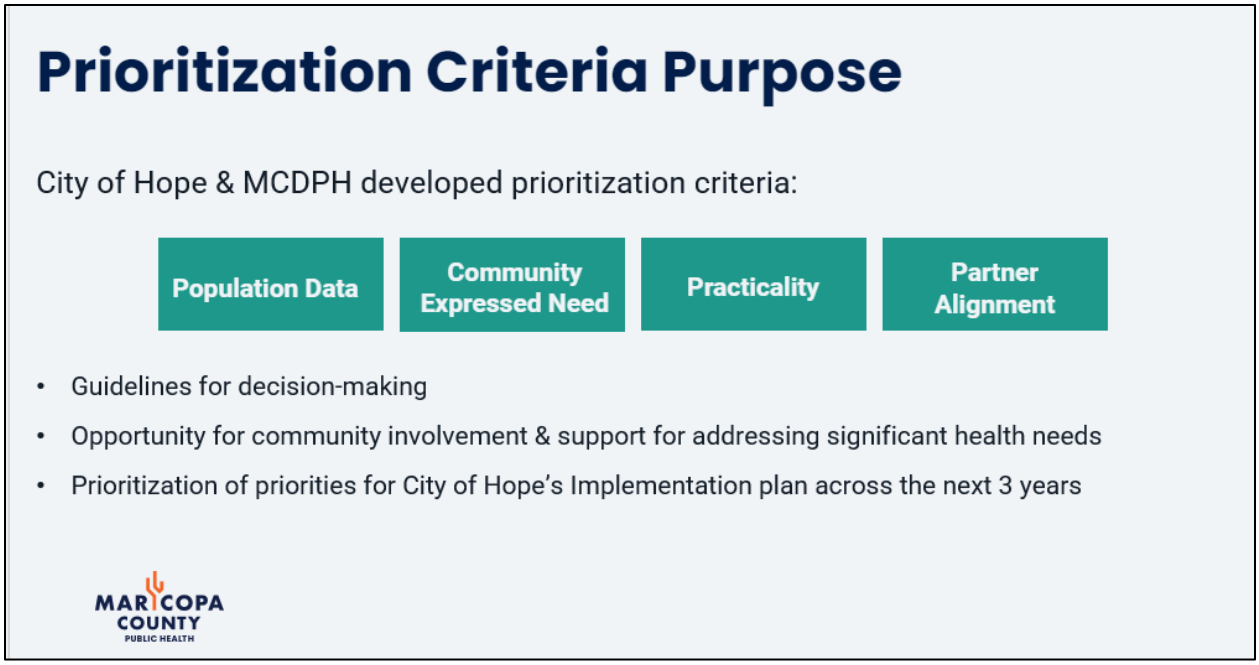
The significant health needs identified in the process were prioritized with input from the community using the following criteria:

[3] Maricopa County Department of Public Health (2019). Maricopa County Community Health Assessment: Community Surveys Report. Retrieved from https://www.maricopa.gov/DocumentCenter/View/63108/Maricopa-County-2019-Community-Survey-Report

[4] Maricopa County Department of Public Health (2021). Maricopa County COVID-19 Impact Community Health Needs Assessment: Community Survey Report. Retrieved from https://www.maricopa.gov/DocumentCenter/View/86357/Maricopa-County-COVID-19-Impact-Community-Survey-Report_September-2021?bidId=

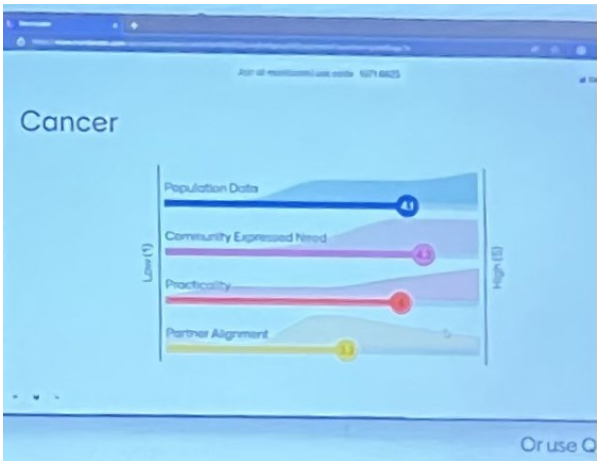
[5] Arizona State University Southwest Interdisciplinary Research Center (2019). Coordinated Community Health Needs Assessment Final Focus Group Results. Retrieved from https://www.maricopa.gov/DocumentCenter/Index/2898

[6] Arizona State University Southwest Interdisciplinary Research Center (2021). COVID-19 Focus Groups: Final Report. Retrieved from https://www.maricopa.gov/DocumentCenter/View/72899/MCDPH-COVID-19-Focus-Group-Report_SIRC_Final_111221-1?bidId=



For this CHNA, we obtained primary data through focus groups, a community survey and interviews with key community stakeholders, public health and service providers, members of the medically underserved, low income, minority populations in the community, and individuals or organizations servicing or representing the interests of such populations.

Stakeholder Validation of Prioritized Needs



Menti application used for prioritization

On July 9, 2024 seven community members joined the Maricopa County Health Department's Synapse team and City of Hope staff in reviewing the significant needs identified in the recent Community Health Needs Assessment (CHNA). The Synapse Team led both the data presentation and the prioritization process. Using the Prioritization Criteria above and the Menti app, community members were asked to rate, on a scale of 1 to 4, the importance the believed the data to impact based on Population Data, Community Expressed Need, Practicality and Partners Alignment. Data was analyzed live and a list of the six identified needs was presented. The stakeholders were then asked to validate a

final list of four. This required robust discussions around the six indicators and eventually resulted in the four listed below.

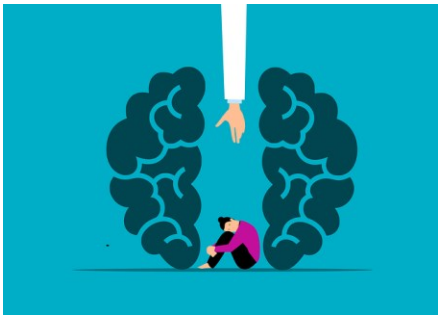
2024 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Mental Health
2	Social Determinants of Health
3	Cancer
4	Access to Care

During the strategy discussion, led by City of Hope, the community members noted that by addressing any one of these issues, we could also tackle many others, given the interconnectedness between root causes and conditions; including the two that did not make the top four, health behaviors and social determinants of health. They also emphasized the need for partnerships. "When we get the right people at the table, we will encumber the resources needed to address programs." Bringing to light the desire for sustainability between all efforts.

What follows next is a thorough examination of the conversations with the stakeholders regarding the issues they prioritized.

No. 1: Mental Health – Prevention and upstream programming to address access, policy and quality services that serve both the adult and youth communities



When data on mental health and substance abuse prevalence in the Valley region was shared, stakeholders unanimously acknowledged it as expected. The primary challenge in addressing mental health appeared to be establishing trust and fostering relationships with community influencers to combat stigma around seeking mental health care.

Community Input

When addressing mental health as a strategy, the community members suggested:

- Hospitals, churches, schools – trusted sources in our community, can help us to address stigma.
- Identify partners who can target the community and go to them. You have to focus on those who don't feel supported and feel stigmatized.
- Education of patients of controlled substances and how to manage or get off meds.
- Collaborate with Public Health and establish relationships with *community-based organizations (CBO's)*
- Need to address the staff stigma regarding mental health.
- Encourage the use of counselors, mental well-being, and coping skills
- Provide education in the communities that have the highest need, ie. Native American communities.

No. 2: Social Determinants of Health – (for example: housing, food, economic insecurity) Addressing the root causes of poor health outcomes and disparities that are often systemic

At the very beginning of the conversations with the community regarding social determinants of health (SDOH), stakeholders said, "We need to work on the root causes so that we can address health issues." Much of our time moving forward will be to build trusting partnerships with community organizations that are currently addressing root cause issues. It will be through these partnerships that, from a logistical perspective, we would be able to leverage the resources and commitments needed to sustainably support community initiatives that impact health outcomes.

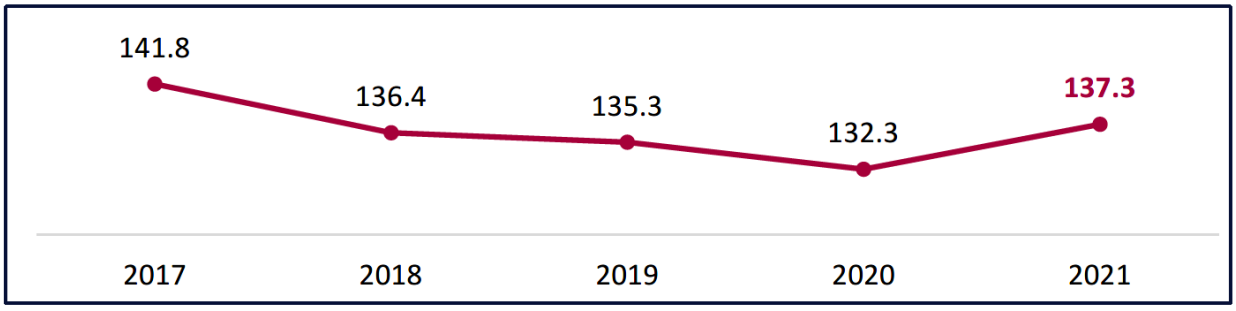
Community Input

- Connect with organizations that can food to people who need it.
- Education, Access to Care and Health organizations need to work hand-in-hand.
- Partner with local school superintendent to increase awareness around STEM
- Work with employees to do food and clothing drives
- Create partnerships that can address social determinants of health
- Integrate prevention education with mental health/substance abuse awareness
- Collaborate on grants and support community partners with letters of support
- Internal staff training around what the social determinants of health are and how to support patients

- Look at the social vulnerability index for clues on populations with greatest need
- Support transportation initiatives that can increase access to care
- It will be important to incorporate access to technology as a way to support communities and increase access.

No. 3: Cancer – Achieving health equity across the cancer continuum, we aim to work collaboratively with community partners and residents to implement strategies that can reduce the risk of cancer.

As a National Cancer Institute comprehensive cancer center, City of Hope will continue to address cancer prevention. In doing so, it was not difficult to see how the issues surrounding economic, housing, food insecurity and mental health have impacted access to care and influenced prevention/screening behaviors. For the top 10 causes of death in Maricopa County, Cancer is ranked third. In the 2021 Community Survey, cancer was ranked eighth as having the greatest impact on the community's health and wellness. During COVID-19 the cancer mortality rates rose higher than they were in the three previous years.



Hospital Discharge Data (2021). Obtained from the Arizona Department of Health Services. Cleaned and analyzed by MCDPH.

When you dive deeper into the data, you will see the disparities between the various racial and ethnic groups. White/Caucasians had the highest rates of brain and other nervous system, esophagus, larynx, leukemias, melanomas of the skin, oral cavity and pharynx, ovary and testis. Black/African Americans had the highest rates of cancer all sites, colon and rectum, corpus and uterus (NOS), breast, lung and bronchus, myeloma, pancreas and prostate. American Indian and

Alaska Natives had the highest rates of kidney and renal pelvis. Hispanics had the highest rates of cervix, liver and intrahepatic bile duct, non-Hodgkin lymphoma, stomach and thyroid.
The conversations with our stakeholders emphasized partnerships with organizations that serve a variety of affinity groups, other hospitals, churches and schools. The main goal of these collaborations was to increase access to cancer prevention, education and care.

Community Input

- To sustain efforts beyond five years, go to existing programs with funding and assign a designated person to liaise between COH and that group.
- Collaborate with the school districts to raise awareness of mammograms, general cancer prevention and health behaviors.
- Seek out organizations that already have cancer as a priority like, Hispanic women's breast cancer awareness or Black prostate awareness
- Utilize culturally relevant storytelling to educate and raise awareness
- Mobilize to reach communities that need it the most through the utilization of a “Point Person” from that community.

No. 4: Access to Care – Cross-sectoral collaborations that increase representation in health care and promote knowledge/awareness/education that decrease barriers to care.

The main themes in the conversations about access to care were building trust and securing partnerships. Our stakeholders emphasized the importance of listening to the community's stories to understand their healthcare experiences. We need to focus on identifying the barriers to care faced by those living in our service area. Ultimately, City of Hope will collaborate with community partners to develop strategies that address these barriers and improve access to care.

Community Input

- Recruit residents for City of Hope and fellowships to enhance care access in Maricopa County.
- Increase diversity in health care by hiring clinicians who look like the populations they serve

- Utilize navigators to provide culturally competent education about health insurance enrollment
- Extend hours and cancer screening locations by partnering with school districts to provide the location, nurses and access to the local community who may not access care otherwise.
- Engage more diverse community partners to help in gathering more granular data
- Focus on ethnicity and cancer rates in all health education and resources

No one wants to get cancer. As a world-renowned cancer research institution, we can help deliver the cancer education, screening and treatment programs that ultimately save lives. We will do so in the Maricopa Valley region through trust-building, listening to our communities and by engaging in lasting partnerships.

Group photo of community stakeholders, Maricopa County Health Department Synapse Team and City of Hope staff

Plan to Address Needs

It would be unreasonable to think that City of Hope can solve all the issues identified in the needs assessment. Given our expertise and resources as a cancer institution, we need to find pragmatic ways to work with our community to address the identified needs. First, we need to acknowledge that the prioritized categories are even more complex than presented above. Next, we need to view the issues through the lens of the Public Health Institute's "Five Core Principles" (Figure 2). As we plan programs, we must ask ourselves, "How will our work impact

the lives of vulnerable people in a way that supports prevention, builds a seamless continuum of care and enables the community to take ownership of their health issues? How can we be a leader in creating a healing environment?" From here, we can tackle the five identified categorical needs by designing program/services and building collaborations that will work to lessen the impact on residents.

Figure 2. Five Core Principles

Collaborations

City of Hope is filled with compassionate individuals dedicated to addressing community needs. We will use these resources to design interventions that target specific issues within our service areas. Our internal teams are already trained to shift their perspective from a marketing focus to a community benefit focus, emphasizing the health impact on targeted groups.

Externally, City of Hope will leverage its diverse relationships with local organizations, schools, universities, governments, other nonprofit hospitals, and dedicated volunteers who serve vulnerable populations. By collaborating with local communities, we can develop systems-level approaches that meet the needs of the most vulnerable in culturally appropriate ways. Additionally, involving community stakeholders in planning our community benefit programs and services ensures these initiatives are built on trust and a shared vision. This creates a strong foundation for programs that will thrive within the community we serve.

Oversight

To guarantee City of Hope's reportable community benefit programs and services are targeting identified needs and are being seen through the lens of the Five Core Principles, we will be convening a Community Benefit Advisory Council that will meet at least four times a year.
To ensure council members represent local vulnerable populations or are experts in issues important to vulnerable communities, we will seek out individuals with the following areas of expertise:

- Residence in a local community with a disproportionate percentage of unmet health-related needs
- Knowledge and expertise in primary disease prevention
- Experience working with local nonprofit community-based organizations
- Knowledge and expertise in epidemiology
- Expertise in the analysis of service utilization and population health data

City of Hope will establish a regular internal meeting schedule to provide technical assistance, develop new data collection tools, and stay informed about staff efforts across the organization that align with the Implementation Strategy. Additionally, City of Hope will report annually on Form 990 and Schedule H to inform the public about our work and its impact on the communities we serve.

Anticipated Impacts on Health Needs

When considering the four priority areas identified by our community, we must approach them realistically, using strategies that align with City of Hope's capabilities. Each priority has a broad measurable outcome indicator. While it may be unrealistic to expect City of Hope to make a significant impact on all these priorities alone, mindful programming and collective efforts can bring about positive changes in our communities. To ensure our work is meaningful, we will draw from the Healthy People 2030 Objectives and community suggestions. Our programs and services will target residents, focusing on areas where their needs intersect.

1. **Mental Health – Culturally relevant partnerships for emotional health that address stigma, create resiliency and improve well-being**

   Healthy People 2030 Strategies

   1.1 Increase the proportion of public schools with a counselor, social worker and psychologist. (AH-R09)
   1.2 Reduce anxiety and depression in family caregivers of people with disabilities. (DH-D01)
   1.3 Increase the proportion of adults with depression who get treatment (MHMD-05)
   1.4 Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders (MHMD-07)

   Community-Driven Strategies

   1.5 Increase access to integrated care.
   1.6 Increase cultural competency training and anti-bias training among mental and behavioral health care providers.
   1.7 Provide trauma-informed care, and particularly care informed by an understanding of mental health conditions and stigma.
   1.8 Provide training for youth/adults on mental health distress coping skills.
   1.9 Destigmatize mental health issues and mental health care services through partnerships with local hospitals, churches and schools.

2. **Social Determinants of Health – (for example: housing, food, economic insecurity) Addressing the root causes of poor health outcomes and disparities that are often systemic**

   Healthy People 2030 Strategies

2.0 Reduce the proportion of adolescents and young adults who aren't in school or working. (AH-09)

2.1 Increase employment in working-age people. (SDOH-02)
2.2 Reduce household food insecurity and hunger. (NWS-01)
2.3 Eliminate very low food security in children. (NWS-02)
2.4 Increase the proportion of schools with policies and practices that promote health and safety. (EH-D01)
2.5 Increase the proportion of adults with broadband internet. (HC/HIT-05)
2.6 Reduce the proportion of people who can't get medical care when they need it (AHS-04)

Community Driven Strategies

2.7 Develop partnerships with organizations to facilitate food distribution to those in need.
2.8 Promote collaboration between education, access to care, and health organizations to improve community health outcomes.
2.9 Establish a partnership with local school superintendents to enhance STEM awareness and engagement in schools.
2.10 Organize and support employee-driven food and clothing drives to benefit local communities.
2.11 Form strategic partnerships to address and mitigate social determinants of health within the community.
2.12 Integrate prevention education with mental health and substance abuse awareness programs to improve overall community well-being.
2.13 Collaborate on grant applications and provide letters of support to bolster community partner initiatives.
2.14 Conduct internal staff training on social determinants of health to enhance support for patients.
2.15 Utilize the social vulnerability index to identify and prioritize populations with the greatest need.
2.16 Support transportation initiatives that improve access to care for underserved populations.
2.17 Incorporate access to technology into community support strategies to enhance connectivity and access to resources.

Cancer – Achieving health equity across the cancer continuum, we aim to work collaboratively with community partners and residents to implement strategies that can reduce the risk of cancer.

Healthy People 2030 Strategies

2.18 Increase the proportion of females who get screened for breast cancer. (C-05)
2.19 Increase the proportion of adults who get screened for colorectal cancer. (C-07)
2.20 Reduce prostate cancer death rate. (C-08)
2.21 Reduce the proportion of students in grades 9 through 12 who report sunburn (C-10)

Community-Driven Strategies

2.22 Improve messaging indicating that providers are safe spaces for immigrants, LGBTQ individuals and other sensitive populations/communities.
2.23 Increase cultural competency and anti-bias training among service providers.
2.24 Increase the number of service providers that share the cultural backgrounds and languages of clients.
2.25 Increase access to cancer prevention and screening services in communities disproportionately impacted by cancer morbidity and mortality.

3. Access to Care – Cross-sectoral collaborations that increase representation in health care and promote knowledge/awareness/education that decrease barriers to care.

Healthy People 2030 Strategies

3.1 Reduce the proportion of people who can't get medical care when they need it. (AHS-04)
3.2 Increase the use of telehealth to improve access to health services. (AHS-R02)
3.3 Increase the proportion of adults who receive appropriate evidence-based clinical preventive services (AHS-08)

Community Driven Strategies

3.4 Recruit and enroll residents in fellowship programs at City of Hope, specifically for serving Maricopa County, to enhance access to healthcare.
3.5 Hire clinicians from diverse backgrounds that reflect the demographics of the populations they serve, thereby increasing cultural competence in healthcare delivery.
3.6 Train and deploy navigators to deliver culturally competent health insurance education to underserved communities.
3.7 Establish partnerships with local school districts to extend cancer screening hours and open new screening locations, providing increased access to screening
3.8 Form collaborations with new diverse community partners to gather more detailed and accurate health data on the local population
3.9 Develop and distribute educational materials that emphasize ethnicity and cancer rates to community centers and clinics.

Moving forward, City of Hope will align its efforts to address the indicators above. Each year, the CBAC will prioritize strategies using the same criteria as the CHNA (e.g., feasibility, size of issue). Specific outcome measures will be developed as programs are planned and delivered. An annual report will detail our efforts to address these issues. Community comments will be accepted year-round to strengthen our resolve to reduce disparities and improve residents' quality of life.

Needs Not Addressed

As a specialty hospital, City of Hope is not required to address issues outside its focus. However, we recognize that social determinants of health and root causes of health disparities are closely linked to cancer and diabetes risk factors. Therefore, we will ensure our language and programming prioritize the most vulnerable populations. We will adhere to the Five Core Principles to guide all programs and services, ensuring we remain focused on communities with the greatest unmet health needs.

Conclusion

City of Hope is committed to being a good steward of the community we serve. Our community benefit process, similar to the spoke-and-hub approach, empowers each department to manage its own planning and delivery of programs and services. The Community Benefit Department will serve as the central hub for collecting all reportable work, providing structure and guidance throughout the year. At the end of the fiscal year, this department, in collaboration with internal stakeholders, will compile the yearly report for the community.

City of Hope is dedicated to strengthening relationships with community partners and continually seeks ways to meet the needs of our vulnerable residents. We aim to maximize collaborations and create sustainable change, making positive contributions alongside other hospitals, organizations, schools, churches, and government entities in our service area.

Thank you for reading our 2024-2027 Implementation Strategy. If you have any questions, please contact our Community Benefit Department at CommunityBenefit@coh.org.

Appendix

Community Resources

Resources Available to Address Needs

Resources available to address identified needs include services and programs provided by hospitals, government agencies and community-based organizations. Resources include access to hospital acute services, federally qualified health centers (FQHC), food banks, homeless shelters and prevention-based community education. **Table 35** identifies organizations who may have resources to address the identified priorities.

Resources Potentially Available	
	2-1-1 **https://www.211.org/- A comprehensive source of information about local resources and services in the country.**
Mental and Behavioral Illness and Substance Use	**Mental Health** • Phoenix Indian Center - mental health services • Human Services Campus - mental health • Native American Connection - behavioral health **Substance Use** • Phoenix Indian Center - substance abuse • Tempe Community Action Agency - substance abuse treatment • Jewish Family and Children's Service - substance abuse counseling • Hushabye Nursery - substance exposed babies and mothers
Chronic Disease	• Healthier Living Program - chronic disease education program, cooking class
Cancer	• Cancer Support Community of Arizona - cancer resource navigator, access to care • American Cancer Society
Healthy Behaviors	• Healthier Living Program - chronic disease education program, cooking class

Access to Health Care	• Chicanos Por La Causa / Keogh Health Connection - enrollment specialists, social services, economic development • Foundation for Senior Living - hospital discharge transition • Mission of Mercy - mobile clinic • Mountain Park Health Center - access to health care • Adelante Healthcare - access to health care
Social Determinants of Health	**Housing** • Chicanos Por La Causa - housing • Maggie's Place • Central Arizona Shelter Services (CASS) - homeless shelter • Phoenix Rescue Mission - homelessness • Circle the City - respite care, homelessness **Food Insecurity** • St. Mary's Food Bank - food boxes • St. Vincent de Paul - food boxes, food pantry • Creighton Community Foundation - food boxes, community gardens, food and nutrition projects • Phoenix Rescue Mission - food bank • Diana Gregory Outreach Services Foundation - mobile produce market

City of Hope PHOENIX

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