

City of  
Hope® | PHOENIX

**2024**

# Community Health Needs Assessment

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## Acknowledgments

Western Regional Medical Center, Inc., dba City of Hope Phoenix (City of Hope Phoenix") worked in partnership with Maricopa County Department of Public Health to conduct this community health needs assessment (CHNA). This report was developed by Maricopa County Department of Public Health.

### **City of Hope Commitment**

City of Hope's mission is to make hope a reality for all touched by cancer and diabetes. Founded in 1913 in Duarte, CA, [City of Hope](#) has grown into one of the largest 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 includes [Translational Genomics Research Institute](#) and [AccessHope™](#).

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 Phoenix. Caring for the vulnerable communities in their catchment area has been a cornerstone of City of Hope's engagement with the community since its origin. Designating community benefit programs as an institutional priority has created meaningful, impactful programs that meet the needs of vulnerable populations in their service area. This institutional commitment is fostering collaboration among City of Hope employees, the local communities and charitable organizations to participate in activities that benefit Maricopa County. By making community benefit a priority, we're placing a more strategic focus on the needs that are critical to their service area and creating pathways for health and healing.

## CHNA Collaborators

The Maricopa County Synapse Coalition includes member hospitals and health care entities who collaborate to conduct CHNAs. The following organizations are part of the Synapse Coalition:



- Adelante Healthcare
- Dignity Health
- Neighborhood Outreach Access to Health
- Banner Health
- Mayo Clinic
- Phoenix Children’s Hospital
- City of Hope
- Native Health
- Valleywise Health

In collaboration with Synapse and the Health Improvement Partnership of Maricopa County (HIPMC), Maricopa County Department of Public Health (MCDPH) spearheaded development of the 2021 CHNA survey used in this report and partnered with diverse community-based organizations to provide mini-grants for survey promotion and distribution. MCDPH contracted with Arizona State University Southwest Interdisciplinary Research Center (ASU SIRC) to conduct and analyze 2021 focus groups—which are also utilized in this report.

## Executive Summary

Founded in 1913, City of Hope is a world leader in cancer treatment and prevention, with experts across the nation at the forefront of cancer research, transforming laboratory breakthroughs into treatments that outsmart cancer. At the heart of this work is our commitment to compassionate and whole-person care, so that life during and after cancer can be rich and rewarding.

### CHNA Purpose Statement

This CHNA aims to identify and prioritize significant health needs for the community served by City of Hope Phoenix. The priorities identified in this report help to direct the health care system's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA will serve as an indicator to determine if the efforts to address perceived needs align with the needs of the communities served.

### Assessment, Process, and Methods

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<sup>1,2</sup> and focus groups<sup>3,4</sup> 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.

### Priority Health Needs

The identified significant community needs were prioritized with input from interviews and focus groups with community stakeholders.

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<sup>1</sup> 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>

<sup>2</sup> 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=](https://www.maricopa.gov/DocumentCenter/View/86357/Maricopa-County-COVID-19-Impact-Community-Survey-Report_September-2021?bidId=)

<sup>3</sup> 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>

<sup>4</sup> 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=](https://www.maricopa.gov/DocumentCenter/View/72899/MCDPH-COVID-19-Focus-Group-Report_SIRC_Final_111221-1?bidId=)

## Significant Health Needs

Top priorities were determined through a cross-sectional assessment of population data, community survey and focus group data, and City of Hope Phoenix mission and resources. To determine magnitude and severity of potential needs, health indicators identified in the secondary data collection were measured against benchmark state data, ranked among comparable indicators, and evaluated for trends over time. Health indicators substantially higher than benchmark data were considered to have met the magnitude or severity criteria. A total of 32 health and social indicators were established in collaboration with City of Hope Phoenix. Community members across Maricopa County were asked to identify and validate “highest impact” community and health issues through surveys, focus groups, and key informant interviews. MCDPH cross-referenced input from the community with Primary Service Area specific population data to identify issues of significance at both the population- and individual-level. Through a series of presentations and conversations with City of Hope Phoenix, the Synapse and HIPMC Coalitions, and community health leaders interpreted the multimodal data through the lens of their organization’s mission and scope of influence.

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- |  |  |
|--|--|
| • <b>Mental and Behavioral Illness and Substance Use</b> | • <b>Chronic Disease</b>               |
| • <b>Cancer</b>  | • <b>Health Behaviors</b>              |
| • <b>Access to Health Care</b>                           | • <b>Social Determinants of Health</b> |
- 

## Report Adoption, Availability and Comments

This CHNA was presented to the Board of Directors of City of Hope Phoenix for adoption during the meeting of the Board on May 17, 2024. This report is available to the public on the hospital’s website, [CityofHope.org/about-city-of-hope/community-outreach/community-benefit](https://CityofHope.org/about-city-of-hope/community-outreach/community-benefit). Written comments on this report can be submitted to Nancy Clifton-Hawkins at [CommunityBenefit@coh.org](mailto:CommunityBenefit@coh.org).

## Public Comment

In compliance with IRS regulations 501(r)(3) for charitable hospitals, a hospital CHNA and Implementation Strategy are to be made widely available to the public, and public comment must be solicited. In compliance with these regulations, the City of Hope Phoenix CHNA and Implementation Strategy were made available to the public at [CityofHope.org/about-city-of-hope/community-outreach/community-benefit](https://CityofHope.org/about-city-of-hope/community-outreach/community-benefit).

## End of Executive Summary

## Introduction

### What Is a Community Health Needs Assessment?

City of Hope Phoenix has undertaken a CHNA pursuant with the Patient Protection and Affordable Care Act through IRS section 501(r)(3). This regulation directs nonprofit, tax-exempt hospitals to conduct a CHNA every three years and develop a three-year Implementation Strategic Plan that responds to community needs.

The CHNA is a report on the health status of a community. It explores the root causes of death and disease and identifies the communities most impacted by these causes. City of Hope Phoenix uses the CHNA as a primary tool to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other services to address unmet community health needs.

#### How to Use This CHNA

We have included data on Maricopa County as it is City of Hope Phoenix's service area. You may find it useful to compare data so you can track trends or identify issues of significance. Take your time diving into the information provided. Use it to learn about your community or to design your own reports or project plans. At City of Hope Phoenix, we will use the data to help us focus on the most serious health issues and social disparities that lead to poor health, so we can best allocate our resources toward improving the lives of residents of our service area.

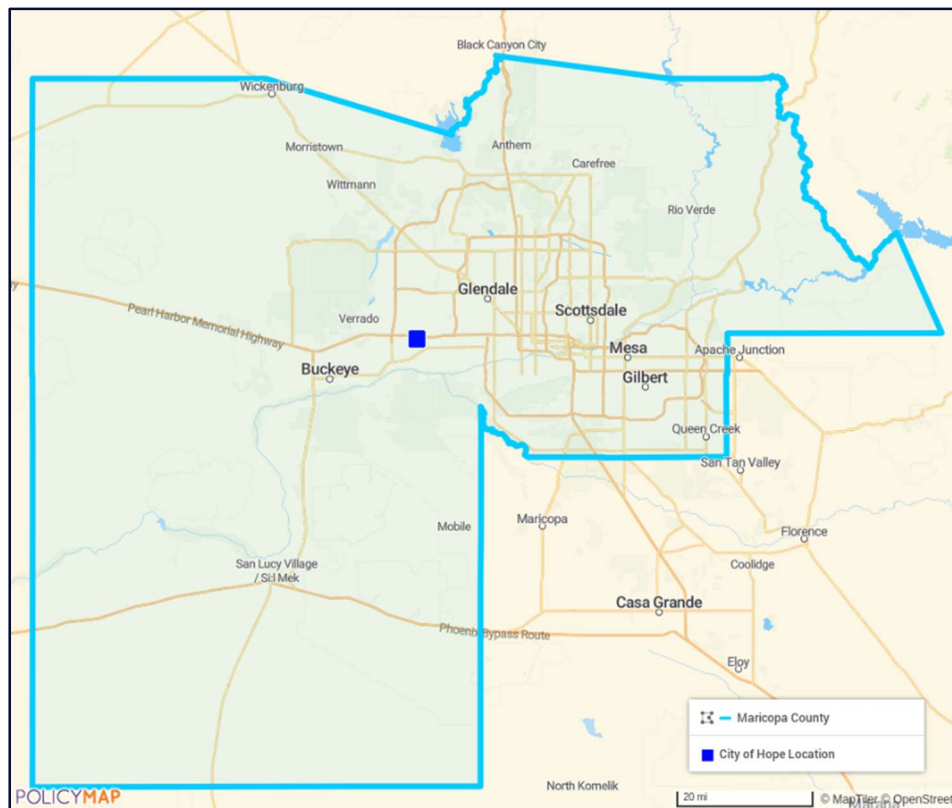
## Primary Service Area

### How to Use This Section

This section introduces you to the people who live in City of Hope Phoenix's primary service area. When working with communities, it is vital to know who the residents are. While reading through this section, think about how language, race/ethnicity, and gender might influence community programs.

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.<sup>5</sup> 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.<sup>6</sup>



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

<sup>5</sup> United States Census Bureau (2021). American Community Survey. Retrieved from <https://data.census.gov/>

<sup>6</sup> Maricopa County. Maricopa County Quick Facts. Retrieved from <https://www.maricopa.gov/3598/County-Quick-Facts>

## Demographic Profile

**Table 1** describes the demographic profile of the population who reside in City of Hope Phoenix’s PSA (Maricopa County) compared to Arizona.<sup>7</sup>

	Maricopa County	Arizona
<b>Total Population</b>	4,367,186	7,079,203
<b>Population by Race/Ethnicity</b>		
<b>American Indian (non-Hispanic)</b>	2%	4%
<b>Asian (non-Hispanic)</b>	4%	3%
<b>Black (non-Hispanic)</b>	5%	4%
<b>White (non-Hispanic)</b>	54%	32%
<b>Hispanic</b>	31%	53%
<b>Population by Sex</b>		
<b>Male</b>	50%	50%
<b>Female</b>	50%	50%
<b>Population by Age Group</b>		
<b>1-14</b>	20%	19%
<b>15-24</b>	13%	13%
<b>25-44</b>	28%	26%
<b>45-64</b>	24%	24%
<b>65+</b>	15%	18%
<b>Citizenship</b>		
<b>Citizen</b>	91.9%	93.0%
<b>Non-Citizen</b>	8.1%	7.0%
<b>Language Spoken at Home</b>		
<b>English</b>	73.5%	73.4%
<b>Spanish</b>	20.1%	20.1%
<b>Indo-European Languages</b>	2.5%	2.0%
<b>Asian and Pacific Island Languages</b>	2.5%	2.0%
<b>Other Languages</b>	1.3%	2.4%

**Table 1.** City of Hope Demographic Profile

Demographic data was pulled from the U.S. Census Bureau using 2021 ACS 5-year estimates. The rates from Hospital Discharge Data (HDD), Birth and Death databases are age-adjusted rates. Age-adjusted rates are statistical tools that allow for fair comparisons of event occurrences, such as diseases and health outcomes, across populations with differing age distributions.<sup>8</sup> Age-adjusted rates are used to remove the influence of age as a confounding factor, enabling more accurate assessments of the true differences in rates between populations.

<sup>7</sup> See Footnote 5.

<sup>8</sup> Centers for Disease Control and Prevention (2022). National Center for Health Statistics. Age Adjustment. Retrieved from <https://www.cdc.gov/nchs/hus/sources-definitions/age-adjustment.htm>

## Medically Underserved Areas

As a part of the CHNA process and IRS requirements, a hospital facility must define the community served. They may take into account the geographic area served by the hospital facility, target populations served, and principal functions. The hospital facility should define its community by including the medically underserved, low-income, or minority populations who live in the service area.<sup>9</sup>

The Arizona Medically Underserved Area report is prepared by the Arizona Department of Health Services (ADHS) to better understand medically underserved areas in Maricopa County. This report is also used for planning the delivery of primary care services. **Table 2** displays primary care areas that were federally designated as medically underserved areas.<sup>10</sup>

• Alhambra Village	• Laveen Village
• Avondale	• Maryvale Village
• Buckeye	• Mesa Central
• Camelback East Village	• Mesa West
• Central City Village	• North Mountain Village
• El Mirage and Youngtown	• Salt River Pima-Maricopa Indian Community
• Estrella Village and Tolleson	• South Mountain Village and Guadalupe
• Fort McDowell Yavapai Nation	• Surprise North and Wickenburg
• Glendale Central	• Tempe North

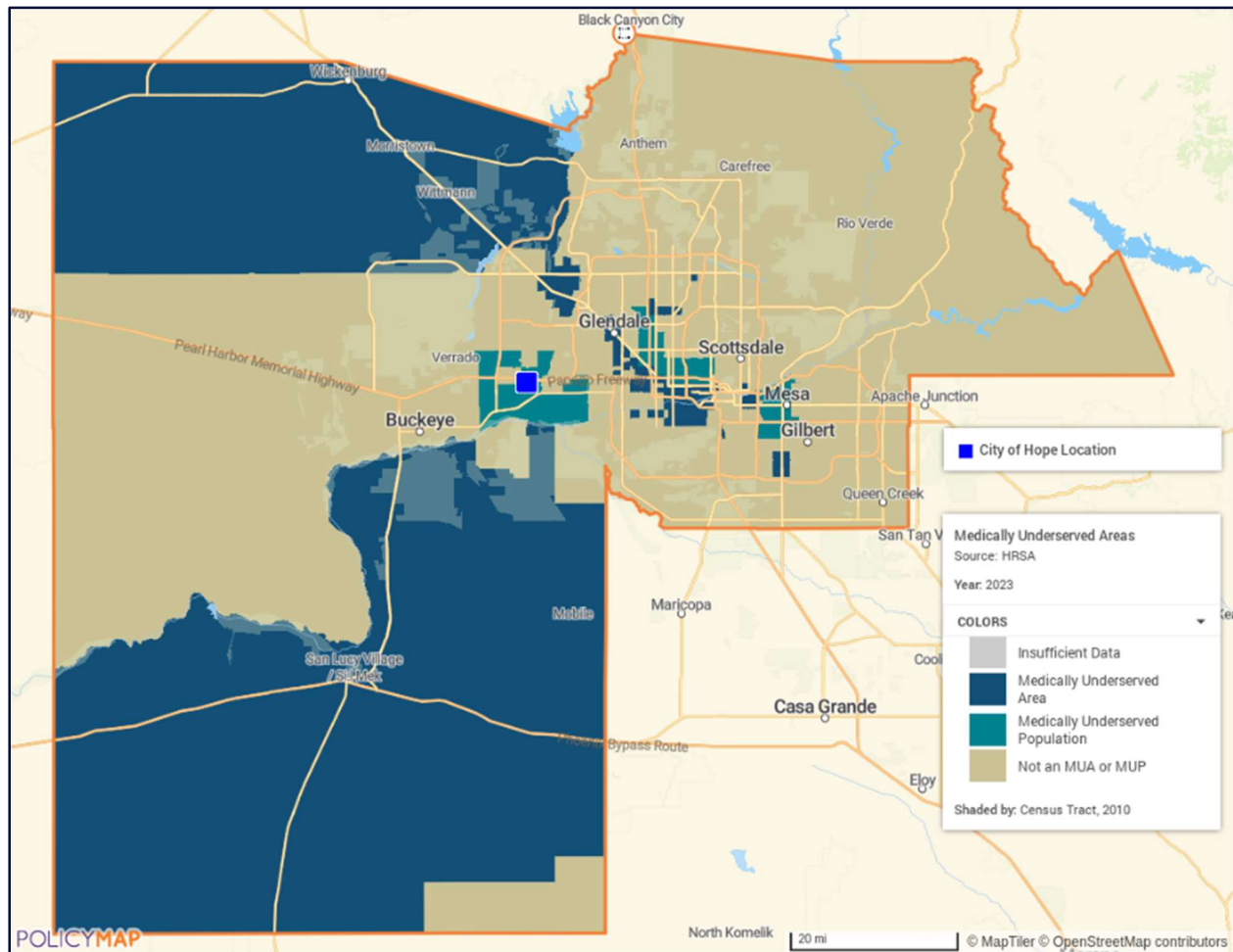
**Table 2.** Medically Underserved Primary Care Areas in Maricopa County

The Health Resources and Services Administration designates Medically Underserved Areas as “having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population. Medically Underserved Populations (MUP) experience economic, cultural, or linguistic barriers to primary medical care. If a population group does not meet the criteria for an MUP, but exceptional conditions exist which are a barrier to health services, they can be designated with a recommendation from the state’s Governor.”<sup>11</sup> **Figure 2** displays medically underserved areas in City of Hope Phoenix’s PSA.

<sup>9</sup> IRS (2024). Community Health Needs Assessment for Charitable Hospital Organizations – Section 501(r)(3). Retrieved from [Community Health Needs Assessment for Charitable Hospital Organizations - Section 501\(r\)\(3\) | Internal Revenue Service \(irs.gov\)](#)

<sup>10</sup> Arizona Department of Health Services (2022). Arizona Medically Underserved Areas Biennial Report. Retrieved from <https://www.azdhs.gov/documents/prevention/health-systems-development/data-reports-maps/reports/azmua-biennial-report.pdf>

<sup>11</sup> Policy Map (2023). Medically Underserved Areas (MUA) as of 2023. Retrieved from <https://mcdph.policymap.com/newmaps#/>



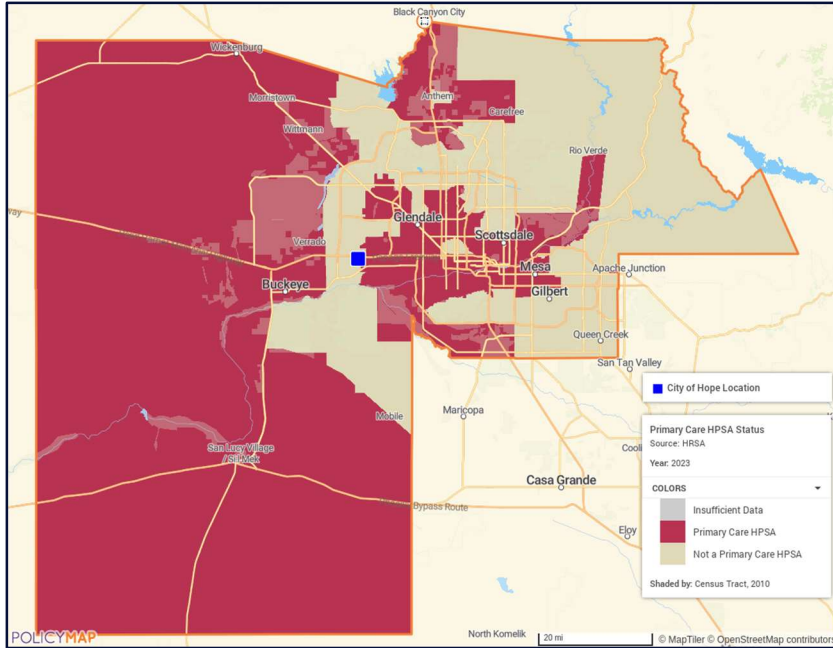
**Figure 2.** Medically Underserved Areas in City of Hope’s PSA

## Primary Care and Mental Health Professional Shortage Area Status

Health Professional Shortage Areas (HPSAs) play a role in health care utilization and overall health outcomes. Although HPSAs may be more prevalent in rural communities due to the lack of access to health care providers and facilities, they can also exist in urban communities due to factors such as poverty, public transportation, or lack of insurance.<sup>12</sup> Pinpointing these HPSAs help to identify underserved communities who need additional health care resources. According to PolicyMap, “All HPSAs are defined based on three criteria: the ratio of population to health providers, percent of population below the federal poverty level, and travel time to the nearest source of care outside the HPSA area.”<sup>13</sup> Primary Care HPSAs also consider infant mortality rate and low birth weight rate. **Figure 3** displays the Primary Care HPSA status in City of Hope Phoenix’s PSA.

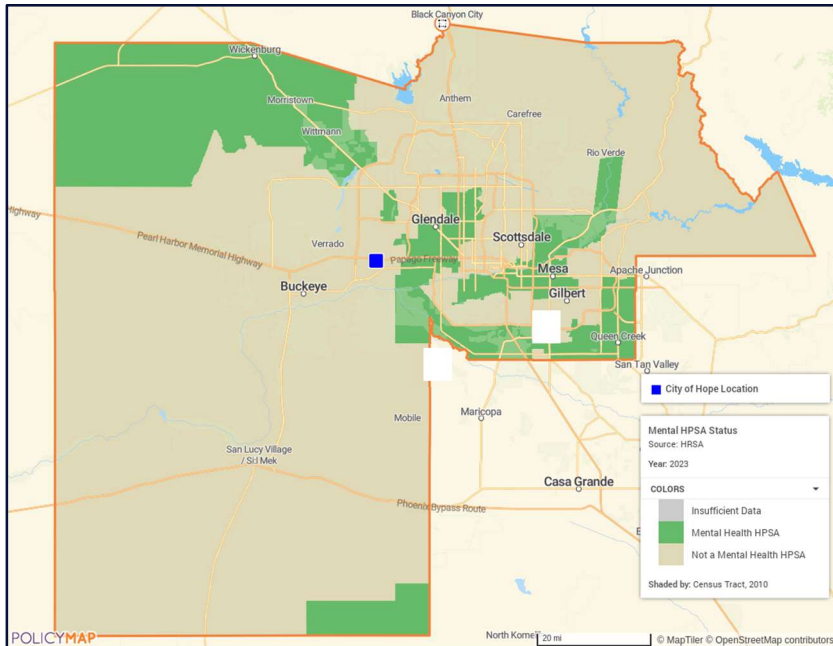
<sup>12</sup> Healthy People 2030 (2020). Access to Health Services. Retrieved from <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services>

<sup>13</sup> See Footnote 11.



**Figure 3. Primary Care HPSA Status in City of Hope Phoenix’s PSA**

**Figure 3** displays the Primary Care HPSA status in 2023 in City of Hope Phoenix’s PSA. Primary Care HPSAs consider infant mortality rate and low birth weight rate.



**Figure 4. Mental HPSA Status in City of Hope’s PSA (2023)**

**Figure 4** displays the Mental HPSA status in 2023 in City of Hope Phoenix’s PSA. Mental HPSAs consider substance and alcohol abuse prevalence, and percentage of the population over the age of 65 or under the age of 18.<sup>14</sup>

Evaluating Primary Care and Mental HPSAs in City of Hope Phoenix’s PSA is fundamental to ensure appropriate community resource allocation and reduce redundant approaches. By utilizing this lens, City of Hope Phoenix can address disparities in health care access efficiently to ensure adequate health care access for all people.

<sup>14</sup> See Footnote 11.

## Assessment, Process, and Methods

Maricopa County health centers and hospitals play significant roles in the region's overall health and economy. In addition to providing high-quality medical care, these institutions work to improve regional health through programs that promote health in response to identified community needs. Recognizing their common objective to serve overlapping communities across Maricopa County, a group of non-profit hospitals and federally qualified health centers (FQHCs) formed the Synapse coalition in 2014. During the 2023-2026 cycle, the following partners joined forces with MCDPH to identify the communities' strengths and greatest needs in a coordinated community health needs assessment: Adelante Healthcare, Banner Health, City of Hope Phoenix, Dignity Health, Mayo Clinic, Native Health, Neighborhood Outreach Access to Health, Phoenix Children's Hospital, and Valleywise Health.

City of Hope Phoenix, as a member of Synapse, contracted with MCDPH to conduct the CHNA process. The CHNA utilizes a mixed-methods approach that includes the collection of primary sources like community input data from focus groups, surveys, and meetings with community stakeholders and secondary sources like hospital discharge and death data. The process incorporated both primary and secondary data to iteratively inform each other, which resulted in high-quality data through cross-referencing multiple sources.

### Primary Data

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

### MCDPH 2019 Community Health Needs Assessment Focus Groups<sup>15</sup> (Appendix B)

A total of 52 focus groups were conducted between August 2018 and December 2019 with medically underserved populations across Maricopa County, including youth in the third and final cycle. The groups consisted of specific ethnic groups: (1) African Americans, (2) Native Americans, (3) Congolese, (4) Hispanics and (5) Filipinos. Other groups represented were: (6) homeless populations; (7) Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) persons, (8) veterans, (9) migrant seasonal farmworkers; (10) people who've been incarcerated; (11) people in rural communities; (12) new parents and (13) parents of children with special health care needs.

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<sup>15</sup> See Footnote 3.

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

### **MCDPH 2021 COVID-19 Impact Community Health Needs Assessment Focus Groups<sup>16</sup> (Appendix B)**

Between February and June 2021, a series of 33 focus groups were conducted which included 186 participants across various community regions, service providers, and individual residents to better understand the impact of COVID-19 on Maricopa County residents. Focus groups helped to identify and address health needs, resource allocation and long-term services needed for COVID-19 response efforts. Members of the community representing subgroups, defined as groups with unique attributes (race/ethnicity, age, sex, culture, lifestyle or residents of a particular area of Maricopa County), were recruited to participate in focus groups. A standard protocol was used for all focus groups (Appendix B) to understand the experiences of these community members as they relate to the impact of COVID-19 on Maricopa County residents. In all, a total of 33 focus groups were conducted with 186 community members from five geographic Maricopa County locations based on the following groups: (1) older adults, (2) African Americans, (3) Hispanics/Latinos, (4) Native Americans, (5) Asian Americans, (6) ethnic minority young adults, (7) LGBTQ persons, (8) veterans, (9) new parents, (10) parents of young children and (11) refugees.

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

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<sup>16</sup> See Footnote 4.

### **2019 Maricopa County Community Survey<sup>17</sup> (Appendix B)**

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

The survey questionnaire was originally developed by the National Association of County and City Health Officials (NACCHO). The survey was modified from its original version by members of the Synapse Coalition, the HIPMC and MCDPH staff. Response options were expanded from the original format to include additional health issues and social determinants of health. The questionnaire was provided on a digital platform using Qualtrics in addition to a paper format. All surveys were provided in English and Spanish. There was minimal request for additional language translations, so MCDPH worked with partners who were able to assist individuals as translators to complete the survey.

The goal for the community survey was 15,000 responses; however, once all data was cleaned to ensure usability a total of 11,893 surveys were collected from community residents ages 14 and above. The digital survey was sent out via extensive community partner networks throughout Maricopa County including internal programs, hospital/health care systems, municipalities, school districts and social media. The survey was widely publicized with community and health care partners prior to March 1, 2019, to secure presence at community events and provide online advertisement to redirect individuals to the survey.

### **2021 Maricopa County COVID-19 Community Impact Survey<sup>18</sup> (Appendix B)**

COVID-19 was declared a global pandemic in March of 2020, and this set off a series of drastic changes to everyday life for residents of Maricopa County. From May to July 2021, MCDPH mobilized data collection resources and community partnerships to explore how COVID-19 had impacted residents. This COVID-focused survey was part of the CCHNA designed to identify priority health issues, resources, and barriers to care. Survey questions were grouped into the following sections: Demographics, Physical and Mental Health, Health Care and Living Expenses, COVID-19 Impact on Employment, Barriers, Strengths, Health Conditions, Community Issues, Survey Usability and Other Noteworthy COVID-19 Experiences. The questionnaire was primarily provided on a digital platform using Alchemer and was provided in 13 languages (Arabic,

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<sup>17</sup> See Footnote 1.

<sup>18</sup> See Footnote 2.

Burmese, Chinese, English, French, Kinyarwanda, Korean, Lao, Spanish, Swahili, Tagalog, Thai and Vietnamese).

The 2021 survey was based off NACCHO's Example Community Health Survey.<sup>19</sup> The survey was modified from its original version by members of the Synapse Coalition, the HIPMC and MCDPH staff. Additional questions and response options were added and modified from the original format to assess the impact of COVID-19 on Maricopa County residents and explore additional health issues and social determinants of health. Free response questions were analyzed through a thematic analysis. A codebook was developed inductively based on the response data, and key themes were identified with the consensus of the MCDPH community impact team and epidemiology team. At least 50% of the collected responses from each region in Maricopa County were analyzed and coded with key themes, totaling 2,186 responses analyzed. Key themes were ranked by frequency.

With the intention of increasing survey data collection by 25% compared to the previous cycle, MCDPH set a goal to collect 15,000 surveys in 2021. MCDPH partnered with an extensive network of community-based organizations and health care partners to collect 14,380 community surveys from residents and professionals within Maricopa County. The MCDPH team wanted to ensure diverse community representation and that the survey provided insight from all regions (Northeast, Northwest, Central, Southeast and Southwest) of the county. MCDPH collaborated with several community-based organizations to provide stipends from \$2,000 to \$5,000 to support survey translation, distribution and completion, social media outreach via networks, purchase of incentives for survey completion, and administrative expenses.

### **2023 Maricopa County Community Survey**

Beginning in spring 2022, MCDPH initiated preparations for the 2023 CHNA data collection cycle with guidance from Synapse. From March to June 2023, MCDPH spearheaded data collection. MCDPH began conducting a thorough data validation and analysis process in October 2023, with results expected in summer 2024. MCDPH is using the recently released MAPP 2.0 framework for analysis and reporting to continue the cycle of timely and relevant community feedback.

### **Secondary Data**

Many of the challenging health problems facing the United States in the 21<sup>st</sup> century requires understanding the health of communities—not just individuals. The challenge of maintaining and improving community health has led to the development of a “population health” perspective. Population health is defined by the Institute for Healthcare Improvement as “the health outcomes of a group of individuals, including the distribution of such outcomes within the

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<sup>19</sup> National Association of County and City Health Officials. Example Community Health Survey. Retrieved from <https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/Example-Survey-CTSA-Community-Health.pdf>

group.”<sup>20</sup> A focus on population health implies a concern for the determinants of health for both individuals and communities. The health of a population grows directly out of the community’s social and economic conditions as well as the quality of its medical care. As a result, the CHNA utilizes a population health framework for this report to develop criteria for indicators used to measure health needs.

Quantitative data used in this report are high quality, population-based data sources and were analyzed by the MCDPH Office of Epidemiology. Secondary data was collected from local, state and national sources from MCDPH, ADHS, U.S. Census Bureau (American Census Survey), Centers for Disease Control and Prevention (CDC), Healthy People 2030 and PolicyMap. Secondary data includes Maricopa County Hospital Discharge Data (HDD - inpatient hospitalization, emergency department, death), Maricopa County birth data, demographic data, health equity definitions, maps related to medically underserved areas, and primary and mental HPSA status.

### **Hospital Discharge Data, Death Data and Birth Data**

MCDPH receives HDD biannually from ADHS.<sup>21</sup> HDD consists of inpatient hospitalization (IP) and emergency department discharge data for most Maricopa County hospitals. Data is collected based on the discharge date of the patient. Since 2015, diagnoses are coded using the 10<sup>th</sup> revision of the International Classification of Diseases (ICD-10). Since these diagnostic codes are recorded by health care providers and do not provide information regarding treatment, this limits MCDPH’s ability to identify and analyze health indicator data by controlled or uncontrolled cases. HDD includes anyone who was hospitalized or visited the emergency department regardless of if they are categorized as controlled or uncontrolled.

MCDPH receives vital records death data annually from ADHS for the previous year. This data includes deaths in Maricopa County regardless of residency status. The finalized and cleaned vital data consisted of death data for residents of Maricopa County. Data was collected based on the event date of the patient, e.g., date of death. The death database was coded using ICD-10. MCDPH receives vital Birth data annually from ADHS. This data includes births in Maricopa County regardless of residency status. Data was collected based on the event date of the patient, e.g., birth date. HDD, birth and death data was obtained from ADHS and cleaned by MCDPH to use for analyses. These datasets were used along with population estimates from the American Census Survey to analyze health indicators for Maricopa County residents. All health indicator rates are age adjusted using the 2000 Standard Population. Age-adjustment methods allow for fairer comparisons between population groups even if the size of the groups is different. The National Center for Health Statistics recommends using the 2000 Standard Population when

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<sup>20</sup> Institute for Healthcare Improvement (2023). Population Health. Retrieved from <https://www.ihl.org/Topics/Population-Health/Pages/default.aspx#:~:text=Population%20health%20is%20defined%20as,such%20outcomes%20within%20the%20group>.

<sup>21</sup> Hospital Discharge Data (2021). Obtained from Arizona Department of Health Services, cleaned and analyzed by MCDPH.

calculating age-adjusted rates. In this report, the 2000 Standard Population was used to standardize HDD and vitals data. Health indicators that were analyzed include fatal and nonfatal chronic conditions, fatal cancer indicators, fatal and nonfatal injuries, mental and behavioral health indicators, and infant birth indicators. Each indicator is analyzed as an overall rate for Maricopa County, and then further analyzed by age, race/ethnicity and sex to highlight disparities.

The American Census Survey by the U.S. Census Bureau measures the social and economic characteristics of U.S. populations. For this assessment, 2021 data was used to analyze demographic data in City of Hope Phoenix’s PSA, Maricopa County, and Arizona. Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 was used in this assessment to define health disparity and health equity and explain how they are intertwined with the CHNA process. PolicyMap provides geographic data that maps demographic, social and health indicators across the United States. PolicyMap was used in this assessment to evaluate social indicators and visualize measures such as medically underserved areas and HPSAs within City of Hope Phoenix’s PSAs in 2023.

### Initial Round of Health and Social Indicators

**Tables 3** display the list of 32 indicators that City of Hope Phoenix selected for initial evaluation. For the health indicators, HDD was analyzed. For the social indicators, PolicyMap data was analyzed. MCDPH CHNA survey and focus group data from both 2019 and 2021 provided community context and examples of lived experience for both health and social indicators.

<b>Mental &amp; Behavioral Illness</b>	<ul style="list-style-type: none"> <li>• All Mental &amp; Behavioral Disorders</li> <li>• Mood &amp; Depressive Disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Schizophrenic Disorders</li> </ul>
<b>Chronic Disease &amp; Cancer</b>	<ul style="list-style-type: none"> <li>• Cardiovascular Disease</li> <li>• Stroke</li> <li>• Diabetes</li> <li>• Asthma</li> </ul>	<ul style="list-style-type: none"> <li>• Chronic Obstructive Pulmonary Disease</li> <li>• Alzheimer’s</li> <li>• Cancers (Breast; Cervical; Lung; Prostate) Incidence &amp; Screenings</li> </ul>
<b>Substance Use &amp; Abuse</b>	<ul style="list-style-type: none"> <li>• All Drug Overdose</li> <li>• Opioid Overdose</li> </ul>	<ul style="list-style-type: none"> <li>• Alcohol Related</li> </ul>
<b>Injury Related</b>	<ul style="list-style-type: none"> <li>• Motor Vehicle Crash Related</li> <li>• Fall Related Injuries</li> </ul>	<ul style="list-style-type: none"> <li>• Assault Related Injuries</li> <li>• Intentional Self-Harm &amp; Suicide</li> </ul>
<b>Nutrition &amp; Diet</b>	<ul style="list-style-type: none"> <li>• Physical Activity</li> <li>• Obesity &amp; BMI</li> </ul>	<ul style="list-style-type: none"> <li>• Fruits &amp; Vegetable Consumption</li> <li>• Food Insecurity</li> </ul>
<b>Social Determinants of Health</b>	<ul style="list-style-type: none"> <li>• Transportation</li> <li>• Housing; Cost Burdened</li> </ul>	<ul style="list-style-type: none"> <li>• Access to Food</li> <li>• Education Level</li> </ul>
<b>Access to Healthcare</b>	<ul style="list-style-type: none"> <li>• Health Insurance Coverage</li> <li>• Health Care Coverage (18-64)</li> <li>• Usual Source of Care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Checkup</li> <li>• Employment Status</li> <li>• Income</li> <li>• Poverty</li> </ul>

**Table 3.** Initial List of Indicators

## Assessment Data and Findings

This section includes overall data and findings from the community surveys, focus groups and social/health indicator analyses. These combined assessments provide a comprehensive picture of the top issues and concerns facing the community.

### Top Health Needs

**Table 4** below displays indicators from the initial round of health needs that City of Hope Phoenix reviewed prior to the prioritization process. Each number within the table represents the ranking of each health indicator based on overall age-adjusted rates per 100,000 population for inpatient hospitalization (IP), emergency department (ED), and deaths.<sup>22</sup> The color gradients are used to help visualize the different rankings among the indicators.



IP/ED/Death Ranking Legend	Top 5	6-9	10+
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*\*Only nonfatal (Inpatient Hospitalization and Emergency Department) rates are analyzed for All Mental and Behavioral Disorders and Mood and Depressive Disorders.*

Indicator	IP	ED	Death
All Mental Disorders	1	3	*
Cardiovascular Diseases	2	2	1
Stroke	4	13	3
Fall Related Injuries	5	1	8
Diabetes	7	7	10
Motor Vehicle Traffic Related	8	4	11
Mood and Depressive Disorders	3	10	*
Chronic Obstructive Pulmonary Disease	10	9	4
Self-Harm	12	8	*
Suicide	*	*	9

**Table 4.** Top Health Issue Indicators in City of Hope’s Combined PSA (2021)

<sup>22</sup> See Footnote 21.

**Table 5** identifies the top causes of death for the combined City of Hope Phoenix 2019 PSA from 2017 to 2021.<sup>23</sup> Heart disease, cancer, and chronic obstructive pulmonary disease (COPD) all maintain the same place in the top 3 in most years.

	2017	2018	2019	2020	2021
1	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	COPD	COPD	Alzheimer's	COVID-19	COVID-19
4	Alzheimer's	Alzheimer's	COPD	Alzheimer's	Stroke
5	Stroke	Stroke	Stroke	COPD	COPD
6	Diabetes	Diabetes	Drug Overdose	Stroke	Drug Overdose
7	All Mental Health	Drug Overdose	Diabetes	Drug Overdose	Alzheimer's
8	Drug Overdose	All Mental Health	All Mental Health	Diabetes	Diabetes
9	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	All Mental Health	Unintentional Injuries
10	Fall	Fall	Suicide	Unintentional Injuries	All Mental Health

**Table 5. Top Causes of Death in City of Hope Phoenix PSA (2017-2021)**

<sup>23</sup> See Footnote 21.

## Maricopa County Overall COVID-19 Impact Survey Results

Figure 5 below displays data from the MCDPH 2021 CHNA survey reflecting top health care barriers, health conditions, community issues and community strengths experienced by Maricopa County participants.<sup>24</sup>


















Top Health Care Barriers			Top Health Conditions		
	Fear of exposure to COVID-19 in a health care setting	28%		Mental Health Issues	48%
	Unsure if health care need is a priority during this time	15%		Overweight/Obesity	40%
	Difficulty finding the right provider for my care	12%		Alcohol/Substance Use	29%
Community Issues			Community Strengths		
	Lack of people immunized to prevent disease	30%		Access to COVID-19 events	47%
	Distracted driving	29%		Access to COVID-19 testing events	41%
	Homelessness	26%		Access to safe walking and biking routes	30%

Figure 5. Top Health and Social Community Issues (2021)

<sup>24</sup> See Footnote 2.

## Qualitative Themes From Focus Groups

The following themes were identified from 2019 and 2021 focus group<sup>25</sup> data and open-ended surveys responses from the 2021 COVID-19 impact survey.<sup>26</sup> In focus groups, participants were asked questions about how they perceive their own health status, how COVID-19 affected their family, where they got information about health/COVID-19, barriers/facilitators to accessing care, and how health/COVID-19 messaging could be improved.

<p><b>Mental Health (2019)</b></p> <ul style="list-style-type: none"> <li>○ Access to social connections and sense of community</li> <li>○ Depression, suicide, and substance abuse increasingly important issues</li> <li>○ Need for mental health services</li> </ul>		<p><b>Mental Health (2021)</b></p> <ul style="list-style-type: none"> <li>○ Decline in mental health due to isolation, depression, and anxiety</li> <li>○ Difficulty accessing mental health services</li> <li>○ Importance of social gatherings and mental health</li> </ul>
<p><b>Health Care (2019)</b></p> <ul style="list-style-type: none"> <li>○ Inaccessible health care appointments with long wait times</li> <li>○ Need more clinics, pharmacies, and specialists</li> <li>○ Need greater insurance coverage</li> </ul>		<p><b>Health Care (2021)</b></p> <ul style="list-style-type: none"> <li>○ Perceived medical discrimination</li> <li>○ Lack of trust in health care</li> <li>○ Issues with accessing physical health and pharmaceutical services</li> </ul>
<p><b>Finances for Living Essentials (2019)</b></p> <ul style="list-style-type: none"> <li>○ High cost of medical care</li> <li>○ Make too much to qualify for AHCCCS but still can't cover daily costs</li> <li>○ Transportation, housing financially inaccessible</li> </ul>		<p><b>Finances for Living Essentials (2021)</b></p> <ul style="list-style-type: none"> <li>○ Financial burden on food, rent/mortgage utilities, clothing, childcare</li> <li>○ Difficulty paying for medical expenses</li> <li>○ Challenge accessing financial services</li> </ul>
<p><b>Information/Education (2019)</b></p> <ul style="list-style-type: none"> <li>○ Lack of education regarding insurance</li> <li>○ Need more information about health conditions, sex-ed, and nutrition</li> <li>○ Indicate medical misinformation is a problem</li> </ul>		<p><b>Information/Education (2021)</b></p> <ul style="list-style-type: none"> <li>○ COVID-19 vaccine misinformation/rumors</li> <li>○ Merits/utility of doctors, primary health care providers, social media, and news as information sources</li> <li>○ Frustrations with politicization of COVID-19 prevention and vaccination measures</li> </ul>
<p><b>Laws/Infrastructure (2019)</b></p> <ul style="list-style-type: none"> <li>○ Access to public libraries, spaces, and events is important</li> <li>○ Suggest laws to improve nutrition</li> </ul>		<p><b>Laws/Infrastructure (2021)</b></p> <ul style="list-style-type: none"> <li>○ Adherence/ambivalence toward COVID-19 prevention measures (face masks, physical distancing, hand washing, testing)</li> </ul>

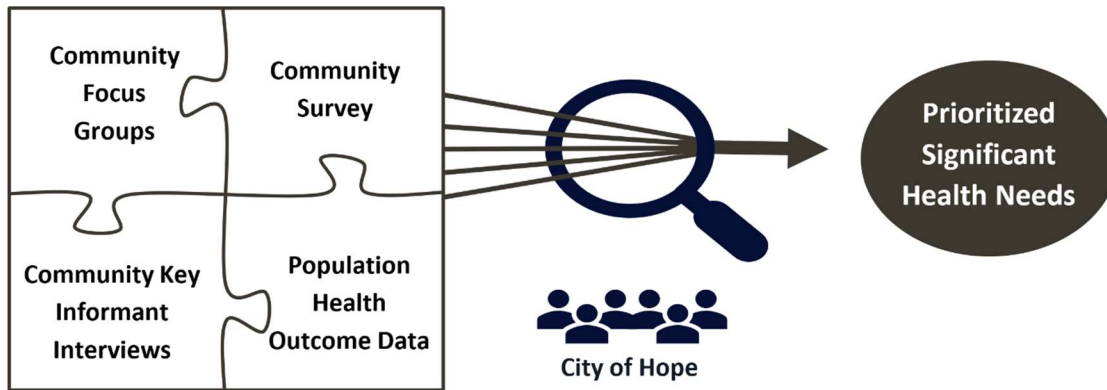
**Table 6.** Qualitative Focus Group Themes (2019 and 2021)

<sup>25</sup> See Footnotes 3 and 4.

<sup>26</sup> See Footnote 2.

## Prioritized Significant Community Health Needs

Top priorities are determined through cross-sectional assessment of population data, community survey and focus group data, and City of Hope Phoenix mission and resources.



### Most Prevalent Causes of Illness and Death Identified

To determine magnitude and severity of potential needs, health indicators identified in the secondary data collection were measured against benchmark state data, ranked among comparable indicators, and evaluated for trends over time. Health indicators substantially higher than benchmark data were considered to have met the magnitude or severity criteria. A total of 32 health and social indicators were established in collaboration with City of Hope Phoenix. These indicators were selected based on highlighted disparities analyzed by race/ethnicity, sex and age in City of Hope Phoenix’s PSA.

### Priorities for Community Members Ranked

Community members across Maricopa County were asked to identify and validate “highest impact” community and health issues (Figure 5 and Table 6 above). These primary data sources included data from multiple years of CHNA surveys, focus groups and key informant interviews. Summarized themes, issue rankings and direct quotes were evaluated to better understand resident experiences.

### Population Data and Community Input Analyzed Intersectionally

MCDPH cross-referenced input from the community with PSA-specific population data to identify issues of significance at both the population- and individual-level. Through a series of presentations and conversations with City of Hope Phoenix as well as the Synapse and HIPMC Coalitions, community health leaders interpreted the multimodal data through the lens of their organization’s mission and scope of influence. For example, mental and behavioral health has been a top issue identified across community input and hospital discharge data, and City of Hope Phoenix has pathways to address mental health through referrals.

The following significant health needs are listed in priority order:

<b>Mental and Behavioral Illness and Substance Use</b>	
<ul style="list-style-type: none"> <li>• All Mental and Behavioral Disorders</li> <li>• Mood and Depressive Disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Intentional Self-Harm and Suicide</li> <li>• Substance Use</li> </ul>
<b>Chronic Disease</b>	
<ul style="list-style-type: none"> <li>• Stroke</li> <li>• Cardiovascular Disease</li> <li>• Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Alzheimer’s</li> <li>• COPD</li> <li>• Asthma</li> </ul>
<b>Cancer</b>	
<ul style="list-style-type: none"> <li>• Incidence</li> </ul>	<ul style="list-style-type: none"> <li>• Mortality</li> </ul>
<b>Health Behaviors</b>	
<ul style="list-style-type: none"> <li>• Physical Activity</li> </ul>	<ul style="list-style-type: none"> <li>• Obesity and BMI</li> </ul>
<b>Access to Health Care</b>	
<ul style="list-style-type: none"> <li>• Employment Status</li> <li>• Income</li> <li>• Poverty</li> </ul>	<ul style="list-style-type: none"> <li>• Health Insurance Coverage</li> <li>• Routine Checkup</li> </ul>
<b>Social Determinants of Health</b>	
<ul style="list-style-type: none"> <li>• Transportation</li> <li>• Housing</li> <li>• Access to Food</li> </ul>	<ul style="list-style-type: none"> <li>• Education Level</li> <li>• Food Insecure</li> </ul>

**Table 7.** Significant Health Needs by Overall- and Subcategories

## Prioritized Health Needs: Disparities

There are many complexities to addressing health disparities and achieving health equity. Advancing health equity takes more than just ensuring that the community, partners and leadership are invested to bridge the gap in resources and health outcomes. To start moving the needle, it's imperative that communities align on concepts of health disparity and health equity to promote effective collaborative work and future opportunities. Healthy People 2030 defines *health disparity* and *health equity* as the following<sup>27</sup>:

### Health Disparity:

“A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

### Health Equity:

“The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

City of Hope prioritized significant health needs by utilizing a health equity lens to identify the most pressing health needs with the most extensive disparities in City of Hope's PSA. An example of how this health equity lens was utilized is that all data indicators were stratified in analysis by race/ethnicity, age and gender.

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<sup>27</sup> Healthy People 2030 (2020). Health Equity in Healthy People 2030. Retrieved from [Health Equity in Healthy People 2030 - Healthy People 2030 | health.gov](https://www.health.gov/healthy-people/2030/health-equity)

## Description of Prioritized Community Health Needs

The following categories are areas of priority for City of Hope Phoenix:

- 1 Mental and Behavioral Illness and Substance Use
- 2 Chronic Disease
- 3 Cancer
- 4 Health Behavior
- 5 Access to Health Care
- 6 Social Determinants of Health

### Health Equity in Data Analysis

Identifying differences in health outcomes based on factors including race/ethnicity, sex, age and socio-economic status is essential to achieving equitable health access and outcomes for all people.

Comparing rates of hospitalization and death between population groups, **Black/African American** and **American Indian** individuals experienced disproportionately high rates across the board. **Individuals aged 65+** had the highest rates of hospitalization and/or death across half the indicators analyzed. Those **25-44** had the highest hospitalization and/or death rates of mental health and substance abuse compared to those **45-64** who had the highest rates of diabetes, obesity/overweight, hypertension, and COPD.

**Tables 8-10 and 14-25** display health indicators analyzed through a health equity lens by highlighting disparities by race/ethnicity, age and sex in City of Hope Phoenix's PSA.

# Mental and Behavioral Illness and Substance Use

## How to Use This Section

Physical and mental health as often thought of as separate entities, however, they are interconnected. If community programs were designed with mental health challenges in mind, barriers could be addressed to ensure future program success. For example, if an organization wants to start a program to get community members walking, but they know that people in the community suffer from stress, they could use that information and design promotional materials that reinforce how regular walking can help decrease stress. Ultimately, this data can help organizations better serve residents by being aware of and ready to address potential mental health issues.

Mental and Behavioral Illness, and Substance Use is the first priority category for City of Hope Phoenix. It includes four indicators for which data will be provided.



All Mental and Behavioral Disorders



Intentional Self-Harm and Suicide



Mood and Depressive Disorders



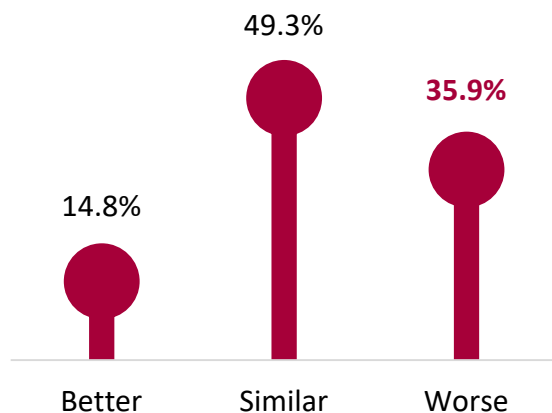
Substance Use

### 2021 Focus Group

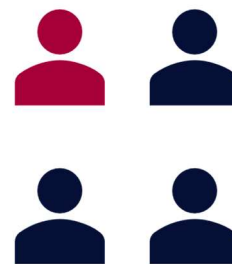


Common **threats to community health** across all groups was the prevalence of **alcohol/drugs, unmet mental health needs** and **smoking/vaping**.

About **36%** of respondents rated their current **mental health** as **worse** compared to their mental health prior to March 2020.



Almost **1 out of 4** respondents stated that **assistance with mental health issues** would have improved overall mental and physical health of their family in the last year.



Source: 2021 COVID-19 Impact Focus Group and Survey

## Community Ranking



In the 2021 Community Survey, **Mental Health Issues** were ranked **first** as having the greatest impact on the community's health and wellness.

*\*Only nonfatal (Inpatient Hospitalization and Emergency Department) rates are analyzed for All Mental and Behavioral Disorders, and Mood and Depressive Disorders.*



## All Mental and Behavioral Disorders

All Mental and Behavioral Disorders is ranked No. 1 for Inpatient Hospitalization (IP) and No. 3 for Emergency Department (ED) rates. American Indians, those aged 25-44, and males have the highest IP and ED rates.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	No. 1	No. 3	*
<b>Race/Ethnicity</b>	American Indian	American Indian	*
<b>Age</b>	25-44	25-44	*
<b>Sex</b>	Male	Male	*

**Table 8.** 2021 Health Indicator Disparities: All Mental and Behavioral Disorders



## Mood and Depressive Disorders

Mood and Depressive Disorders is ranked No. 3 for IP and No. 10 for ED rates. American Indians, those aged 25-44, and females have the highest IP rates. Black/ African Americans, those aged 15-24, and females have the highest ED rates.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	No. 3	No. 10	*
<b>Race/Ethnicity</b>	American Indian	Black/ African American	*
<b>Age</b>	25-44	15-24	*
<b>Sex</b>	Female	Female	*

**Table 9.** 2021 Health Indicator Disparities: Mood and Depressive Disorders

### From a Community Member (2021)

“I wish we had more mental health access for everyone. It's difficult to find a person and also like to see mental health covered by insurance. It's really sad that this one area of health is always getting overlooked. I have many mental health issues and I have given up on the search because I can't afford one. And I refuse to see a county medical professional.”

(55-64 years old, COVID-19 Impact Survey)



## Intentional Self-Harm and Suicide

Intentional Self-Harm and Suicide is ranked No. 8 for ED and No. 9 for death rates. American Indians, those aged 25-44, and females have the highest IP rates. American Indians, those aged 15-24, and females have the highest ED rates. White/Caucasians, those aged 25-44, and males have the highest death rates.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	N/A	No. 8	No. 9
<b>Race/Ethnicity</b>	American Indian	American Indian	White/Caucasian
<b>Age</b>	25-44	15-24	25-44
<b>Sex</b>	Female	Female	Male

**Table 10.** 2021 Health Indicator Disparities: Intentional Self-Harm and Suicide

### From a Community Member (2021)

 *Concerns regarding youth/adolescents who were isolated from peers for so long and the sharp increase in mental health, SUDs, and suicide rates. We need captivating, programs/activities to get these youth involved in where screening can occur.* 

*(55-64 years old, COVID-19 Impact Survey)*



## Substance Use

### Community Ranking



In the 2021 Community Survey, **Alcohol/Substance Abuse** was ranked **third** as having the greatest impact on the community's health and wellness.

### Focus Group



**Alcohol and substance abuse** was rated as the **greatest threat to community health** in the 2021 focus group. Similarly, substance abuse (including alcohol) was a key theme.

### Alcohol Consumption

Alcohol consumption has been strongly linked to cause several types of cancer. In its report on carcinogens, the National Toxicology Program of the U.S. Department of Health and Human Services lists alcoholic beverages as a known human carcinogen.<sup>28</sup> In Maricopa County, about 16% of adult respondents participated in binge drinking which exceeds Arizona's rate. About 6% reported heavy drinking which did not exceed Arizona's rate. Binge drinking is defined as consuming large quantities of alcohol within a set period. For males, this is five or more drinks

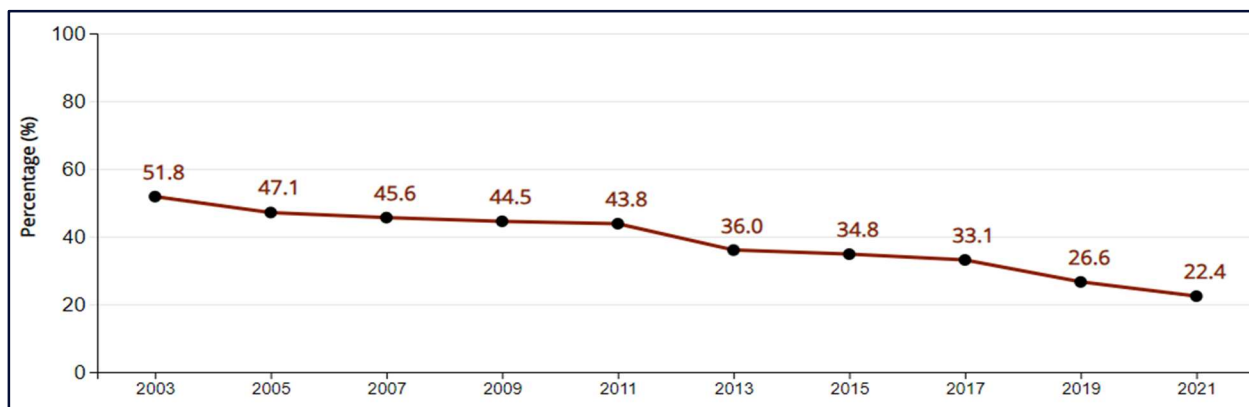
<sup>28</sup> NTP (National Toxicology Program). 2021. Report on Carcinogens, Fifteenth Edition. Research Triangle Park, NC: U.S. Department of Health and Human Services, Public Health Service. <https://ntp.niehs.nih.gov/go/roc15>  
DOI: <https://doi.org/10.22427/NTP-OTHER-1003>

per occasion and for females, four or more drinks. Heavy drinkers are defined as adult men having more than 14 drinks per week and adult women having more than seven drinks per week.

Report Area	Maricopa County	Arizona
Binge Drinking in the Past Year	16.5%	15.9%
Heavy Drinking in the Past Year	5.9%	6.3%

**Table 11.** Adult Drinking Behavior Among Adults in Maricopa County and Arizona

Although there has been a steady decline in the prevalence of teen drinking, among youth who have taken the Youth Risk Behavior Surveillance System (YRBSS) survey, about 22% of respondents said they currently drink alcohol (**Figure 6**).



**Figure 6.** Prevalence of High School Students Who Currently Drink Alcohol (AZ, 2021)

## Tobacco Use

### Community Ranking



In the 2021 Community Survey, **Tobacco Use including Vaping** was ranked **sixth** as having the greatest impact on the community’s health and wellness.

### Focus Group



Youth rated the conditions with the greatest impact on their community’s overall health and wellness similar to adults. However, youth rated tobacco use higher than adults (46.8% vs. 32.8%).

Tobacco use is the single most preventable cause of cancer and premature death worldwide. It causes 80% of lung cancer cases in men and 40% in women worldwide.<sup>29</sup> Smokeless tobacco-use such as chewing tobacco or vaping can cause a variety of oral health problems like cancer of the mouth and gums, periodontitis and even death.<sup>30</sup> Moreover, while cigarette smoking among

<sup>29</sup> Thun MJ, DeLancey JO, Center MM, Jemal A, Ward EM. The global burden of cancer: priorities for prevention. *Carcinogenesis*. 2010 Jan;31(1):100-10. doi: 10.1093/carcin/bgp263. Epub 2009 Nov 24. PMID: 19934210; PMCID: PMC2802672.

<sup>30</sup> Muthukrishnan A, Warnakulasuriya S. Oral health consequences of smokeless tobacco use. *Indian J Med Res*. 2018 Jul;148(1):35-40. doi: 10.4103/ijmr.IJMR\_1793\_17. PMID: 30264752; PMCID: PMC6172921.

adults has steadily declined over the decades, it remains the leading cause of preventable death in the United States.<sup>31</sup> According to Cornelius et al., the disparities among those who use tobacco products nationally is highest among:

- Those who have annual income less than \$35,000/year
- LGBTQ+ adults
- Uninsured, or those with Medicaid
- People who have a disability or a generalized anxiety disorder
- Those with the equivalent of a General Education Equivalent (GED) certificate

Approximately 12% of adults in Maricopa County reported being a current smoker compared to 13% for Arizona and about 23% reported being a former smoker in Maricopa County compared to 26% for Arizona. In a similar trend, approximately 60% of adults in Maricopa County reported never having smoked compared to 61% for Arizona.

Report Area	Maricopa County	Arizona
<b>Current Smoker</b>	11.6%	13.1%
<b>Former Smoker</b>	23.3%	26.2%
<b>Never Smoked</b>	59.8%	60.7%

**Table 12.** Smoker Status Among Adults in Maricopa County and Arizona (2021)

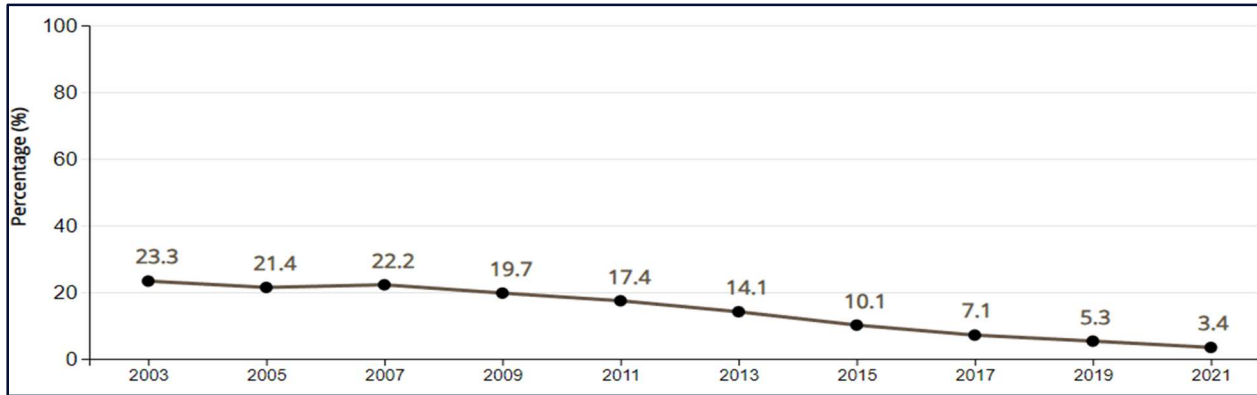
Appropriately 4% of adults in Maricopa County reported being a current e-cigarette user every day or some days. About 82% of respondents stated they were former e-cigarette users, and 9% stated they had never used e-cigarettes.

Report Area	Maricopa County	Arizona
<b>Current e-cigarette user - every day</b>	4.1%	4.3%
<b>Current e-cigarette user - some days</b>	4.3%	4.4%
<b>Former e-cigarette user</b>	82.2%	82.1%
<b>Never used e-cigarettes</b>	9.4%	9.1%

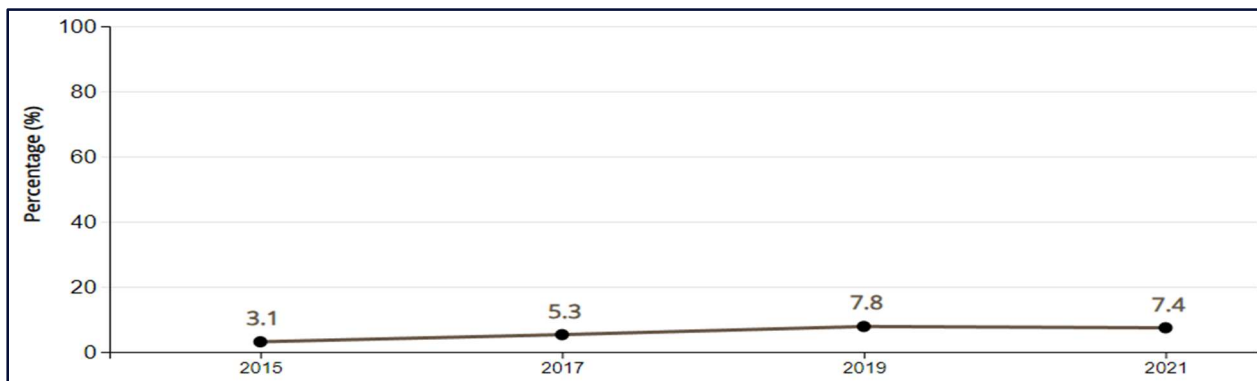
**Table 13.** E-cigarette User Status Among Adults in Maricopa County and Arizona (2021)

In **Figures 7** and **8**, there is a decline in the prevalence of YRBSS respondents who stated they currently smoke cigarettes but there is an incline in prevalence for those who use electronic vapor products frequently. In 2021, about 3.4% of respondents said they currently smoke cigarettes, and 7.4% said they currently use vapor products frequently.

<sup>31</sup> Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults - United States, 2019. MMWR Morb Mortal Wkly Rep. 2020 Nov 20;69(46):1736-1742. doi: 10.15585/mmwr.mm6946a4. PMID: 33211681; PMCID: PMC7676638. Retrieved 11/14/22.



**Figure 7.** Prevalence of High School Students Who Currently Smoke Cigarettes (AZ, 2021)



**Figure 8.** Prevalence of High School Students Who Currently Use Electronic Vapor Products Frequently (AZ, 2021)

**From a Community Member (2021)**

“ The shutdowns and the need to handle online school while working have taken an unbelievable toll on the mental and physical health of every mother I know. We are falling apart. Not just those of us who are broke either. We are not having more children, we are drinking more, we have gained weight, and we cannot handle this added burden... ”

(35-44 years old, COVID-19 Impact Survey)

**From a Community Member (2021)**

“ I am an RN who was working on the COVID unit... It seemed like some mental health options became a resource for the hospital staff. I think more of it is needed. We are seeing a lot of drug and alcohol cases - from loss : loss of jobs, families, support. I think we need more help getting people help at home- detoxing safely, outlets etc. ”

(55-64 years old, COVID-19 Impact Survey)

# Chronic Disease

## How to Use This Section

Chronic disease is complex as there are many intersecting health and social factors that play a role in health outcomes. This section addresses health status and various chronic diseases including stroke, diabetes, heart disease and chronic obstructive pulmonary disease. The data presents disparities by race/ethnicity, age, sex and how the community perceived these conditions impacting their lives. How could you use this information to build a program or deliver services when funding is lean? Community input can provide rich detail on how best to address barriers and ensure program success.

Chronic Disease is the second priority category for City of Hope Phoenix. It includes six indicators for which data will be provided.



Stroke



Cardiovascular Disease



Diabetes



Asthma



Chronic Obstructive  
Pulmonary Disease



Alzheimer's

## Community Ranking



In the 2021 Community Survey the following were ranked as having the greatest impact on the community's health and wellness:

- **Stroke and Cardiovascular Disease as seventh**
- **Diabetes as fifth**
- **Lung disease (asthma, COPD, emphysema) as tenth**
- **Alzheimer's as ninth**

## Focus Group



**The 2021 focus group participants:**

Provided diverse suggestions for **health improvement** and a common recurring theme among all groups was related to increasing **education** on topics such as **chronic disease management** and how to manage the health care system.

Discussed the **need for resources** and **information** regarding **high blood pressure** and **diabetes**, which was also listed as the **third** and **fourth** largest threat to the community, respectively.

Source: 2021 MCDPH COVID-19 Impact Focus Group and

## Stroke

Smoking and health conditions like high blood pressure, high cholesterol, obesity and diabetes are the leading causes of stroke. This is especially troubling as 1 in 3 U.S. adults is a smoker or has at least one of these health conditions.<sup>32</sup> Stroke ranked No. 4 for IP and No. 3 for death rates. American Indians had the highest IP rate and Black/ African Americans had the highest ED and death rates. Those aged 65+ had the highest IP, ED and death rates. Males had the highest IP and ED rates, and females had the highest death rate.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	No. 4	N/A	No. 3
<b>Race/Ethnicity</b>	American Indian	Black/African American	Black/African American
<b>Age</b>	65+	65+	65+
<b>Sex</b>	Male	Male	Female

**Table 14.** 2021 Health Indicator Disparities: Stroke

## Cardiovascular Disease

Cardiovascular disease (CVD) is one of the leading causes of death and results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.<sup>33</sup> CVD ranked No. 2 for IP and ED rates and No. 1 for death rate. American Indians had the highest IP rate and Black/ African Americans had the highest ED and death rates. Those aged 65+ and males had the highest IP, ED and death rates.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	No. 2	No. 2	No. 1
<b>Race/Ethnicity</b>	American Indian	Black/African American	Black/African American
<b>Age</b>	65+	65+	65+
<b>Sex</b>	Male	Male	Male

**Table 15.** 2021 Health Indicator Disparities: Cardiovascular Disease

### From a Community Member (2021)

**“** My dad was out of work due to COVID and decided to relocate here to Arizona to resume work, shortly after he got here, he was experiencing some heart issues and had to go to the hospital. He was working but had not been here long enough to yet have benefits. For that he is stuck with huge hospital bills... **”**

(55-64 years old, COVID-19 Impact Survey)

<sup>32</sup> Tsao CW, Aday AW, Almarzooq ZI, Beaton AZ, Bittencourt MS, Boehme AK, et al. Heart Disease and Stroke Statistics—2023 Update: A Report From the American Heart Association. *Circulation*. 2023;147:e93–e621

<sup>33</sup> Heart Disease and Stroke Statistics-2019 Update: A Report from the American Heart Association. *Circulation* 2019; Jan 31. Benjamin EJ, Muntner P, Alonso A, et al. Available at <https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2019/02/15/14/39/aha-2019-heart-disease-and-stroke-statistics>. Accessed [October, 2022]

## Diabetes

Although modifiable behavior and lifestyle factors can help reduce a person’s risk of developing diabetes, it is the seventh leading cause of death in the United States.<sup>34</sup> Diabetes ranked No. 7 for IP and ED rates and No. 10 for death. American Indians had the highest IP and death rate, and Black/ African Americans had the highest ED rate. Those aged 45-65 had the highest IP and ED rates, and those 65+ had the highest death rate. Males had the highest IP, ED and death rates.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	No. 7	No. 7	No. 10
<b>Race/Ethnicity</b>	American Indian	Black/African American	American Indian
<b>Age</b>	45-64	45-64	65+
<b>Sex</b>	Male	Male	Male

**Table 16.** 2021 Health Indicator Disparities: Diabetes

### From a Community Member (2021)

“ Since I had covid I have several issues that I did not before... Pain, fatigue, muddled thinking, and diabetes. The biggest problem I personally have is that some chores are extremely difficult for me to complete and there is no help for me... ”

(55-64 years old, COVID-19 Impact Survey)

## Asthma

The direct cause of asthma is unknown and although the initial onset of asthma cannot be prevented, it can be controlled. Asthma affects people of all ages, but it is the most common chronic disease among children.<sup>35</sup> Asthma ranked No. 5 for ED rates. Black/African Americans had the highest IP and ED rates, while White/Caucasians had the highest death rates. Those aged 1-14 had the highest IP and ED rates, and those 65+ had the highest death rate. Females had the highest IP, ED and death rates.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	N/A	No. 5	N/A
<b>Race/Ethnicity</b>	Black/African American	Black/African American	White/Caucasian
<b>Age</b>	1-14	1-14	65+
<b>Sex</b>	Female	Female	Female

**Table 17.** 2021 Health Indicator Disparities: Asthma

<sup>34</sup> U.S. Department of Health and Human Services. Healthy People 2020. Retrieved from: <https://health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes/reduce-number-diabetes-cases-diagnosed-yearly-d-01#cit2> . 11/14/22.

<sup>35</sup> Pate CA, Zahran HS, Qin X, Johnson C, Hummelman E, Malilay J. Asthma Surveillance — United States, 2006–2018. MMWR Surveill Summaries 2021;70(No. SS-5):1–32. DOI: <http://dx.doi.org/10.15585/mmwr.ss7005a1>

## Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is the fourth leading cause of death in the United States. Almost 16 million people are affected, with millions more undiagnosed or untreated.<sup>36</sup> COPD ranked No. 10 for IP, No. 9 for ED, and No. 4 for death rates. Black/African Americans had the highest IP and ED rates, while White/Caucasians had the highest death rate. Those aged 65+ had the highest IP and death rates, and those aged 45-64 had the highest ED rate. Females had the highest IP and ED rates and males had the highest death rate.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	No. 10	No. 9	No. 4
<b>Race/Ethnicity</b>	Black/African American	Black/African American	White/Caucasian
<b>Age</b>	65+	45-64	65+
<b>Sex</b>	Female	Female	Male

**Table 18.** 2021 Health Indicator Disparities: Chronic Obstructive Pulmonary Disease

### From a Community Member (2021)

“My mother has been in the hospital on respirator three times this year, she has severe COPD and when I tried to get help paying our electric bill they said they ran out of funds... she has a life saving device that uses electric to keep her breathing (oxygen machine). And we really need to have electric or she will die. We have already lost our home and transportation and still haven't fully recovered from the pandemic.”

(35-44 years old, COVID-19 Impact Survey)

## Alzheimer's

Alzheimer's is the most common type of dementia and is the fifth leading cause of death among adults aged 65+ in the United States.<sup>37</sup> In Maricopa County, Alzheimer's ranked No. 5 for death rate among all residents. Black/African Americans had the highest IP and ED rates, and White/Caucasians had the highest death rate. Those aged 65+ had the highest IP, ED and death rates. Females had the highest IP and death rates and Males had the highest ED rate.

Category Callouts	Inpatient Hospitalization	Emergency Department	Death
<b>Top 10 Ranking</b>	N/A	N/A	No. 5
<b>Race/Ethnicity</b>	Black/African American	Black/African American	White/Caucasian
<b>Age</b>	65+	65+	65+
<b>Sex</b>	Female	Male	Female

**Table 19.** 2021 Health Indicator Disparities: Alzheimer's

<sup>36</sup> Wheaton AG, Cunningham TJ, Ford ES, Croft JB. Employment and activity limitations among adults with chronic obstructive pulmonary disease — United States, 2013. MMWR Morb Mortal Wkly Rep. 2015;64 (11):290–295.

<sup>37</sup> Heron M. Deaths: leading causes for 2010. National vital statistics reports; vol. 62, no 6. Hyattsville, MD: National Center for Health Statistics. 2013.

# Cancer

## How to Use This Section

Inequalities in social and economic factors make it hard for people to engage in behaviors that can prevent certain cancers and get help when needed. Use this section to find information about variation in cancer prevalence by racial/ethnic subpopulations and gender. You can also use this section to compare cancer incidence rates against cancer mortality by subpopulation — observing that some groups are more likely to have a shortened lifespan than others due to cancer.

Cancer is the third priority category for City of Hope Phoenix. It includes two indicators for which data will be provided.



Incidence



Mortality

## Community Ranking

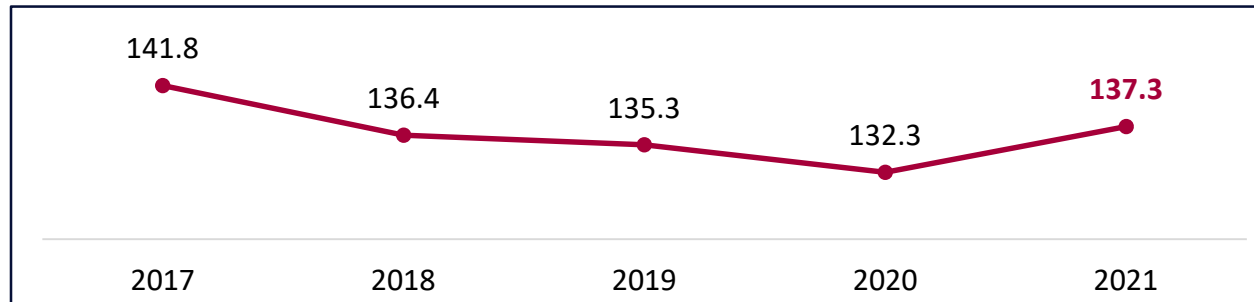


In the 2021 Community Survey, **Cancer** was ranked **eighth** as having the greatest impact on the community's health and wellness.



**All Cancer** ranked **third** by frequency in the **top 10 causes of death**.

Cancer affects all population groups, but due to social, environmental and economic disadvantages, certain groups are disproportionately affected by the burden of cancer.<sup>38</sup> According to a study conducted in 2020, the impact of the COVID-19 pandemic on cancer care in the U.S. has resulted in decreases and delays in identifying new cancer and delivery of treatment.<sup>39</sup> As seen below from the HDD, there was a steady decline in mortality rates of all cancer from 2017 to 2020, and in 2021, the mortality rate rose above the previous three years.



<sup>38</sup> National Cancer Institute (2024). Cancer Disparities. Retrieved from <https://www.cancer.gov/about-cancer/understanding/disparities>

<sup>39</sup> Patt D., Gordan L., Diaz M., et al. Impact of COVID-19 on Cancer Care: How the Pandemic is Delaying Cancer Diagnosis and Treatment for American Seniors. *JCO Clin Cancer Inform*, 4, 1059-1071. doi: 10.1200/CCI.20.00134

## Incidence

Overall rates of cancer incidence in Maricopa County are higher than the state level. Additionally, the rates of **breast cancer** (117.6 per 100,000 persons), **leukemias** (10.9 per 100,000 persons), **melanomas of the skin** (30.7 per 100,000 women), **non-Hodgkin lymphoma** (15.4 per 100,000 persons), **pancreas** (12.5 per 100,000 persons), **prostate** (77.8 per 100,000 persons) and **thyroid** (12.8 per 100,000 women) exceed state rates.<sup>40</sup>

Types of Cancer	Maricopa County	Arizona
Cancer all sites	<b>380.2</b>	376.6
Brain and Other Nervous System	5.9	5.9
Cervix	5.8	<b>6.1</b>
Colon and Rectum	30.1	<b>30.8</b>
Corpus and Uterus, NOS	23.2	<b>23.4</b>
Esophagus	3.8	<b>4</b>
Breast (Female)	<b>117.6</b>	113
Hodgkin Lymphoma	<b>2.1</b>	2
Kaposi Sarcoma	0.2	0.2
Kidney and Renal Pelvis	15.4	<b>16</b>
Larynx	1.6	<b>1.8</b>
Leukemias	<b>10.9</b>	10.7
Liver and Intrahepatic Bile Duct	7.1	7.7
Lung and Bronchus	41.5	<b>41.6</b>
Melanomas of the Skin	<b>30.7</b>	28.9
Mesothelioma	0.7	0.7
Myeloma	<b>5.4</b>	5.3
Non-Hodgkin Lymphoma	<b>15.4</b>	14.6
Oral Cavity and Pharynx	8.4	<b>9</b>
Ovary	9.4	<b>9.7</b>
Pancreas	<b>12.5</b>	12
Prostate	<b>77.8</b>	76.4
Stomach	5.2	5.2
Testis	<b>5.8</b>	5.7
Thyroid	<b>12.8</b>	12.2
Urinary Bladder	17.2	<b>17.4</b>

**Table 20.** Cancer Incidence Rates, Age-Adjusted, per 100,000 Persons, 2016-2020

<sup>40</sup> U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; [www.cdc.gov/cancer/dataviz](http://www.cdc.gov/cancer/dataviz)

When examined by ethnicity:

- **White/Caucasians** had the highest rates of **cancer all sites, brain and other nervous system, esophagus, breast (female), leukemias, melanomas of the skin, oral cavity and pharynx, testis and thyroid.**
- **Black/African Americans** had the highest rates of **Hodgkin lymphoma, lung and bronchus, myeloma, pancreas and prostate.**
- **American Indian and Alaska Natives** had the highest rates of **colon and rectum, corpus and uterus (NOS), kidney and renal pelvis, liver and intrahepatic bile duct; non-Hodgkin lymphoma and ovary.**
- **Hispanics** had the highest rates of **cervix, Kaposi sarcoma, mesothelioma and stomach.**

“—”Indicates Data Not Available

Types of Cancer	White/ Caucasian	Black/ African American	American Indian and Alaska Native	Asian and Pacific Islander	Hispanic
<b>Cancer all sites</b>	<b>400.9</b>	350.2	326.1	222.2	311.4
<b>Brain and Other Nervous System</b>	<b>6.7</b>	3.1	—	2.6	4.8
<b>Cervix</b>	5.5	4	—	4.3	<b>7.7</b>
<b>Colon and Rectum</b>	30.4	31.7	<b>35.9</b>	19	30.1
<b>Corpus and Uterus, NOS</b>	22.7	20.7	<b>40.9</b>	14.2	23.3
<b>Esophagus</b>	<b>4.2</b>	2.5	—	—	2.8
<b>Breast (Female)</b>	<b>127.1</b>	105.2	68.3	86	92.8
<b>Hodgkin Lymphoma</b>	2.3	<b>3.2</b>	—	—	1.8
<b>Kaposi Sarcoma</b>	—	—	—	—	<b>0.03</b>
<b>Kidney and Renal Pelvis</b>	14.9	16.2	<b>26.2</b>	6.2	18.5
<b>Larynx</b>	1.6	1.7	—	—	1.4
<b>Leukemias</b>	<b>11.2</b>	9.9	10.6	7.2	9.3
<b>Liver and Intrahepatic Bile Duct</b>	5.8	8.3	<b>18.6</b>	8.1	12.4
<b>Lung and Bronchus</b>	44.5	<b>46.9</b>	23.6	28.5	26
<b>Melanomas of the Skin</b>	<b>38.1</b>	—	7.2	—	5.7
<b>Mesothelioma</b>	0.6	—	—	—	<b>0.8</b>
<b>Myeloma</b>	5.1	<b>10</b>	7	4.1	5
<b>Non-Hodgkin Lymphoma</b>	15.9	11.4	<b>16.3</b>	10.4	14.4
<b>Oral Cavity and Pharynx</b>	<b>9.6</b>	5	4.7	5.5	5
<b>Ovary</b>	9.5	7.2	<b>11.6</b>	7	9.2
<b>Pancreas</b>	12.6	<b>14.6</b>	11.7	7.2	12.4
<b>Prostate</b>	79.5	<b>106.2</b>	39.9	34.2	61.2
<b>Stomach</b>	4.1	7.7	6.7	6.6	<b>8.8</b>
<b>Testis</b>	<b>6.6</b>	—	—	—	5.7
<b>Thyroid</b>	<b>13.8</b>	7.6	12.6	10.3	12.6

Table 21. Cancer Incidence Rates, Age-Adjusted, per 100,000 Persons, by Race/Ethnicity, 2016-2020

**When examined by sex:**

- **Males** had the highest rates of most cancers — **cancer all sites, brain and other nervous system, esophagus, kidney and renal pelvis, larynx, lung and bronchus, melanomas of the skin, myeloma, non-Hodgkin lymphoma, oral cavity and pharynx and stomach.**
- **Females** had the highest incidence rate of **thyroid cancer.**

“—”Indicates Data Not Available

Types of Cancer	Male	Female
Cancer all sites	399.6	368.4
Brain and Other Nervous System	7.1	4.9
Cervix	—	5.8
Colon and Rectum	33.6	26.9
Corpus and Uterus, NOS	—	23.2
Esophagus	6.7	1.4
Breast (Female)	—	117.6
Hodgkin Lymphoma	2.4	1.8
Kaposi Sarcoma	—	—
Kidney and Renal Pelvis	21.7	9.8
Larynx	2.8	0.5
Leukemias	13.6	8.6
Liver and Intrahepatic Bile Duct	10.6	4
Lung and Bronchus	43.9	39.7
Melanomas of the Skin	41.2	22.2
Mesothelioma	1.1	0.3
Myeloma	6.6	4.3
Non-Hodgkin Lymphoma	18.9	12.4
Oral Cavity and Pharynx	12.9	4.5
Ovary	—	9.4
Pancreas	14.5	10.8
Prostate	77.8	—
Stomach	6.7	3.9
Testis	5.8	—
Thyroid	6.7	18.9

**Table 22.** Cancer Incidence Rates, Age-Adjusted, per 100,000 Persons, by sex, 2016-2020

**From a Community Member (2021)**

“ My mother die[d] of pancreatic cancer because she was scared to go to the doctor... She started experiencing symptoms in March of 2020, and by the time we were able to force her to the doctor... it was too late and she was dead by the end of September 2020. ”

(45-54 years old, COVID-19 Impact Survey)

## Mortality

Overall rates of cancer mortality are lower in Maricopa County than at the state level. However, the rates of **breast** (18.3 per 100,000 persons), **leukemia** (6 per 100,000 persons), **non-Hodgkin lymphoma** (4.5 per 100,000 persons), and **pancreas** (10.5 per 100,000 persons) exceed state rates.

Types of Cancer	Maricopa County	Arizona
Cancer all sites	130.1	<b>132.3</b>
Brain and Other Nervous System	4.1	4.1
Cervix	2	2
Colon and Rectum	12.2	12.2
Corpus and Uterus, NOS	3.9	3.9
Esophagus	3.3	<b>3.5</b>
Breast (Female)	<b>18.3</b>	18
Hodgkin Lymphoma	0.3	0.3
Kaposi Sarcoma	0	0
Kidney and Renal Pelvis	3.4	<b>3.6</b>
Larynx	0.7	0.7
Leukemias	<b>6</b>	5.6
Liver and Intrahepatic Bile Duct	6	<b>6.3</b>
Lung and Bronchus	27	<b>27.7</b>
Melanomas of the Skin	2.2	2.2
Mesothelioma	0.6	0.6
Myeloma	2.8	2.8
Non-Hodgkin Lymphoma	<b>4.5</b>	4.4
Oral Cavity and Pharynx	1.9	<b>2</b>
Ovary	6.1	<b>6.2</b>
Pancreas	<b>10.5</b>	10.2
Prostate	16.8	<b>17.1</b>
Stomach	2.4	<b>2.5</b>
Testis	0.4	0.4
Thyroid	0.5	0.5
Urinary Bladder	3.9	<b>4</b>

**Table 23.** Cancer Mortality Rates, Age-Adjusted, per 100,000 Persons, 2016-2020

**When examined by race and ethnicity:**

- **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.**

“—”Indicates Data Not Available

Types of Cancer	White/ Caucasian	Black/ African American	American Indian and Alaska Native	Asian and Pacific Islander	Hispanic
<b>Cancer all sites</b>	131.4	<b>160.9</b>	112.7	93.4	114.7
<b>Brain and Other Nervous System</b>	<b>4.8</b>	2	—	1.6	2.7
<b>Cervix</b>	1.7	—	—	—	<b>3.1</b>
<b>Colon and Rectum</b>	12.1	<b>16.7</b>	9.6	9.2	11.8
<b>Corpus and Uterus, NOS</b>	3.7	<b>5.5</b>	—	3.4	4
<b>Esophagus</b>	<b>3.6</b>	2.3	—	—	2.1
<b>Breast (Female)</b>	18.6	<b>28.5</b>	13.7	13.9	15.1
<b>Hodgkin Lymphoma</b>	0.3	—	—	—	—
<b>Kaposi Sarcoma</b>	—	—	0	0	0
<b>Kidney and Renal Pelvis</b>	3.2	3.2	<b>5.8</b>	1.9	4
<b>Larynx</b>	<b>0.6</b>	—	—	—	0.5
<b>Leukemias</b>	<b>6.2</b>	5.5	—	3.7	4.6
<b>Liver and Intrahepatic Bile Duct</b>	5	8.2	9.9	8.9	<b>10</b>
<b>Lung and Bronchus</b>	28.5	<b>34</b>	18	20.8	16.3
<b>Melanomas of the Skin</b>	<b>2.8</b>	—	—	—	0.8
<b>Mesothelioma</b>	0.6	—	—	—	0.6
<b>Myeloma</b>	2.6	<b>6.9</b>	—	2	3
<b>Non-Hodgkin Lymphoma</b>	4.5	2.6	—	3.8	<b>5</b>
<b>Oral Cavity and Pharynx</b>	<b>2</b>	1.7	—	—	1.3
<b>Ovary</b>	<b>6.1</b>	5.9	—	5.4	4.9
<b>Pancreas</b>	10.5	<b>15</b>	—	7.3	9.6
<b>Prostate</b>	16.2	<b>36.6</b>	—	9.1	16.7
<b>Stomach</b>	1.8	4	—	3.6	<b>4.8</b>
<b>Testis</b>	<b>0.3</b>	—	—	—	—
<b>Thyroid</b>	0.4	—	—	—	<b>0.9</b>

**Table 24.** Cancer Mortality Rates, Age-Adjusted, per 100,000 Persons, by Race/Ethnicity, 2016-2020

When examined by sex, males had the highest rates of most cancers, most notably — cancer all sites, colon and rectum, esophagus, kidney and renal pelvis, liver and intrahepatic bile duct, melanomas of the skin and oral cavity and pharynx.

“—”Indicates Data Not Available

Types of Cancer	Male	Female
Cancer all sites	152.5	112.4
Brain and Other Nervous System	5.1	3.3
Cervix	—	2
Colon and Rectum	14.5	10.1
Corpus and Uterus, NOS	—	3.9
Esophagus	5.8	1.1
Breast (Female)	—	18.3
Hodgkin Lymphoma	0.3	0.2
Kaposi Sarcoma	—	—
Kidney and Renal Pelvis	5.2	1.8
Larynx	1.2	0.2
Leukemias	7.7	4.7
Liver and Intrahepatic Bile Duct	8.4	4
Lung and Bronchus	31.1	23.7
Melanomas of the Skin	3.4	1.3
Mesothelioma	0.9	0.3
Myeloma	3.6	2.2
Non-Hodgkin Lymphoma	5.8	3.4
Oral Cavity and Pharynx	3.1	0.9
Ovary	—	6.1
Pancreas	12.4	8.8
Prostate	16.8	—
Stomach	2.8	2
Testis	0.4	—
Thyroid	0.5	0.5

Table 25. Cancer Mortality Rates, Age-Adjusted, per 100,000 Persons, by Sex, 2016-2020

**From a Community Member (2021)**

“ I had 3 family members die because of covid. One person is dying now of cancer because they could not get cancer treatment during covid & now it has spread to the point they can't do anything for them. We tried to be careful, but work required us to meet with the public. ”

(55-64 years old, COVID-19 Impact Survey)

# Health Behaviors

## How to Use This Section

Many health problems exist because of lifestyle or health habits that increase the risk of death and chronic disease. Obesity increases the risk for chronic diseases like diabetes and cancer, and diabetes weakens the body’s ability to fight cancer. Health behavior data can help design programs that address root causes of chronic health issues such as diabetes or cancer.

Health Behaviors is the fourth priority category for City of Hope Phoenix. It includes two indicators for which data will be provided.



Obesity and BMI



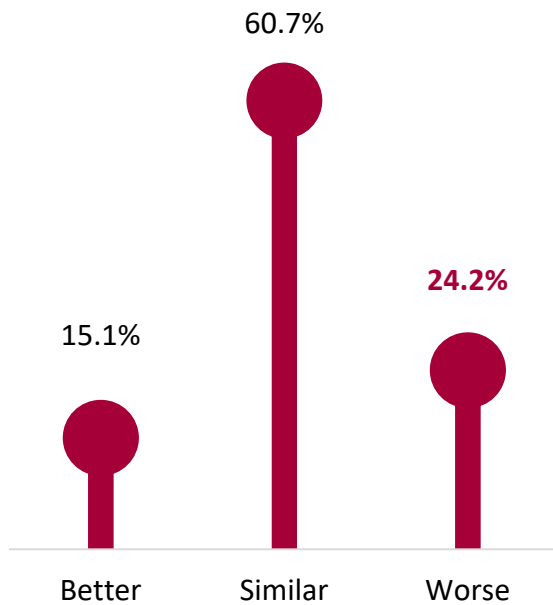
Physical Activity

### Community Ranking

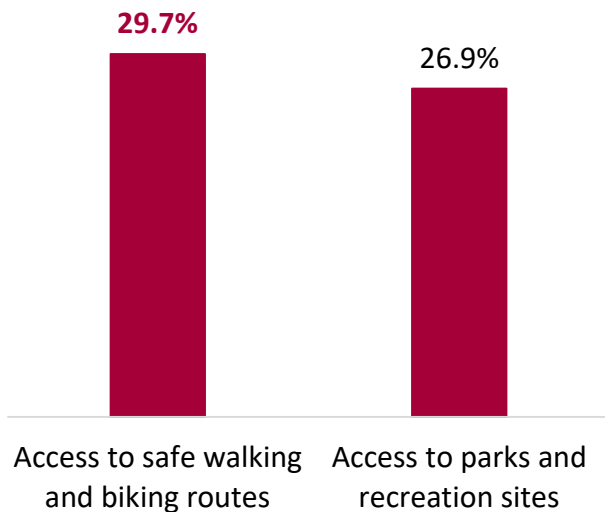


In the 2021 Community Survey, **lack of safe spaces to exercise and be physically active** were ranked the **seventh** great community health issue.

**24%** of respondents rated their current **physical health** as **worse** compared to their mental health prior to March 2020.



About **30%** of respondents stated they had access to **safe walking and biking routes** and **27%** said they had access to **parks and recreation sites**.



Source: 2021 COVID-19 Impact Survey

## Community Ranking



In the 2021 Community Survey, **Overweight/Obesity** was ranked as having the **second** greatest impact on the community’s health and wellness.



## Obesity and BMI

Being overweight or obese can detrimentally impact health outcomes — leading to serious health consequences, such as cardiovascular disease, type 2 diabetes, musculoskeletal disorders like osteoarthritis, and some cancers like endometrial, breast, and colon cancer.<sup>41</sup> **Table 26** displays the overweight and obese prevalence in Maricopa County and Arizona.

Indicator	Maricopa County	Arizona
Body Mass Index – Overweight	38.4%	36.6%
Body Mass Index – Obese	29.4%	31.3%

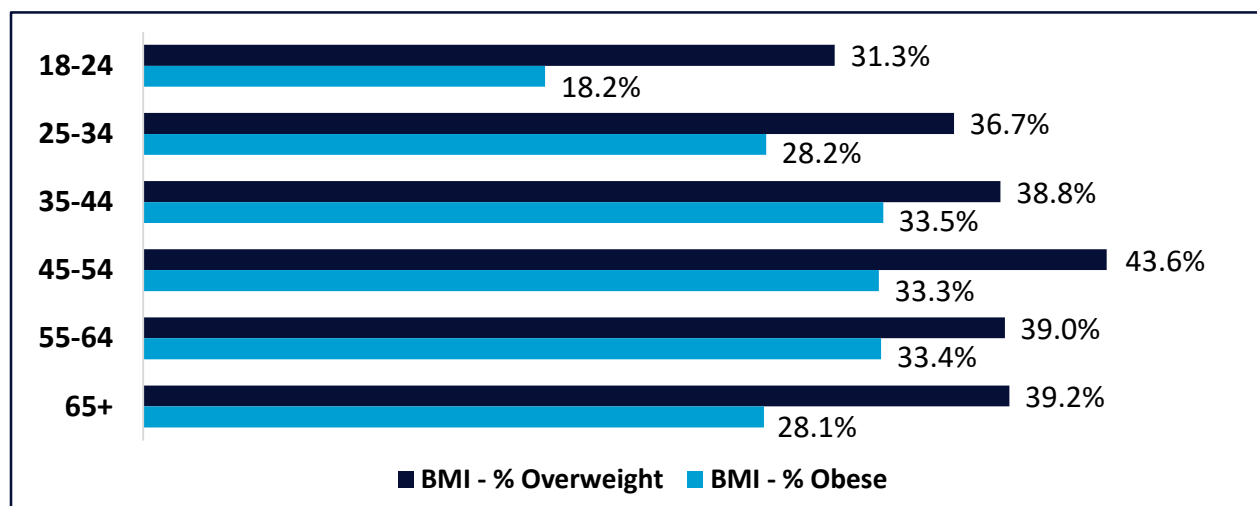
**Table 26.** Overweight and Obesity Among Adults in Maricopa County and Arizona (2021)

In Maricopa County, Hispanic people have higher overweight and obesity rates than the White, Non-Hispanic population (**Table 27**).

Indicator	White, Non-Hispanic	Hispanic
Body Mass Index – Overweight	37.0%	41.8%
Body Mass Index – Obese	27.5%	32.8%

**Table 27.** Overweight and Obesity by Ethnicity in Maricopa County (2021)

Adults in the age group **45-54** years had the **highest overweight rate**, and adults aged **35-44** had the **highest obesity rate**. While adults **18-24** had the **lowest prevalence of overweight or obesity**, almost **one in three were overweight**, and almost **1 in 5 were obese** (**Figure 9**).



**Figure 9.** Adult Overweight and Obesity Prevalence by Age in Maricopa County

<sup>41</sup> World Health Organization (2024). Obesity: Health consequences of being overweight. Retrieved from <https://www.who.int/news-room/questions-and-answers/item/obesity-health-consequences-of-being-overweight>

## Physical Activity

Physical inactivity is one of the leading risk factors for noncommunicable diseases (heart disease, stroke, cancer and diabetes). People who are insufficiently active have a 20% - 30% increased risk of death compared to people who are sufficiently active.<sup>42</sup> Increasing physical activity can contribute to improved health and well-being. Maricopa County reported higher rates of meeting physical activity recommendations in the last 30 days compared to the state rate (**Table 28**).

Indicator	Maricopa County	Arizona
Met Physical Activity Recommendations in Last 30 Days	78.6%	77.3%

**Table 28.** Physical Activity Among Adults in Maricopa County and Arizona (2021)

### From a Community Member (2021)

**“** Telecommuting allowed for decreased stress with sitting in traffic for 3 hours a day. It allowed for more daily, healthy exercise as there was more time since not sitting in stress causing traffic. **”**

(55-64 years old, COVID-19 Impact Survey)

### From a Community Member (2021)

**“** My 7 year old grandson became obese during the Pandemic and there's not much support for children to have access to work out facilities and support groups for Children who are experiencing Over eating disorders. **”**

(45-54 years old, COVID-19 Impact Survey)

### From a Focus Group Participant (2021)

**“** How you live, because if you're always running in your life... Always cleaning, taking care of your kids— You need to take some time for yourself, exercise a bit more, going out with your kids and spending more time with them. Making time for them. **”**

(Spanish Speaking Focus Group Participant)

<sup>42</sup> World Health Organization (2022). Physical Activity. Retrieved from <https://www.who.int/news-room/factsheets/detail/physical-activity>

## Access to Health Care

### How to Use This Section

Access to health care has been a longstanding challenge for many communities. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met. Access to affordable, quality health care is important to physical, social and mental health. Health insurance helps individuals and families access needed primary care, specialists and emergency care, but does not necessarily ensure access — providers are needed to offer available and affordable care within adequate proximity to patients. This section will explore access to health care through health insurance coverage and usual source of care. The data will focus on Maricopa County and Arizona.

*Tip: Use the data in this section for grant writing or program reporting.*

Access to Health Care is the fifth priority category for City of Hope Phoenix. It includes two indicators for which data will be provided.



#### Health Insurance Coverage

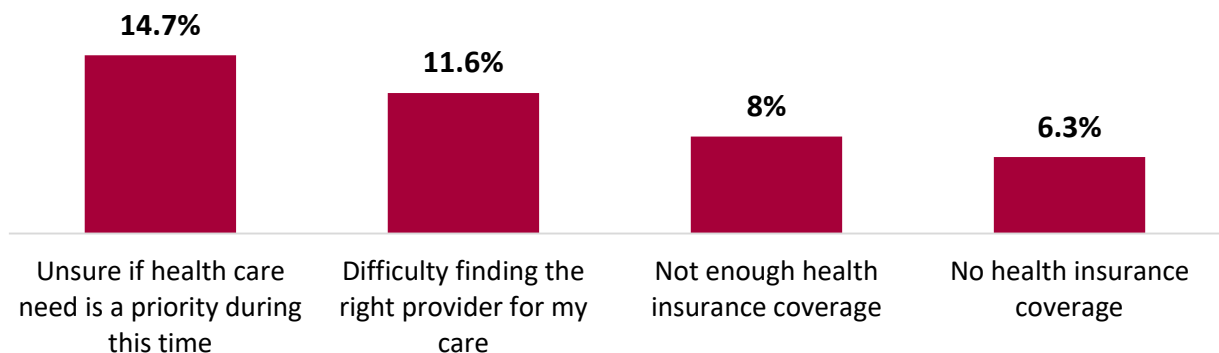


#### Usual Source of Care

### Community Ranking



The following factors ranked as having the greatest impact on the community's ability to receive needed medical care: unsure if health care need is a priority during this time, difficulty finding the right provider, and not enough or no health insurance coverage.



### From a Community Member (2021)

“ Even as someone who has remained employed, at an above average salary, I cannot afford the copays required for frequent doctor visits, let alone dental care and mental health care. I have had many chronic symptoms for months that sound like long covid but just can't afford to get thoroughly checked out. ”

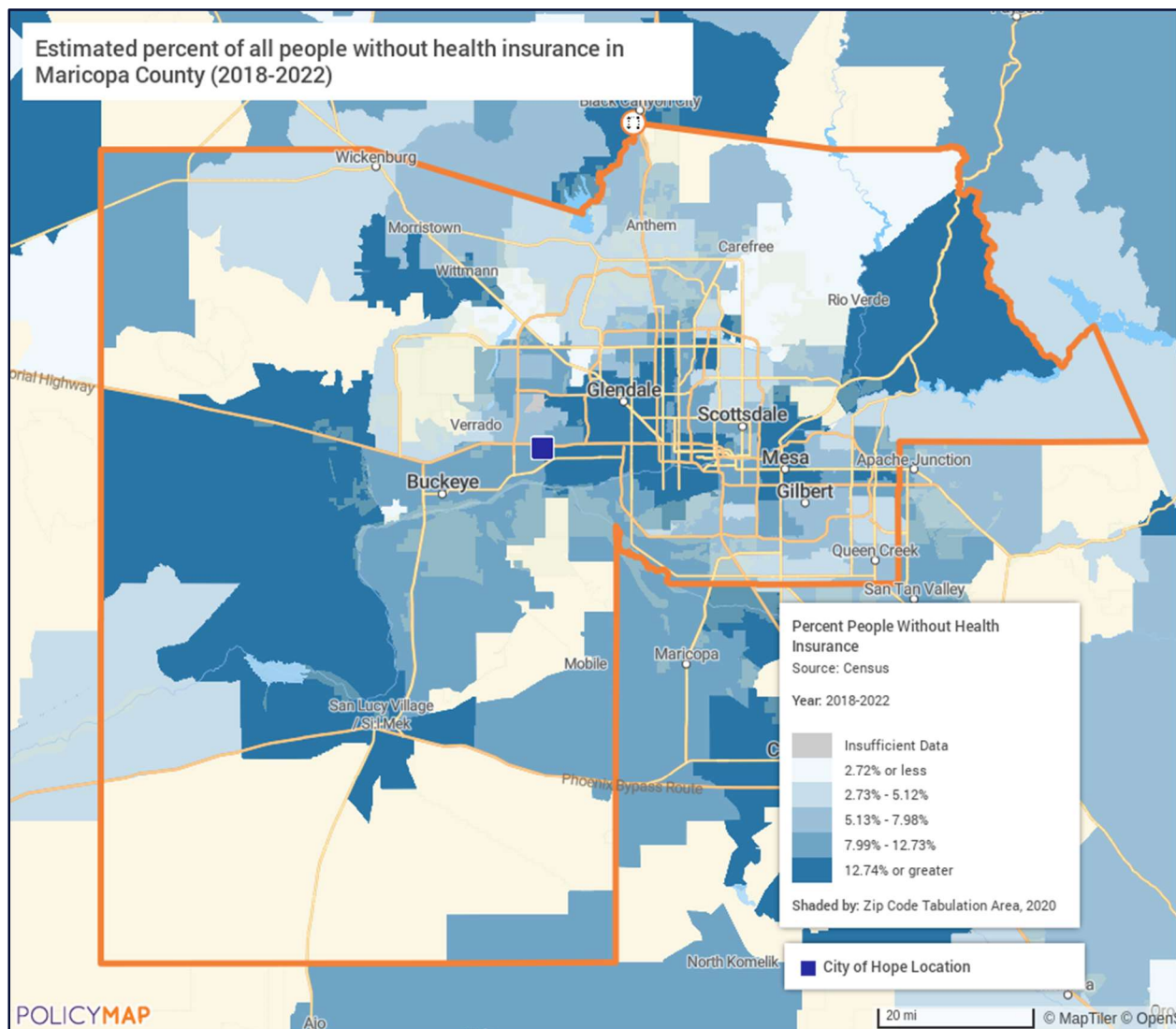
(35-44 years old, COVID-19 Impact Survey)

## Health Insurance Coverage

Health insurance coverage improves access to care, supports positive health outcomes and reduces financial strain on individuals, families and communities.<sup>43</sup> Inadequate health care coverage can be a significant barrier for many marginalized communities. As a result, individuals may delay or forgo necessary care. In Maricopa County, 87.3% of residents have health insurance, slightly lower than the statewide coverage of 90.1% (Table 29). Figure 10 displays the estimated percentage of all people without health insurance in Maricopa County.

Indicator	Maricopa County	Arizona
Health Care Coverage (18-64)	87.3%	90.1%

**Table 29.** Health Care Coverage Among Adults in Maricopa County and Arizona (2021)



**Figure 10.** Estimated percent of all people without health insurance in Maricopa County

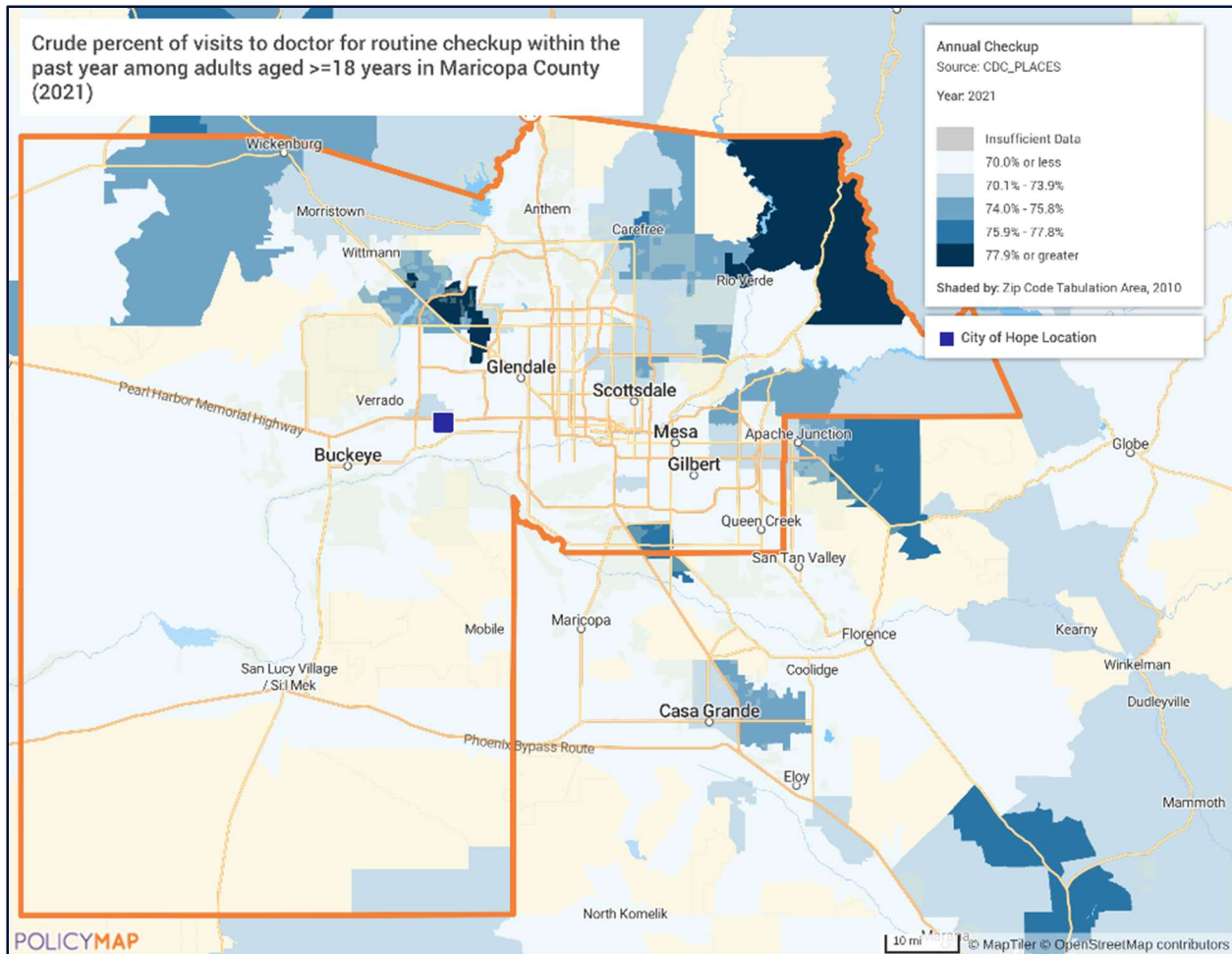
<sup>43</sup> American Hospital Association. Report: The Importance of Health Coverage. Retrieved from <https://www.aha.org/guidesreports/report-importance-health-coverage>

## Usual Source of Care

Having a usual source of care is important for improving health outcomes, decreasing health care expenses and ultimately increasing quality of life. Usual source of care is defined as having one person or a group of doctors that an individual thinks of as their personal health care provider. There are existing disparities in usual source of care between urban and rural areas, as rural populations may face barriers, such as having limited access to health care resources (*e.g., primary care providers or specialist doctors*).<sup>44</sup> Usual source of care is defined as an individual having one or more doctors that serve as routine health care providers (**Table 30**). **Figure 11** shows the crude percent of visits to a doctor for routine checkup within the past year.

Indicator	Maricopa County	Arizona
Usual Source of Care	77.1%	77.6%

**Table 30.** Usual Source of Care Among Adults in Maricopa County and Arizona (2021)



**Figure 11.** Crude Percent of Visits to Doctor for Routine Checkup Within the Past Year

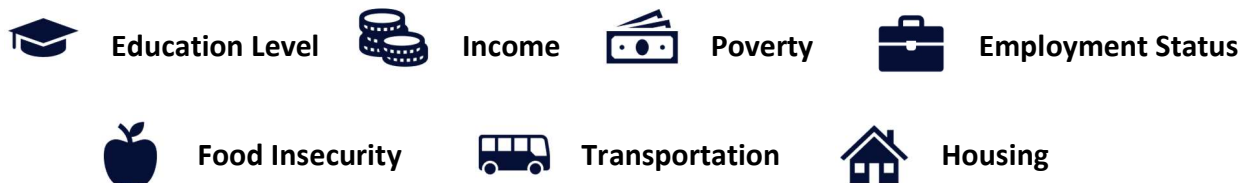
<sup>44</sup> Chen X, Orom H, Hay JL, et al. (2019) Differences in Rural and Urban Health Information Access and Use. *J Rural Health*. 35(3): 405-417. doi: 10.1111/jrh.12335.

# Social Determinants of Health


## How to Use This Section

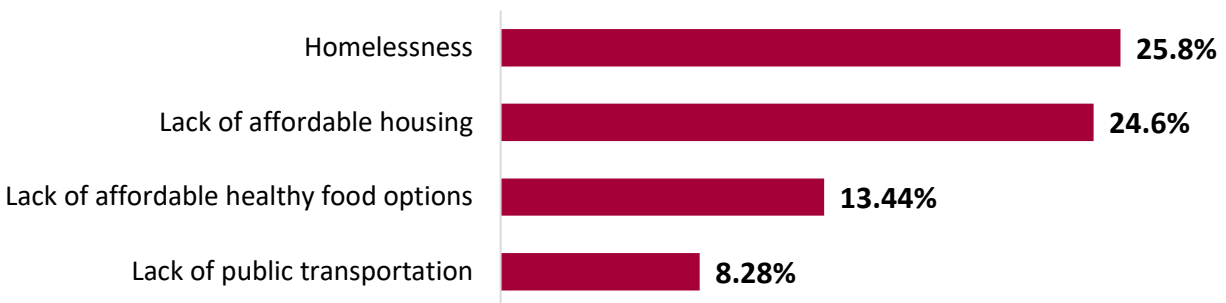
This section will explore social determinants of health (SDOH). According to Healthy People 2030, SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality of life outcomes and risks.<sup>45</sup> The health inequity gap continues to grow in populations who are disproportionately impacted. The roots of these inequities are molded by SDOH, which contribute to decreased opportunities for communities to improve and maintain their health. Ultimately, targeting upstream SDOH-related factors can help improve health, reduce disparities and achieve health equity in all communities.

Social Determinants of Health is the sixth category for City of Hope Phoenix. It includes seven indicators for which data will be provided.



## Community Ranking

 In the 2021 Community Survey, the following social determinants of health were ranked as having the greatest impact on the community's health and wellness:



## Focus Group



The most frequently cited **community concerns** in the focus groups were **lack of:**

- **Adequate-affordable housing and homelessness**
- **Healthy food options including an overabundance of non-nutritious foods**
- **Feeling safe at home, in parks, bus stops and neighborhoods in general**

Source: 2021 COVID-19 Impact Focus Group and Survey

<sup>45</sup> Healthy People 2030. Social Determinants of Health. Retrieved from <https://health.gov/healthypeople/priority-areas/social-determinants-health>

## Educational Attainment

Educational attainment is crucial to shaping long-term health and quality of life. Access to and the quality of education plays an important role in promoting health and safety among communities and helping them build lifelong healthy behaviors. Education is interconnected with other factors like income and employment. Educational attainment is key to unlocking opportunities for improved community health status. **Table 31** provides a snapshot of educational attainment in Maricopa County and Arizona.

Educational Attainment	Maricopa County	Arizona
Less than 9 <sup>th</sup> grade	5%	5%
9 <sup>th</sup> – 12 <sup>th</sup> grade, no diploma	6%	7%
High school graduate (includes equivalency)	22%	24%
Some college, no degree	24%	25%
Associate degree	9%	9%
Bachelor’s degree	22%	19%
Graduate or professional degree	13%	12%

**Table 31.** Educational Attainment in Maricopa County and Arizona (2021)

## Income

Income is one of the most impactful SDOH factors as it can have a large influence on health. Income levels shape health-related behaviors, living conditions, access to essential health care services and quality of life. Oftentimes, those in a higher income bracket have greater access to health care resources and a higher likelihood to adopt and maintain healthy behaviors that foster good health. Those in a lower income bracket tend to have minimized access to health care and may face financial burden with expenses on insurance, medication and services. Income is a driving element behind the health disparities that marginalized populations experience. As the most populous and urban county in Arizona, Maricopa County has the highest median income in the state. **Table 32** provides a snapshot of median household income in Maricopa County compared to Arizona.

	Maricopa County	Arizona
Median Household Income	Median: \$72,944	Median: \$65,913

**Table 32.** Median Household Income in Maricopa County and Arizona (2021)

## Poverty

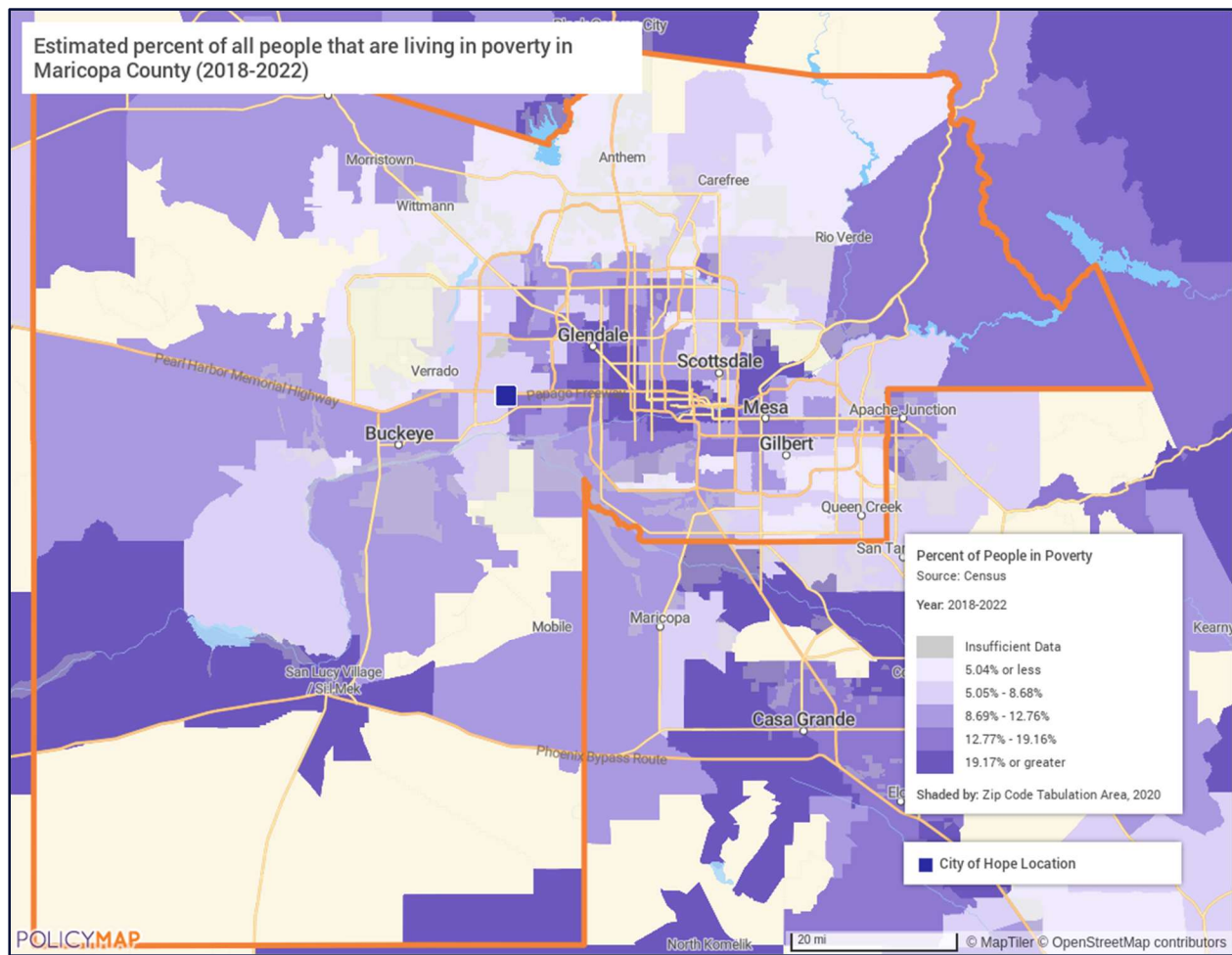
Poverty is a complex determinant of health and has been long recognized as a strong predictor of morbidity and mortality. Communities who live in poverty often have reduced access to resources essential to support a healthy quality of life such as stable housing, healthy foods, safe neighborhoods and educational and employment opportunities.<sup>46</sup> Poverty can also significantly

<sup>46</sup> Healthy People 2030. Poverty. Retrieved from [Poverty - Healthy People 2030 | health.gov](https://www.health.gov/ourpriorities/healthy-people-2030/poverty)

impact children as it can follow them into adulthood. Research shows that children who live in poverty have worse physical and mental health outcomes as adults due to increased exposure to adversity and stress. Additionally, they're less likely to have access to comprehensive health care, good nutrition, safe neighborhoods and high-quality education.<sup>47</sup> **Table 33** displays the poverty level in Maricopa County and Arizona. **Figure 12.** shows that one out of every ten Maricopa County residents lives in poverty.

	Maricopa County	Arizona
<b>Percent persons below poverty level</b>	12%	14%
<b>Under age 18 in poverty</b>	17%	19%

**Table 33.** Poverty level in Maricopa County and Arizona (2021)



**Figure 12.** Estimated Percent of People Living in Poverty in Maricopa County

<sup>47</sup> University of Washington. Poverty and Childhood Health. Retrieved from [Poverty and childhood health | Population Health \(washington.edu\)](https://www.washington.edu/population-health/poverty-and-childhood-health/)

## Employment Status

Employment status and health outcomes can be viewed as having a mutual relationship. Employment can provide a level of financial security to support standard of living. Health outcomes can also influence an individual’s employment status — poor health can threaten employment opportunities and financial security. Employment provides income and oftentimes benefits, such as health insurance, paid sick leave and workplace wellness programs that support opportunities for healthy choices. However, the “working poor” face challenges such as lack of health insurance or access to preventative care and are more like likely to experience hazardous work environments.<sup>48</sup> Closing the unemployment gap can significantly impact life expectancy, quality of life and health care expenses. **Table 34** displays the employment status in Maricopa County compared to Arizona.

Employment Status	Maricopa County	Arizona
<b>Civilian labor force (16+)</b>	2,236,183	3,401,906
<b>Employed</b>	95%	94%
<b>Unemployed</b>	5%	6%

**Table 34.** Employment Status in Maricopa County and Arizona (2021)

### From a Community Member (2021)

“ I lost my job because I am 64 and have underlying conditions. My job was customer contact and expose risk was too great. Seems that part of the population was overlooked. Now I am too old to get new employment and losing unemployment benefits. ”

(55-64 years old, COVID-19 Impact Survey)

### From a Community Member (2021)

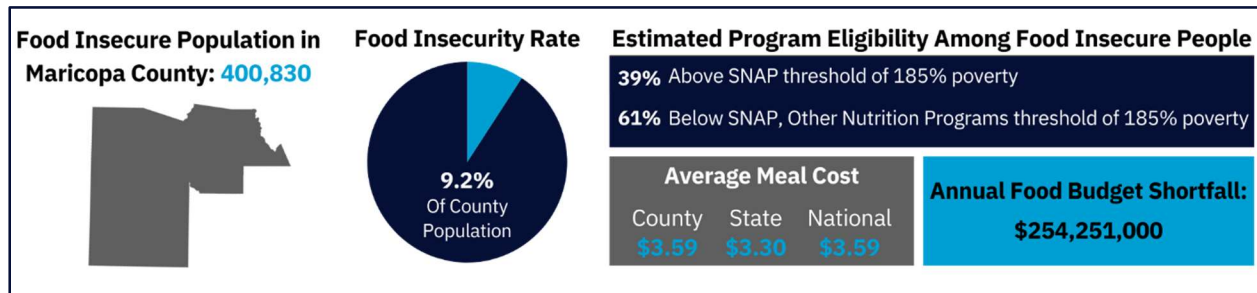
“ I lost my job before the stimulus funding trickled down to my organization. That caused me to be forced to take a lower paying job. I lost 40% of my income and that was still too much to qualify for aid. We're in the gray area with income but not poor enough for aid. It's frustrating to not have temporary aid to bridge families like mine until the economy recovers. ”

(45-54 years old, COVID-19 Impact Survey)

<sup>48</sup> County Health Rankings & Roadmaps. Employment. Retrieved from <https://www.countyhealthrankings.org/health-data/health-factors/social-economic-factors/employment>

## Food Insecurity

Food insecurity is one of the most pressing issues that communities face. This multifaceted issue takes a toll on poor nutrition, adverse health outcomes and increased health care costs for marginalized populations. Similar to other common determinants of health, food insecurity does not exist in isolation as many households face overlapping issues with housing, poverty, medical expenses and chronic health conditions. Increasing access to healthy and affordable food and promoting nutrition education helps empower communities to develop and maintain healthy dietary patterns which result in better health outcomes. **Figure 13** displays the 2021 food insecure population, the food insecurity rate, the estimated program eligibility among food insecure people in Maricopa County, average meal costs for Maricopa County, Arizona, and United States and the annual food budget shortfall.<sup>49</sup>



**Figure 13.** Food Insecurity in Maricopa County

### From a Community Member (2021)

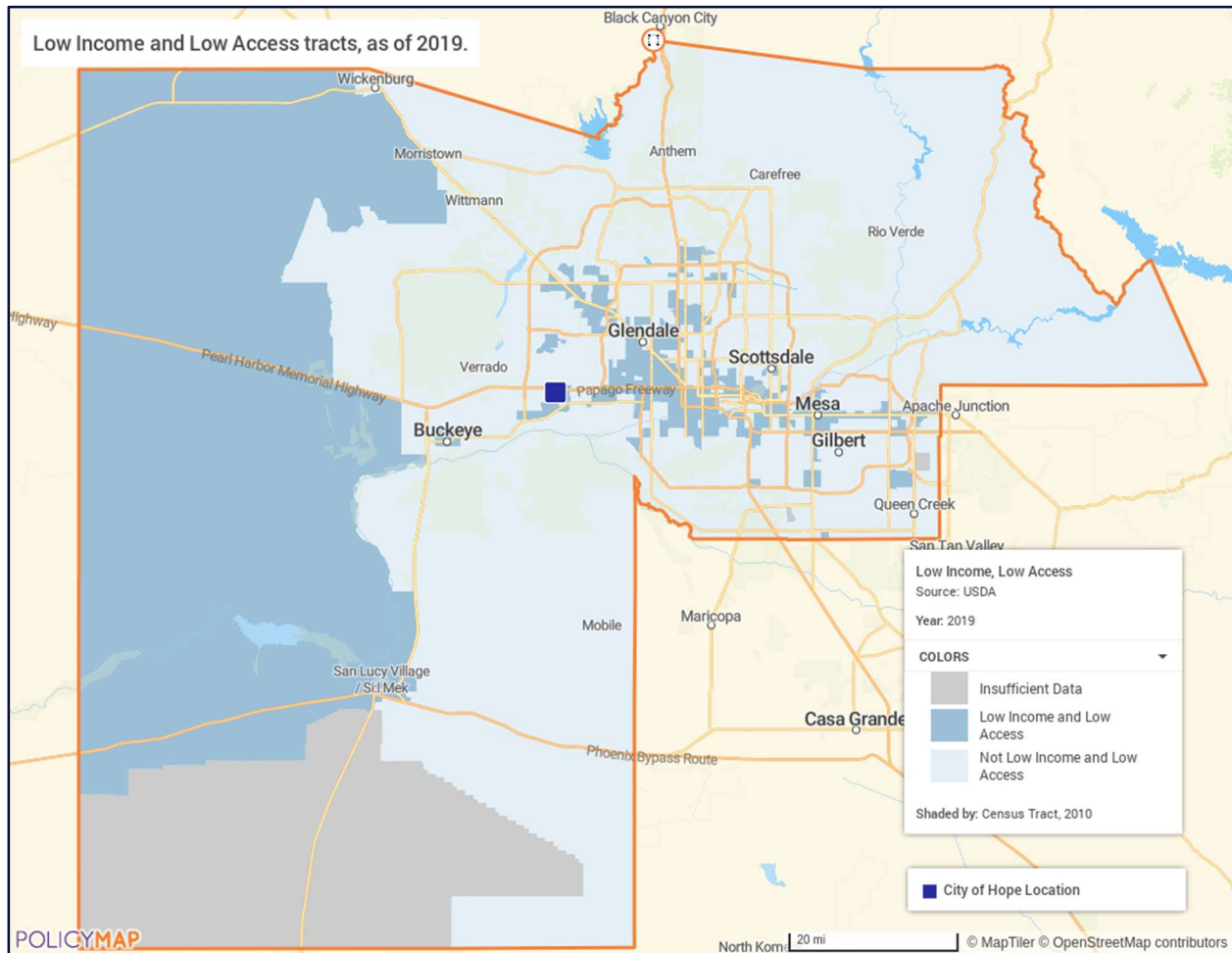
“ My daughter was furloughed from her job and needed to apply for medicaid, food stamps and unemployment. Then recently she was diagnosed with breast cancer which made things even more difficult. She's still receiving chemo treatments and will need surgery afterwards. She will not be able to start looking for a job until after she recovers from surgery but her unemployment is going to end before that. She's a single mom with 2 children and she is worried about how this diagnosis has complicated her situation. Before losing her job she would have had FMLA and her employee medical insurance. Now she will be looking for a new job under a totally different situation and additional worries. Her biggest worry now is having her unemployment run out before she is able to look for work.”

(65-74 years old, COVID-19 Impact Survey)

Rural communities who experience income inequality can face an increased likelihood of food insecurity. These financial restraints can limit the accessibility to healthy and affordable foods in these populations. Developing a better understanding of low income and low access tracts can

<sup>49</sup> Feeding America (2021). Food Insecurity among Overall (all ages) Population in Maricopa County. Retrieved from <https://map.feedingamerica.org/county/2021/overall/arizona/county/maricopa>

help local community organizations move the needle with funding and program development. “Low Income and Low Access tracts includes low-income tracts with at least 500 people or 33 percent of the population living more than 0.5 miles (in urban areas) or more than 10 miles (in rural areas) from the nearest supermarket, supercenter, or large grocery store.”<sup>50</sup> **Figure 14** displays 2019 low income and low access tracts in Maricopa County.



**Figure 14.** Low Income and Low Access Tracts in Maricopa County

**From a Community Member (2021)**

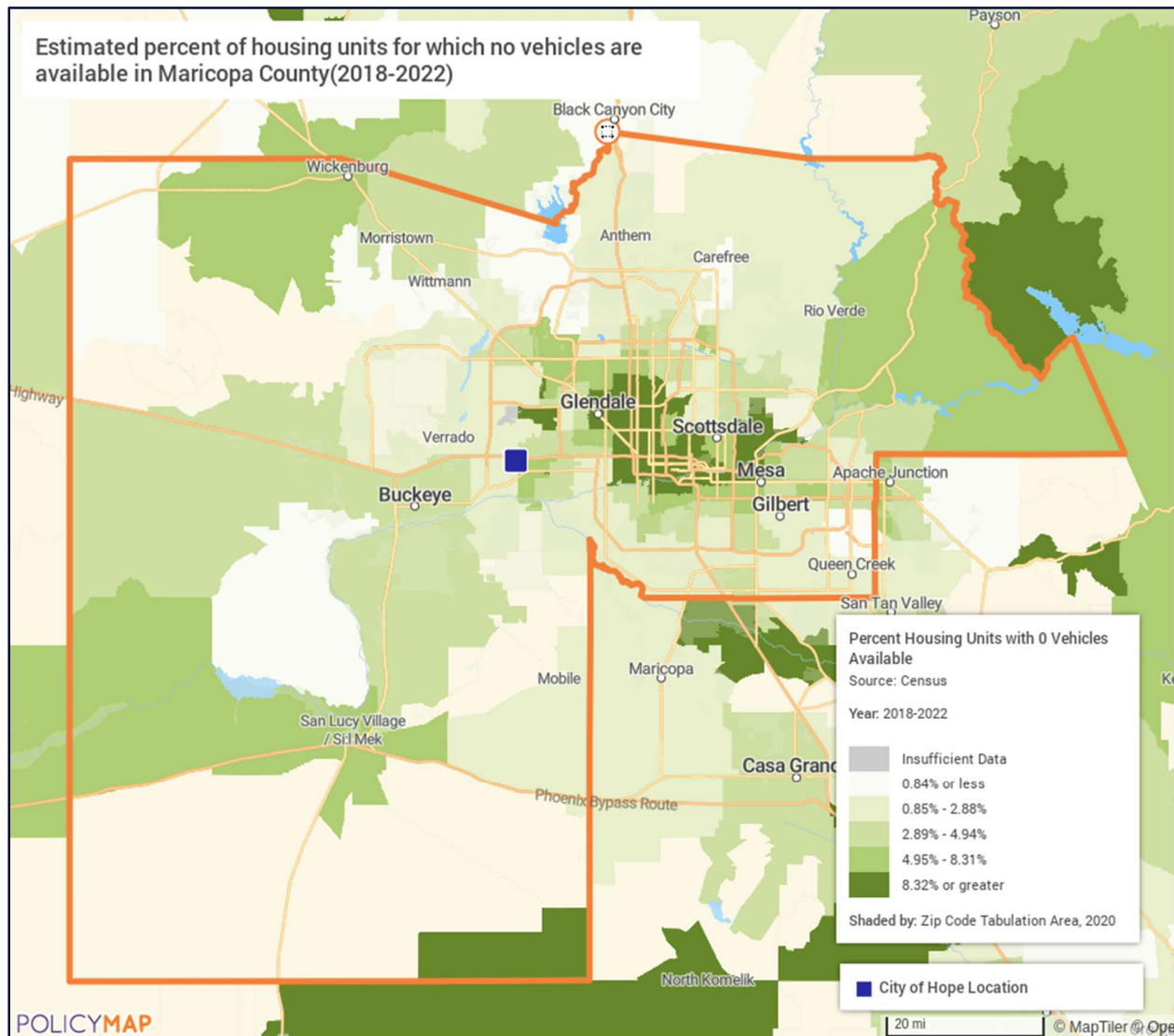
“Biggest issue: 1) Food banks were empty, very sparse, and the food items on site were expired food not fit for consumption. 2) Financial assistance not offered in Maricopa County. 3) No good paying jobs.. Cannot support self let alone a family on very limited income. 4) NO affordable housing...”

(45-54 years old, COVID-19 Impact Survey)

<sup>50</sup> See Footnote 11.

## Transportation

Transportation impacts many other determinants of health such as access to health care, jobs, grocery stores, etc. — all essential to support a healthy life. Transportation challenges impact rural and urban communities and include lack of vehicle access, inadequate infrastructure, long commutes to reach needed services, and high transportation costs.<sup>51</sup> Transportation can support or impede individual health (*e.g. increase accessibility to essential needs or contribute to missed appointments and delayed care*). Developing affordable and appropriate transportation options like walkable communities and other healthy transit options can help improve health outcomes. **Figure 15** shows the estimated percent of households with no vehicles in Maricopa County.

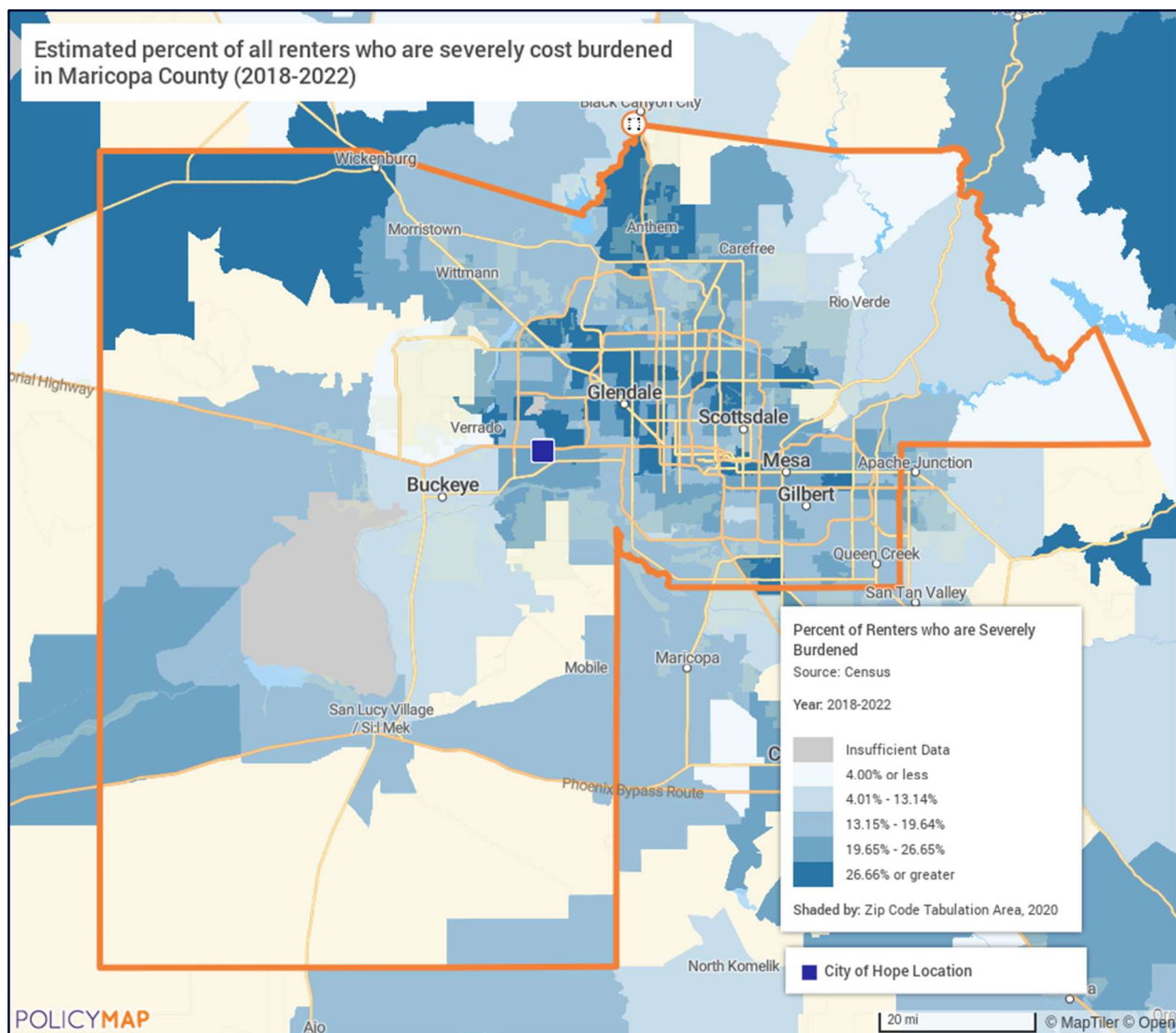


**Figure 15.** Estimated Percent of Households With No Vehicles in Maricopa

<sup>51</sup> American Hospital Association. Social Determinants of Health Series: Transportation and the Role of Hospitals. Retrieved from <https://www.aha.org/ahahret-guides/2017-11-15-social-determinants-health-series-transportation-and-role-hospitals>

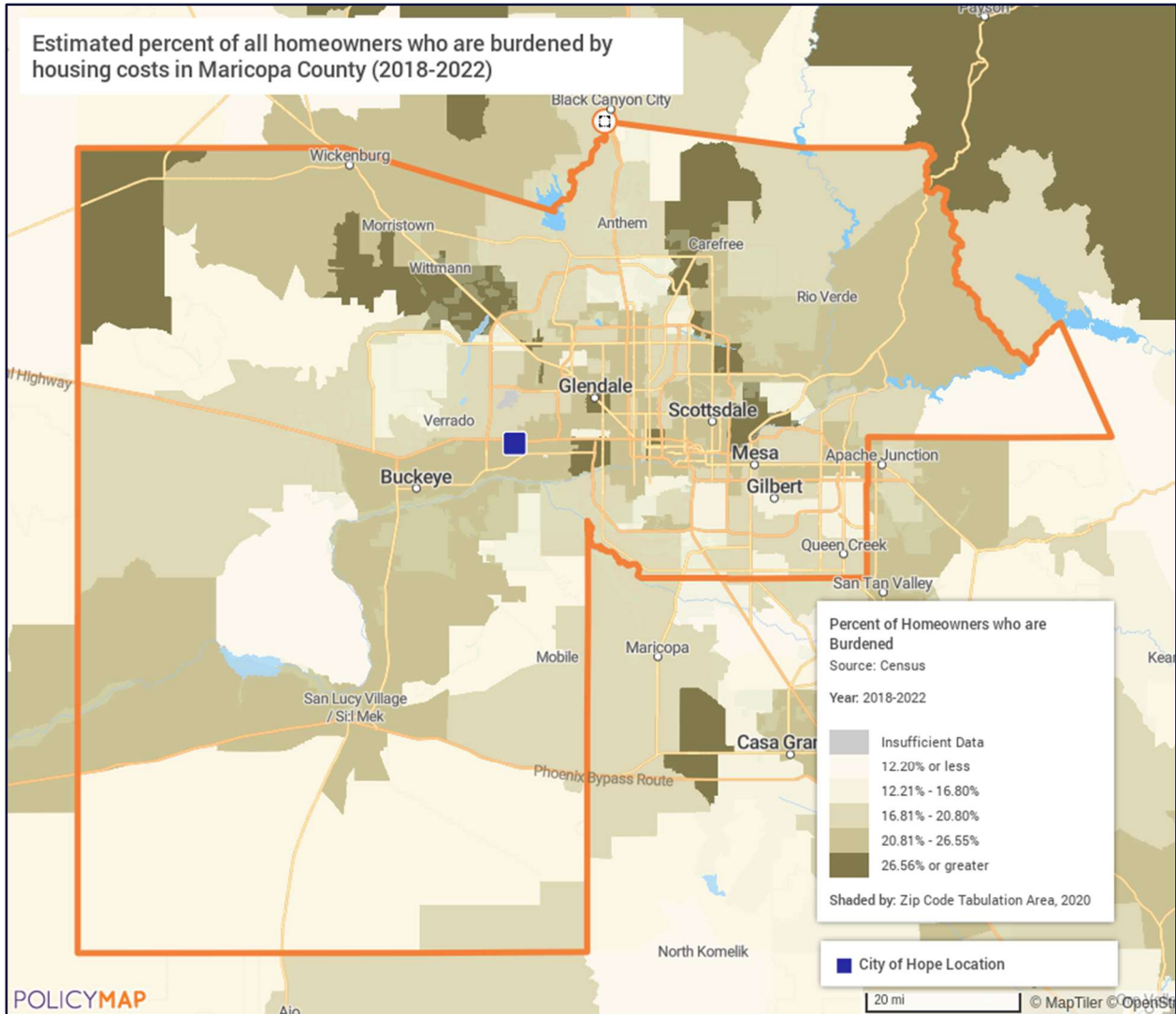
## Housing

Housing intersects with many other determinants of health such as income, employment, poverty and educational level. Increasing access to affordable housing can increase opportunities for communities to concentrate their resources on other essential needs like food and health care, which contributes to improved health outcomes. Home design and structure significantly influence housing quality and can disproportionately impact marginalized communities. Poor housing conditions, such as the presence of lead, mold or asbestos, poor air quality and overcrowding, can contribute to chronic disease and injury.<sup>52</sup> **Figures 16** and **17** display the estimated percent of all renters and homeowners who are severely cost burdened by housing costs in Maricopa County.



**Figure 16.** Estimated Percent of All Renters Who are Severely Cost Burdened by Housing Costs in Maricopa County

<sup>52</sup> Healthy People 2030. Quality of Housing. Retrieved from <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/quality-housing>



**Figure 17.** Estimated Percent of All Homeowners Who are Cost Burdened by Housing Costs in Maricopa County.

**From a Community Member (2021)**

“ I am currently homeless with my disabled veteran husband and our 7 children because affordable homes are unavailable. We lost our home because our landlord decided to sell while prices were high, and we had no protections because we paid our rent in full and on time. We have been looking for 2 months and have had no luck. This isn't right. ”

(25-34 years old, COVID-19 Impact Survey)

As housing costs and inflation for essentials such as food continue to skyrocket, more communities are experiencing housing instability and homelessness. People experiencing homelessness face greater health disparities in health and health care. The Point-in-Time (PIT) Homeless Count is an annual street and shelter count that determines the number of people

experiencing homelessness in Maricopa County during a given point in time. In 2023, 9,642 people experienced homelessness in Maricopa County (Figure 18).<sup>53</sup> Of the 9,642 people who experienced homelessness, 49% were sheltered and 51% were unsheltered. Sheltered is defined as those living in an emergency shelter, transitional housing or a safe haven program. Unsheltered is defined as those who are living in a place that is not meant for human habitation.

The ethnic breakdown of the PIT count has remained the same over the years, with a significant majority identifying as non-Hispanic or non-Latino. Figure 19 displays the race/ethnic, gender, and age breakdown of the 2023 PIT

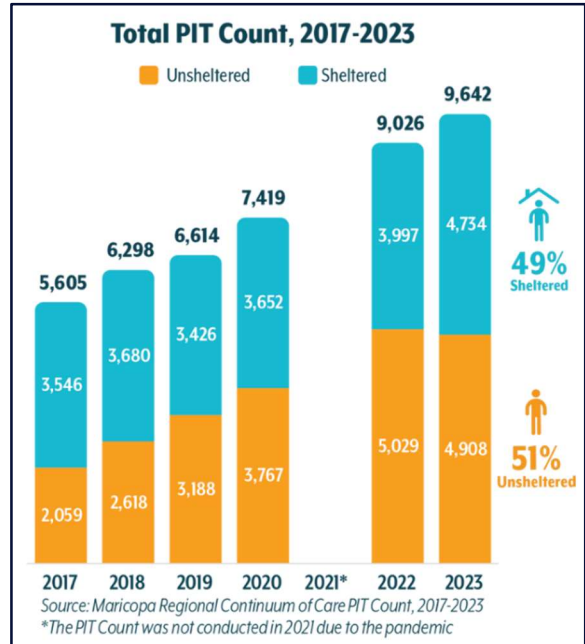


Figure 18. Total PIT Count (2017-2023)

count. Of those experiencing homelessness, 64% identified as male, 35% identified as female and 1% identified as either transgender, gender nonconforming, or questioning. The largest age group was adults 25-34 and adults 35-44, which each accounted for 21% of the PIT population.

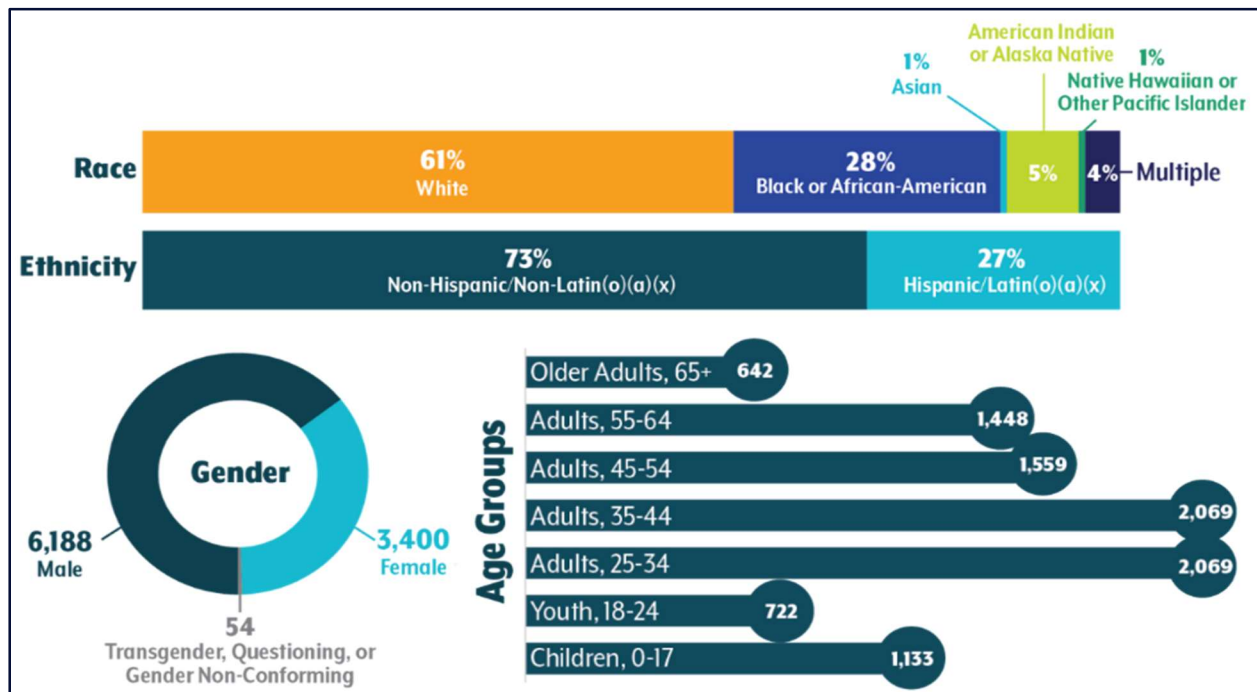



Figure 19. Total PIT Count Breakdown by Race/Ethnicity, Gender and Age

<sup>53</sup> Maricopa Association of Governments (2023). 2023 Point-in-Time (PIT) Count Report. Retrieved from [https://azmag.gov/Portals/0/Homelessness/PIT-Count/2023/2023-PIT-Count-Report-Final.pdf?ver=3to\\_Hr4cxOTZboaVUI4H3Q%3d%3d](https://azmag.gov/Portals/0/Homelessness/PIT-Count/2023/2023-PIT-Count-Report-Final.pdf?ver=3to_Hr4cxOTZboaVUI4H3Q%3d%3d)

## 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	
	<p>2-1-1</p> <p><a href="https://www.211.org/">https://www.211.org/</a>- A comprehensive source of information about local resources and services in the country.</p>
<p><b>Mental and Behavioral Illness and Substance Use</b></p>	<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>• Phoenix Indian Center - mental health services</li> <li>• Human Services Campus - mental health</li> <li>• Native American Connection - behavioral health</li> </ul> <p><b>Substance Use</b></p> <ul style="list-style-type: none"> <li>• Phoenix Indian Center - substance abuse</li> <li>• Tempe Community Action Agency - substance abuse treatment</li> <li>• Jewish Family and Children’s Service - substance abuse counseling</li> <li>• Hushabye Nursery - substance exposed babies and mothers</li> </ul>
<p><b>Chronic Disease</b></p>	<ul style="list-style-type: none"> <li>• Healthier Living Program - chronic disease education program, cooking class</li> </ul>
<p><b>Cancer</b></p>	<ul style="list-style-type: none"> <li>• Cancer Support Community of Arizona - cancer resource navigator, access to care</li> <li>• American Cancer Society</li> </ul>
<p><b>Healthy Behaviors</b></p>	<ul style="list-style-type: none"> <li>• Healthier Living Program - chronic disease education program, cooking class</li> </ul>
<p><b>Access to Health Care</b></p>	<ul style="list-style-type: none"> <li>• Chicanos Por La Causa / Keogh Health Connection - enrollment specialists, social services, economic development</li> <li>• Foundation for Senior Living - hospital discharge transition</li> <li>• Mission of Mercy - mobile clinic</li> <li>• Mountain Park Health Center - access to health care</li> <li>• Adelante Healthcare - access to health care</li> </ul>

<p><b>Social Determinants of Health</b></p>	<p><b>Housing</b></p> <ul style="list-style-type: none"> <li>• Chicanos Por La Causa - housing</li> <li>• Maggie’s Place</li> <li>• Central Arizona Shelter Services (CASS) - homeless shelter</li> <li>• Phoenix Rescue Mission - homelessness</li> <li>• Circle the City - respite care, homelessness</li> </ul> <p><b>Food Insecurity</b></p> <ul style="list-style-type: none"> <li>• St. Mary’s Food Bank - food boxes</li> <li>• St. Vincent de Paul - food boxes, food pantry</li> <li>• Creighton Community Foundation - food boxes, community gardens, food and nutrition projects</li> <li>• Phoenix Rescue Mission - food bank</li> <li>• Diana Gregory Outreach Services Foundation - mobile produce market</li> </ul>
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**Table 35.** Resources Potentially Available

City of Hope Phoenix also participates in the Health Improvement Partnership of Maricopa County — a collaborative effort between MCDPH and a diverse array of public and private organizations addressing healthy eating, active living, linkages to care, and tobacco-free living. With more than 100 partner organizations, this is a valuable resource to help City of Hope Phoenix connect to other community-based organizations that are targeting many of the same health priorities.



# Appendices

The appendix includes the following documents:

**Appendix A**

2019 and 2021 Focus Group Discussion Schedules

**Appendix B**

Primary Data Collection Tools

**Appendix C**

Comparison of 2019 and 2021 Maricopa County Community Survey Results

**Appendix D**

2019 and 2021 Community Survey Demographics

**Appendix E**

Top 10 City of Hope Phoenix IP, ED, and Death Rankings by Overall Rates

**Appendix F**

Data Indicator Matrix

## Appendix A – 2019 and 2021 Focus Group Discussion Schedules

### 2019 Focus Group Schedule

#### Cycle 1

Date	Time	Population	Location
4/8 (Mon.)	6:00pm – 8:00pm	Native American Adult Males [n = 8]	<b>Native American Fatherhood &amp; Families Association</b> (460 N. Mesa Dr, Suite 115, Mesa, AZ)
4/16 (Tues.)	10:00am – 12:00pm	Homeless Males over 60 [n = 10]	<b>St. Vincent de Paul</b> (420 W. Watkins Rd., Phoenix, AZ)
4/17 (Wed.) & 5/16 (Thurs.)	6:00pm -8:00pm & 5:30pm–7:30pm	Native American Adults [n = 17]	<b>Mesa Public Schools</b> (1025 N. Country Club, Mesa, AZ) & <b>Native Health (East Valley)</b> (777 W. Southern Ave., Building C, Mesa, AZ)
4/18 (Thurs.)	10:30am - 12:30pm	Homeless Women with Children [n = 15]	<b>UMOM</b> (3333 E. Van Buren St., Phoenix, AZ)
4/18 (Tues.)	5:30pm - 7:30pm	African American Males [n = 7]	<b>Hatton Hall</b> (34 E. 7 <sup>th</sup> St., Tempe, AZ)
4/23 (Tues.)	4:30pm - 6:30pm	LGBTQI Adults [n = 7]	<b>Southwest Center for HIV/AIDS (Parson's Center)</b> (1101 N. Central Ave, Phoenix, AZ)
4/24 (Wed.)	6:00pm – 8:00pm	Homeless Youth (14-21) [n = 7]	<b>Native American Connections/HomeBase</b> (931 E. Devonshire, Phoenix, AZ)
4/25 (Thurs.)	12:30pm- 2:30pm	Adults over 60 (New Retirees) [n = 13]	<b>Ahwatukee Foothills Family YMCA</b> (1030 E. Liberty Lane, Phoenix, AZ)
4/26 (Fri.)	10:30am- 12:30pm	New Parents [n = 7]	<b>Adelante Healthcare – WIC Office</b> (1705 W. Main St., Mesa, AZ)
4/27 (Sat.)	10:30am- 12:30pm	Homeless Veterans [n = 15]	<b>MANA House</b> (2422 W. Holly St., Phoenix, AZ)
4/29 (Mon.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [n = 9]	<b>Ignacio Conchos Elementary School</b> (1718 W. Vineyard Rd., Phoenix, AZ)
4/30 (Tues.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [SPANISH; n = 7]	<b>Ignacio Conchos Elementary School</b> (1718 W. Vineyard Rd., Phoenix, AZ)
5/4 (Sat.)	10:30am – 12:30pm	Filipino Adults [n = 8]	<b>Chandler Community Center</b> (125 E. Commonwealth Ave., Chandler, AZ)
5/14 (Tues.)	5:30pm - 7:30pm	Veterans [n = 7]	<b>Tanner Community Development Corporation</b> (700 E. Jefferson St., Phoenix, AZ)
5/16 (Wed.)	8:30am- 10:30am	New Parents [SPANISH; n = 11]	<b>Moon Mountain Elementary School</b> (13425 N. 19 <sup>th</sup> Ave, Phoenix, AZ)

## Cycle 2

Date	Time	Population	Location
4/8 (Mon.)	6:00pm – 8:00pm	Native American Adult Males [n = 8]	<b>Native American Fatherhood &amp; Families Association</b> (460 N. Mesa Dr, Suite 115, Mesa)
4/16 (Tues.)	10:00am – 12:00pm	Homeless Males over 60 [n = 10]	<b>St. Vincent de Paul</b> (420 W. Watkins Rd., Phoenix)
4/17 (Wed.) & 5/16 (Thurs.)	6:00pm -8:00pm & 5:30pm-7:30pm	Native American Adults [n = 17]	<b>Mesa Public Schools</b> (1025 N. Country Club, Mesa, AZ) & <b>Native Health (East Valley)</b> (777 W. Southern Ave., Mesa)
4/18 (Thurs.)	10:30am - 12:30pm	Homeless Women with Children [n = 15]	<b>UMOM</b> (3333 E. Van Buren St., Phoenix)
4/18 (Tues.)	5:30pm - 7:30pm	African American Males [n = 7]	<b>Hatton Hall</b> (34 E. 7 <sup>th</sup> St., Tempe)
4/23 (Tues.)	4:30pm - 6:30pm	LGBTQI Adults [n = 7]	<b>Southwest Center for HIV/AIDS (Parson's Center)</b> (1101 N. Central Ave, Phoenix)
4/24 (Wed.)	6:00pm – 8:00pm	Homeless Youth (14-21) [n = 7]	<b>Native American Connections/HomeBase</b> (931 E. Devonshire, Phoenix, AZ)
4/25 (Thurs.)	12:30pm- 2:30pm	Adults over 60 (New Retirees) [n = 13]	<b>Ahwatukee Foothills Family YMCA</b> (1030 E. Liberty Lane, Phoenix)
4/26 (Fri.)	10:30am- 12:30pm	New Parents [n = 7]	<b>Adelante Healthcare – WIC Office</b> (1705 W. Main St., Mesa)
4/27 (Sat.)	10:30am- 12:30pm	Homeless Veterans [n = 15]	<b>MANA House</b> (2422 W. Holly St., Phoenix, AZ)
4/29 (Mon.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [n = 9]	<b>Ignacio Conchos Elementary School</b> (1718 W. Vineyard Rd., Phoenix, AZ)
4/30 (Tues.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [SPANISH; n = 7]	<b>Ignacio Conchos Elementary School</b> (1718 W. Vineyard Rd., Phoenix, AZ)
5/4 (Sat.)	10:30am – 12:30pm	Filipino Adults [n = 8]	<b>Chandler Community Center</b> (125 E. Commonwealth Ave., Chandler, AZ)
5/14 (Tues.)	5:30pm - 7:30pm	Veterans [n = 7]	<b>Tanner Community Development Corporation</b> (700 E. Jefferson St., Phoenix, AZ)
5/16 (Wed.)	8:30am- 10:30am	New Parents [SPANISH; n = 11]	<b>Moon Mountain Elementary School</b> (13425 N. 19 <sup>th</sup> Ave, Phoenix, AZ)

### Cycle 3

Date	Time	Population	Location
<b>10/16 (Wed.)</b>	1:00 pm – 3:00 pm	Native Americans - Young adults (19-24)	<b>ASU Discovery Hall</b> 250 E Lemon St. Tempe 85281
<b>10/17 (Thurs.)</b>	10:00 am – 12:00 pm	Immigrants/Refugee/Asylum Seekers - Congolese	<b>IRC</b> 4425 W Olive #400 Glendale 85302
<b>10/17 (Thurs.)</b>	1:30 pm – 3:30 pm	Asian Americans - South and southeast Asia [n = 29]	<b>Asian Pacific Community in Action-IACRF Hall</b> 2809 W Maryland Phoenix 85017
<b>10/22 (Tues)</b>	4:00 pm – 6:00 pm	LGBTQ - Young adults (19-24)	<b>One.n.ten</b> 931 #202 Phoenix 85004
<b>10/28 (Mon.)</b>	11:00 am – 1:00 pm	Homeless - Young adults (19- 24)	<b>Homebase</b> 931 E Devonshire Phoenix 85014
<b>11/1 (Sat.)</b>	1:00 pm – 3:00 pm	Youth Focus Groups (14 - 18) - African Americans 1	<b>Ironwood Library</b> 4333 E Chandler Phoenix 85048
<b>11/5 (Tues.)</b>	10:00 am – 12:00 pm	Adults over 65 - Hispanic/Latino [n = 6]	<b>Gila Bend Family Resource Center</b> 303 E Pima St, Gila Bend, AZ 85337
<b>11/6 (Wed.)</b>	5:30 pm – 7:30 pm	People Living with Special Healthcare Needs - Parents/caregivers	<b>Sunset Library</b> 4930 W Ray, Chandler
<b>11/7 (Thurs.)</b>	12:00 pm – 2:00 pm	Adults over 65 - African Americans [n = 12]	<b>Muriel Smith Center</b> 2230 W Roeser Rd, Phoenix 85041
<b>11/7 (Thurs.)</b>	5:00 pm – 7:00 pm	African Americans- Young adults (19-24) [n = 4]	<b>Muriel Smith Center</b> 2230 W Roeser Rd, Phoenix 85041
<b>11/12 (Wed.)</b>	5:00 pm – 7:00 pm	Youth Focus Groups (14-18) - Homeless	<b>UMOM</b> 2344 E Earll Drive
<b>11/13 (Wed.)</b>	8:30 am – 10:30 am	Youth Focus Groups (14 - 18) - Hispanic	<b>Natalie's room North High School</b> 1101 E Thomas Phoenix 85014
<b>11/13 (Wed.)</b>	4:00 pm – 6:00 pm	People who have been previously incarcerated – combined	<b>Black Canyon building</b> 2445 W Indianola
<b>11/13 (Wed.)</b>	5:00 pm – 7:00 pm	Youth Focus Groups (14 - 18) - Native American	<b>Seewa Tomteme Community Center</b> 8066 S Avenida del Yaqui Guadalupe 85283

2021 Focus Group Schedule

FG#	Date	Region	Group (Location/provider)	Number
1	2/16/2021	SE	I-HELP Chandler	8
2	2/17/2021	Central	Native Health- Phoenix	8
3	2/18/2021	NE	Paiute - South Scottsdale	4
4	2/18/2021	SE	Native Health - Mesa	5
5	2/25/2021	NW	Sun Health - NW Valley	5
6	3/02/2021	NW	Sun Health - NW Valley	5
7	3/10/2021	South Central	South Mountain	6
8	3/12/2021	NW	Family Resource Center –English	6
9	3/19/2021	NW	Family Resource Center-Spanish	5
10	3/24/2021	SW	Gila Bend - English	8
11	3/26/2021	SW	Gila Bend - Spanish	6
12	3/29/2021	NE	Paiute, S. Scottsdale – Spanish - 9am	8
13	3/29/2021	NE	Paiute, S. Scottsdale – Spanish -11:30	6
14	3/30/2021	South Central	South Phoenix (AA/Black)	6
15	4/07/2021	SE	Gilbert - AZCEND Moms Club Gilbert	6
16	4/26/2021	South Central	S Phoenix Young Parents	5
17	5/10/2021	SE	African American/Black Women 85048	5
18	5/12/2021	South Central	Parents w/minors living home 85041	4
19	5/14/2021	*	Asian Americans 65+	8
20	5/16/2021	NW	Parents of Young Children 85086	4
21	5/17/2021	*	Hispanic/Latino Men	6
22	5/17/2021	*	Asian Americans	7
23	5/20/2021	*	Racial/Ethnic Minority Young Adults	7
24	5/27/2021	*	Guadalupe	6
25	6/01/2021	*	LGBTQIA+ Community Members	3
26	6/02/2021	*	Veterans	5
27	6/04/2021	*	Parents with Young Children	8
28	6/07/2021	*	Expectant Mothers & Parents of Young Children	5
29	6/08/2021	*	Young Adults	5
30	6/09/2021	*	Seniors & Veterans	2
31	6/11/2021	*	Central Phoenix residents	10
32	6/14/2021	*	Immigrants - Spanish	4
33	6/14/2021	*	Refugees - Advocates	4
<b>Total Participants</b>				<b>186</b>

\* Community members participated from various regions of Maricopa County

## **Appendix B – Primary Data Collection Tools**

### **2019 Coordinated Community Health Needs Assessment Focus Group Questions**

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

#### **Opening Question (5 minutes)**

To begin, why don't we go around the table and say your name (or whatever you would like us to call you) and what community event brings everybody out? (such as: festival, school play, sporting event, parade; what brings all the people together for fun)

#### **General Community Questions (15 minutes)**

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

1. What does quality of life mean to you?
2. What makes a community healthy?
3. When thinking about health, what are the greatest strengths in your community?
4. What makes people in the community healthy?
  - a. Why are these people healthier than those who have (or experience) poor health?

#### **Community Health Concerns (15 minutes)**

Next, let's discuss any health issues you have in your community.

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

[Prompt – ask this if it does not come up naturally]

- i. What are the biggest health problems/conditions in your community?
- ii. Do other communities in this area have the same health problems?

6. A) What makes it hard to access health care for people in your community?

[Prompt – ask this if it does not come up naturally]

- i. Are there any cost issues that keep you from caring for your health? (such as copays or high-deductible insurance plans)
- ii. If you are uninsured, do you experience any barriers to becoming insured?
- iii. If you do not regularly seek care, are there provider concerns that keep you from caring for your health? (prompt – ask if there are concerns about providers not identifying with them)

- B) How do these barriers affect the health of your community? Your family? Children? You?

7. For this question, think about the last year. Was there a time when you or someone in your family needed to see a doctor but could not? Did anything keep you from going?

### **Community Health Recommendations (15 minutes)**

As the experts in your community, I would like to spend this final part of the focus group discussion talking about your ideas to improve community health.

8. What are some ideas you have to help your community get or stay healthy? To improve the health and quality of life?
9. A) What else do you (your family, your children) need to maintain or improve your health?

[Prompt – ask this if it does not come up naturally]

- i. Services, support or information to manage a chronic condition or change health behaviors such as smoking, eating habits, physical activity, or substance use
- ii. Preventative services such as flu shots, screenings or immunizations
- iii. Specialty healthcare services or providers (such as heart doctors or dermatologists)

B) What health services do you or your family need that aren't in your community?

10. What resources does your community have/use to improve your health?

[Prompt – ask this if it does not come up naturally]

- i. Why do you use these particular services or supports?

### **Ending Question (5 minutes)**

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

### **Facilitator Summary and Closing Comments (5-10 minutes)**

Let's take a few minutes to reflect on responses you provided today. We will review the notes we took and the themes we observed. This is your opportunity to clarify your thoughts or to provide alternative responses. [Co-facilitator provides a brief summary of responses for each of the questions or asks clarifying questions if she thinks she may have missed something.]

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

## **2021 COVID-19 Focus Group Questions**

### **A. Information about COVID-19**

Let's start our conversation about how COVID-19 has affected you and your family.

1. How has COVID-19 affected you and your family?
2. What do people close to you (e.g., your family/friends) say about the COVID-19 vaccine?
  - a. What about your neighbors? Faith/religious leaders or faith community?
  - b. PROBE: And what about schools (if applicable)? Colleagues? Employers? Medical professionals? How has COVID-19 affected you differently because of your race/ethnicity or ethnicity?
3. Where have you seen information about the COVID-19 vaccine?
  - a. PROBE: Word of mouth? TV? Radio? Social media (e.g., Facebook, Twitter, text message sources)? Online sources?
  - b. Where are some places you've noticed health messages in general?
    - i. PROBE: Grocery store? Shopping stores (e.g., Walmart, Costco, Walgreens, CVS)? Doctor's office? Health clinic? Community/faith-based organization? Other?
  - c. What kind of messaging are you seeing? What do you think of these messages? Do you think they reach Arizona's communities?
4. Who do you trust and/or rely on information or updates about the COVID-19 vaccine?
  - a. PROBE: Why do you trust this person/s?
  - b. PROBE: Who don't you trust? Why?
5. Is there anything about COVID-19 or vaccine that you want to know more about?
  - a. PROBE: Why would you like to know this information?
  - b. PROBE: How would you like to receive this information?
  - c. PROBE: Language preference? Radio? TV? Pamphlets?
6. Where do you usually go to get health care or for your health needs?
  - a. PROBE: Urgent care? Hospital/ER? Clinic? Telehealth?
7. What thoughts do you have on preventing COVID-19?
  - a. Where did you get that information?

### **B. Intent to get vaccinated against COVID-19**

The following questions are about your intentions to get vaccinated against COVID-19 when a vaccine becomes available to the general public.

1. What do you think about a COVID-19 (Pfizer vaccine? Moderna? Johnson and Johnson)?
  - a. PROBE: What are some reasons you think that (about each)?
2. What are some reasons why you and/or your family did/ would get vaccinated for COVID-19?
  - a. PROBE: Where would you go?
3. What concerns do you have about getting vaccinated for COVID-19?

- a. **\*\*NOTE:** List concerns and probe – ex. “I don’t know what is in the vaccine?” ASK: What do you think is in it? What have you heard?
  - b. **PROBE:** What concerns do you have about elders getting vaccinated for COVID19? Children?
4. In your opinion, what barriers do you think there may be to get vaccinated against COVID-19 (e.g., cost)?  
**PROBE:** perhaps you’ve already had the vaccine?
5. What challenges do you, your family, and/or your community have in getting the COVID19 vaccine?

### **C. Communication and Messaging**

Now let’s discuss communication about COVID-19 and messaging.

1. What information would your reluctant family/friends need before getting the vaccine?
2. What are some ways we can communicate updates on “COVID-19 vaccines and research information” specifically to [BLACK, INDIGENOUS, HISPANIC/LATINO] communities?
  - a. **PROBE:** What are some things that may work?
3. What ways could community leaders build and maintain trust with your community [or BLACK, INDIGENOUS, HISPANIC/LATINO] communities?
4. What kind of messaging would you or your community need to know the vaccine is safe?
5. Do you think COVID has affected different groups of people differently? (Why do you think this is and how do you think we could we improve this situation?)

### **D. FINAL WRAP UP QUESTION**

1. At this time, what do you and your family need to maintain or improve your health?
2. Is there anything else related to the topics we discussed today that you think I should know that I didn’t ask or that you have not yet shared?

## **2019 Maricopa County Community Health Needs Assessment Survey**

The purpose of this brief survey is to get your opinion about issues related to community health and quality of life here in Maricopa County. Information collected in this survey will be kept confidential and used only in combination with others participating in the survey. No personal identifying information will be collected. Your feedback will be used to help guide future community health improvement planning efforts. Thank you for supporting your community. This survey should take about 10 minutes. If you have questions about the survey or need it provided in an alternative format, please visit <http://www.MaricopaHealthMatters.org>.

*In this survey, “community” is defined as the areas where you work, live, learn and/or play.*

**1. In general, how would you rate your physical health?**

Poor                      Fair                      Good                      Very Good                      Excellent

**2. How would you rate your mental health, including your mood, stress level, and your ability to think?**

Poor                      Fair                      Good                      Very Good                      Excellent

**3. How often are you able to get the services you need to maintain your mental health?**

Never                                      Sometimes                                      Always

**4. On a monthly basis, do you have enough money to pay for essentials such as food, clothing and housing?**

Never                                      Sometimes                                      Always

**5. In your community, do people trust one another and look out for one another?**

Never                                      Sometimes                                      Always

**6. On a monthly basis, do you have enough money to pay for health care expenses (e.g. doctor bills, medications, etc.)?**

Never                                      Sometimes                                      Always

**7. How do you pay for your health care (including medications, dental and health treatments)? (Check all that apply.)**

- |   |  |
|---|--|
| <input type="checkbox"/> Health insurance purchased on my own or by family member | <input type="checkbox"/> Medicare  |
| <input type="checkbox"/> Health Insurance purchased / provided through employer   | <input type="checkbox"/> Travel to a different country to afford health care |
| <input type="checkbox"/> I do not use health care services                        | <input type="checkbox"/> Use free clinics                                    |
| <input type="checkbox"/> Indian Health Services                                   | <input type="checkbox"/> Use my own money (out of pocket)                    |
| <input type="checkbox"/> Medicaid/AHCCCS  | <input type="checkbox"/> Veterans Administration                             |
|   | <input type="checkbox"/> Other: _____  |

**8. What are the biggest barriers to accessing healthcare in your community? (Check up to 3.)**

- Childcare
- Difficulty finding the right provider for my care
- Distance to provider
- Inconvenient office hours
- Other: \_\_\_\_\_
- No health insurance coverage
- Not enough health insurance coverage
- Transportation to appointments
- Understanding of language, culture, or sexual orientation differences

**9. What are the greatest strengths of your community? (Check all that apply.)**

- Ability to communicate with city/town leadership and feel that my voice is heard
- Accepting of diverse residents and cultures
- Access to affordable after school activities
- Access to affordable childcare
- Access to affordable healthy foods
- Access to affordable housing
- Access to community classes and trainings
- Access to cultural events
- Access to fitness programs
- Access to good schools
- Access to jobs & healthy economy
- Access to medical care
- Access to mental health services
- Access to parks and recreation sites
- Access to public libraries and community centers
- Access to public transportation
- Access to religious or spiritual events
- Access to safe walking and biking routes
- Access to services for seniors
- Access to social services for residents in need or crisis
- Access to substance abuse treatment services
- Access to support networks such as neighbors, friends and family
- Clean environments and streets
- Good place to raise children
- Low crime/safe neighborhoods
- Other: \_\_\_\_\_

**10. Which health conditions have the greatest impact on your community's overall health and wellness? (Check up to 5.)**

- Alcohol/Substance abuse
- Anorexia/bulimia and other eating disorders
- Arthritis
- Autism
- Cancers
- Chronic stress
- Chronic Pain
- Dementia/Alzheimer's
- Dental problems (oral health)
- Diabetes
- Food allergies/anaphylaxis
- Heart disease and stroke
- High blood pressure or cholesterol
- HIV/AIDS
- Lung disease (asthma, COPD, emphysema)
- Vaccine preventable disease such as flu, measles, and pertussis (whooping cough)
- Mental health issues (depression, anxiety, bipolar, etc.)
- Overweight/obesity
- Sexually transmitted diseases
- Suicide
- Tobacco use including vaping
- Other: \_\_\_\_\_





## 2021 COVID-19 Impact Community Health Survey

The purpose of this brief survey is to get your opinion about COVID-19’s impact on community health and quality of life in Maricopa County since March of 2020. Information collected in this survey will be kept confidential and used only in combination with others participating in the survey. No personal identifying information will be collected. Your feedback will be used to help guide future community health improvement planning and funding efforts. This survey should take about 15 minutes. If you have questions about the survey or need it provided in an alternative language or format, please email [Tiffany.Tu@maricopa.gov](mailto:Tiffany.Tu@maricopa.gov) and we will do our best to accommodate.

The following information is used for demographic purposes and does NOT identify you; all responses are confidential. To learn more about why CHNAs are important, please visit <https://www.cdc.gov/publichealthgateway/cha/plan.html>.

1. What is the ZIP code that you currently reside in? \_\_\_\_\_

2. What is your gender?

<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Transgender	<input type="checkbox"/> Prefer to self-describe	<input type="checkbox"/> Prefer not to answer
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3. What is your age range?

<input type="checkbox"/> 12-17	<input type="checkbox"/> 18-24	<input type="checkbox"/> 25-34	<input type="checkbox"/> 35-44
<input type="checkbox"/> 45-54	<input type="checkbox"/> 55-64	<input type="checkbox"/> 65-74	<input type="checkbox"/> 75+

4. Which racial and/or ethnic group do you identify with? (Check no more than two)

<input type="checkbox"/> African American/Black	<input type="checkbox"/> American Indian/Native American	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latinx
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Prefer not to answer

5. Which group(s) do you most identify with? (check all that apply)

<input type="checkbox"/> Adult with children under age 18 or living in the same home	<input type="checkbox"/> Single parent	<input type="checkbox"/> LGBTQI	<input type="checkbox"/> Person experiencing homelessness
<input type="checkbox"/> Person living with a disability	<input type="checkbox"/> Immigrant	<input type="checkbox"/> Refugee	<input type="checkbox"/> Veteran
<input type="checkbox"/> Person living with HIV/AIDS	<input type="checkbox"/> Other	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> None

6. What range is your household income?

<input type="checkbox"/> Less than \$20,000	<input type="checkbox"/> \$20,000 - \$29,000	<input type="checkbox"/> \$30,000 - \$49,000
<input type="checkbox"/> 50,000 - \$74,000	<input type="checkbox"/> \$75,000 - \$99,999	<input type="checkbox"/> Over \$100,000
<input type="checkbox"/> Prefer not to answer		

**7. What is the highest level of education you have completed?**

<input type="checkbox"/> Less than a high school graduate	<input type="checkbox"/> High school diploma or GED	<input type="checkbox"/> Some College or Associate degree (2yr)	<input type="checkbox"/> Graduate of vocational/trade school
<input type="checkbox"/> Currently enrolled in college	<input type="checkbox"/> Bachelor’s Degree (4yr)	<input type="checkbox"/> Postgraduate Degree	<input type="checkbox"/> Other
<input type="checkbox"/> Prefer not to answer			

In this survey, “community is defined as the areas where you work, live, learn and/or play.

**8. Since March of 2020 (the start of the COVID-19 pandemic), how would you rate your physical health?**

Excellent	Very Good	Good	Fair	Poor
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**9. Would you rate your current physical health as Better, Similar, or Worse compared to your physical health prior to March of 2020?**

Better	Similar	Worse
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**10. Since March of 2020 (the start of the COVID-19 pandemic), how would you rate your mental health, including your mood, stress level, and your ability to think?**

Excellent	Very Good	Good	Fair	Poor
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**11. Would you rate your current mental health as Better, Similar, or Worse compared to your mental health prior to March 2020?**

Better	Similar	Worse
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**12. Since March of 2020 (the start of the COVID-19 pandemic), if you sought services to address your mental health, including your mood, stress level and/or your ability to think, how often have you been able to get the services you need?**

Always	Sometimes	Never	Not Applicable
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**13. What services would have improved overall mental and physical health of your family in the last year? (check all that apply)**

<input type="checkbox"/> Childcare services	<input type="checkbox"/> In-person school	<input type="checkbox"/> Technology and internet service	<input type="checkbox"/> Assistance with finding employment
<input type="checkbox"/> Assistance with paying utilities	<input type="checkbox"/> Assistance with paying rent	<input type="checkbox"/> Assistance with finding healthcare	<input type="checkbox"/> Assistance with finding substance use treatment
<input type="checkbox"/> Assistance with mental health issues	<input type="checkbox"/> Assistance with finding COVID-19 vaccine	<input type="checkbox"/> Other	

**14. Since March of 2020, have you had enough money to pay for essentials such as:**

Food	Always	Sometimes	Never	N/A
Housing: Rent/Mortgage	Always	Sometimes	Never	N/A
Utilities	Always	Sometimes	Never	N/A
Car/Transportation	Always	Sometimes	Never	N/A
Insurance	Always	Sometimes	Never	N/A
Clothing/Hygiene Products	Always	Sometimes	Never	N/A
Medication/Treatments	Always	Sometimes	Never	N/A
Childcare	Always	Sometimes	Never	N/A
Tuition or Student Loans	Always	Sometimes	Never	N/A

**15. Since March of 2020, have you applied for any of the following financial assistance due to the impact of the COVID-19 pandemic to assist with the essential cost of living expenses listed above?**

COVID-19 Relief Funding for You/Family	Yes	No
COVID-19 Relief Funding for your business	Yes	No
Unemployment due to loss of job (laid off)	Yes	No
Unemployment due to staying home to care for children, elderly parents, or ill family members	Yes	No
Unemployment due to COVID-19 illness (self)	Yes	No
WIC (Women, Infant, and Children)	Yes	No
SNAP Food Stamps	Yes	No
Medicaid Insurance	Yes	No

**16. Since March of 2020, how often did you seek financial assistance to help pay for healthcare expenses (e.g. doctor bills, medications, medical treatments, doctor co-pay, etc.)**

Always	Sometimes	Never	N/A
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**17. If you received a stimulus check in the fall of 2020 and spring of 2021, what impact did this have on alleviating your essential living expenses and access to healthcare?**

Strong Impact	Moderate Impact	Weak Impact	No Impact/No difference	Did Not Receive
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**18. Since March of 2020, was your employment impacted due to the COVID 19 pandemic? (check all that apply)**

<input type="checkbox"/> No, continued working the same number of hours	<input type="checkbox"/> No, required to continue working onsite	<input type="checkbox"/> Yes, work hours were reduced	<input type="checkbox"/> Yes, required to telework
<input type="checkbox"/> Yes, furloughed (temporary job loss, able to return to work once management contacts you)	<input type="checkbox"/> Yes, laid off	<input type="checkbox"/> Yes, quit to care for children due to school closure	<input type="checkbox"/> Yes, quit to care for ill family members
<input type="checkbox"/> Yes, <u>quit</u> due to COVID-19 illness (self)	<input type="checkbox"/> Yes, unable to return to work due to COVID-19 illness (long-term effects)	<input type="checkbox"/> Yes, started a new job	<input type="checkbox"/> Other: _____

**19. Since March of 2020, how do you currently pay for your healthcare including medications, dental, and health treatments? (check all that apply)**

<input type="checkbox"/> Health insurance purchased on my own or by family member	<input type="checkbox"/> Health insurance provided through employer	<input type="checkbox"/> Indian Health Services	<input type="checkbox"/> Medicaid/AHCCCS
<input type="checkbox"/> Medicare	<input type="checkbox"/> Use free clinics	<input type="checkbox"/> Use my own money (out of pocket)	<input type="checkbox"/> <u>Veterans</u> administration
<input type="checkbox"/> Did not seek healthcare since March of 2020	<input type="checkbox"/> Other: _____		

**20. Since March of 2020, what have been the primary barriers to seeking or accessing healthcare in your community? (check all that apply)**

<input type="checkbox"/> Lack of childcare	<input type="checkbox"/> Difficulty finding the right provider for my care	<input type="checkbox"/> Fear of exposure of COVID-19 in a healthcare setting	<input type="checkbox"/> Unsure if healthcare need is a priority during this time
<input type="checkbox"/> Distance to provider	<input type="checkbox"/> Inconvenient office hours	<input type="checkbox"/> No health insurance coverage	<input type="checkbox"/> Not enough health insurance coverage
<input type="checkbox"/> Transportation to appointments	<input type="checkbox"/> Understanding of language, culture, or sexual orientation differences	<input type="checkbox"/> I have not experienced any barriers	<input type="checkbox"/> Other: _____

**21. Since March of 2020, what have been the greatest strengths of your community? (check all that apply)**

<input type="checkbox"/> Ability to communicate with city/town leadership and feel that my voice is heard	<input type="checkbox"/> Accepting of diverse residents and cultures	<input type="checkbox"/> Access to schools or school alternatives	<input type="checkbox"/> Access to affordable childcare
<input type="checkbox"/> Access to affordable healthy foods	<input type="checkbox"/> Access to COVID-19 testing events	<input type="checkbox"/> Access to cultural & educational events	<input type="checkbox"/> Access to medical care
<input type="checkbox"/> Access to affordable housing	<input type="checkbox"/> Access to COVID-19 vaccine events	<input type="checkbox"/> Access to quality online school options	<input type="checkbox"/> Access to mental health services
<input type="checkbox"/> Access to community programming such as classes & trainings	<input type="checkbox"/> Access to Flu vaccine events	<input type="checkbox"/> Access to jobs & healthy economy	<input type="checkbox"/> Access to parks and recreation sites
<input type="checkbox"/> Access to public libraries and community centers	<input type="checkbox"/> Access to safe walking and biking routes	<input type="checkbox"/> Access to substance abuse treatment services	<input type="checkbox"/> Access to low crime / safe neighborhoods
<input type="checkbox"/> Access to public transportation	<input type="checkbox"/> Access to services for seniors	<input type="checkbox"/> Access to support networks such as neighbors, friends, and family	
<input type="checkbox"/> Access to religious or spiritual events	<input type="checkbox"/> Access to social services for residents in need or crisis	<input type="checkbox"/> Access to clean environments and streets	<input type="checkbox"/> Other: _____

**22. Since March of 2020, in addition to COVID-19, which health conditions have had the greatest impact on your community’s overall health and wellness? (check all that apply)**

<input type="checkbox"/> Alcohol/Substance abuse	<input type="checkbox"/> Cancers	<input type="checkbox"/> Dementia/Alzheimer’s	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease and stroke	<input type="checkbox"/> High blood pressure or cholesterol	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Lung disease (asthma, COPD, emphysema)
<input type="checkbox"/> Vaccine preventable disease such as flu, measles, and pertussis (whooping cough)	<input type="checkbox"/> Mental health issues (depression, anxiety, bipolar, etc)	<input type="checkbox"/> Overweight/ obesity	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Tobacco use including vaping	<input type="checkbox"/> Other: _____		

**23. Since March of 2020, which of the following issues have had the greatest impact on your community's health and wellness? (check all that apply)**

<input type="checkbox"/> Child abuse/elder abuse & neglect	<input type="checkbox"/> Distracted driving (such as cell phone use, texting while driving)	<input type="checkbox"/> Domestic violence / sexual assault	<input type="checkbox"/> Gang-related violence
<input type="checkbox"/> Gun-related injuries	<input type="checkbox"/> Limited/lack of access to COVID19 testing	<input type="checkbox"/> Lack of affordable healthy food options	<input type="checkbox"/> Lack of people immunized to prevent disease
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Limited access to healthcare	<input type="checkbox"/> Lack of affordable housing	<input type="checkbox"/> Lack of public transportation
<input type="checkbox"/> Drug/substance abuse (illegal & prescribed)	<input type="checkbox"/> Limited access to mental/behavioral health services	<input type="checkbox"/> Lack of jobs	<input type="checkbox"/> Lack of quality and affordable childcare
<input type="checkbox"/> Lack of COVID-19 vaccine access	<input type="checkbox"/> Limited access to educational and supportive programming for children and adolescents	<input type="checkbox"/> Lack of alternative educational opportunities	<input type="checkbox"/> Lack of safe spaces to exercise and be physically active
<input type="checkbox"/> Lack of support networks such as neighbors, friends, and family	<input type="checkbox"/> Motor vehicle & motorcycle crash injuries	<input type="checkbox"/> Racism/ discrimination	<input type="checkbox"/> Suicide
<input type="checkbox"/> Teen Pregnancy	<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**24. Overall, how easy was it to navigate this electronic survey?**

<input type="checkbox"/> Very easy to use	<input type="checkbox"/> Easy to use	<input type="checkbox"/> Neither easy nor difficult to use	<input type="checkbox"/> Difficult to use	<input type="checkbox"/> Very difficult to use
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**25. Based on the given survey questions above, the information provided was easy to understand.**

<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Agree	<input type="checkbox"/> Neutral	<input type="checkbox"/> Disagree	<input type="checkbox"/> Strongly disagree
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**26. What else would you like to share with us regarding your experience with COVID-19 that we didn't ask?**

**27. Want to tell us more? We want to share community members' stories. Let us know you're interested by indicating your type of experience along with sharing your email address/phone so we can contact you.**

- I experienced COVID-19. \_\_\_\_\_
- A loved one experienced COVID-19. \_\_\_\_\_
- My work was impacted by COVID-19. \_\_\_\_\_
- Other: \_\_\_\_\_

## Appendix C – Comparison of 2019 and 2021 Maricopa County Community Survey Results

Some health priorities changed due to COVID-19 while others were merely exacerbated. From 2019 to 2021, the top 3 community health issues remained the same, but *mental health* rose to the top. Community issues still included *distracted driving* and *homelessness*, with *lack of people immunized* as a leading issue. *Access to outdoor spaces and biking paths* remained a top community strength. *Fear of COVID-19 exposure* and *uncertainty if health care is a priority at this time* rose to the top for barriers to health care, but *difficulty finding the right provider* remained a top choice.<sup>3, 4</sup>

**Table 36.** Ranked Community Survey Results – 2019 and 2021

Rank	2019	2021
<b>Community Issues</b>		
1	Distracted driving (46.1%)	Lack of people immunized to prevent disease (29.5%)
2	Homelessness (28.9%)	Distracted driving (28.5%)
3	Illegal drug use (24.1%)	Homelessness (25.8%)
<b>Community Strengths</b>		
1	Access to parks and recreation sites (55.9%)	*Access to COVID-19 vaccine events (46.7%)
2	Access to public libraries and community centers (50.3%)	*Access to COVID-19 testing events (41.1%)
3	Clean environments and streets (39.1%)	Access to safe walking and biking routes (29.7%)
<b>Health Conditions</b>		
1	Alcohol/substance abuse (48.3%)	Mental health issues (47.8%)
2	Overweight/obesity (38.4%)	Overweight/obesity (39.6%)
3	Mental health issues (37.5%)	Alcohol/substance abuse (28.6%)
<b>Barriers to Accessing Healthcare</b>		
1	Not enough health insurance coverage (32.9%)	*Fear of exposure to COVID-19 in a healthcare setting (28.2%)
2	Difficulty finding the right provider for my care (32.1%)	*Unsure if healthcare need is a priority during this time (14.7%)
3	Inconvenient office hours (25.4%)	Difficulty finding the right provider for my care (11.6%)

***\*Response was not available in 2019 survey***

In the 2021 COVID-19 Impact survey, participants were asked: “Since March of 2020, which of the following issues have had the greatest impact on your community’s health and wellness?” **Table 37** and **Table 38** display the greatest community issues analyzed by race/ethnicity and special populations.<sup>4</sup>

**Table 37.** Greatest Community Issues – Race/Ethnicity (2021)

	①	②	③
<b>African American/Black</b>	Racism/discrimination	Lack of affordable housing	Homelessness
<b>American Indian/Native American</b>	Homelessness	Distracted driving	Lack of affordable housing
<b>Asian/Native Hawaiian/Pacific Islander</b>	Racism/discrimination	Lack of people immunized to prevent disease	
<b>Caucasian/White</b>	Lack of people immunized to prevent disease	Distracted driving	Homelessness
<b>Hispanic/Latinx</b>	Homelessness	Lack of affordable housing	Distracted driving
<b>Two or more races</b>		Racism/discrimination	Lack of affordable housing
<b>Unknown/Not Given</b>	Distracted driving	Homelessness	

**Table 38.** Greatest Community Issues – Special Populations (2021)

	①	②	③
<b>Adult with Kids</b>	Lack of people immunized to prevent disease	Distracted driving	Lack of affordable housing
<b>Single Parent</b>	Lack of affordable housing	Homelessness	Lack of people immunized to prevent disease
<b>LGBTQI+</b>	Racism/discrimination	Lack of affordable housing & Homelessness	
<b>Person experiencing homelessness</b>	Lack of affordable housing & Homelessness		Racism/discrimination
<b>Person with disability</b>	Lack of people immunized to prevent disease	Lack of affordable housing	Homelessness
<b>Immigrant</b>	Homelessness	Distracted driving & Racism/discrimination	
<b>Refugee</b>	Distracted driving	Racism/discrimination	Lack of people immunized to prevent disease
<b>Veteran</b>		Lack of people immunized to prevent disease	Homelessness

## Appendix D – 2019 and 2021 Community Survey Demographics

2019	
<b>Total # of participants</b>	<b>11,893</b>
<b>Race/Ethnicity</b>	
African American/Black	3.0%
American Indian/ Native American	2.0%
Asian	25.0%
Caucasian/White	61.0%
Hispanic/Latinx	4.0%
Other	6.0%
<b>Age</b>	
12-24	8.0%
25-44	32.0%
45-64	39.0%
65+	21.0%
<b>Gender</b>	
Female	73.0%
Male	25.0%
Other	1.0%

2021	
<b>Total # of participants</b>	<b>14,380</b>
<b>Race/Ethnicity</b>	
African American/Black	4.1%
American Indian/ Native American	1.4%
Asian	4.5%
Caucasian/White	64.5%
Hispanic/Latinx	18.3%
Native Hawaiian/ Other Pacific Islander	1.2%
Two or more race/ethnicities	1.2%
Unknown/Not given	4.9%
<b>Age</b>	
12-24	6.4%
25-44	30.9%
45-64	43.0%
65+	20.0%
<b>Gender</b>	
Female	68.9%
Male	29.1%
Additional Genders	0.6%
Unknown/Not Given	1.4%

**Appendix E – Top 10 City of Hope IP, ED and Death Rankings by Overall Rates**

<b>Rank</b>	<b>Inpatient Hospitalization</b>	<b>Emergency Department</b>	<b>Death</b>
<b>1</b>	All Mental Disorders	Falls Related Injuries	CVD
<b>2</b>	CVD	CVD	All Drug Overdose
<b>3</b>	Mood and Depressive Disorders	All Mental Disorders	Stroke
<b>4</b>	Schizophrenic	Motor Vehicle Traffic Related	COPD
<b>5</b>	Stroke	Asthma	Alcohol Related
<b>6</b>	Falls Related Injuries	Interpersonal Violence	Opioid Overdose
<b>7</b>	Diabetes	Diabetes	Alzheimer's
<b>8</b>	Motor Vehicle Traffic Related	Hypertension	Falls Related Injuries
<b>9</b>	All Drug Overdose	All Drug Overdose	Lung Cancer
<b>10</b>	COPD	COPD	Suicide

## Appendix F – Data Indicator Matrix

<b>Resource Responsibility</b>	<b>Source</b>	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	<b>Level</b>	Maricopa County	Regions	Zipcode	National	State
<b>HDD</b> - Hospital Discharge Data																	
<b>BRFSS</b> - Behavioral Risk Factor Surveillance Survey																	
<b>ACS</b> - American Community Survey (Census)																	
<b>YRBS</b> - Youth Risk Behavior Survey																	
<b>AYS</b> - Arizona Youth Survey																	
<b>H-CUP</b> - The Healthcare Coast & Utilization Project																	
<b>IP</b> - Inpatient hospitalization																	
<b>ED</b> - Emergency Department Visits																	
<b>Population Demographics</b>																	
Gender																	
Age Groups																	
Race/Ethnicity																	
Education																	
Income																	
Employment Status																	
<b>Access to Health Care</b>																	
Health Insurance Coverage																	
Poverty																	
Health Care Coverage (18-64)																	
Usual Source of Care																	
Routine Checkup (last year)																	
Primary Payer Type for ED/IP																	
<b>Birth Related</b>																	
IMR																	
Low Birth Weight																	
PreTerm Births																	
Teen Birth																	
Prenatal Care Began																	
<b>Top 5 leading casuse of death</b>																	
<b>Youth top 5 leading casuse of death</b>																	
<b>Top 5 leading emergency department and hospitalization reasons</b>																	
<b>Cancer Incidence &amp; Prevention</b>																	
Cancer (by type) Incidence																	
Cancer (by type) Screening																	
Cancer (by type) Deaths																	
<b>Chronic Disease</b>																	
Stroke																	
Stroke Deaths																	
<i>% Been told they have high blood pressure</i>																	
Cardiovascular Disease																	
Cardiovascular Disease Deaths																	
<i>% Told they have high cholesterol</i>																	
Diabetes																	
Diabetes Deaths																	
<i>Been told they have diabetes</i>																	
Alzheimer's ED/IP																	
Alzheimer's Deaths																	
<i>% told they have Confusion/Memory Loss</i>																	
COPD ED/IP																	
COPD Deaths																	
<i>Been told they have asthma</i>																	
Asthma ED/IP																	
Asthma Deaths																	
<i>Been told they have asthma</i>																	

<b>Resource Responsibility</b>	<b>Source</b>	HDD	BRFSS	ACS; Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	<b>Level</b>	Maricopa County	Regions	Zipcode	National	State	
<b>HDD</b> - Hospital Discharge Data <b>BRFSS</b> - Behavioral Risk Factor Surveillance Survey <b>ACS</b> - American Community Survey (Census) <b>YRBS</b> - Youth Risk Behavior Survey <b>AYS</b> - Arizona Youth Survey <b>H-CUP</b> - The Healthcare Coast & Utilization Project <b>IP</b> - Inpatient hospitalization <b>ED</b> - Emergency Department Visits																		
<b>Mental/Behavioral Illness</b>																		
Mood and Depressive Disorders																		
Schizophrenic Disorders																		
Drug-Induced Mental and Behavioral Disorders																		
All Mental/Behavioral disorders																		
<b>Behavioral Health Risk Factors</b>																		
Alcohol Related ED/IP																		
Alcohol Related Deaths																		
Intentional Self-Harm/Suicide ED/IP																		
Intentional Self-Harm/Suicide Death																		
Opioids - Unintentional overdose ED/IP																		
Opioids - Unintentional overdose Deaths																		
Alcohol/Drug use																		
Youth Alcohol/drug use																		
Smoking																		
Youth Smoking																		
Nutrition/Diet																		
Youth Nutrition/Diet																		
Physical Activity																		
Youth Physical Activity																		
Obesity																		
Youth Obesity																		
<b>Injury</b>																		
Motor Vehicle Crash related ED/IP																		
Motor Vehicle Crash related Deaths																		
Fall Related ED/IP																		
Fall Related Deaths																		
Violence-related ED/IP																		
Violence-related Deaths																		
<b>Social Determinants of Health</b>																		
Transportation; no vehicle households																		
Access to Food; Low Income Low Access																		
Housing; cost burdened																		

