Community Health Needs Assessment Report
NATIVE HEALTH
2022

Adopted October 2022

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Executive Summary

CHNA Purpose Statement

NATIVE HEALTH conducted a community health needs assessment (CHNA) to understand the current needs of the communities we serve, which include the urban American Indian population in the Phoenix metropolitan area. The assessment is conducted approximately every three to four years and is a requirement of the NATIVE HEALTH Title V Contract with Indian Health Services (IHS) as well as a requirement for reaccreditation through the Accreditation Association of Ambulatory Health Care (AAAHC). Additionally, this assessment will serve as an indicator to determine if our efforts to address perceived needs align with the real needs of the communities we serve.

NATIVE HEALTH Commitment and Mission Statement

The mission of NATIVE HEALTH is to provide accessible holistic patient centered care, to empower our community to achieve the highest quality health and well-being. Currently, NATIVE HEALTH provides primary care services in the following areas: medical, dental, behavioral health, and community health and wellness programs.

CHNA Collaborators

NATIVE HEALTH participates in a collaboration called the Synapse Partnership. Synapse members include hospital and healthcare entities that come together to conduct coordinated Community Health Needs Assessments. The following organizations are part of the Synapse Partnership: Banner Health, Dignity Health, Mayo Clinic Hospital, NATIVE HEALTH, Neighborhood Outreach Access to Health (NOAH), Phoenix Children's Hospital, Valleywise Health, the Health Improvement Partnership of Maricopa County (HIPMC) and Maricopa County Department of Public Health (MCDPH). With input from Synapse, MCDPH spearheaded development of the CHNA survey, and partnered with many diverse local community-based organizations to provide stipends for survey translation, distribution, and promotion. MCDPH contracted with Arizona State University Southwest Interdisciplinary Research Center (ASU SIRC) to conduct and analyze focus groups.

Assessment Process and Methods

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

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

Process and Criteria to Identify and Prioritize Significant Health Needs

The health needs prioritization process began with an initial review and analysis of primary and secondary data sources. Primary sources included data that was derived from the 2019 and 2021 community survey and focus group sessions. Secondary sources included data that was derived from County inpatient hospitalization, emergency department, and death rates to assemble 28 total health indicators. Additionally, external data sources such as PolicyMap were utilized to analyze and highlight two social indicators.

Compiled primary and secondary data sources were presented to the Senior Management Team (SMT) on June 1, 2022. The SMT provided input on the data, which was reflected in the final selected priorities.

List of Prioritized Significant Health Needs

The following statements summarize each of the priority areas for NATIVE HEALTH and are based on data and information gathered through the CHNA.

Chronic Disease: Chronic disease was selected as a top priority issue for NATIVE HEALTH. Chronic diseases such as cardiovascular disease and diabetes ranked as top ten health issues in the 2019 and 2021 community surveys. Practicing healthy behaviors and addressing social determinants of health that drive chronic disease is key in preventing greater health risks and maintaining a healthy lifestyle.

Cancer: Cancer (breast, lung, cervical, prostate, colorectal) was selected as a top priority issue for NATIVE HEALTH. COVID-19 has exacerbated cancer-related screenings, illness, and death. In the 2019 focus groups, cancer was noted as one of the greatest threats to community health. In the 2021 community survey, cancer was ranked as the eighth top health condition that had the greatest community impact.

Substance Use: Substance use was selected as a top priority issue for NATIVE HEALTH. Maricopa County residents identified substance abuse as the third top community issue in 2019 and eighth top community issue in 2021. Many communities continue to face challenges in accessing appropriate care and resources to support their mental health needs.

Prenatal Care: Prenatal care was selected as a top priority issue for NATIVE HEALTH. Prenatal care is critical to prevent health complications and support a healthy pregnancy. Early childhood health and literacy are both critical to promote healthy growth and development.

The health issues listed above are often caused or exacerbated by social determinants of health such as:

Access to Health Care: Access to health care was selected as a top priority issue for NATIVE HEALTH. In the 2019 and 2021 focus groups, participants shared major barriers to healthcare access such as financial limitations, transportation, insurance, unaware of existing services/resources, lack of cultural understanding and sensitivity. In the 2021 community survey, fear of exposure of COVID-19 in healthcare setting, unsure if healthcare need is a priority, and difficulty finding the right provider were top three barriers to seeking healthcare. Families and individuals who face financial barriers may significantly impact their access to care, quality of care received, and overall well-being.

Housing: Housing was selected as a top priority issue for NATIVE HEALTH. The COVID-19 pandemic has exacerbated housing insecurity and inequality. Housing is often identified as a critical social determinant of health, recognizing the range of ways in which a lack of housing or poor-quality housing, can negatively affect health and wellbeing.

Prioritized Health Needs: Disparities

Using a Health Equity Lens: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Robert Woods Johnson Foundation). NATIVE HEALTH is working toward improving health and promoting health equity for across all prioritized significant health needs. The following data displays a high-level summary of health disparities for each prioritized health need in NATIVE HEALTH's combined PSAs (Central, Mesa, and West).

CVD – Black/African Americans had the highest IP, ED, and death rates.[xviii]

Diabetes – Black/African Americans had the highest IP and ED rates while American Indians had the highest death rate.[xix]

Cancer – The highest lung, breast, prostate, and colorectal cancer death rates were among Black/African Americans. The highest cervical cancer death rate was among Hispanics.[xviii]

Substance Use – American Indians had the highest IP, ED, and death rate due to alcohol-related injuries. Black/African Americans had the highest IP rate while American Indians had the highest ED and death rates due to opioid overdose. [xviii]

Prenatal Care – Black/African Americans had the highest rate due to inadequate prenatal care.[xxviii]

Housing – In 2019, 58.3% of renters aged 65+ were considered cost-burdened (rent is 30% or more of household income).[xvii]

Access to Health Care – In 2019, 14.1% of adults under the age of 65 were uninsured.[xvii]

Resources Potentially Available

Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community-based organizations. Resources include access to over 40 hospitals for emergency and acute care services, over 10 Federally Qualified Health Centers (FQHC), over 12 food banks, 8 homeless shelters, school-based health clinics, churches, transportation services, health enrollment navigators, free or low cost medical and dental care, and prevention-based community education.

The Health Improvement Partnership of Maricopa County (HIPMC) is a collaborative effort between MCDPH and a diverse array of public and private organizations addressing healthy eating, active living, linkages to care and tobacco-free living. With more than 100 partner organizations, this is a valuable to resource to help NATIVE HEALTH connect to other community-based organizations that are targeting many of the same health priorities.[i]

Report Adoption, Availability, and Comments

This CHNA report was adopted by the NATIVE HEALTH board on October 15, 2022. This report is widely available to the public on the web site https://www.nativehealthphoenix.org/, and a paper copy is available by request from Francie Spencer, Fund Development Officer, at fspencer@nachci.com. Written comments on this report can be submitted to Francie Spencer, NATIVE HEALTH 4041 N. Central Ave. Building C Phoenix, AZ 85012, or by email at: fspencer@nachci.com.

Community Definition

NATIVE HEALTH's community is defined as Maricopa County. The entire County, which excludes reservation-based communities was chosen as the community definition due to the broad range of NATIVE HEALTH's service area. Figure 1 below displays NATIVE HEALTH's primary service areas (PSAs) – which span Maricopa County. NATIVE HEALTH's primary service area-specific information is also provided when available. A list of all NATIVE HEALTH's PSA zip codes are located in Appendix D.

Maricopa County is the fourth most populous county in the United States. Based on 2019 American Community Survey (ACS five-year estimates, Maricopa County has an estimated population of over 4.3 million and growing, home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations.

NATIVE HEALTH serves patients across Maricopa County, hence the community definition extends beyond its physical location in the City of Mesa and the City of Phoenix. The City of Mesa is the 3rd largest city in Arizona with a total population of 499,720 and median age of 35.9 in 2019.[ii,iii] The racial and ethnic makeup of Mesa is diverse and are as follows: Caucasian/White (84.6%), Hispanic/Latino (27.7%), Black/African American (5.4%), American Indian and Alaska Native (3.6%), Asian (3.3%) and Native Hawaiian and Other Pacific Islander (0.8%).[iii] In 2019, the median household income in Mesa was $58,181 with a poverty rate of 13.3%.[iv,v] The educational attainment statistics in Mesa for 2019 were as follows: less than high school graduate (15.5%), high school graduate (34.4%), some college/associate's degree (42.4%), and bachelor's degree or higher (7.7%).[vi]

The City of Phoenix is the 5th largest city in the United States by population, making it the most populous state capital. Its population in 2019 was 1,633,017 with a median age of 33.8.[vii] The City of Phoenix is made up of predominantly Caucasian/White individuals (76.1%), followed by Latino/Hispanic (42.6%), Black/African American (8.6%), Asian (5.0%), American Indian/Alaska Native (3.0%), and Native Hawaiian and Other Pacific Islander (0.5%).[viii] In 2019, the median household income in Phoenix was $57,459 with a poverty rate of 18.0%.[ix] The educational attainment statistics in Phoenix for 2019 were as follows: less than high school graduate (18.0%), high school graduate (36.0%), some college/associate's degree (37.6%), and bachelor's degree or higher (8.4%).[x]

Figure 1. NATIVE HEALTH's Service Areas in Maricopa County
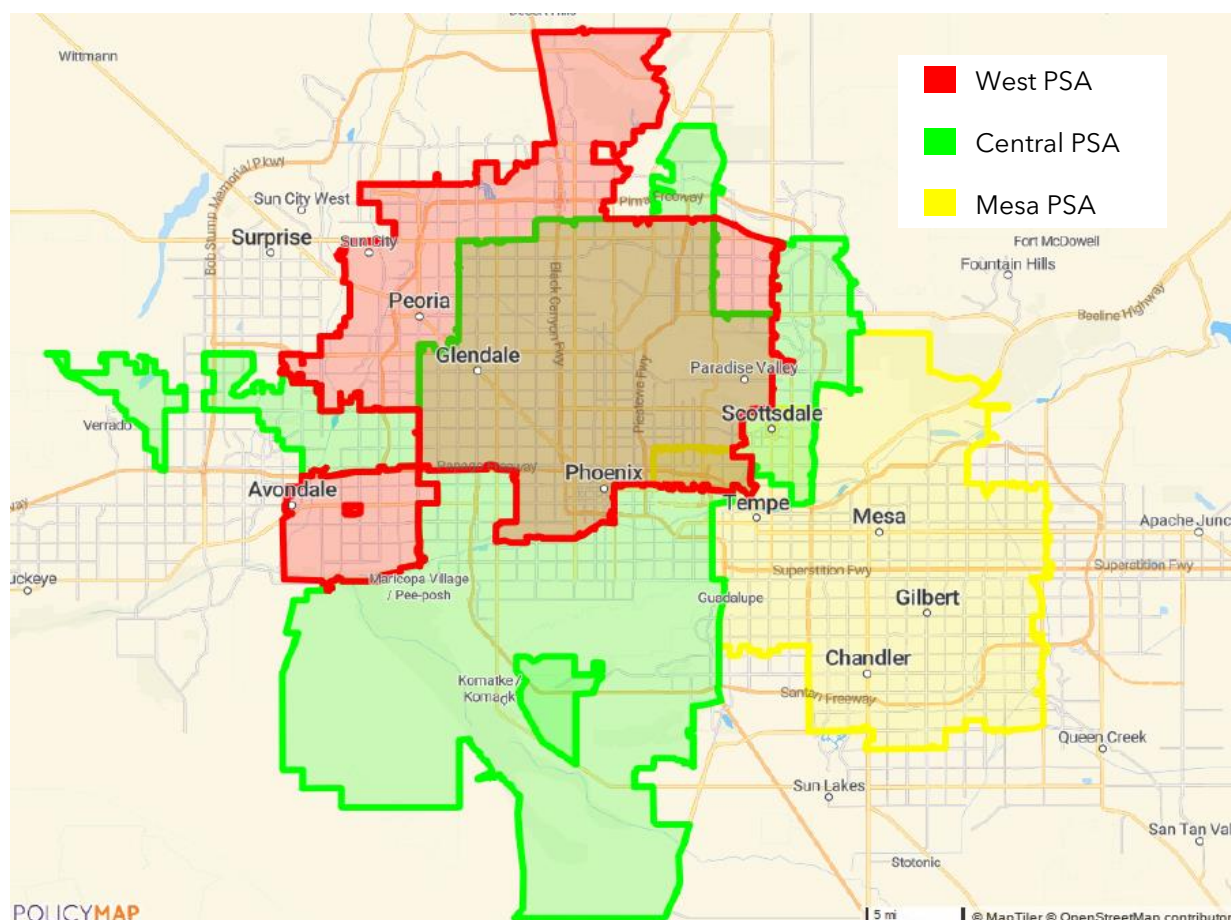
Primary Care Area (PCA) Statistical Profiles are revised annually and provide detailed information on the demographics, health resources, hospital utilization, and health status indicators in defined geographic areas throughout Arizona. According to the 2020 Arizona Department of Health Services (ADHS) Arizona Medically Underserved Areas Biennial Report, the Alhambra Village, Avondale, Buckeye, Camelback East Village, Central City Village, El Mirage & Youngtown, Estrella Village & Tolleson, Fort McDowell Yavapai Nation, Glendale Central, Laveen Village, Maryvale Village, Mesa Central, Mesa West, New River/Cave Creek, North Gateway/Rio Vista Village, North Mountain Village, Peoria South, Salt River Pima-Maricopa Indian Community, Scottsdale South, South Mountain Village & Guadalupe, Sun City, Surprise North & Wickenburg, and Tempe North PCAs have been federally designated as a Medically Underserved Areas.[xi]

Table 1 provides the specific age, sex, and race/ethnicity distribution and data on key socio-economic drivers of health status of the NATIVE HEALTH PSA population compared to Maricopa County and Arizona.

Table 1. Demographic and Socioeconomic Profile

	NATIVE HEALTH	Maricopa County	Arizona
Total Population	3,194,935	4,485,414	7,151,502
Population by Race/Ethnicity			
American Indians	2%	2%	5%
Asian	3%	4%	3%
Black	5%	5%	5%
Hispanic	28%	25%	32%
White	61%	65%	78%
Population by Gender			
Male	49%	49%	49.70%
Female	51%	51%	50.30%
Population by Age Group			
1-14	21%	20%	19%
15-24	14%	13%	13%
25-44	29%	28%	26%
45-64	23%	24%	24%
65+	12%	15%	18%
Population by Educational Attainment			
Less than 9th grade	6.9%	5.6%	5.5%
9th to 12th grade, no diploma	7.8%	6.7%	7.4%
High school graduate (includes equivalency)	22.7%	22.4%	23.9%
Some college, no degree	23.2%	24.1%	25.2%
Associate's degree	8.1%	8.5%	8.6%
Bachelor's degree	19.9%	20.8%	18.4%
Graduate or professional degree	11.5%	11.9%	11.1%
Median Household Income			
	$64,468	$64,468	$58,945
Poverty			
Percent persons below poverty level	15.9%	13.8%	15.8%
Under age 18 in Poverty	22.2%	19.8%	21.5%
Employment Status			
Civilian labor force (16+)	1,640,001	2,171,216	3,308,608
Employed	94.8%	95.0%	94.2%
Unemployed	5.2%	5.0%	5.8%
Health Insurance Coverage			
Under 19 years, Uninsured	19.4%	19.9%	19.8%
19 to 64 years, Uninsured	79.1%	78.8%	78.8%
65 years and older, Uninsured	1.5%	1.4%	1.4%

*Source: *Census, 2020 ACS 5-Year Estimates*

Assessment, Process and Methods

Maricopa County hospitals and health centers play significant roles in the region's overall economy and health. In addition to providing safe and high-quality medical care, these institutions work to improve regional health through programs that promote health in response to identified community needs. Additionally, health care partners are often serving the same or portions of the same communities across Maricopa County. As a result, Banner Health, Dignity Health, Mayo Clinic Hospital, NATIVE HEALTH, Neighborhood Outreach Access to Health, Phoenix Children's Hospital, and Valleywise Health have joined forces with MCDPH through the Synapse partnership to identify the communities' strengths and greatest needs in a coordinated community health needs assessment. NATIVE HEALTH, as a member of Synapse, contracted with MCDPH to conduct the CHNA process. The CHNA utilizes a mixed-methods approach that includes the collection of secondary data from existing data sources and community input data from focus groups, surveys, and meetings with community stakeholders. The process was iterative as both the secondary and primary data were used to help inform each other. The advantage of using this approach is that it validates data by cross-verifying from a multitude of sources.

Primary Data

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

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

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

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

COVID-19 Focus Groups (Appendix B)

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

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

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

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

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

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

COVID-19 Community Impact Survey (Appendix B)

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

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

The goal for the community survey was 15,000 responses, however a total of 14,380 surveys were completed by residents of Maricopa County. MCDPH partnered with an extensive network of community-based organizations and healthcare partners to collect community surveys from residents and professionals within Maricopa County. The MCDPH team wanted to ensure diverse community representation and that the survey provided insight from all regions (Northeast, Northwest, Central, Southeast, and Southwest) of the county. MCDPH collaborated with several community-based organizations to provide stipends from $2,000 - $5,000 to support survey translation, distribution & completion, social media outreach via networks, purchase of incentives for survey completion, and administrative expenses.

Secondary Data

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

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

Hospital Discharge Data, Death Data, and Birth Data

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

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

Hospital Discharge Data, Death and Birth Data are obtained from ADHS and cleaned by MCDPH to use for analyses. These datasets are used along with population estimates from the American Census Survey to analyze health indicators for Maricopa County residents. All health indicator rates are age adjusted using the 2000 Standard Population.[xiv] Age-adjustment methods allow for fairer comparisons between population groups even if the size of the groups is different. The National Center for Health Statistics recommends using the 2000 Standard Population when calculating age-adjusted rates. In this report, the 2000 Standard Population is used to standardize HDD and vitals data. Health indicators that were analyzed include fatal and nonfatal chronic conditions, fatal cancer indicators, fatal and non-fatal injuries, mental and behavioral health indicators, and infant birth indicators. Each indicator is analyzed as an overall rate for Maricopa County, and then further analyzed by age, race, and gender to highlight disparities.

Other Secondary Data

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

Synapse partners selected approximately 100 data indicators to help examine the health needs of the community. These indicators were based on the Center for Disease Control and Prevention's (CDC) Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics report.[xv] From the approximately 100 data indicators, Table 2 displays the initial round of 28 health indicators Table 3 displays the initial round of four social indicators that NATIVE HEALTH selected for further analysis. For the health indicators, hospital discharge, birth, and death databases were utilized to perform this analysis.

Table 2. Initial Round Health Indicators

Alzheimer's	Mood & Depressive Disorder
Asthma	Schizophrenia
Chronic Obstructive Pulmonary Disease (COPD)	Drug Induced Mental Health Disorders
Diabetes	Breast Cancer
Cardiovascular Disease (CDVD)	Cervical Cancer
Stroke	Lung Cancer
Alcohol Related Injuries	Prostate Cancer
Assault Related Injuries	All Cancers
Unintentional Falls Related	Infant Mortality Rate
Opioid Overdose	Low Birthweight
Motor Vehicle Crash Related	Preterm Births
Self-Harm	Teen Births
Suicide	Adequate Prenatal Care
All Mental Health Disorders	Inadequate Prenatal Care

Table 3. Initial Round Social Indicators

Housing	Access to Health Care
Access to Food	Transportation

Input from the Community

NATIVE HEALTH engaged in a community-based process to gather input from the community, which involved iterations of data presentations co-led by MCDPH. NATIVE HEALTH met with their Senior Management Team (SMT) and Board of Directors (BOD) on June 1, 2022, and July 19, 20212 to narrow indicators down from 28 to six priorities. The SMT consists of the Primary Care, Behavioral Health, Community Health and Wellness, Development and Fundraising, Administration, and Marketing Division Directors, Quality Management, Technology, Chief Financial Officer, Chief Operating Officer, and Chief Executive Officer. The BOD is based on volunteerism and are actively engaged in all aspects of the agency.

Assessment Data and Findings

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

In this Section:

➢ Indicator data for top social issues and top health issues (Tables 3-6)

➢ Qualitative data themes from 2019 and 2021 focus groups and open-ended survey questions. (Table 7)

➢ Quantitative data from 2019 and 2021 community surveys
- Top health and social issues from 2021 COVID-19 Impact Survey
- Comparison of top issue rankings from 2019 and 2021 survey results (Table 8)
- Top health and social issue rankings analyzed by race and special populations (Tables 9-10)

Top Social and Health Needs

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Some examples of SDOH include housing, access to care, transportation, financial security, food insecurity, and racial equity. SDOH can contribute to wide health disparities and inequities.[xvi] Table 4 displays the top social issues identified in Maricopa County and Arizona.[xvii]

Table 4.

Top Social Issues Identified in Maricopa County (MC) and Arizona - 2019		
Indicator	Significance to MC	Significance to AZ
Housing	45.1% of renters were considered cost-burdened (gross rent >30% of household income). 21.7% of homeowners are cost-burdened.	44.5% of renters were considered cost-burdened (gross rent >30% of household income). 21.6% of homeowners are cost-burdened.
Access to Health Care	10.62% of residents were considered uninsured.	10.4% of residents were uninsured.
Usual Source of Care	70.5% of MC residents had a usual source of care (one person you think of as your personal doctor or health care provider).	65.3% of AZ residents had a usual source of care (one person you think of as your personal doctor or health care provider).
Employment Status	4.2% of MC residents were unemployed.	4.9% of AZ residents were unemployed.
Poverty	13.8% of MC residents were living below the poverty line.	15.8% of AZ residents were living below the poverty line.
Source: PolicyMap - data in this table was collected in 2019 unless stated otherwise		

Table 5 identifies the top causes of death for the combined NATIVE HEALTH PSA from 2016 to 2019.[xviii] Cancer, CVD, and chronic lower respiratory issues all maintain the same place in the top three year to year. From 2016 to 2019, drug overdose has risen from the sixth to fourth leading cause of death.

Table 5.

Top Causes of Death in NATIVE HEALTH Combined PSA (by frequency)			
2016	2017	2018	2019
Cancer	Cancer	Cancer	Cancer
Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease
Chronic Lower Respiratory	Chronic Lower Respiratory	Chronic Lower Respiratory	Chronic Lower Respiratory
Stroke	Stroke	Stroke	Drug Overdose, All Drugs
All Mental Health	Drug Overdose, All Drugs	Drug Overdose, All Drugs	Stroke
Drug Overdose, All Drugs	All Mental Health	All Mental Health	All Mental Health
Fall	Suicide	Suicide	Suicide
Suicide	Fall	Fall	Fall
Unintentional Injury	Diabetes	Diabetes	Diabetes
Diabetes	Unintentional Injury	Unintentional Injury	Unintentional Injury
Influenza and Pneumonia	Influenza and Pneumonia	Influenza and Pneumonia	Influenza and Pneumonia
Infectious Disease	Infectious Disease	Infectious Disease	COPD
COPD	COPD	COPD	Infectious Disease
Arthritis	Arthritis	Arthritis	Arthritis

Of the 28 health indicators that were analyzed, the following indicators displayed in Table 6 had the highest overall rates per 100,000 for in patient hospitalization (IP), emergency department visits (ED), and deaths.[xix, xviii] Each number within the table represents the ranking of each health indicator for IP, ED, and deaths. The color gradients are used to help visualize the different rankings among the health indicators.

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

Table 6.

Top Health Indicators Identified in NATIVE HEALTH Combined PSA			
Indicator	Inpatient Hospitalizations (IP)	Emergency Department Visits (ED)	Deaths
Cardiovascular Disease	1	3	1
Mental & Behavioral Health	2	2	.
Falls	3	1	3
Stroke	4	11	6
Diabetes	5	7	10
COPD	6	8	4
Motor Vehicle Traffic Related	7	4	11
Asthma	8	5	13
Assault Related Injuries	9	6	12
Alcohol Related Injuries	10	12	7
Self-Harm Related Injuries/Suicide	11	9	9
Opioid Overdose	12	10	8
Alzheimer's	13	13	5
Cancer	.	.	2

Health Equity

According to the Robert Wood Johnson Foundation, "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare."[xx] Addressing health equity requires understanding differences in health outcomes based on race, gender, age, and socio-economic status – among other factors. The following health indicators are broken down by race, gender, and age in Table 7 to highlight health disparities in NATIVE HEALTH's combined PSAs (Central, Mesa, and West).

Table 7.

Top Health Indicators Disparities in NATIVE HEALTH's Combined Primary Service Area			
Indicator	Gender Disparity	Age Disparity	Racial Disparity
Cardiovascular Disease (CVD)	Males had the highest IP, ED, and death rates.	Individuals aged 65+ had the highest IP, ED, and death rates.	Black/African Americans had the highest IP, ED, and death rates.
Diabetes	Males had the highest IP, ED, and death rates.	Individuals aged 45-64 had the highest IP and ED rates while those aged 65+ had the highest death rate.	Black/African Americans had the highest IP and ED rates while American Indians had the highest death rate.
Substance Use (Alcohol Related)	Males had the highest IP, ED, and death rates.	Individuals aged 45-64 had the highest IP and death rates while those aged 25-44 had the highest ED rate.	American Indians had the highest IP, ED, and death rates.
Substance Use (Opioid Overdose)	Males had the highest IP, ED, and death rates.	Individuals aged 25-44 had the highest IP, ED, and death rates.	Black/African Americans had the highest IP rate while American Indians had the highest ED and death rates.

Lung Cancer	Males had the highest death rate.	Individuals aged 65+ had the highest death rate.	Black/African Americans had the highest death rate.
Breast Cancer		Individuals aged 65+ had the highest death rate.	Black/African Americans had the highest death rate.
Cervical Cancer		Individuals aged 45-64 had the highest death rate.	Hispanics had the highest death rate.
Prostate Cancer		Individuals aged 65+ had the highest death rate.	Black/African Americans had the highest death rate.
Colorectal Cancer	Males had the highest death rate.	Individuals aged 65+ had the highest death rate.	Black/African Americans had the highest death rate.
Inadequate Prenatal Care	Males had the highest rate for inadequate prenatal care.	Individuals aged 25-44 had the highest rate for inadequate prenatal care.	Black/African Americans had the highest rate for inadequate prenatal care.
Source: Maricopa County's 2019 Hospital Discharge and Death Database			

Qualitative Themes from Focus Groups

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

Table 8. Qualitative focus group themes from 2019 and 2021.

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

Maricopa County Overall COVID-19 Impact Survey Results

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

Top Healthcare Barriers

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

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

Top Health Conditions

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

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

Community Issues

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

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

Community Strengths

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

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

Comparison of 2019 & 2021 Community Survey Results

*Response was not available in 2019 survey

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

Table 9. Ranked Community Survey Results 2019 & 2021 by Overall and Native American Respondents
*Survey option was not available in the 2019 community survey

Rank	2019 Overall Respondents	2019 Native American Respondents	2021 Overall Respondents	2021 Native American Respondents
Community Issues				
Frequency	n = 10,183	n = 382	n = 13,823	n =196
1	Distracted driving (46.1%)	Homelessness (37.7%)	Lack of people immunized to prevent disease (29.5%)	Homelessness (33.7%)
2	Homelessness (28.9%)	Distracted driving (31.9%)	Distracted driving (28.5%)	Distracted driving (27.6%)
3	Illegal drug use (24.1%)	Illegal drug use (29.1%)	Homelessness (25.8%)	Lack of affordable housing (27.0%)
Community Strengths				
Frequency	n = 11,280	n = 527	n = 14,004	n = 198
1	Access to parks and recreation sites (55.9%)	Access to parks and recreation sites (52.0%)	*Access to COVID-19 vaccine events (46.7%)	*Access to COVID-19 testing events (50.0%)
2	Access to public libraries and community centers (50.3%)	Access to public libraries and community centers (49.7%)	*Access to COVID-19 testing events (41.1%)	*Access to COVID-19 vaccine events (38.4%)
3	Clean environments and streets (39.1%)	Access to public transportation (44.4%)	Access to safe walking and biking routes (29.7%)	Access to school or school alternatives (25.8%)
Health Conditions				
Frequency	n = 10,374	n = 400	n = 13,839	n = 199

1	Alcohol/substance abuse (48.3%)	Alcohol/substance abuse (63.8%)	Mental health issues (47.8%)	Overweight/obesity (51.3%)
2	Overweight/obesity (38.4%)	Diabetes (50.0%)	Overweight/obesity (39.6%)	Mental health issues (44.2%)
3	Mental health issues (37.5%)	Overweight/obesity (39.8%)	Alcohol/substance abuse (28.6%)	Alcohol/substance abuse (41.2%)
Barriers to Accessing Healthcare				
Frequency	n = 10,559	n = 512	n = 14,141	n = 201
1	Not enough health insurance coverage (32.9%)	Difficulty finding the right provider for my care (29.7%)	*Fear of exposure to COVID-19 in a healthcare setting (28.2%)	*Fear of exposure to COVID-19 in a healthcare setting (37.3%)
2	Difficulty finding the right provider for my care (32.1%)	Transportation to appointments (27.1%), Distance to provider (27.1%)	*Unsure if healthcare need is a priority during this time (14.7%)	Inconvenient office hours (21.4%)
3	Inconvenient office hours (25.4%)	Not enough health insurance coverage (23.4%)	Difficulty finding the right provider for my care (11.6%)	*Unsure if healthcare need is a priority during this time (19.4%)

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

Table 10. Greatest Community Issues – Race/Ethnicity

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

Table 11. Greatest Community Issues – Special Populations

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

Prioritized Description of Significant Community Health Needs

The top health and social issues were identified based on data collection and community feedback. Health conditions and outcomes were assessed from County inpatient hospitalization, emergency department and death data, along with external data sources. All data was presented to NATIVE HEALTH's Senior Management Team (SMT) and Board of Directors (BOD), who provided feedback about what they experience in their life and work. A total of 28 health indicators with several subcategories were analyzed. These indicators were established in collaboration with NATIVE HEALTH by selecting health indicators of interest that have historically demonstrated high rates or those with known disparities when broken out by race/ethnicity, gender, and age.

Of the 28 indicators that were analyzed, a chart ranking the top ten rates for inpatient hospitalizations, emergency department visits, and death was presented to the SMT and BOD. For each top ranked indicator, existing data trends and disparities broken out by race/ethnicity, age group, and gender were also shared. Throughout each data presentation, NATIVE HEALTH's SMT and BOD participated in interactive discussion sessions where participants were invited to come off mic or respond through chat to the following questions:

- Are there any health and social issues that have not been addressed?
- Do we approve these priorities?

All responses received from the SMT and BOD meetings were compiled and evaluated through a health equity lens (represented by the funnel to the right). Health equity is an underlying factor for many health and social needs. Improving health and health care requires a focus on equity – equity of access, treatment, and outcomes. Health equity is realized when everyone has a fair opportunity to achieve their full health potential.[xxi] Health data shows that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions, including diabetes and heart disease, when compared to their white counterparts.[xxii] Addressing the fairway between racial inequities and poor health outcomes is necessary to bridge the health equity gap. MCDPH and NATIVE HEALTH utilized a health equity lens to investigate disparities in health and wellbeing based on race, gender, age, economic status, and other social factors.

Two top social issues were identified by the SMT and BOD: access to health care and housing. A similar process was utilized to determine the top health issues identified by community partners. The following top health issues were identified: chronic disease (cardiovascular disease and diabetes), cancer, substance use, and prenatal care (early childhood health and literacy). Based on the identified top health and social needs, approval was granted from the SMT and BOD to proceed with the focus of six significant health needs.
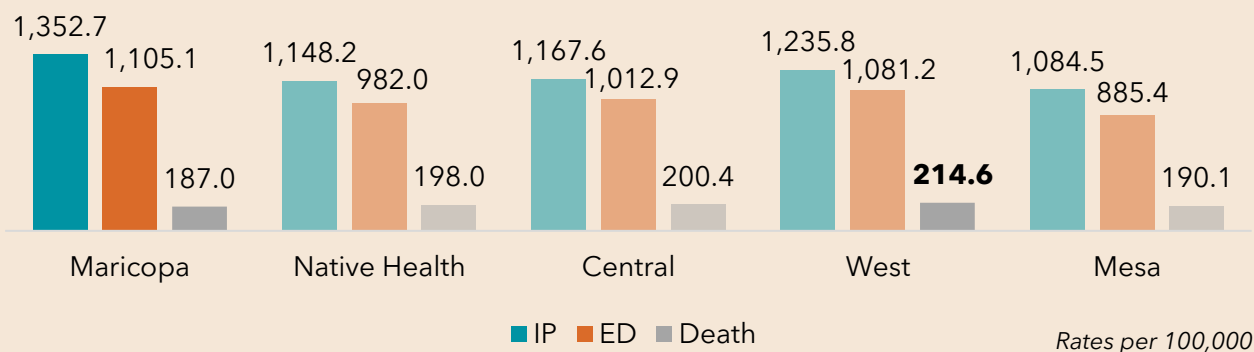
Chronic diseases such as cardiovascular disease and diabetes are leading causes of death and disability in the United States. Many chronic diseases are caused by risk behaviors such as tobacco use, poor nutrition, physical inactivity, and excessive alcohol use.[xxiii] Prevention of chronic disease begins with the recognition of how social determinants of health intersect with disease development. CVD and diabetes were selected as priority issues for NATIVE HEALTH.

Cardiovascular Disease (CVD)

In 2019, **NATIVE HEALTH's West PSA** had the highest overall **death** rate for CVD compared to the Maricopa County overall.

	Maricopa	Native Health	Central	West	Mesa
IP	1,352.7	1,148.2	1,167.6	1,235.8	1,084.5
ED	1,105.1	982.0	1,012.9	1,081.2	885.4
Death	187.0	198.0	200.4	**214.6**	190.1

■ IP ■ ED ■ Death

Rates per 100,000

Diabetes

In 2019, **NATIVE HEALTH's West PSA** had the highest overall **IP**, **ED**, and **death** rate for diabetes compared to the Maricopa ounty overall.

	Maricopa	Native Health	Central	West	Mesa
IP	208.1	189.7	205.9	**210.5**	173.7
ED	275.0	275.3	314.3	**322.7**	226.9
Death	10.0	11.0	12.8	**13.1**	9.7

■ IP ■ ED ■ Death

Rates per 100,000
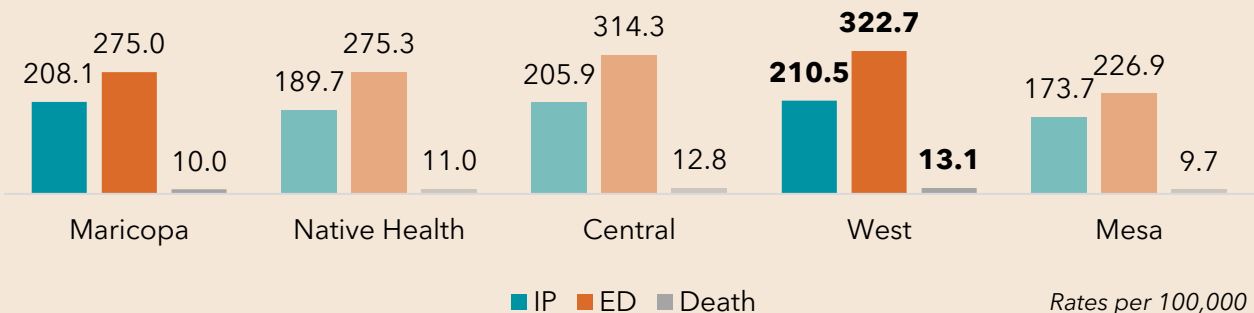
Words from a 2019 Focus Group Participant

"What are people eating at home and usually what's easy or cheap, which on my race, it is fast food…we got all them fast food places there, but we don't really have a healthy cheap alternative to that. So, I think that definitely contribute to our health as a community."

(Native American Young Adult)

Rated physical health as fair/poor since March 2020:

19.1%
of all respondents rated their physical health as fair/poor

27.5%
of Native American respondents rated their physical health as fair/poor

Sources: Hospital Discharge & Death Data, obtained from ADHS, cleaned/analyzed by MCDPH, COVID-19 Impact Survey

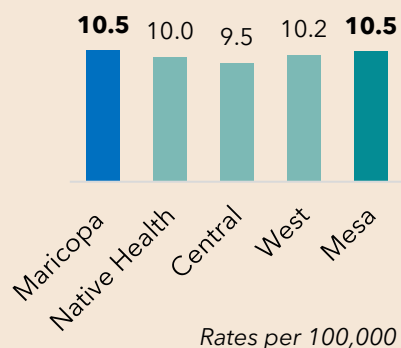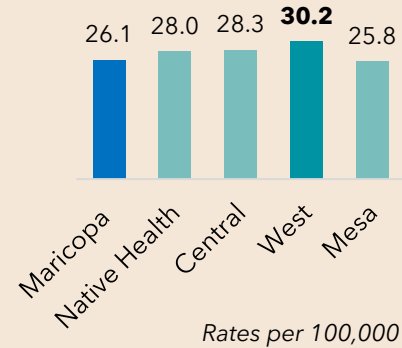# Cancer

Cancer is a significant health issue facing the population today. COVID-19 has exacerbated cancer-related screenings, illness, and death. According to a study conducted in 2020, the impact of the COVID-19 pandemic on cancer care in the US has resulted in decreases and delays in identifying new cancer and delivery of treatment.[xxiv] Cancer (breast, lung, prostate, cervical, was selected as a priority issue for NATIVE HEALTH.
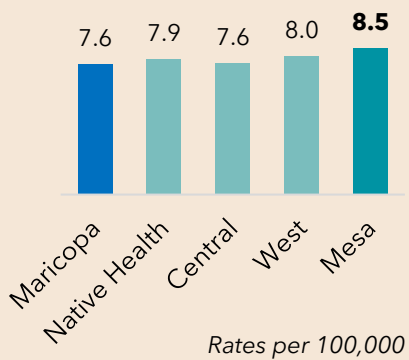

In 2019, the overall **breast** cancer death rates were highest in both **NATIVE HEALTH's Mesa PSA** and Maricopa County overall.

Maricopa 10.5 | Native Health 10.0 | Central 9.5 | West 10.2 | Mesa 10.5

Rates per 100,000

In 2019, the overall **lung** cancer death rate was highest in **NATIVE HEALTH's West PSA** compared to Maricopa County overall.

Maricopa 26.1 | Native Health 28.0 | Central 28.3 | West 30.2 | Mesa 25.8

Rates per 100,000

In 2019, the overall **prostate** cancer death rate was highest in **NATIVE HEALTH's Mesa PSA** compared to Maricopa County overall.

Maricopa 7.6 | Native Health 7.9 | Central 7.6 | West 8.0 | Mesa 8.5

Rates per 100,000

In 2019, the overall **cervical** cancer death rate was highest in **NATIVE HEALTH's Mesa PSA** compared to Maricopa County overall.

Maricopa 1.2 | Native Health 1.2 | Central 1.1 | West 1.1 | Mesa 1.3

Rates per 100,000
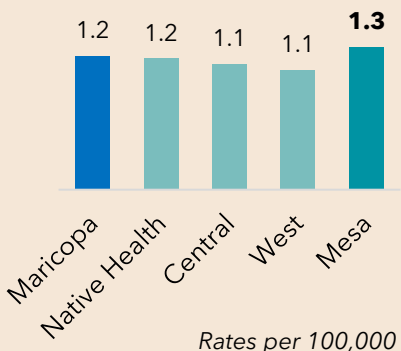
In 2019, the overall **colorectal** cancer death rate was highest in **NATIVE HEALTH's West PSA** compared to Maricopa County overall.

Maricopa 12.9 | Native Health 14.0 | Central 14.8 | West 14.9 | Mesa 13.5

Rates per 100,000
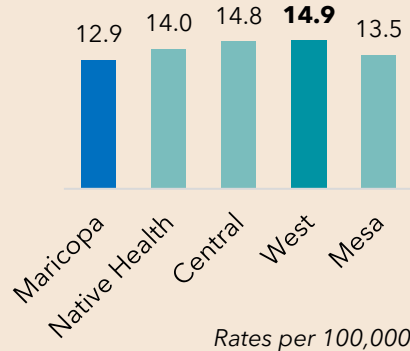
In 2019, **AZ** had a **higher** rate of **mammogram screening** while **MC** had a higher rate of **prostate screening**.

Mammogram Screening: Maricopa County 67.4%, Arizona 75.3%
Prostate Screening: Maricopa County 41.1%, Arizona 26.1%

■ Maricopa County ■ Arizona
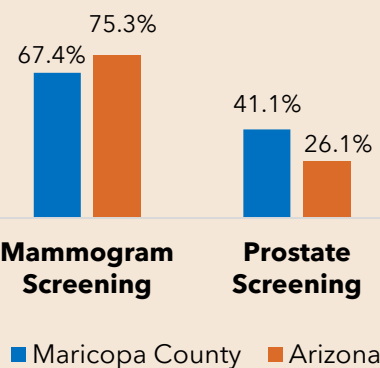
Words from a COVID-19 Impact Survey Participant

"I had family 3 members due because of COVID-19. One person is dying now of cancer because they could not get cancer treatment…& now it has spread to the point they can't do anything for them…"

(White/Caucasian, PHX , 55-64)

Primary barriers to seeking healthcare since March 2020 (Native American respondents):

1 Fear of exposure to COVID in healthcare settings

2 Inconvenient office hours

3 Unsure if healthcare need is a priority during this time

Sources: Death Data obtained from ADHS, cleaned/analyzed by MCDPH, BRFSS, COVID-19 Impact

Substance use has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical and mental health problems that include: teenage pregnancy,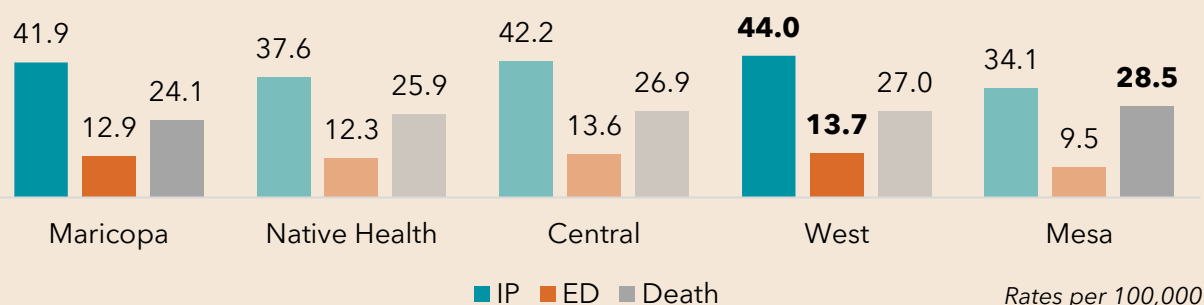 sexually transmitted diseases, motor vehicle crashes, crime, suicide, etc.[xxv] Social isolation and anxiety due to COVID-19 have likely contributed to an increase in substance use and related injuries and death.[xxvi] Substance use was selected as a priority issue for NATIVE HEALTH.
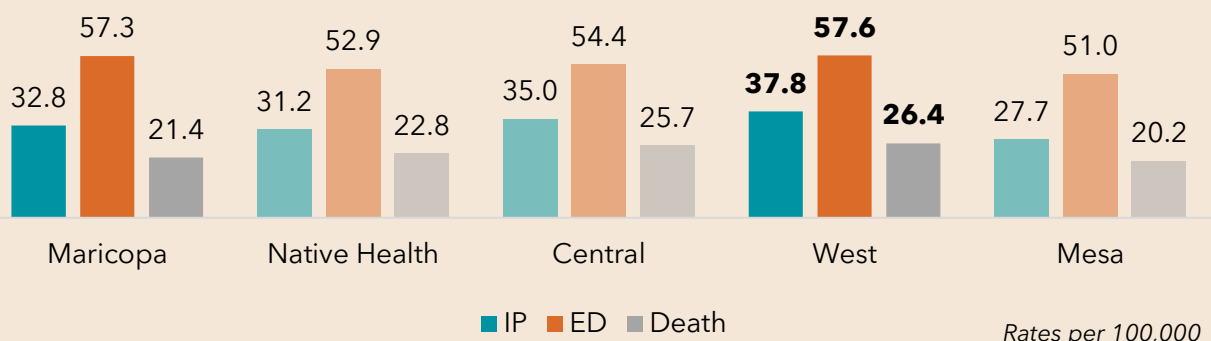
Alcohol-Related Injuries

In 2019, **NATIVE HEALTH's West PSA** had the highest overall **IP** rate and **ED** rate for *alcohol-related injuries*, while the **Mesa PSA** had the highest death rate compared to Maricopa County overall.

	Maricopa	Native Health	Central	West	Mesa
IP	41.9	37.6	42.2	**44.0**	34.1
ED	12.9	12.3	13.6	**13.7**	9.5
Death	24.1	25.9	26.9	27.0	**28.5**

■ IP ■ ED ■ Death

Rates per 100,000

Opioid Overdose

In 2019, **NATIVE HEALTH's West PSA** had the highest overall **IP**, **ED**, and death rate for *opioid overdose* compared to Maricopa County overall.

	Maricopa	Native Health	Central	West	Mesa
IP	32.8	31.2	35.0	**37.8**	27.7
ED	57.3	52.9	54.4	**57.6**	51.0
Death	21.4	22.8	25.7	**26.4**	20.2

■ IP ■ ED ■ Death

Rates per 100,000

Words from a COVID-19 Impact Survey Participant

"Many younger adults in this community need help with substance abuse issues, depression, etc...but do not know where to go to get the help or don't have much faith in helping "programs" to follow through with the help their promising."

(Native American, SE, 25-34)

Mental Health Rating Since March 2020:

36.6% of all respondents rated their mental health as fair/poor
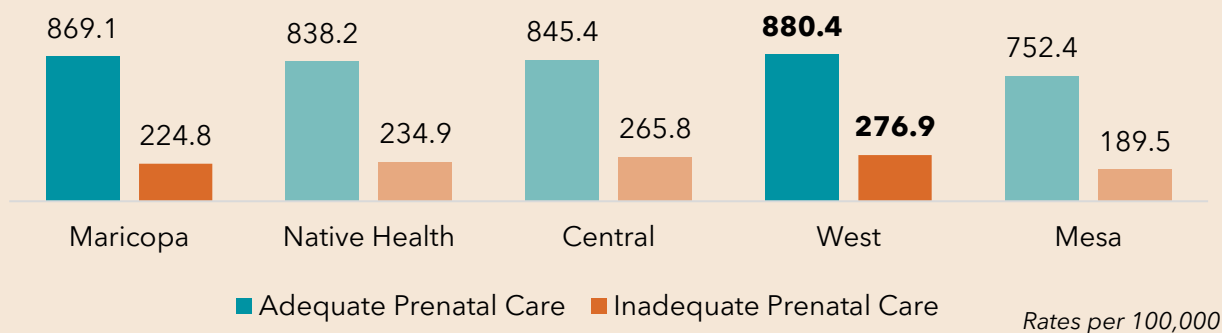
46.8% of Native American respondents rated their mental health as fair/poor

Sources: Hospital Discharge & Death Data, obtained from ADHS, cleaned/analyzed by MCDPH, COVID-19 Impact Survey

Prenatal care is critical to improve maternal health and birth outcomes. In many communities, women, newborns, and children are the most vulnerable to health problems.[xxvii] Mothers who do not receive the prenatal care that they need are at an increased risk of experiencing a low-birth weight baby, pre-term delivery, or even infant death. For many, COVID-19 infections added severe strain to women and families during the pregnancy period and created heightened risk during routine medical care and exposure in hospitals during delivery. The overall rates for adequate and inadequate prenatal care for NATIVE HEALTH's PSAs are provided below.[xxviii] Prenatal care including early childhood health and literacy were selected as priority issues for NATIVE HEALTH.

In 2019, **NATIVE HEALTH's West PSA** had the highest overall rates for **adequate** and **inadequate** prenatal care compared to Maricopa County overall.

	Maricopa	Native Health	Central	West	Mesa
Adequate Prenatal Care	869.1	838.2	845.4	**880.4**	752.4
Inadequate Prenatal Care	224.8	234.9	265.8	**276.9**	189.5

■ Adequate Prenatal Care ■ Inadequate Prenatal Care

Rates per 100,000

IN ARIZONA (2019)

84% Fourth graders (Native Americans) scored below proficient reading level

61% Young children (Native Americans) were not in school

37% Fourth graders (Native Americans) were chronically absent from school

4.2% American Indian/Alaska Native participants were enrolled in Head Start programs from 2018-2019

69% Fourth graders scored below proficient reading level

61% Young children were not school

26% Fourth graders were chronically absent from school

63% Fourth graders scored below proficient math level

Words from a COVID-19 Impact Survey Participant

"*I was pregnant and delivered a baby during covid so my answers to mental health are also affected by the changes due to postpartum, however I do believe staying home a lot made it worse.*"

(Hispanic/Latino, NW, 25-34)

Nearly **3** out of **5**

Children did not go to preschool in 2021

AZ

Nearly **3** out of **4**

Children under 3 did not receive timely developmental screenings in 2021

Sources: Kids Count Data Center, Office of Head Start – Head Start Services Snapshot, First Things First Annual Report

Figure 2 displays the estimated percent of people aged three or older who are enrolled in nursery school or preschool with all NATIVE HEALTH's PSAs overlaid.[xvii]

Figure 2.

Estimated percent of people age three or older who are enrolled in nursery school or preschool, between 2016-2020.
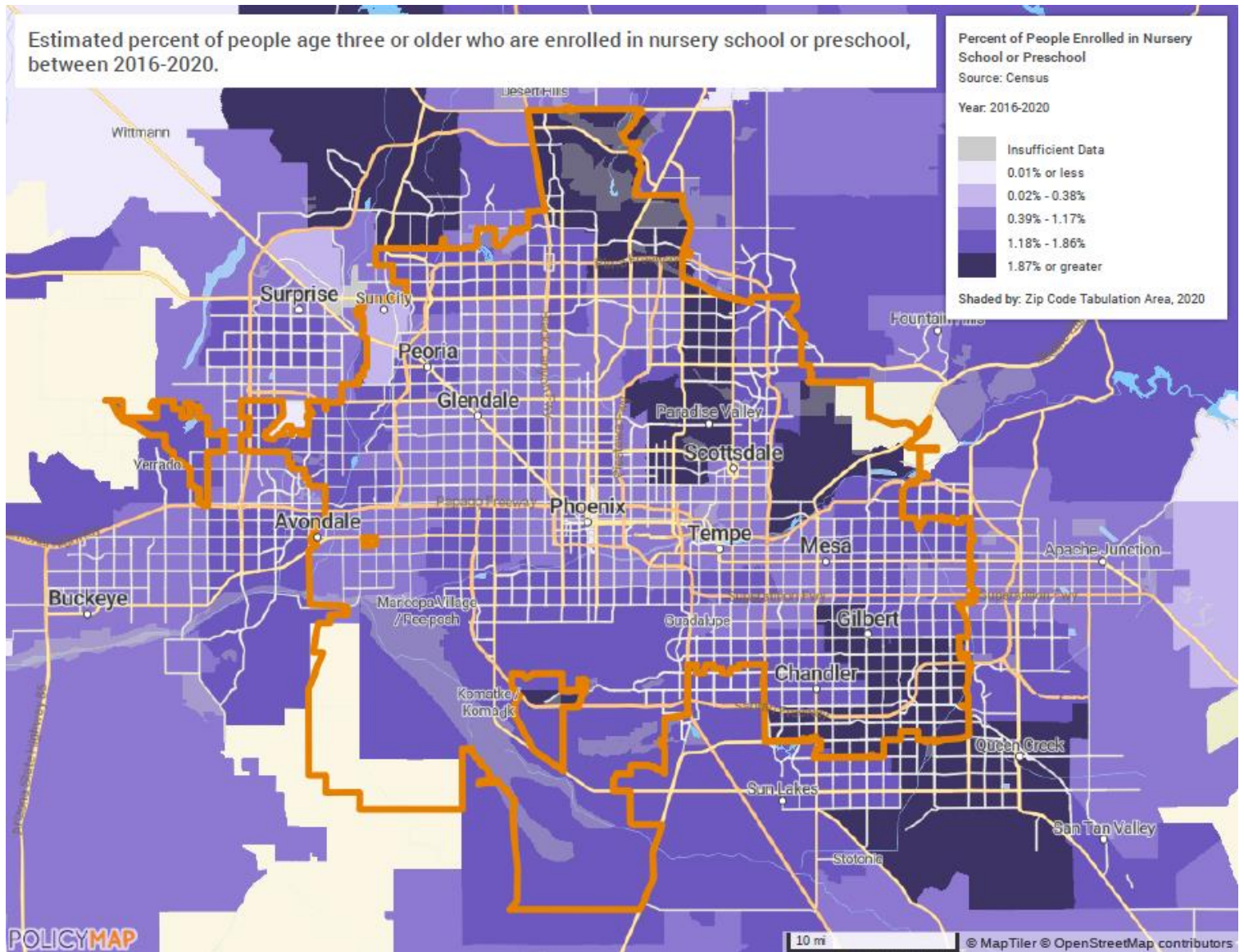
Housing instability has been exacerbated by the COVID-19 pandemic leading to stress and an increase in homelessness. The lack of affordable housing and the limited scale of housing assistance programs contributes to the current housing crisis. High rent burdens, overcrowding, and substandard housing has increased the number of people without housing and at risk of losing housing.[xxix] As an important social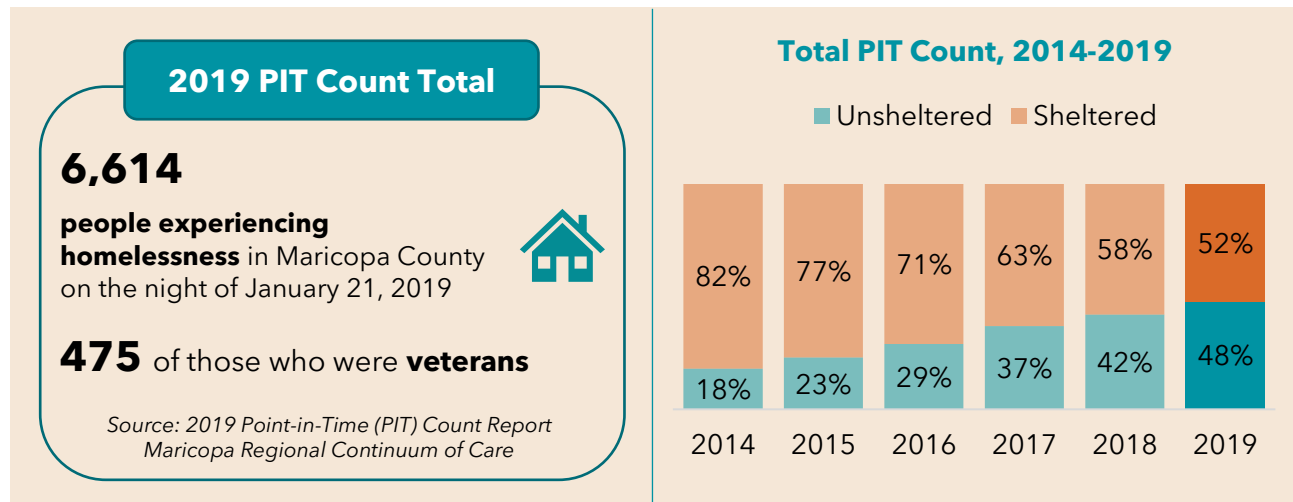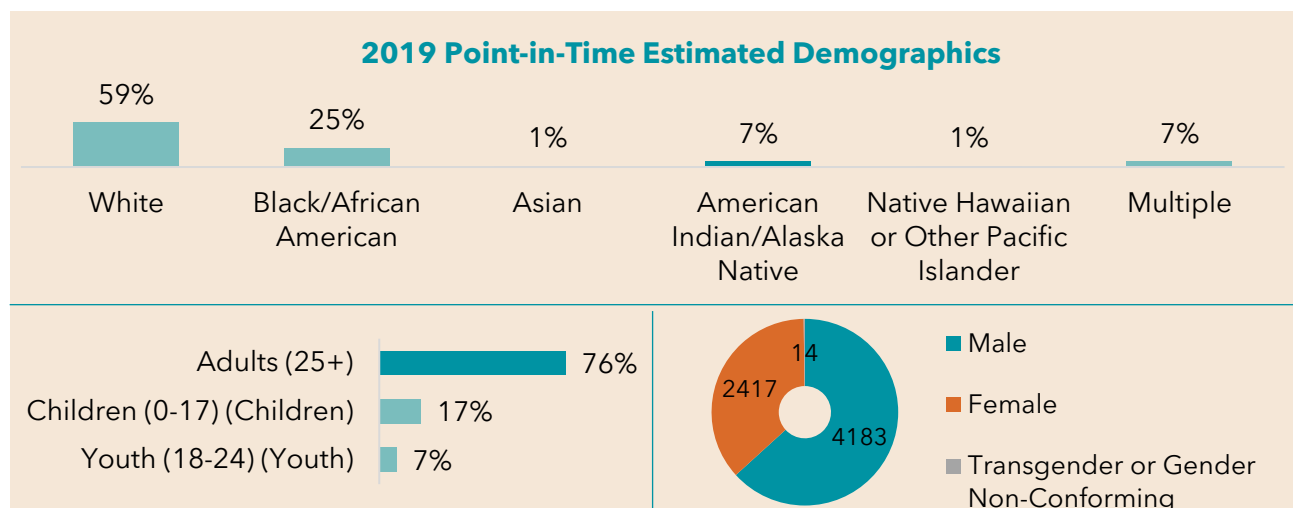 determinant of health, access to housing plays a large role in achieving the highest potential of health and well-being. Displayed below, the Point-in-Time (PIT) Homeless Count is an annual street and shelter count that determines the number of people experiencing homelessness in Maricopa County.[xxx] Housing was selected as priority issue for NATIVE HEALTH.

2019 Point-in-Time Estimated Demographics

59%	25%	1%	7%	1%	7%
White	Black/African American	Asian	American Indian/Alaska Native	Native Hawaiian or Other Pacific Islander	Multiple

Adults (25+) — 76%	14
Children (0-17) (Children) — 17%	2417
Youth (18-24) (Youth) — 7%	4183

- Male
- Female
- Transgender or Gender Non-Conforming

2019 PIT Count Total

6,614

people experiencing homelessness in Maricopa County on the night of January 21, 2019

475 of those who were **veterans**

Source: 2019 Point-in-Time (PIT) Count Report Maricopa Regional Continuum of Care

Total PIT Count, 2014-2019

- Unsheltered   Sheltered

Year	Sheltered	Unsheltered
2014	82%	18%
2015	77%	23%
2016	71%	29%
2017	63%	37%
2018	58%	42%
2019	52%	48%

Words from a COVID-19 Impact Survey Participant

"Getting rental assistance has been impossible. I risk being homeless in July when the CDC order is up. The summer heat is going to cause a lot of deaths because a lot of us will be homeless. Services are very difficult for many people to apply for. Waiting on hold for 5 hrs. is impossible for a lot of people. The system needs improvement badly!

(Native American, PHX, 65-74)

Paying for Essentials Since March 2020 :

34.2%
of Native American respondents stated they sometimes/never had enough money to pay for housing

Source: COVID-19 Impact Survey

Figure 3 displays the estimated percent of all renters who are cost burdened or renter households for whom gross renter is 30% or more of household income with all NATIVE HEALTH's PSAs overlaid.[xvii]

Figure 3.

Estimated percent of all renters who are cost burdened, between 2015-2019 with All Native PSAs Overlaid
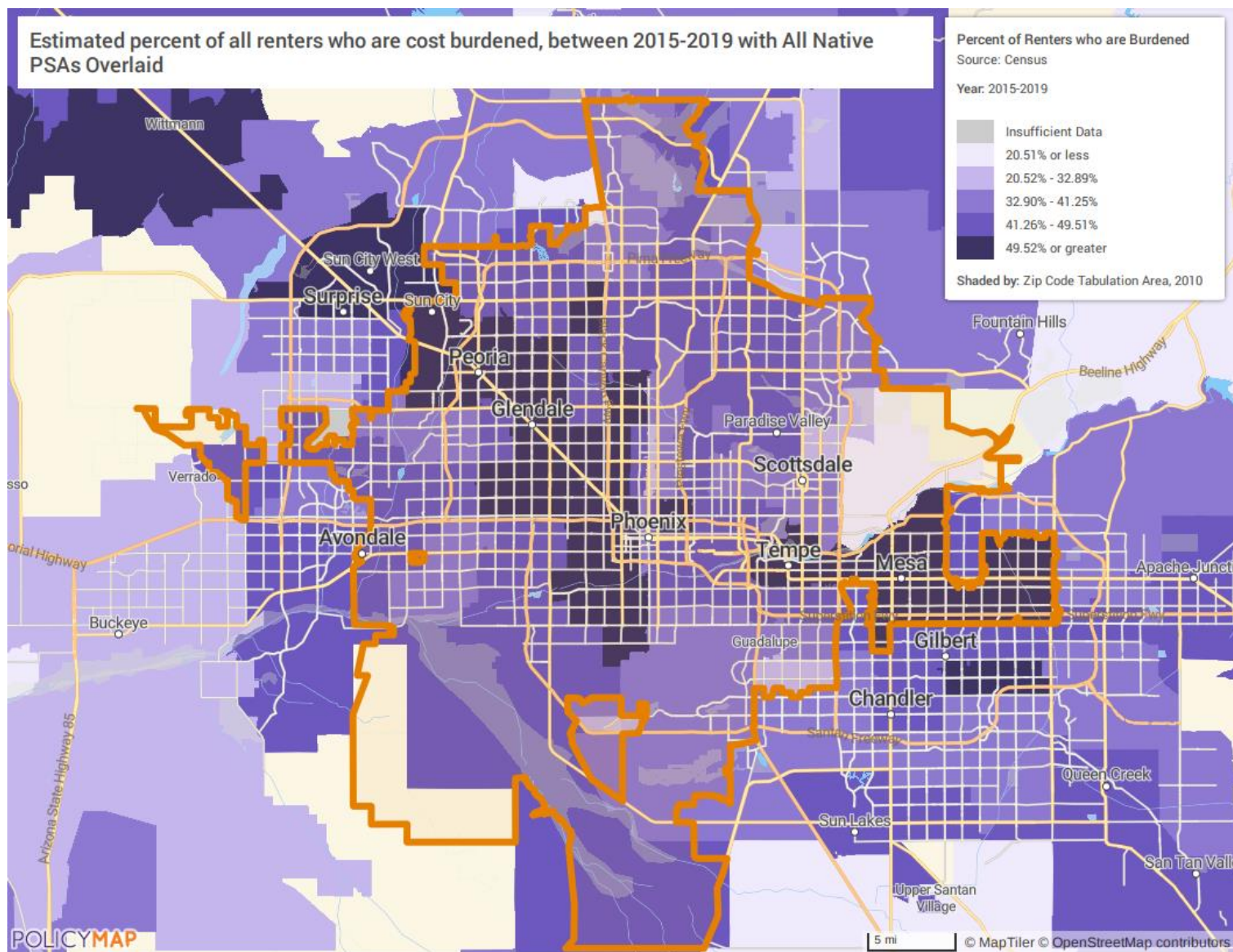
Access to Health Care

Access to healthcare is a longstanding challenge for many communities, and the COVID-19 pandemic has only exacerbated this issue. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met. Access to affordable, quality health care is important to physical, social, and mental health.[xxxi] Access to health care was selected as priority issue for NATIVE HEALTH.

Health Insurance Coverage

In 2019, **10.6%** of Maricopa County residents were **uninsured** and those aged **25-34 years** could not **afford needed healthcare**.

18-24	
25-34	24.2 / 21.8
35-44	
45-54	
55-64	

■ Maricopa County ■ Arizona

Source: BRFSS
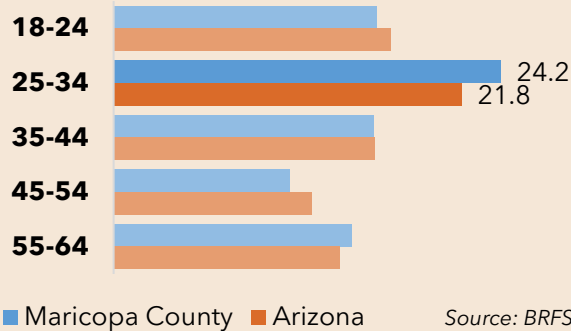
Employment Status

In 2019, the **unemployment rate** was **highest** in **Arizona** followed by **NATIVE HEALTH**.

- Native Health: 5.2%
- Maricopa County: 5.0%
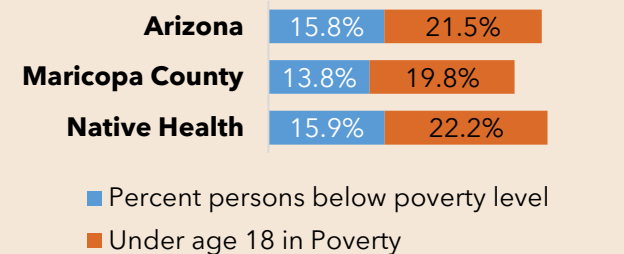- Arizona: 5.8%

Source: ACS Census
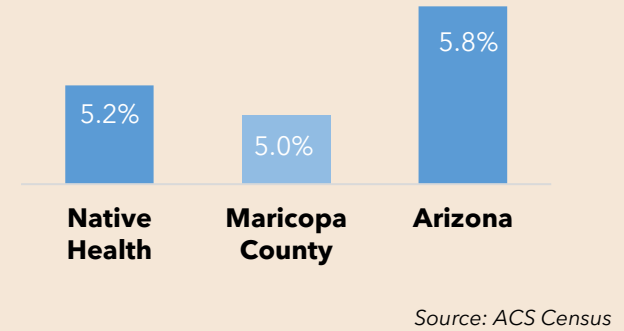
Usual Source of Care/ Routine Checkup

In 2019, **70.5%** of Maricopa County residents had **a usual source of care**. **Less than 60%** of residents aged **18-24 years** went to a **routine checkup** within the past 12 months in Maricopa County.

18-24	25-34	35-44	45-54	55-64
57.4	59.4	62.8	79.2	78.1

■ Maricopa County —— Arizona

Source: BRFSS
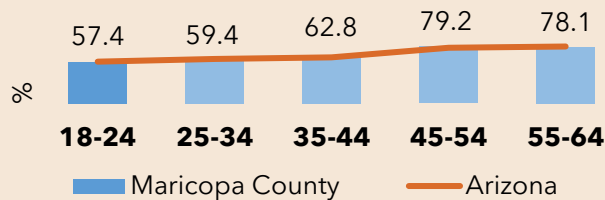
Poverty

In 2019, there was a **higher** percentage of persons living **below the poverty line** among **NATIVE HEALTH's service area** compared to MC and AZ overall.

	Percent persons below poverty level	Under age 18 in Poverty
Arizona	15.8%	21.5%
Maricopa County	13.8%	19.8%
Native Health	15.9%	22.2%

■ Percent persons below poverty level
■ Under age 18 in Poverty

Source: ACS Census

Words from a COVID-19 Impact Survey Participant

"Retired military problems. Most retired do not use VA due to incompetence."

(Native American, PHX, 75+)

32.2%

of Native American respondents sometimes/never had enough money to pay for medical expenses since March 2020.

Source: COVID-19 Impact Survey

Figure 4 displays the estimated percent of the population without health insurance coverage with all NATIVE HEALTH's PSAs overlaid.[xvii]
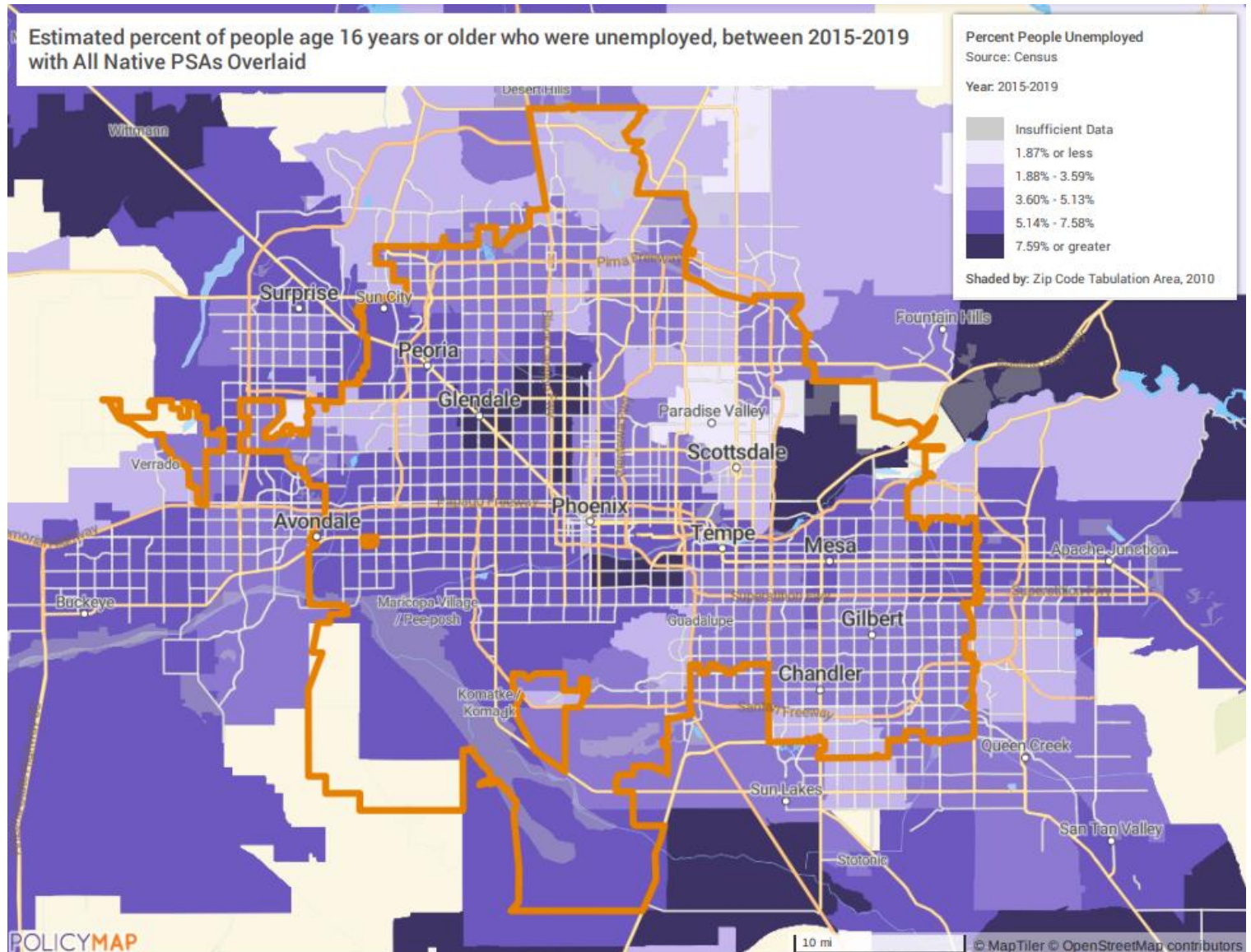
Figure 4.

Estimated percent of people age 16 years or older who were unemployed, between 2015-2019 with All Native PSAs Overlaid

Figure 5 displays the estimated percent of households with no internet access with all NATIVE HEALTH's PSAs overlaid.[xvii]

Figure 5.

Estimated percent of households with no internet access, between 2016-2020, with all Native PSAs overlaid
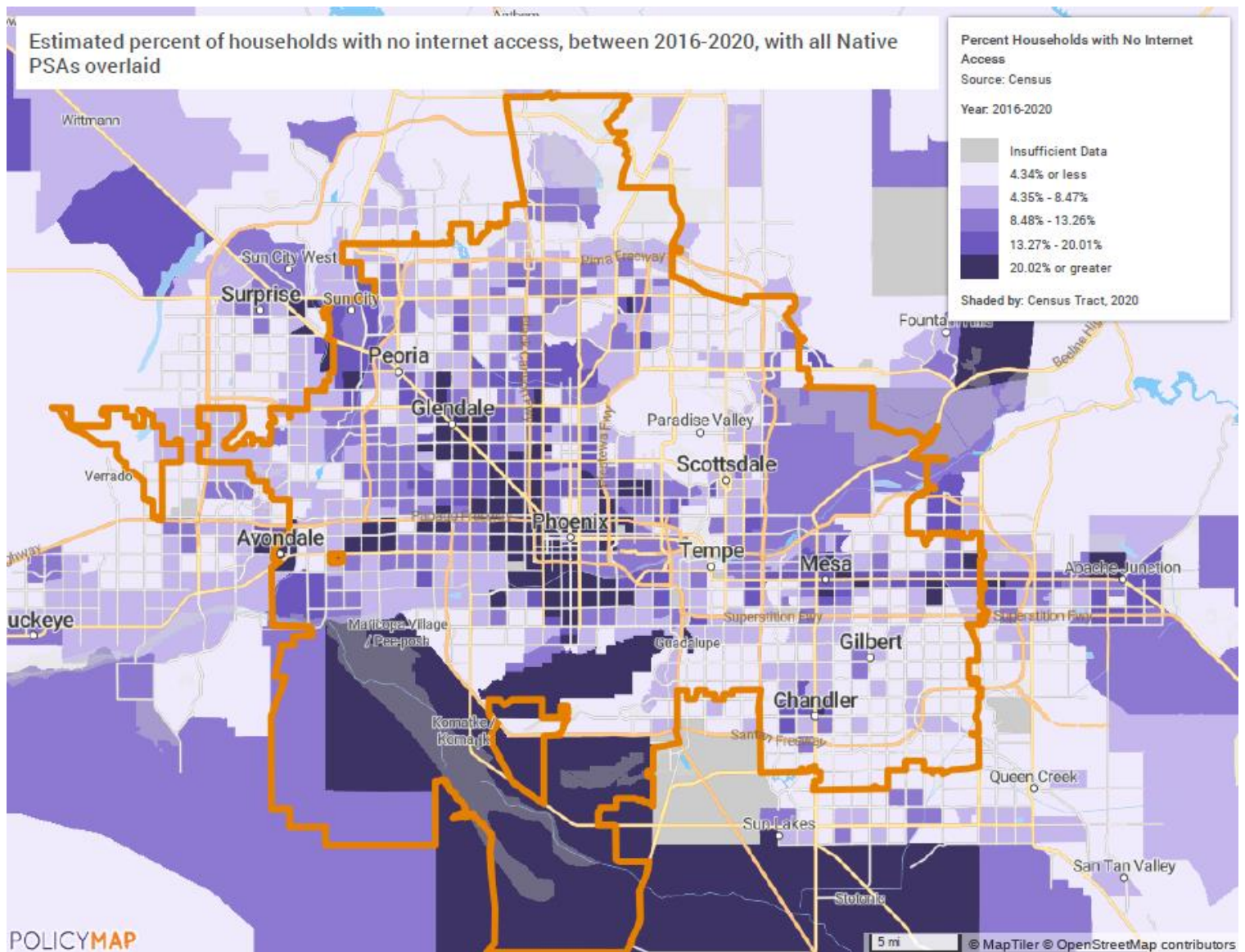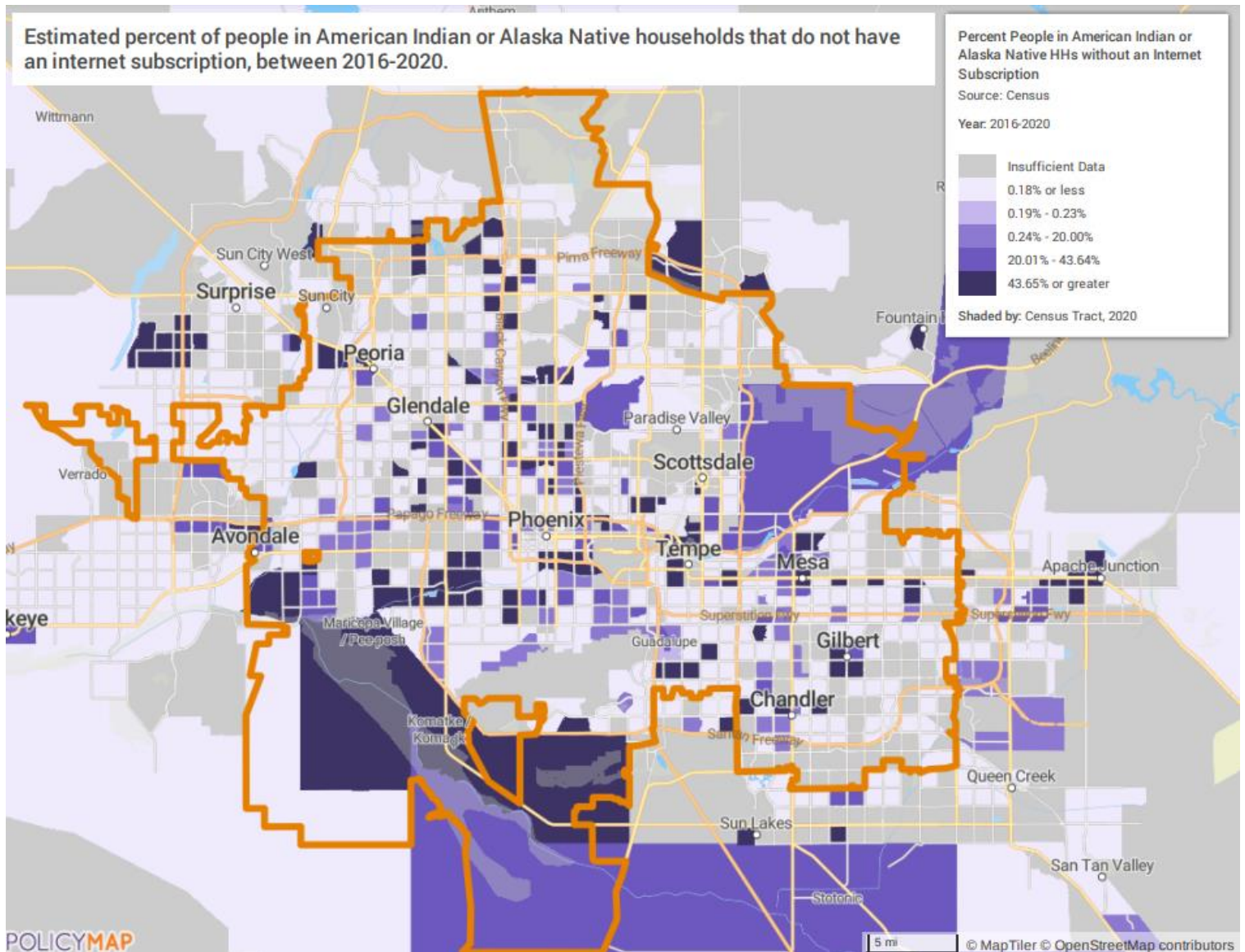
Figure 6 displays the estimated percent of people in American or Alaska Native households that do not have an internet subscription with all NATIVE HEALTH's PSAs overlaid.[xvii]

Figure 6.

Estimated percent of people in American Indian or Alaska Native households that do not have an internet subscription, between 2016-2020.

Resources Potentially Available to Address Needs

Resources potentially available to address identified needs include services and program available through hospital, government agencies, and community-based organizations. Resources include access to hospital emergency and acute services. Federally Qualified Health Centers (FQHCs), food banks, homeless shelter, faith communities, transportation services, health navigators, and prevention-based community education.

Community Resources

The following community organizations have resources potentially available to address the identified significant health needs. NATIVE HEALTH partners with several of these organizations to provide connected care to the Maricopa County community. A complete list of resources potentially available can be found in Appendix F.

Health Need	Resources Potentially Available
Chronic Disease (CVD, Diabetes)	• IHS Special Diabetes Program • Community Garden • Center for Family Wellness – The Society of St. Vincent de Paul • Phoenix Indian Medical Center – Diabetes Self-Management Education Program • Valleywise Health Diabetes Care & Support • Phoenix Children's Hospital and Medical Group, Division of Endocrine and Diabetes
Cancer	• St. Vincent de Paul • AZ Oncology • Valleywise • Virginia G. Piper Cancer Care Network • Banner MD Anderson • Dignity Health Cancer Institute at St. Josephs
Substance Use	• Native Connections • Sunrise Native Recovery • Community Bridges, Inc.

Prenatal Care (Early Childhood Health, Literacy)	• Southwest Human Development • Head Start – City of Phx • First Things First • Child Crisis AZ • AzEIP – DES Arizona Early Intervention Program • Quality First AZ • Parents Partners Plus • Phoenix Public Library
Housing	• Central Arizona Shelter Services (CASS) • Phoenix Rescue Mission • Lutheran Social Services of the Southwest • Human Services Campus
Access to Health Care	• Phoenix Indian Medical Center • ValleyWise • Abrazo Central Campus

Appendices

The appendix includes the following documents:

Appendix A
2019 & 2021 Focus Group Discussion Schedules

Appendix B
Primary Data Collection Tools

Appendix C
2019 & 2021 Community Survey Demographics

Appendix D
NATIVE HEALTH PSA Zip Codes

Appendix E
Top 10 NATIVE HEALTH IP, ED, and Death Rankings

Appendix F
Resources Potentially Available

Appendix G
Data Indicator Matrix

Appendix H
References

Appendix A – 2019 & 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]	**Native American Fatherhood & Families Association** (460 N. Mesa Dr, Suite 115, Mesa, AZ)
4/16 (Tues.)	10:00am – 12:00pm	Homeless Males over 60 [n = 10]	**St. Vincent de Paul** (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]	**Mesa Public Schools** (1025 N. Country Club, Mesa, AZ) & **Native Health (East Valley)** (777 W. Southern Ave., Building C, Mesa, AZ)
4/18 (Thurs.)	10:30am - 12:30pm	Homeless Women with Children [n = 15]	**UMOM** (3333 E. Van Buren St., Phoenix, AZ)
4/18 (Tues.)	5:30pm - 7:30pm	African American Males [n = 7]	**Hatton Hall** (34 E. 7th St., Tempe, AZ)
4/23 (Tues.)	4:30pm - 6:30pm	LGBTQI Adults [n = 7]	**Southwest Center for HIV/AIDS (Parson's Center)** (1101 N. Central Ave, Phoenix, AZ)
4/24 (Wed.)	6:00pm – 8:00pm	Homeless Youth (14-21) [n = 7]	**Native American Connections/HomeBase** (931 E. Devonshire, Phoenix, AZ)
4/25 (Thurs.)	12:30pm- 2:30pm	Adults over 60 (New Retirees) [n = 13]	**Ahwatukee Foothills Family YMCA** (1030 E. Liberty Lane, Phoenix, AZ)
4/26 (Fri.)	10:30am- 12:30pm	New Parents [n = 7]	**Adelante Healthcare – WIC Office** (1705 W. Main St., Mesa, AZ)
4/27 (Sat.)	10:30am- 12:30pm	Homeless Veterans [n = 15]	**MANA House** (2422 W. Holly St., Phoenix, AZ)
4/29 (Mon.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [n = 9]	**Ignacio Conchos Elementary School** (1718 W. Vineyard Rd., Phoenix, AZ)
4/30 (Tues.)	6:00pm - 8:00pm	Parents of Children with Special Health Needs [SPANISH; n = 7]	**Ignacio Conchos Elementary School** (1718 W. Vineyard Rd., Phoenix, AZ)
5/4 (Sat.)	10:30am – 12:30pm	Filipino Adults [n = 8]	**Chandler Community Center** (125 E. Commonwealth Ave., Chandler, AZ)
5/14 (Tues.)	5:30pm - 7:30pm	Veterans [n = 7]	**Tanner Community Development Corporation** (700 E. Jefferson St., Phoenix, AZ)
5/16 (Wed.)	8:30am- 10:30am	New Parents [SPANISH; n = 11]	**Moon Mountain Elementary School** (13425 N. 19th Ave, Phoenix, AZ)

Cycle 2

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

Cycle 3

Date	Time	Population	Location
10/16 (Wed.)	1:00 pm – 3:00 pm	Native Americans - Young adults (19-24)	**ASU Discovery Hall** 250 E Lemon St. Tempe 85281
10/17 (Thurs.)	10:00 am – 12:00 pm	Immigrants/Refugee/Asylum Seekers - Congolese	**IRC** 4425 W Olive #400 Glendale 85302
10/17 (Thurs.)	1:30 pm – 3:30 pm	Asian Americans - South and southeast Asia [n = 29]	**Asian Pacific Community in Action-IACRF Hall** 2809 W Maryland Phoenix 85017
10/22 (Tues)	4:00 pm – 6:00 pm	LGBTQ - Young adults (19-24)	**One.n.ten** 931 #202 Phoenix 85004
10/28 (Mon.)	11:00 am – 1:00 pm	Homeless - Young adults (19-24)	**Homebase** 931 E Devonshire Phoenix 85014
11/1 (Sat.)	1:00 pm – 3:00 pm	Youth Focus Groups (14 - 18) - African Americans 1	**Ironwood Library** 4333 E Chandler Phoenix 85048
11/5 (Tues.)	10:00 am – 12:00 pm	Adults over 65 - Hispanic/Latino [n = 6]	**Gila Bend Family Resource Center** 303 E Pima St, Gila Bend, AZ 85337
11/6 (Wed.)	5:30 pm – 7:30 pm	People Living with Special Healthcare Needs - Parents/caregivers	**Sunset Library** 4930 W Ray, Chandler
11/7 (Thurs.)	12:00 pm – 2:00 pm	Adults over 65 - African Americans [n = 12]	**Muriel Smith Center** 2230 W Roeser Rd, Phoenix 85041
11/7 (Thurs.)	5:00 pm – 7:00 pm	African Americans- Young adults (19-24) [n = 4]	**Muriel Smith Center** 2230 W Roeser Rd, Phoenix 85041
11/12 (Wed.)	5:00 pm – 7:00 pm	Youth Focus Groups (14-18) - Homeless	**UMOM** 2344 E Earll Drive
11/13 (Wed.)	8:30 am – 10:30 am	Youth Focus Groups (14 - 18) - Hispanic	**Natalie's room North High School** 1101 E Thomas Phoenix 85014
11/13 (Wed.)	4:00 pm – 6:00 pm	People who have been previously incarcerated – combined	**Black Canyon building** 2445 W Indianola
11/13 (Wed.)	5:00 pm – 7:00 pm	Youth Focus Groups (14 - 18) - Native American	**Seewa Tomteme Community Center** 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
Total Participants				186

* 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 healthcare 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?

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     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 & 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 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 & 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.)

☐ Health insurance purchased on my own or by family member	☐ Health insurance purchased/provided through employer	☐ I do not use health care services	☐ Indian Health Services
☐ Medicaid/AHCCCS	☐ Medicare	☐ Travel to a different country to afford health care	☐ Use free clinics
☐ Use my own money (out of pocket)	☐ Veterans Administration	☐ 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
☐ No health insurance coverage	☐ Not enough health insurance coverage	☐ Transportation to appointments	☐ Understanding of language, culture, or sexual orientation differences
☐ Other: _____			

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 substsance abuse treatment services	☐ Access to support networks such as neighbors, friends, and family	☐ Clean environment 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 diseases 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: _____	☐	☐

11. Which <u>issues</u> have the greatest impact on your community's health and wellness? (Check up to 5.)

☐ Bullying/peer pressure	☐ Child abuse/neglect	☐ Distracted driving (such as cell phone use, texting while driving)	☐ Domestic violence
☐ Dropping out of school	☐ Elder abuse/neglect	☐ Gang-related violence	☐ Gun-related injuries
☐ Homelessness	☐ Homicide (murder)	☐ Illegal drug use	☐ Limited access to healthcare
☐ Lack of affordable healthy food options	☐ Lack of affordable housing	☐ Lack of child car seats and seat belts use	☐ Lack of good jobs
☐ Lack of good schools	☐ Lack of people immunized to prevent disease	☐ Lack of public transportation	☐ Lack of quality and affordable childcare
☐ Lack of safe spaces to exercise and be physically active	☐ Lack of support networks such as neighbors, friends and family	☐ Limited places to buy groceries	☐ Motor vehicle & motorcycle crash injuries
☐ Racism/discrimination	☐ Rape/sexual assault	☐ Smoking/electronic cigarette use or caping	☐ Suicide
☐ Teen pregnancy	☐ Unsafe working conditions	☐ Other: _____	

For the next four questions, please imagine a ladder with steps numbered from one at the bottom to ten at the top. The top of the ladder represents the <u>best possible life</u> and the bottom of the ladder represents the <u>worst possible life.</u>

12. Which step represents the health of your community?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst Possible | | | | | | | | Best Possible |

13. Indicate where on the ladder you feel you personally stand right now.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst Possible | | | | | | | | Best Possible |

14. On which step do you think you will stand about five years from now?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst Possible | | | | | | | | Best Possible |

15. Now imagine the top of the ladder represents the best possible *financial situation* for you, and the bottom of the ladder represents the worst possible *financial situation* for you. Please indicate where on the ladder you stand right now.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst Possible | | | | | | | | Best Possible |
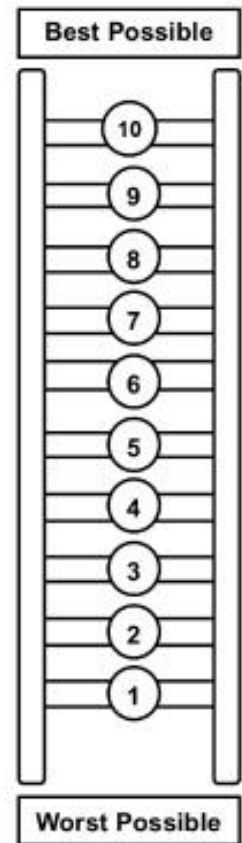
The following information is used for demographic purposes and does NOT identify you; all responses are confidential.

16. What is your ZIP code? _____

17. What is your gender?

☐ Male	☐ Female	☐ Transgender	☐ Other

18. What is your age?

☐ 12-17	☐ 18-24	☐ 25-34	☐ 35-44
☐ 45-54	☐ 55-64	☐ 65-74	☐ 75+

19. Which racial or ethnic group do you identify with? (Check only 1.)

☐ White	☐ Asian	☐ American Indian: Tribal Affiliation _____	☐ Hispanic or Latino
☐ Black of African American	☐ Native Hawaiian or Other Pacific Islander	☐ Alaskan Native	☐ Multi-racial
☐ Other			

20. Which group(s) do you most identify with? (Check all that apply.)

☐ Adult with children	☐ Adult with no children	☐ Caregiver	☐ LGBTQI
☐ Person experiencing homelessness	☐ Person with a disability	☐ Refugee/Asylum Seeker	☐ Single parent
☐ Veteran	☐ Person living with HIV/AIDS	☐ Other: _____	☐ None

21. What range is your household income?

☐ Less than $20,000	☐ $20,000 - $29,000	☐ $30,000 - $49,000
☐ 50,000 - $74,000	☐ $75,000 - $99,999	☐ Over $100,000

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

☐ Less than a high school graduate	☐ High school diploma or GED	☐ Associate's Degree	☐ Currently enrolled at vocational school or college
☐ College degree or higher	☐ 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 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?**

☐ Female	☐ Male	☐ Transgender	☐ Prefer to self-describe	☐ Prefer not to answer

3. **What is your age range?**

☐ 12-17	☐ 18-24	☐ 25-34	☐ 35-44
☐ 45-54	☐ 55-64	☐ 65-74	☐ 75+

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

☐ African American/Black	☐ American Indian/Native American	☐ Asian	☐ Hispanic/Latinx
☐ Native Hawaiian or other Pacific Islander	☐ Caucasian/White	☐ Other: _____	☐ Prefer not to answer

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

☐ Adult with children under age 18 or living in the same home	☐ Single parent	☐ LGBTQI	☐ Person experiencing homelessness
☐ Person living with a disability	☐ Immigrant	☐ Refugee	☐ Veteran

☐ Person living with HIV/AIDS	☐ Other	☐ Prefer not to answer	☐ None

6. What range is your household income?

☐ Less than $20,000	☐ $20,000 - $29,000	☐ $30,000 - $49,000
☐ 50,000 - $74,000	☐ $75,000 - $99,999	☐ Over $100,000
☐ Prefer not to answer		

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

☐ Less than a high school graduate	☐ High school diploma or GED	☐ Some College or Associate degree (2yr)	☐ Graduate of vocational/trade school
☐ Currently enrolled in college	☐ Bachelor's Degree (4yr)	☐ Postgraduate Degree	☐ Other
☐ 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

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

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

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

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

13. What services would have improved overall mental and physical health of your family in the last year? (Check all that apply)

☐ Childcare services	☐ In-person school	☐ Technology and internet service	☐ Assistance with finding employment
☐ Assistance with paying utilities	☐ Assistance with paying rent	☐ Assistance with finding healthcare	☐ Assistance with finding substance use treatment
☐ Assistance with mental health issues	☐ Assistance with finding COVID-19 vaccine	☐ 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

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

18. Since March of 2020, was your employment impacted due to the COVID 19 pandemic? (Check all that apply)

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

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

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

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

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

21. Since March of 2020, what have been 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 schools or school alternatives	☐	Access to affordable childcare
☐	Access to affordable healthy foods	☐	Access to COVID-19 testing events	☐	Access to cultural & educational events	☐	Access to medical care
☐	Access to affordable housing	☐	Access to COVID-19 vaccine events	☐	Access to quality online school options	☐	Access to mental health services
☐	Access to community programming such as classes & trainings	☐	Access to Flu vaccine events	☐	Access to jobs & healthy economy	☐	Access to parks and recreation sites
☐	Access to public libraries and community centers	☐	Access to safe walking and biking routes	☐	Access to substance abuse treatment services	☐	Access to low crime / safe neighborhoods
☐	Access to public transportation	☐	Access to services for seniors	☐	Access to support networks such as neighbors, friends, and family		
☐	Access to religious or spiritual events	☐	Access to social services for	☐	Access to clean environments and streets	☐	Other: _____

		residents in need or crisis		

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)

☐ Alcohol/Substance abuse	☐ Cancers	☐ Dementia/Alzheimer's	☐ Diabetes
☐ 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 disease
☐ Tobacco use including vaping	☐ 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)

☐ Child abuse/elder abuse & neglect	☐ Distracted driving (such as cell phone use, texting while driving)	☐ Domestic violence / sexual assault	☐ Gang-related violence
☐ Gun-related injuries	☐ Limited/lack of access to COVID19 testing	☐ Lack of affordable healthy food options	☐ Lack of people immunized to prevent disease
☐ Homelessness	☐ Limited access to healthcare	☐ Lack of affordable housing	☐ Lack of public transportation
☐ Drug/substance abuse (illegal & prescribed)	☐ Limited access to mental/behavioral health services	☐ Lack of jobs	☐ Lack of quality and affordable childcare
☐ Lack of COVID-19 vaccine access	☐ Limited access to educational and supportive programing for children and adolescents	☐ Lack of alternative educational opportunities	☐ Lack of safe spaces to exercise and be physically active

☐ Lack of support networks such as neighbors, friends, and family	☐ Motor vehicle & motorcycle crash injuries	☐ Racism/ discrimination	☐ Suicide
☐ Teen Pregnancy	☐ Other: _____		

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

☐ Very easy to use	☐ Easy to use	☐ Neither easy nor difficult to use	☐ Difficult to use	☐ Very difficult to use

25. Based on the given survey questions above, the information provided was easy to understand.

☐ Strongly agree	☐ Agree	☐ Neutral	☐ Disagree	☐ Strongly disagree

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: _____

Thank you for completing MCDPH's COVID-19 Impact Community Health Assessment Survey.

Appendix C – 2019 & 2021 Community Survey Demographics

2019

Total # of participants	11,893
Race/Ethnicity	
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%
Age	
12-24	8.0%
25-44	32.0%
45-64	39.0%
65+	21.0%
Gender	
Female	73.0%
Male	25.0%
Other	1.0%

2021

Total # of participants	14,380
Race/Ethnicity	
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 races	1.2%
Unknown/Not given	4.9%
Age	
12-24	6.4%
25-44	30.9%
45-64	43.0%
65+	20.0%
Gender	
Female	68.9%
Male	29.1%
Additional Genders	0.6%
Unknown/Not Given	1.4%

Appendix D – NATIVE HEALTH's PSA Zip Codes

NATIVE HEALTH Central

85003	85016	85031	85053	85044
85004	85017	85032	85251	85048
85006	85018	85033	85253	85050
85007	85019	85034	85257	85250
85008	85020	85035	85301	85258
85009	85021	85040	85302	85260
85012	85022	85041	85303	85392
85013	85023	85042	85304	85339
85014	85028	85043	85306	85340
85015	85029	85051	85037	

NATIVE HEALTH Mesa

85008	85205	85225	85257	85286
85201	85206	85233	85281	85295
85202	85210	85234	85282	85296
85203	85213	85251	85283	85297
85204	85224	85256	85284	

NATIVE HEALTH West

85003	85015	85024	85053	85306
85004	85016	85027	85085	85307
85006	85017	85028	85253	85308
85007	85018	85029	85254	85323
85008	85019	85031	85301	85345
85009	85020	85032	85302	85351
85012	85021	85033	85303	85353
85013	85022	85035	85304	85381
85014	85023	85051	85305	85382

Appendix E – NATIVE HEALTH's Top 10 IP, ED, and Death Rankings

Inpatient Hospitalization Rankings

Rank	All Native PSA	Central PSA	West PSA	Mesa PSA
1	Cardiovascular Disease	All Mental Health	All Mental Health	Cardiovascular Disease
2	All Mental Health Disorders	Cardiovascular Disease	Cardiovascular Disease	All Mental Health
3	Mood and Depressive Disorder	Mood and Depressive Disorder	Mood and Depressive Disorder	Mood and Depressive Disorder
4	Unintentional Fall Related Injuries	Schizophrenic	Schizophrenic	Schizophrenic
5	Stroke	Unintentional Fall Related Injuries	Unintentional Fall Related Injuries	Unintentional Fall Related Injuries
6	Schizophrenic	Stroke	Stroke	Stroke
7	Diabetes	Diabetes	Diabetes	Diabetes
8	COPD	COPD	COPD	COPD
9	Motor Vehicle Traffic Related	Motor Vehicle Traffic Related	Motor Vehicle Traffic Related	Motor Vehicle Traffic Related
10	Drug Induced Mental Health	Drug Induced Mental Health	Drug Induced Mental Health	Drug Induced Mental Health

Emergency Department Rankings

Rank	All Native PSA	Central PSA	West PSA	Mesa PSA
1	Unintentional Fall Related Injuries	Unintentional Fall Related Injuries	Unintentional Fall Related Injuries	Unintentional Fall Related Injuries
2	All Mental Health Disorders	All Mental Health Disorders	All Mental Health Disorders	All Mental Health Disorders
3	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease
4	Motor Vehicle Traffic Related	Motor Vehicle Traffic Related	Motor Vehicle Traffic Related	Motor Vehicle Traffic Related
5	Asthma	Asthma	Asthma	Asthma
6	Assault Related Injuries	Assault Related Injuries	Assault Related Injuries	Assault Related Injuries
7	Diabetes	Diabetes	Diabetes	Diabetes
8	COPD	COPD	COPD	COPD
9	Self Harm Related Injuries	Self Harm Related Injuries	Mood and Depressive Disorder	Self Harm Related Injuries
10	Mood and Depressive Disorder	Mood and Depressive Disorder	Self Harm Related Injuries	Mood and Depressive Disorder

Death Rankings

Rank	All Native PSA	Central PSA	West PSA	Mesa PSA
1	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease
2	Opioid Overdose	Opioid Overdose	Opioid Overdose	Opioid Overdose
3	COPD	COPD	COPD	Alzheimer's
4	Unintentional Fall Related	Unintentional Fall Related	Unintentional Fall Related	COPD
5	Alzheimer's	Alzheimer's	Alzheimer's	Unintentional Fall Related
6	Lung Cancer	Lung Cancer	Lung Cancer	Alcohol Related Injuries
7	Stroke	Alcohol Related Injuries	Stroke	Stroke
8	Alcohol Related Injuries	Stroke	Alcohol Related Injuries	Lung Cancer
9	Suicide	Suicide	Suicide	Suicide
10	Diabetes	Diabetes	Diabetes	Breast Cancer

Appendix F – Resources Potentially Available

Health Need	Resources Potentially Available
Food Insecurity	• Andre House of Arizona • Mom's Pantry • St. Vincent De Paul • Nourish Phoenix • United Food Bank • St. Mary's Food Bank
Basic Needs (Clothing, etc.)	• Nourish Phoenix • Forgotten Treasures • Gila Bend Community Action Program • Vineyard North Phoenix

Appendix G – Data Indicator Matrix

Resource Responsibility

HDD - Hospital Discharge Data
BRFSS - Behavioral Risk Factor Surveillance Survey
ACS - American Community Survey (Census)
YRBS - Youth Risk Behavior Survey
AYS - Arizona Youth Survey
H-CUP - The Healthcare Coast & Utilization Project
IP - linpatient hospitalization
ED - Emergency Department Visits

Indicator	Source										Level				
	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	Maricopa County	Regions	Zipcode	National	State
Population Demographics															
Gender			■							■	■	■	■	■	■
Age Groups			■							■	■	■	■	■	■
Race/Ethnicity			■							■	■	■	■	■	■
Education			■							■	■	■	■	■	■
Income			■							■	■	■	■	■	■
Employment Status			■							■	■	■	■	■	■
Access to Health Care															
Health Insurance Coverage			■								■	■	■		
Poverty			■								■	■	■		
Health Care Coverage (18-64)		■									■			■	■
Usual Source of Care		■									■			■	■
Routine Checkup (last year)		■									■			■	■
Primary Payer Type for ED/IP	■									■	■			■	■
Birth Related															
IMR					■	■					■	■	■		■
Low Birth Weight						■					■	■	■		■
PreTerm Births						■					■	■	■		■
Teen Birth						■					■	■	■		■
Prenatal Care Began						■					■	■	■		■
Top 5 leading cause of death					■						■	■	■		■
Youth top 5 leading cause of death					■						■	■	■		■
Top 5 leading emergency department and hospitalization reasons	■									■	■	■	■		■
Cancer Incidence & Prevention															
Cancer (by type) Incidence							■				■				
Cancer (by type) Screening		■									■			■	■
Cancer (by type) Deaths					■						■	■	■	■	■
Chronic Disease															
Stroke	■									■	■	■	■		■
Stroke Deaths					■						■	■	■		■
% Been told they have high blood pressure		■									■			■	■
Cardiovascular Disease	■										■	■	■		■
Cardiovascular Disease Deaths					■						■	■	■		■
% Told they have high cholesterol		■									■			■	■
Diabetes	■									■	■	■	■		■
Diabetes Deaths					■						■	■	■		■
Been told they have diabetes		■									■			■	■
Alzheimer's ED/IP	■									■	■	■	■		■
Alzheimer's Deaths					■						■	■	■		■
% told they have Confusion/Memory Loss		■									■			■	■
COPD ED/IP	■									■	■	■	■		■
COPD Deaths					■						■	■	■		■
Been told they have asthma		■									■			■	■
Asthma ED/IP	■									■	■	■	■		■
Asthma Deaths					■						■	■	■		■
Been told they have asthma			■								■			■	■

Resource Responsibility

HDD - Hospital Discharge Data
BRFSS - Behavioral Risk Factor Surveillance Survey
ACS - American Community Survey (Census)
YRBS - Youth Risk Behavior Survey
AYS - Arizona Youth Survey
H-CUP - The Healthcare Coast & Utilization Project
IP - linpatient hospitalization
ED - Emergency Department Visits

	HDD	BRFSS	ACS;Census	YRBS	Death	Birth	ADHS	AYS	PolicyMap	H-CUP	Maricopa County	Regions	Zipcode	National	State
Mental/Behavioral Illness															
Mood and Depressive Disorders	✓									✓	✓	✓	✓	✓	✓
Schizophrenic Disorders	✓									✓	✓	✓	✓	✓	✓
Drug-Induced Mental and Behavioral Disorders	✓									✓	✓	✓	✓	✓	✓
All Mental/Behavioral disorders	✓									✓	✓	✓	✓	✓	✓
Behavioral Health Risk Factors															
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				✓											✓
Injury															
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					✓						✓	✓	✓		✓
Social Determinants of Health															
Transportation; no vehicle households									✓		✓	✓	✓	✓	✓
Access to Food; Low Income Low Access									✓		✓	✓	✓	✓	✓
Housing; cost burdened									✓		✓	✓	✓	✓	✓

Appendix H - References

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