2025

Banner Boswell Medical Center

Community Health Needs Assessment

Banner Health

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Letter from Banner Leadership

At Banner we're deeply committed to our mission, *making health care easier so life can be better.* We serve unique communities, from rural towns to large metropolitan areas, supporting our community members through all stages of life. Our wide array of services do just that, including acute care, employed physician groups, outpatient surgery centers, urgent care locations, retail pharmacies, imaging centers, physical therapy, behavioral health services, academics, research, home health, and health insurance plans.

Banner recently completed the fifth cycle of our Community Health Needs Assessments (CHNA) across the six states we serve. In partnership with local community health departments, we engaged with community members to identify areas of need. The completion of this report is three-years in the making.

Through engagement with the community during our CHNA process, we reviewed the changing needs and social determinants of health for the underserved—seeking input from target populations with greater health care needs such as children, women and the elderly.

This health needs assessment will guide the ways in which Banner continues promoting health and wellness in the communities we serve.

Following the completion of the CHNA reports, Banner Health will develop Implementation Plans to address the identified priority health needs for the communities we serve. The Implementation Plans will provide a framework for Banner Health to continue to support our communities in their health journeys.

We would like to recognize and thank our partners for their collaboration in the CHNA process. Your support has helped us optimize care in more places, improving the health of the communities we serve.

Amy Perry

President and CEO

Banner Health

Executive Summary

Headquartered in Phoenix, AZ, Banner Health is one of the nation's largest nonprofit health care systems and is guided by our nonprofit mission: *Making health care easier, so life can be better.* This mission is the cornerstone of operations at all our 33 acute care hospitals as well as in our health centers and clinics. Banner hospitals range from large regional medical centers to small town critical access facilities in Colorado, Wyoming, Arizona, Nebraska, Nevada and California, all serving an incredibly diverse patient population.

The 2025 Community Health Needs Assessment (CHNA) process included insights and input from a range of community members, including public health experts and representatives of underserved populations. This inclusive approach ensures that the assessment reflects diverse perspectives and community experiences. The priorities identified in this report help to guide the hospital's ongoing community health improvement programs and community benefit activities. In addition, this report also complies with federal tax requirements set forth in Internal Revenue Code Section 501(r), requiring hospital facilities owned and operated by an organization described in Internal Revenue Code Section 501(c)(3) to conduct a CHNA at least once every three years.

The 2025 CHNA process was developed and organized by the CHNA Steering Committee, led by the Executive Leader Todd Werner, President of Community Delivery with input and support from Banner's Strategy and Growth Department's Senior Program Director. Additional guidance was provided by the CEO for Banner's Arizona, Western Division, Academic and Rehabilitation Divisions as well as the CEOs from local facilities. In Maricopa County, the Synapse Coalition, with the Maricopa County Department of Public Health (MCDPH), worked together to identify community strengths and address the most pressing needs through a coordinated CHNA. Synapse is a coalition of non-profit and federally qualified health care providers that work together to collect data and conduct CHNAs to guide community investments. The following organizations are a part of the Synapse Coalition:

- Adelante Healthcare
- Banner Health
- City of Hope
- Circle the City
- Dignity Health
- Mayo Clinic
- Native Health
- Neighborhood Outreach Access to Health (NOAH)
- Phoenix Children's
- Valleywise Health

- Vitalyst Health Foundation

This effort was supported by Arizona State University's Southwest Interdisciplinary Research Center (SIRC) in developing and conducting focus groups; the OMNI Institute for conducting key informant interviews; and community-based agencies and healthcare partners to collect community surveys within Maricopa County. Health indicators were compiled and analyzed by MCDPH's Division of Epidemiology and Informatics. Crescendo Consulting Group leveraged data collected via the Synapse coalition to produce the charts, graphs, maps, and narratives that appear in this report.

Overall Methodology

The CHNA methodology involved a 4-stage process which included an environmental analysis, community input, and prioritization as outlined below.

Input was solicited and provided by at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in Section 338J of the Public Health Services Act, with knowledge, information, or expertise relevant to the health needs of the community.

Secondary Data

These data points provide critical insights into the demographics of Maricopa County. Topics included indicators for communicable and chronic disease, birth statistics, causes of death, causes for hospitalizations, along with social, behavioral, demographic, and environmental data. The data was collected and analyzed by MCDPH's Division of Epidemiology and Informatics. That team accessed multiple data sources to collect and analyze health indicators at the national, state, and county levels.

Qualitative Research

The OMNI Institute conducted 24 key informant interviews between January and May of 2024. MCDPH also contracted with SIRC who conducted 46 focus groups with 366 participants reaching 15 priority populations during the summer of 2023. Priority populations included representatives of the Asian, Black/African American, Hispanic, Native American, Native Hawaiian/Pacific Islander, youth ages 12-17, older adults ages 65 and older, low-income individuals, religious minorities,

unsheltered, disables, veterans, LGBTQ+, refugee / immigrant / migrant community, formerly incarcerated and people living in rural areas of Maricopa County.

Community Survey

The survey was administered in 14 languages (Arabic, Burmese, Mandarin Chinese, Dari, English, French, Kinyarwanda, Korean, Lao, Navajo, Spanish, Swahili, Thai, and Vietnamese). To increase accessibility, MCDPH provided large-font printed paper surveys, offered verbal surveys taken over the phone through the CARES Line, and partnered with SAAVI Services for the Blind to develop surveys in Unified English Braille. Surveys in languages other than English were translated by fluent language speakers and for analysis, free-text responses were translated back into English.

All survey data was collected between March and June of 2023. A total of 18,297 responses were collected and analyzed. SIRC conducted additional focus groups with a total of 309 participants during the summer of 2023.

Prioritized Needs

The needs prioritization is a critical final step in the Community Health Needs Assessment process. The quantitative and qualitative research results for Maricopa County were presented. A modified Hanlon Method was used to identify the top priorities on which Banner Boswell Medical Center will focus in their 2025-2028 Implementation Strategy. The top four priorities are as follows:

Next Steps: From Analysis to Action

The priorities identified in this report help to guide the hospital's ongoing community health improvement programs and community benefit activities. Per Affordable Care Act (ACA) requirements, each nonprofit hospital must adopt an implementation strategy that describes how the hospital will address the identified significant community health needs. To satisfy this requirement, the CHNA findings and selected priority areas were used to inform our 2025-2028 Hospital Implementation Strategies plan.

This CHNA report was adopted by Banner Health's board December 2025.

Introduction

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs of the community served by Banner Boswell Medical Center (BBWMC), Sun City. The priorities identified in this report help to guide the hospital's ongoing community health improvement programs and community benefit activities. This CHNA report meets the requirements of the Affordable Care Act (ACA) that nonprofit hospitals conduct a CHNA at least once every three years. BBWMC is dedicated to enhancing the health of the communities it serves. The findings from this CHNA report serve as a foundation for understanding the health needs found in the community and will inform the implementation strategies selected. This report complies with federal tax requirements set forth in Internal Revenue Code Section 501(r), requiring hospital facilities owned and operated by an organization described in Internal Revenue Code Section 501(c)(3) to conduct a CHNA at least once every three years. Regarding the CHNA, the ACA specifically requires nonprofit hospitals to:

1. Collect and take into account input from public health experts, community leaders, and representatives of high need populations – this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions;
2. Identify and prioritize community health needs;
3. Document a separate CHNA for each individual hospital; and,
4. Make the CHNA report widely available to the public.

In addition, each nonprofit hospital must adopt an implementation strategy that describes how the hospital will address the identified significant community health needs. This is the fifth cycle for Banner Health, with the fourth cycle completed in 2022. Feedback on the previous CHNA and Implementation Strategy will be addressed later in the report. This CHNA report was adopted by Banner Health's board December 2025.

This report is widely available to the public on the hospital's website https://www.bannerhealth.com/staying-well/community/health-needs-assessments-report.

Please use the following link to either submit written comments on these reports and / or request paper copies: CHNA.CommunityFeedback@bannerhealth.com.

About Community Health Needs Assessments

The Community Health Needs Assessment (CHNA) is a comprehensive process that identifies the health needs, barriers to accessing care, and the social drivers of health (SDoH) in a community. Intentional outreach was made to include the voices and lived experiences of the community members that may not have historically participated in this process in prior years. The Community Health Needs Assessment is also a requirement of all non-profit hospitals to complete every three years as part of the Patient Protection and Affordable Care Act (the ACA) and codified under IRS Section 501(r)(3). After a CHNA, hospitals must also complete a three-year Implementation Strategy Plan (ISP) that identifies how the hospital plans to address identified prioritized needs of the community.

About Banner Health

Headquartered in Phoenix, AZ, Banner Health is one of the nation's largest nonprofit health care systems and is guided by our nonprofit mission: Making health care easier, so life can be better. This mission is the cornerstone of operations at our 33 hospitals and clinics, ranging from large regional medical centers to small town critical access facilities in Colorado, Wyoming, Arizona, Nebraska, Nevada and California, all serving an incredibly diverse patient population. Banner provides more than $1B annually in community benefit and charity care—treatment without expectation of being paid. As a nonprofit organization, we reinvest revenues to add new hospital beds, enhance patient care and support services, expand treatment technologies as well as maintain equipment and facilities. Furthermore, Banner subsidizes medical education costs for hundreds of physicians in our residency training programs in Arizona (Phoenix, Tucson, Payson) and Colorado (Greeley).

With organizational oversight from a 13-member board of directors and guidance from both clinical and non-clinical system and facility leaders, more than 55,000 employees work tirelessly to provide excellent care to patients in Banner's acute care hospitals, rehabilitation hospitals, urgent cares, clinics, surgery centers, home care, telehealth and other care settings.

Banner has the experience and expertise to provide primary care, hospital care, outpatient services, imaging services, rehabilitation services, long-term acute care and home care to patients facing virtually any health conditions. In addition, an array of core services and specialized services are also provided such as cancer care, emergency care, heart care, maternity services, neurosciences, orthopedics, pediatrics and surgical care. Specialized services include behavioral health, burn care, high-risk obstetrics, Level 1 Trauma care, organ and bone marrow transplantation and medical toxicology. Our lifesaving air medical transport program brings patients to our centers quickly and compassionately. And our expanded telemedicine offerings ensure everyone has access to the best care. We also participate in a multitude of local, national and global research initiatives, including those spearheaded by researchers at our three Banner – University Medical Centers, Banner Alzheimer's Institute and Banner Sun Health Research Institute.

Ultimately, Banner's unwavering commitment to the health and well-being of its communities has earned accolades from an array of industry organizations. For example, Banner's Supply Chain team was nationally recognized for advancing supply chain diversity in 2024, and in 2024 was among the nation's most trustworthy by *Newsweek*. Banner Alzheimer's Institute has also garnered international recognition for its groundbreaking Alzheimer's Prevention Initiative, brain imaging research and patient care programs. Further, Banner continues to be recognized as one of the Best Places to Work by *Becker's Hospital Review,* has been Great Place to Work certified for two consecutive years, and named in *Newsweek's* Most Trustworthy Companies in America.

About Banner Boswell Medical Center

Banner Boswell Medical Center (BBWMC) opened its doors on November 16, 1970, as the Walter O. Boswell Hospital, which later became the Sun Health Boswell Hospital. In 2008, the facility became part of the Banner Health System and was renamed Banner Boswell Medical Center. Banner MD Anderson (BMDA) Cancer Center is also located on BBWMC's campus, providing surgical oncology and radiation oncology.

Over the past five years investments in the facility have included a new Emergency Department, main entrance and patient towers, and added two additional patient bays and larger operating room to support the Endoscopy service line. Completed 2021, these were the first major expansion efforts in 30 years and will help ease access to care for the community.

BBWMC is committed to providing a wide range of quality care, based on the needs of the community, including the following services:

- BMDA surgical oncology, radiation oncology
- Endoscopy
- Medical Imaging
- Heart Care
- Vascular Care
- Stroke Care
- Intensive Care
- Surgical Care
- Nutrition Services
- Rehabilitation Services

BBWMC's many accolades over the past three years include:

- Stroke Gold Plus, Target Stroke Honor Role Elite, American Heart Association
- Type 2 Diabetes Honor Roll, American Heart Association
- 3 out of 3 STARS Cardiac – ISO CAB and CAB & MVRR, Society for Thoracic Surgeons (STS)
- 3 out of 3 STARS Thoracic – Lobectomy and Lung Resection for Cancer, Society for Thoracic Surgeons (STS)
- Regionally Ranked #4 in Phoenix, #6 in Arizona, US News and World Report
- High Performing in Colon Cancer Surgery, Lung Cancer Surgery, Aortic Valve Surgery, Heart Bypass Surgery, Heart Failure, Hip Replacement, Knee Replacement, and Pneumonia
- Healthgrades Specialty Clinical Quality - 2024 Outpatient Joint Replacement Excellence Award
- Healthgrades Specialty Clinical Quality - 2025 Cardiac Surgery Excellence Award

- Top 100 Hospitals – OR at Banner Boswell Medical Center, Truven Health Analytics
- Structural Heart Program – performed first Triclip procedure, TMVr (expanded access), achieved 2 out of 3 STARS for TAVR program

BBWMC also proudly supports and participates in the Heart Walk, March of Dimes, and the Sun Health Foundation.

In 2024, BBWMC employed 1563 team members who were supported by volunteers, who gave 14,774 hours of their time.

Description of Community Served

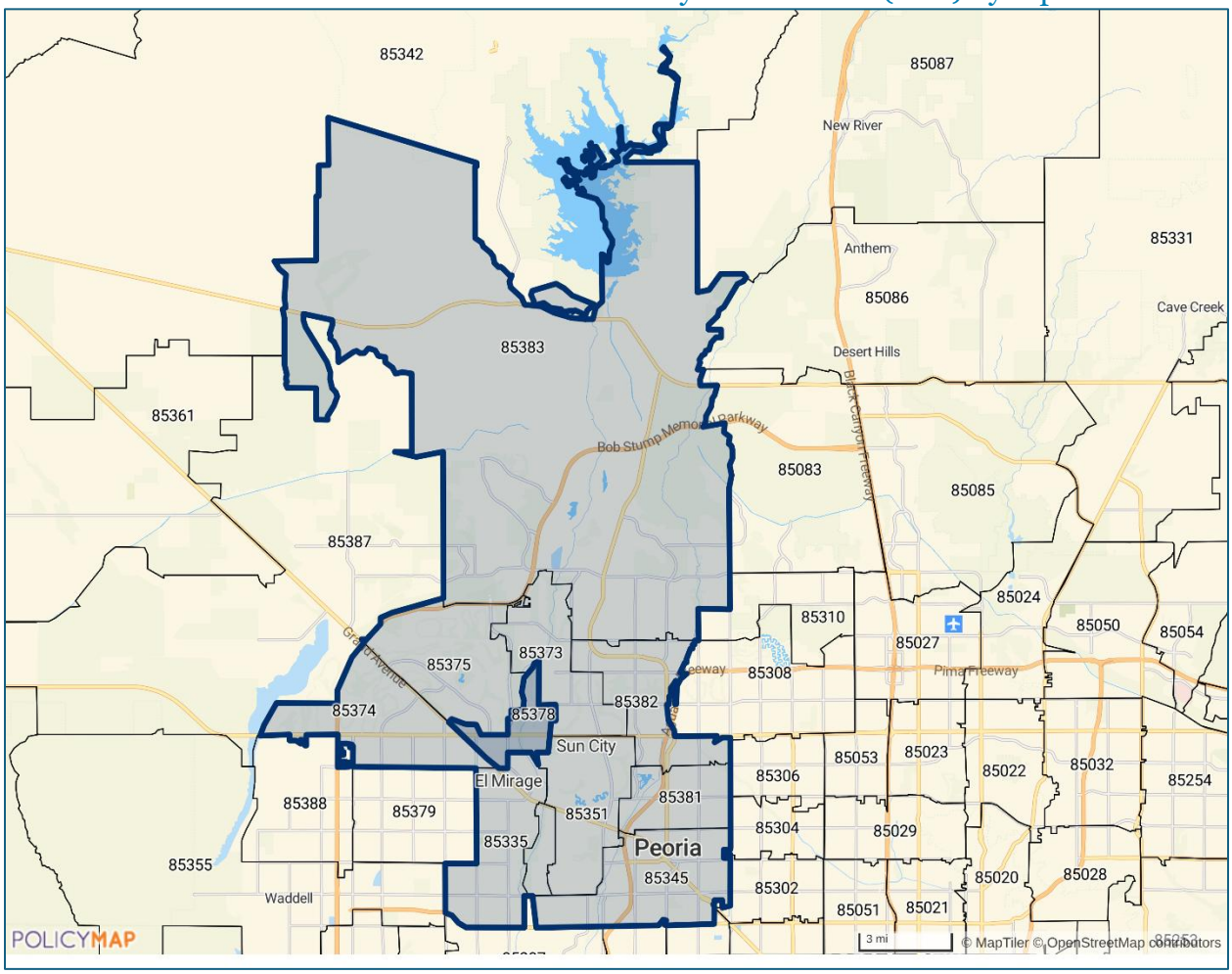
BBWMC is in Sun City, Maricopa County, Arizona. Maricopa County is the fourth most populous county in the United States. With an estimated population of four million and growing, Maricopa County is home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations.

The demographic area for this CHNA is Maricopa County, the common community for all partners participating in the Synapse Coalition collaborative. However, primary service area (PSA) information for BBWMC will also be provided when available. BBWMC's PSA includes the zip codes making up the top 75% of the total inpatient cases. The PSA includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

The following map (Exhibit 1) depicts BBWMC's origins by zip code identified through BBWMC's discharge data.

Facility Inpatient Origin by Zip Code Map

Exhibit 1: Banner Boswell Medical Center Primary Service Area (PSA) by Zip Code



CHNA Collaborators and Methods

Maricopa County health centers and hospitals play a vital role in enhancing the region's health and economy. Beyond providing high-quality medical care, these institutions implement programs that address community-specific needs. Many healthcare partners serve overlapping populations, leading to collaboration through the Synapse Coalition. The Synapse Coalition, with the Maricopa County Department of Public Health (MCDPH), work together to identify community strengths and address the most pressing needs through a coordinated CHNA. Synapse is a coalition of non-profit and federally qualified health care providers that work together to collect data and conduct CHNAs to guide community investments. The following organizations are a part of the Synapse Coalition:

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This effort was supported by Arizona State University's Southwest Interdisciplinary Research Center (SIRC) in developing and conducting focus groups; the OMNI Institute for conducting key informant interviews; and community-based agencies and healthcare partners to collect community surveys within Maricopa County. Health indicators were compiled and analyzed by MCDPH's Division of Epidemiology and Informatics. Crescendo Consulting Group leveraged data collected via the Synapse coalition to produce the charts, graphs, maps, and narratives that appear in this report.

This mixed-methods approach leverages a combination of primary and secondary quantitative and qualitative research methods designed to evaluate the perspectives and opinions from a wide variety of community stakeholders.

Each activity is described below in more detail.

Secondary Data

These data points provide a critical insight into the demographics of Maricopa County. Topics included indicators for communicable and chronic disease, birth statistics, causes of death, causes for hospitalizations, along with social, behavioral, demographic, and environmental data. The data was collected and analyzed by MCDPH's Division of Epidemiology and Informatics. That team accessed multiple data sources to collect and analyze health indicators at the national, state, and county levels.

Qualitative Research

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Community Survey

The survey was originally developed by the National Association of County and City Health Officials (NACCHO) and modified by MCDPH, Synapse Coalition, and the Health Improvement Partnership of Maricopa County (HIPMC) partners. The electronic version of the survey was developed in Alchemer© and paper-based surveys were provided upon request and distributed at community events and through community-based organizations. Results from paper-based surveys were entered into Alchemer© by trained data entry specialists. The survey was administered in 14 languages (Arabic, Burmese, Mandarin Chinese, Dari, English, French, Kinyarwanda, Korean, Lao, Navajo, Spanish, Swahili, Thai, and Vietnamese). To increase accessibility, MCDPH provided large-font printed paper surveys, offered verbal surveys taken over the phone through the CARES Line, and partnered with SAAVI Services for the Blind to develop surveys in Unified English

Braille. Surveys in languages other than English were translated by fluent language speakers and for analysis, free-text responses were translated back into English.

All survey data was collected between March and June of 2023. A total of 18,297 responses were collected and analyzed. SIRC conducted additional focus groups with a total of 309 participants during the summer of 2023.

Data Limitations

Secondary data sources are often large-scale efforts that take time to collect, clean, and analyze data prior to publication. Due to the time required between data collection and publication, many of these sources publish data collected up to 18 to 24 months before publication. Therefore, while this report was published in 2025, many data sources cited herein are dated in prior years. Data available from rural areas can also be limited due to small numbers.

Qualitative data collection efforts can be affected by the rurality in the regions where data collection efforts were conducted. Participation is also often limited to those who choose to or can engage, which may not reflect the experiences of everyone in a community.

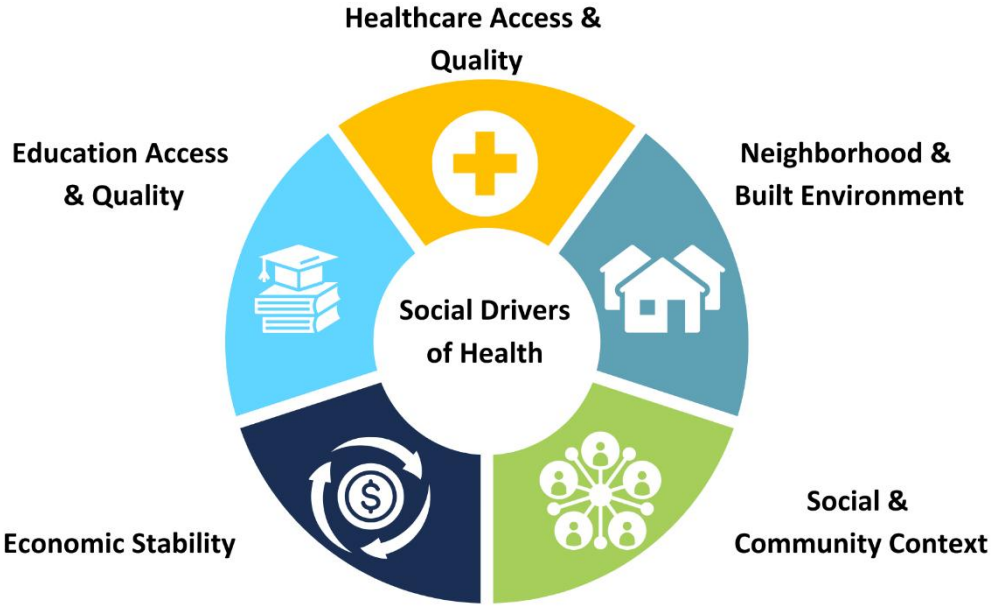
Not all survey respondents provided demographic information, and not all survey respondents answered each question.

Social Drivers of Health

The social drivers of health (SDoH), also called social determinants of health, 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.[1] Clinical care impacts only 20.0% of health outcomes, while social drivers impact as much as 50.0% of health outcomes.[2] Examples of SDoH include economic stability, safe and affordable housing, access to nutritious foods, and many more. The social drivers of health model consists of five domains shown below in Exhibit 2. This framework is included to highlight the broader social and environmental conditions that influence health and can provide useful context when considering the findings in this report.

1 ODPHP, n.d. Social Determinants of Health.
2 Whitman et al. (ASPE), 2022.

Exhibit 2: Social Drivers of Health Framework



Healthy People 2030

Healthy People 2030 sets data-driven national objectives to improve health and well-being of communities across the United States over the next decade. The federal initiative is managed by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. The identified needs of the CHNA use similar language to the Healthy People 2030 objectives and indicators. For more information about Healthy People 2030, please visit https://odphp.health.gov/healthypeople.[3]

[3] ODPHP, n.d. Social Determinants of Health.

Overview of Needs Prioritization Process

On July 28, 2025, 9 participants from Banner Boswell Medical Center leadership came together to prioritize the most significant health needs for their region.

The needs prioritization is a critical final step in the Community Health Needs Assessment process. The quantitative and qualitative research results for Maricopa County were presented. A modified Hanlon Method was used to identify the top priorities on which the Banner Boswell Medical Center will focus in their 2025-2028 Implementation Strategy. A complete description of this process is provided on page 65. A list of those needs appears in the following section.

List of Prioritized Needs

- Access to Mental and Behavioral Health Services
- Access to Specialty Care
- Access to Primary Care
- Mental & Behavioral Health Conditions

Needs Assessment Findings

The following sections outline the findings that surfaced during the formative research. These findings were used during the needs prioritization process.

The following findings provide a snapshot of health needs within the hospital's PSA. All data in this section was collected and analyzed by SYNAPSE.

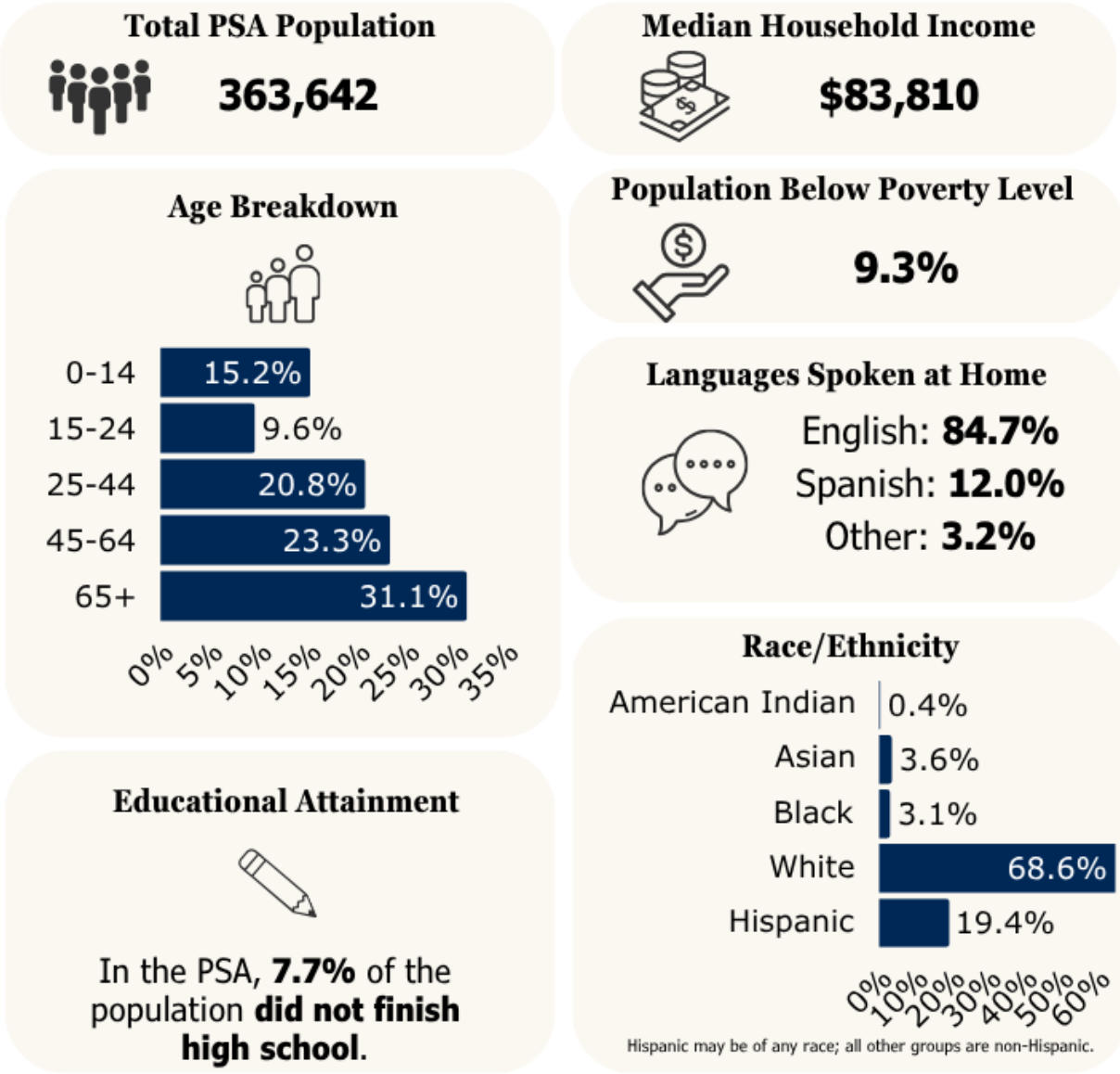
Most of the secondary data reflects conditions within the PSA. When PSA-level data is not available or when broader comparisons are helpful, data for Maricopa County or the state of Arizona is included and clearly noted.

Community survey data was collected across Maricopa County and analyzed by region. This report includes only the survey results from the region or regions that align with the PSA. The prioritized needs are then identified in the Prioritized Needs section.

Secondary Data Findings

Demographics

Understanding the makeup of the population is an important first step in identifying community health needs. Demographic data provides context about who lives in the area and helps highlight differences in health outcomes across groups. It also sheds light on the underlying factors that shape access to care, social and economic opportunity, and overall well-being.



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Health Behaviors and Risk Factors

This section includes information on how Maricopa County residents view their overall health, the choices they make that influence it, and risk factors that may increase the chance of illness or disease.

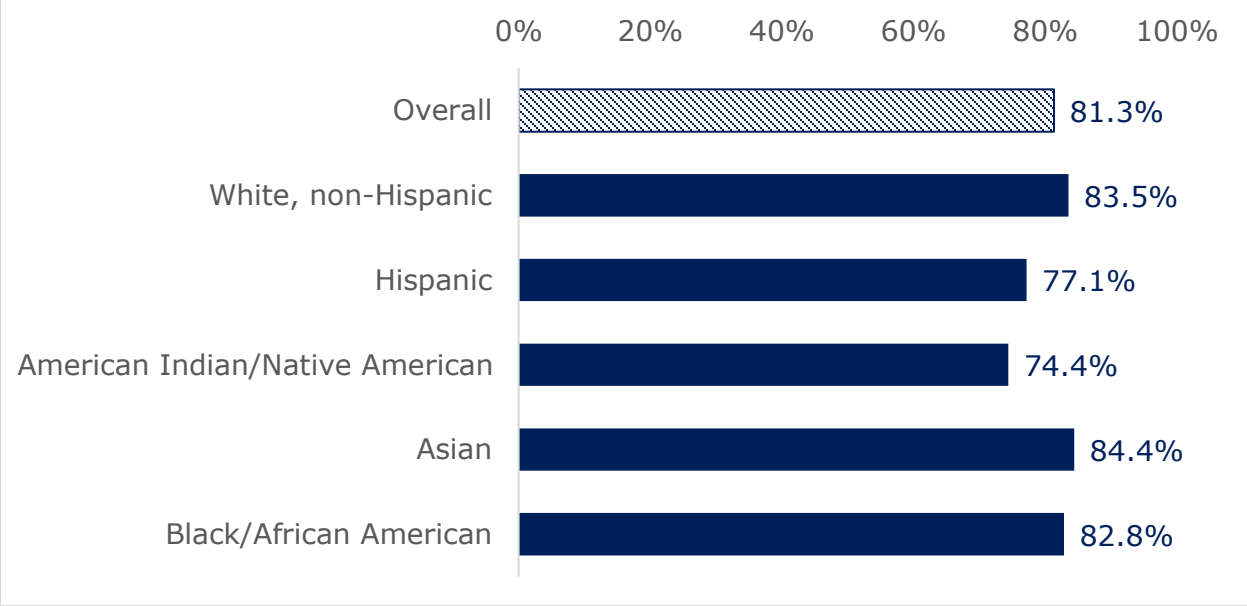
Self-rated health is widely used in public health research because it has been shown to predict outcomes such as hospitalization, disease incidence, and mortality.[4]

As seen in Exhibit 3, in 2022, 81.3% of Maricopa County adults self-reported their health as excellent, very good, or good. While this countywide average is relatively high, differences across racial and ethnic groups are clear.

- Asian (84.4%) and White, non-Hispanic (83.5%) residents had the highest rates of positive self-rated health.
- Black/African American residents followed closely at 82.8%.
- Hispanic (77.1%) and American Indian/Native American (74.4%) residents were less likely to report good or better health.

These differences hint at patterns across Maricopa County, where the conditions that support good health aren't available to everyone in the same way.

Exhibit 3: Self-Rated Health Status (Excellent, Good, Very Good), 2022 (Maricopa County)



Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

[4] CDC, 2024. Health Status.

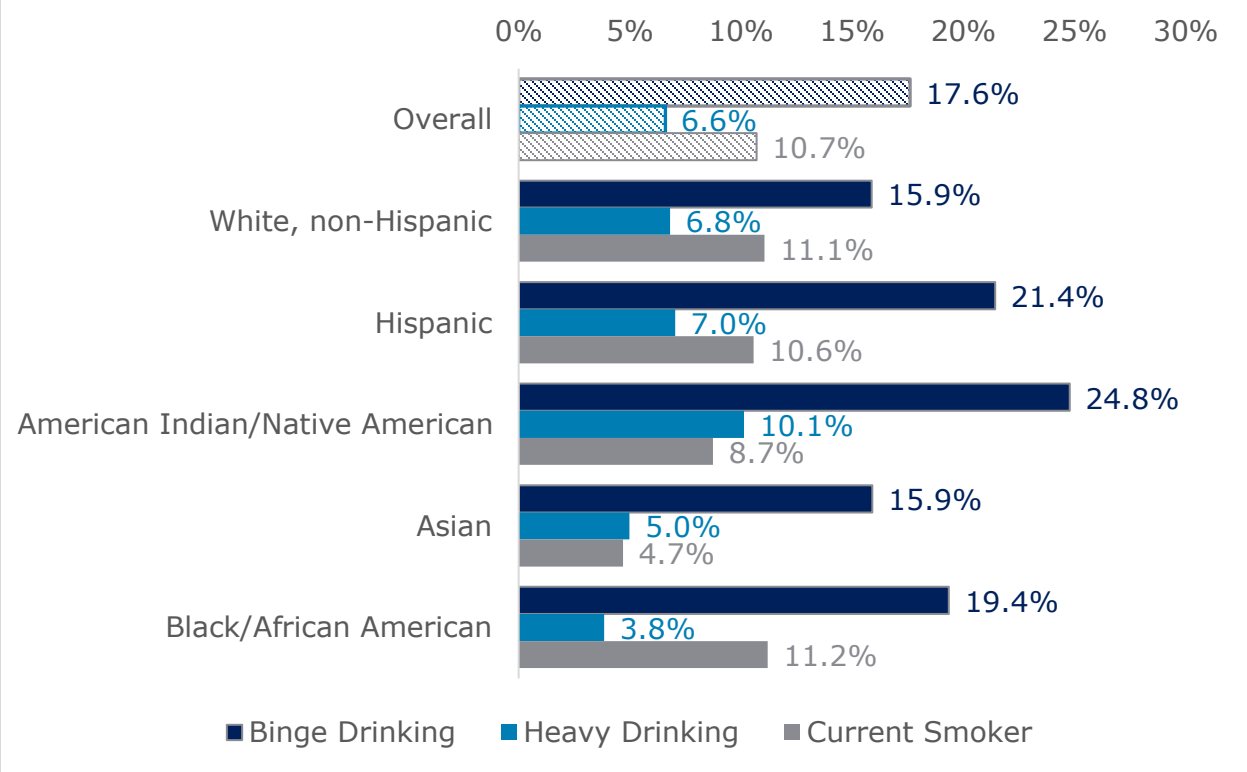
Health behaviors like smoking and alcohol use are important indicators of community health. They contribute to long-term outcomes such as heart disease, cancer, and other chronic conditions.[5]

As seen Exhibit 4, in 2022, 17.6% of adults in Maricopa County reported engaging in binge drinking, 6.6% reported heavy drinking, and 10.7% were current smokers. These behaviors varied by race and ethnicity:

- American Indian/Native American adults had the highest reported rates across the binge drinking (24.8%) and heavy drinking (10.1%) categories.
- Hispanic adults also reported elevated rates of binge drinking (21.4%).
- Asian and Black/African American adults reported the lowest rates of heavy drinking and binge drinking.
- Smoking rates were higher among Black/African American adults (11.2%) and White, non-Hispanic adults (11.1%).

These differences may reflect varying access to resources that support healthier choices, such as tobacco-free environments, substance use prevention efforts, and culturally relevant health education.

Exhibit 4: Health Behaviors, 2022 (Maricopa County)



Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

[5] CDC, 2024. About Chronic Diseases: Risk Factors.

After looking at behaviors like smoking and drinking, it's also important to consider daily habits that influence long-term health, including physical activity, nutrition, and weight. These factors are also closely tied to the risk of developing chronic diseases such as diabetes, heart disease, and certain cancers.[6]

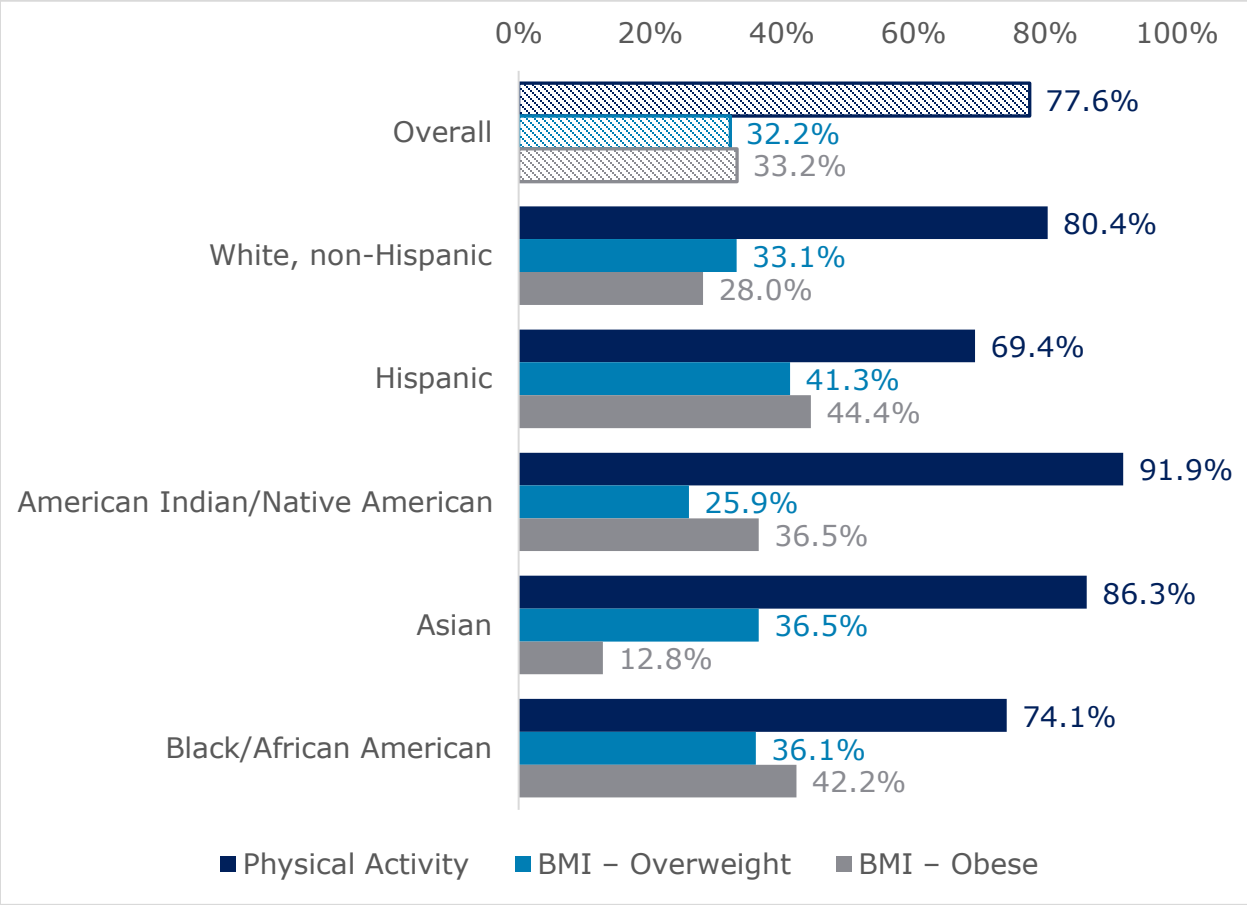
As seen in Exhibit 5, in 2022, 77.6% of Maricopa County adults reported getting some form of physical activity in the past month. However, activity levels and weight status varied by race and ethnicity:

- White, non-Hispanic (80.4%) and Asian (86.3%) adults were the most likely to report being physically active.
- Hispanic adults (69.4%) had the lowest rate of reported physical activity.
- Obesity rates were highest among Black/African American (42.2%), Hispanic (44.4%), and American Indian/Native American (36.5%) adults.
- Asian adults (12.8%) had the lowest obesity rate and were also the least likely to be overweight.

These differences may reflect unequal access to resources that support healthy habits, such as affordable nutritious food, safe outdoor spaces, and consistent preventive care.

[6] CDC, 2024. Nutrition, Physical Activity, and Weight Status.

Exhibit 5: Chronic Disease-Related Risk Factors, 2022, by Race/Ethnicity (Maricopa County)[7]



Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

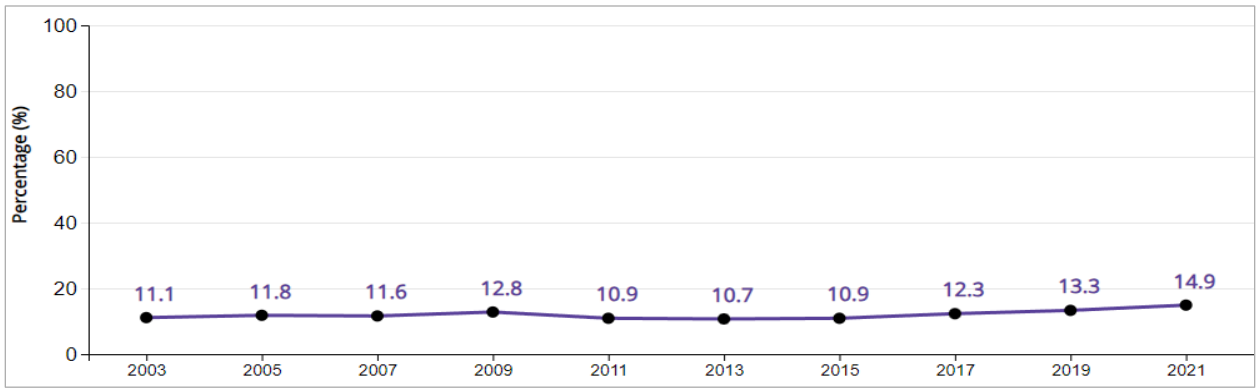
[7] "Physical activity" reflects the percentage of adults who reported participating in any physical activity during the past month. Higher percentages indicate more widespread activity.

It's also important to understand how health risks show up earlier in life. Looking at youth trends can provide insight into future health challenges and help shape prevention strategies.

In 2021, 14.9% of Arizona high school students had obesity, the highest level reported since 2003. The increase in 2021 represents a notable shift after obesity rates remained relatively steady for more than a decade.

Obesity in childhood and adolescence increases the risk of developing chronic health conditions like type 2 diabetes, high blood pressure, and joint problems. It can also affect mental health and social development.[8]

Exhibit 6: Prevalence of High School Students Who Had Obesity, 2021 (Arizona)



Source: Youth Risk Behavior Surveillance (YRBS), 2021, Arizona

[8] CDC, 2022. Consequences of Obesity.

Health Outcomes

This section reflects the leading causes of hospitalizations, emergency department visits, and death in the community. Together, they offer a snapshot of the most common and serious health challenges affecting residents.

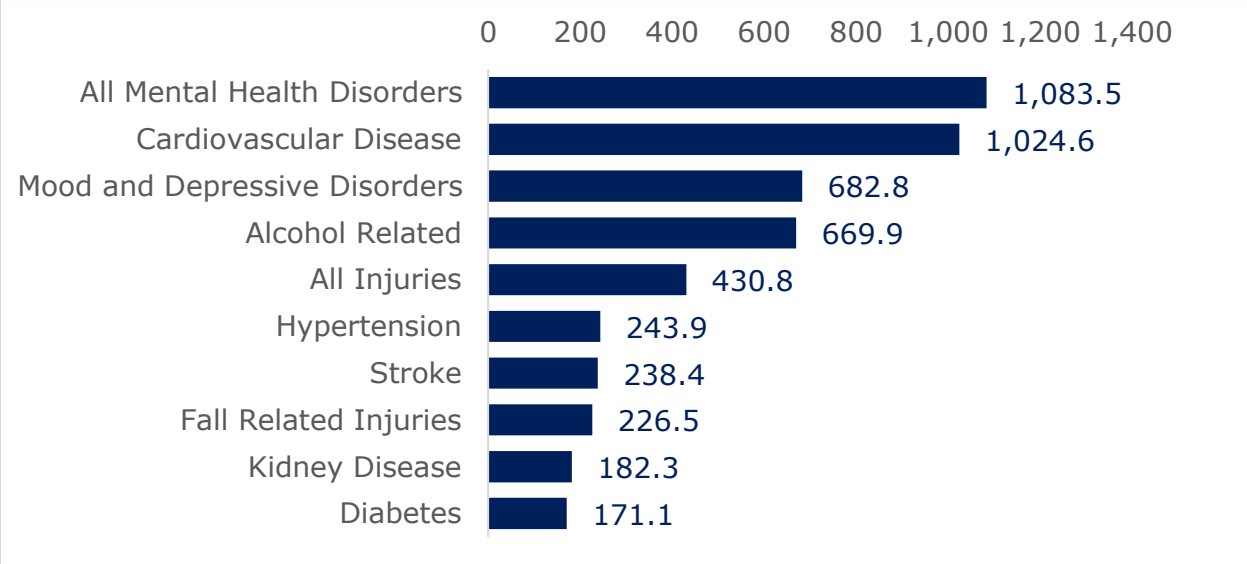
Understanding which conditions lead to hospital visits or early death helps paint a broader picture of health in the region. These outcomes are shaped by many factors, some clinical and some social, and they tell us what types of conditions are most frequently driving people in the PSA to seek care.

As shown in Exhibit 7, the top causes of inpatient hospitalization include mental health conditions, cardiovascular disease, and substance use. Mental health disorders had the highest hospitalization rate, with more than 1,080 inpatient stays per 100,000 people. Cardiovascular disease followed closely behind. Mood and depressive disorders and alcohol-related conditions also ranked high among reasons for hospitalization.

Injuries accounted for over 400 hospitalizations per 100,000, while chronic conditions like hypertension, diabetes, and kidney disease contributed to ongoing inpatient care needs. Stroke and fall-related injuries were also notable.

The range of causes reflects how behavioral health, chronic disease, and acute health events all play a role in driving inpatient hospital use in the region.

Exhibit 7: Top Causes of Inpatient Hospitalizations, 2023 Overall Rates per 100,000 (PSA)



Source: Hospital Discharge Data and Death Data, obtained from ADHS, cleaned and analyzed by MCDPH

Inpatient hospitalizations offer one view of health needs that require extended or planned care.

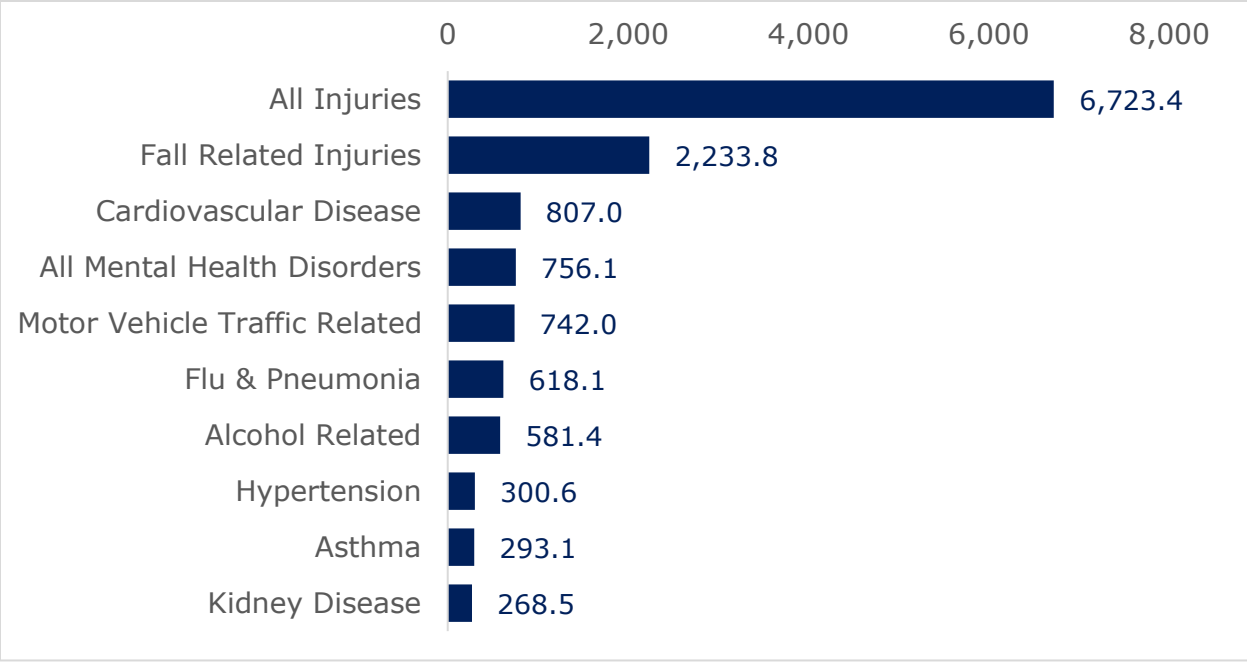
Exhibit 8 provides another part of the picture by showing the most common reasons people visit the emergency department, often for more immediate or urgent concerns. The top reasons include injuries, cardiovascular conditions, and behavioral health needs.

Injuries were the most common reason for ED visits, with a rate of 6,723.4 per 100,000 people. About one in three of these visits were due to falls.

Cardiovascular disease and mental health disorders followed, each contributing more than 750 visits per 100,000. Motor vehicle crashes, flu and pneumonia, and alcohol-related concerns also ranked high among ED visits. Chronic conditions like hypertension, asthma, and kidney disease appeared lower on the list but still accounted for a notable share of visits.

The data reflects a wide range of urgent health concerns that bring people to the ED, including physical injuries, sudden illness, and complications from ongoing health conditions.

Exhibit 8: Top Causes of Emergency Department Visits, 2023 Overall Rates per 100,000 (PSA)



Source: Hospital Discharge Data and Death Data, obtained from ADHS, cleaned and analyzed by MCDPH

While emergency department data helps highlight urgent health needs, mortality data offers a broader view of the conditions most commonly contributing to death in the region.

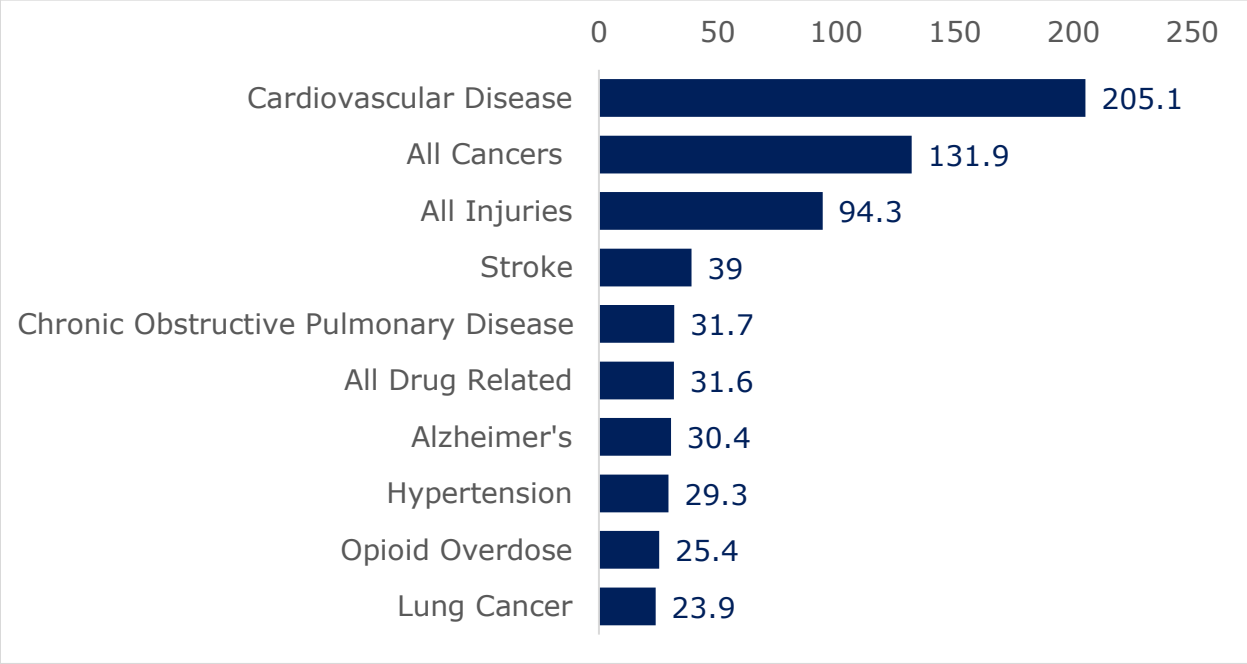
Exhibit 9 shows the leading causes of death in the region, adding another layer to understanding of community health. The top causes include cardiovascular disease, cancer, and injuries.

Cardiovascular disease was the leading cause of death in the region, with a rate of 205.1 per 100,000 people. Cancer followed at 131.9, and injuries ranked third at 94.3 deaths per 100,000.

Stroke, COPD, and drug-related deaths also contributed to the overall mortality burden, along with Alzheimer's disease, hypertension, and opioid overdoses.

The data reflects a mix of chronic conditions, sudden health events, and substance-related deaths that shape patterns of mortality across the region.

Exhibit 9: Top Causes of Death, 2023 Overall Rates per 100,000 (PSA)



Source: Hospital Discharge Data and Death Data, obtained from ADHS, cleaned and analyzed by MCDPH

Healthcare Access and Utilization

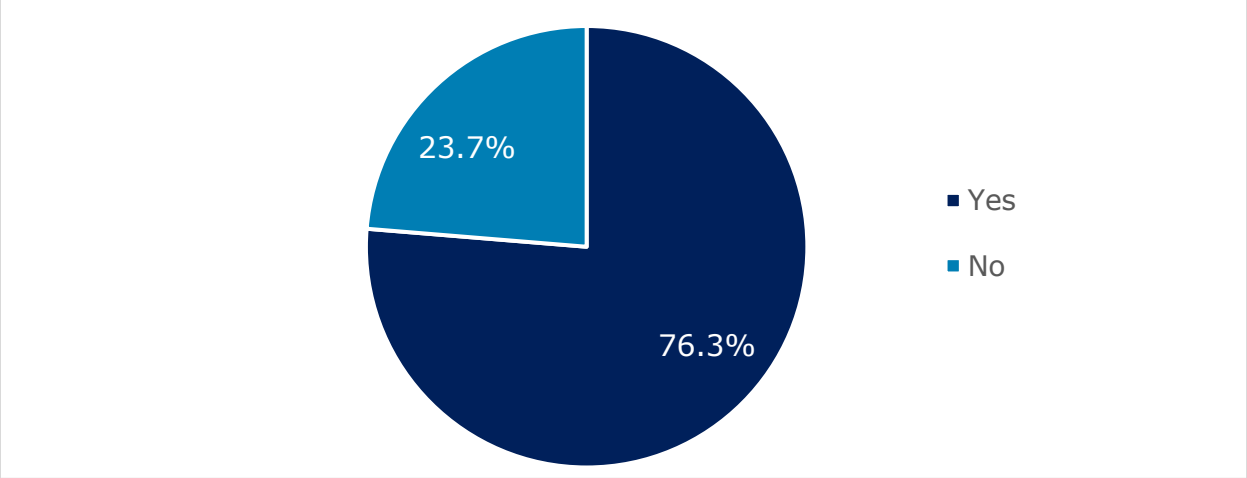
This section explores whether people have regular access to care and how often they use healthcare services. It includes information on insurance coverage, usual sources of care, and patterns in hospital visits by payer type.

Having a usual source of care, such as a regular doctor, clinic, or health center, can make it easier for people to manage chronic conditions, stay up to date on preventive services, and get help when new health issues come up.[9]

In 2022, 76.3% of Maricopa County adults reported having a usual source of care, while 23.7% said they did not. This means nearly one in four adults in the county may be navigating the healthcare system without a consistent care team.

Lacking a usual source of care can create delays in treatment, reduce access to preventive care, and increase the likelihood of using emergency departments for non-emergency issues.[10]

Exhibit 10: People with a Usual Source of Care, 2022 (Maricopa County)



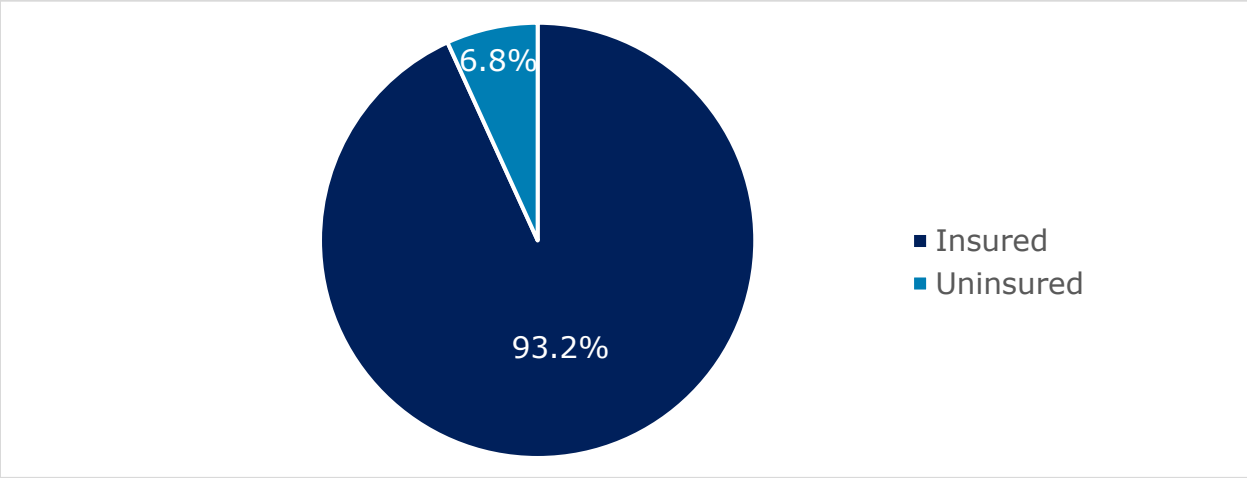
Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

[9] AHRQ, 2013. 2012 National Healthcare Quality Report.
[10] CDC, 2022. Access to Health Services.

To better understand why some people may be going without a usual source of care, Exhibit 11 looks at what percentage of the PSA population is uninsured. These are individuals who may be falling through the cracks in the healthcare system.

In 2023, 6.8% of residents in the PSA were uninsured. While most had health coverage, this still reflects a segment of the population who may be navigating care without the support of insurance.

Exhibit 11: Health Insurance Status, 2023 (PSA)



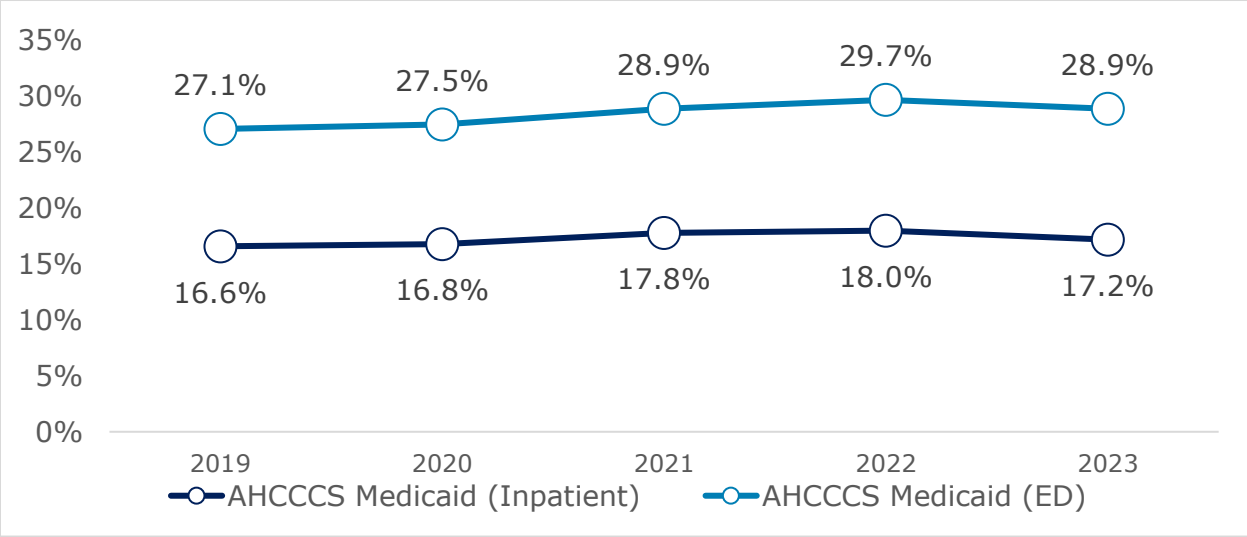
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

While Exhibit 11 highlights the portion of the population without insurance, it's also important to understand how those with public coverage are using the healthcare system.

Exhibit 12 looks at trends in hospital visits covered by Medicaid, offering insight into how lower-income residents are accessing care, how demand on the system may be shifting, and where continued support may be needed.

Over the past five years, inpatient stays in the PSA covered by Medicaid ranged from about 16 to 18%. ED visits were more likely to be billed to Medicaid, hovering around 27 to 30% over the same period. These patterns highlight the steady role that public insurance plays in helping lower-income residents access both emergency and inpatient care.

Exhibit 12: Trends in AHCCCS Medicaid Coverage Among Hospital Visits, 2019–2023 (PSA)



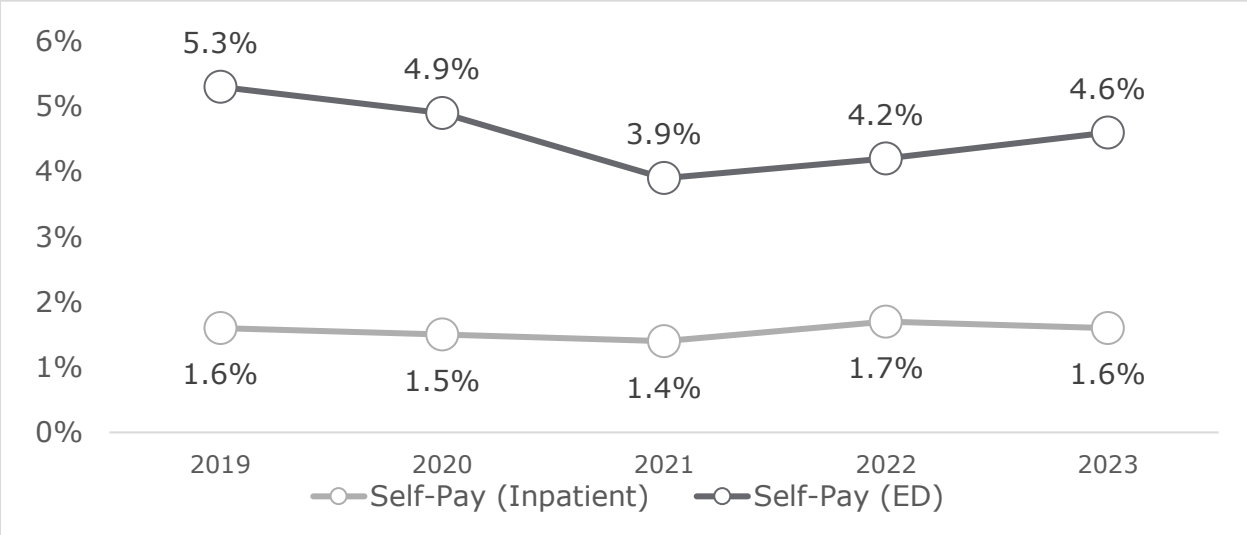
Source: Hospital Discharge Data, obtained from ADHS, cleaned and analyzed by MCDPH

While Medicaid trends help show how publicly insured residents are interacting with the healthcare system, it's also important to look at those who may be receiving care without any form of insurance.

Exhibit 13 shows trends in self-pay hospital visits, which can signal gaps in coverage, lead to financial hardship or delayed care that becomes more costly over time.[11]

Self-pay visits made up a small but steady share of hospital use in the PSA, with ED visits consistently higher than inpatient stays. ED rates declined from 2019 to 2021, reaching a low of 3.9%, before climbing to 4.6% in 2023. Inpatient self-pay visits remained low throughout the five-year period, hovering around 1.5 to 1.7%. These patterns may reflect how some residents are accessing care without insurance or outside the traditional coverage system.

Exhibit 13: Trends in Self-Pay Hospital Visits, 2019–2023 (PSA)



Source: Hospital Discharge Data, obtained from ADHS, cleaned and analyzed by MCDPH

[11] Scott et al., 2021. Catastrophic Health Expenditures Among the Uninsured.

Chronic Disease and Cancer

This section focuses on long-term conditions like heart disease, diabetes, and cancer. These indicators show how common these illnesses are in the community.

Chronic diseases like heart disease, diabetes, and cancer are common conditions in the United States that develop over time and are influenced by a mix of health behaviors, genetics, environment, and access to care.[12]

This section looks at how chronic disease and cancer show up in the healthcare system and in the community. It includes data on hospitalizations for chronic conditions and the most common types of cancer diagnosed in the county. Together, these indicators help show where long-term health needs are most visible and where prevention, early detection, and treatment efforts may have the greatest impact.

Exhibit 14 shows the percent change in hospitalization, emergency department visits, and deaths related to chronic diseases, comparing 2023 data to the four-year average from 2019–2022. This snapshot helps identify where rates are rising or falling, offering a clearer picture of emerging issues and areas where prevention or care management efforts may be making an impact.

Chronic disease patterns shifted in a few notable ways across the PSA. Inpatient stays for conditions like diabetes and asthma ticked upward, while others such as cardiovascular disease and hypertension stayed fairly steady.

Both inpatient admissions and ED visits related to long COVID increased. This is not unexpected when considering the timeline of the COVID-19 pandemic. Continued monitoring of this trend will increase understanding of the strain it places on the healthcare system and can help develop appropriate interventions.

Stroke-related ED visits rose nearly 30%. At the same time, deaths related to asthma rose by about a third.

There were also some signs of improvement. Fewer people were hospitalized or died from flu and pneumonia, and rates tied to Alzheimer's and COPD declined. Overall, data points to some areas where chronic disease may be getting better managed and others where the need for early detection and steady care could be growing.

[12] CDC, 2023. About Chronic Disease

Exhibit 14: Percent Change in Chronic Disease Related Hospitalizations and Deaths Between 2023 and 4-Year Averages (2019-2022)[13] (PSA)

	Inpatient	ED	Death
Alzheimer's	-30.5	1.8	-17.1
Arthritis	-75.4[14]	-2.0	
Asthma	13.9	12.4	33.3
Cardiovascular Disease	3.5	9.0	-4.4
Chronic Obstructive Pulmonary Disease	-6.1	-5.6	-10.6
Diabetes	12.0	10.7	1.6
Flu & Pneumonia	-7.6	6.2	-16.3
Hypertension	3.1	2.5	-14.0
Kidney Disease	1.5	5.6	10.2
Long COVID[15]	9.8	30.6	
Overweight & Obesity	8.4	-	
Stroke	2.8	28.3	3.2

Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

[13] Color gradient indicates the direction and magnitude of change. Green cells reflect a decrease in rates (improvement), while red cells indicate an increase in rates (worsening outcomes). Darker shades represent larger changes. For Arthritis, Long COVID, and Overweight/Obesity, death rates are not reported.
[14] The decline in arthritis IP rates may stem from reduced osteoarthritis cases from 2019-2023, due to coding changes or a true population decline.
[15] The rise in Long COVID-related hospital visits likely reflects a combination of increased diagnostic coding and greater awareness rather than a direct comparison to pre-pandemic years.

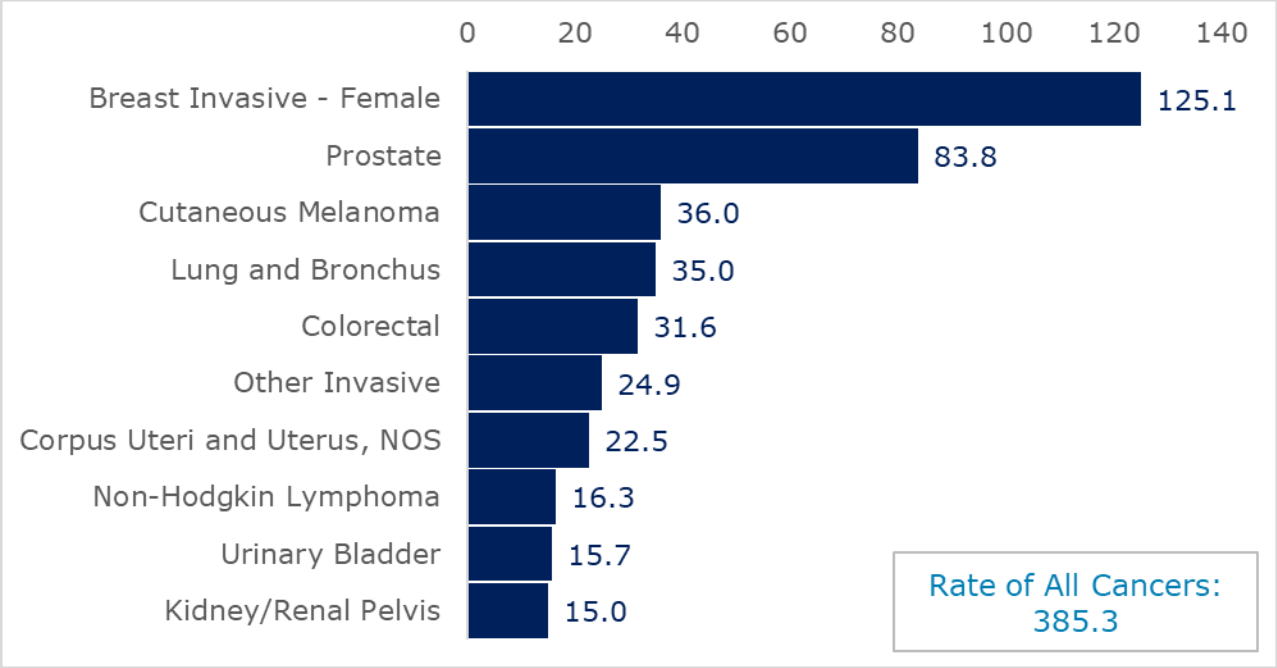
Cancer is another significant part of the chronic disease landscape in the community. Many of the same factors that influence conditions like diabetes or heart disease, including access to screening, early detection, and consistent care, can also affect cancer. Exhibit 15 highlights which types of cancer are being diagnosed most often across Maricopa County.

In 2022, the overall cancer incidence rate in the county was 385.3 cases per 100,000 people. The most commonly diagnosed cancers included:

- Breast and prostate cancer, had notably higher incidence rates compared to other types of cancer.
- Melanoma, lung, and colorectal cancers occurred as the next most frequent.

Understanding which cancers are most commonly diagnosed helps inform prevention and screening strategies across the region.

Exhibit 15: Cancer Incidence by Type, 2022 Age-Adjusted Rates per 100,000 (Maricopa County)[16]



Source: ADHS Cancer Registry

[16] Only Arizona residents are included. County at diagnosis is collected for every cancer case.

Mental Health and Substance Use

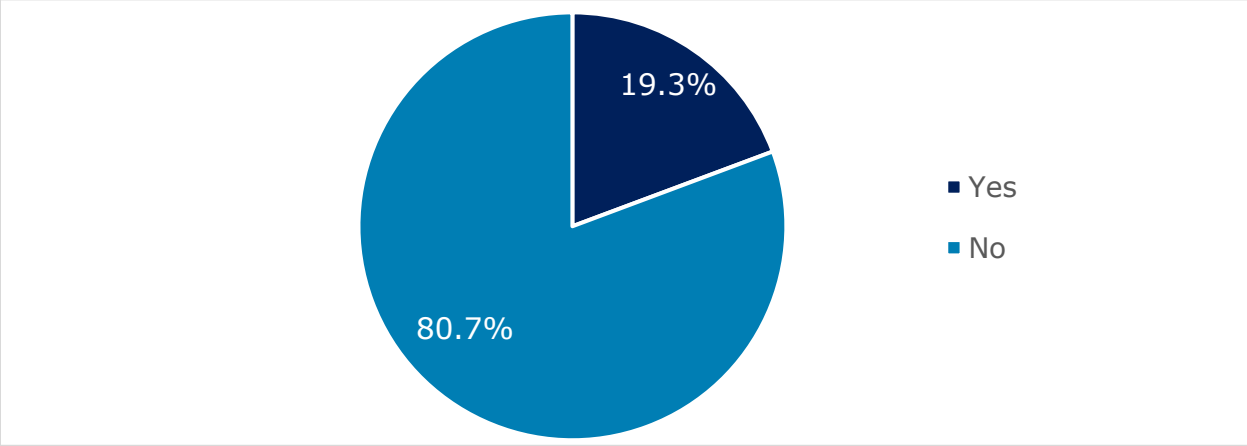
This section includes data on mental health diagnoses, hospital visits for mental health or substance use, and deaths related to suicide, alcohol, or drug use.

Mental health is an important part of overall well-being, affecting how people manage stress, maintain relationships, and engage with their communities.[17] Understanding the scope of mental health needs in the region begins with looking at how many people report living with a diagnosed condition.

Exhibit 16 shows that in 2022, 19.3% of adults in Maricopa County said a medical provider had told them they have or had a depressive disorder, according to BRFSS data. This reflects nearly one in five adults, highlighting how common depression is across the county's population.

While this indicator doesn't capture undiagnosed conditions or the severity of symptoms, it does show how many residents have had at least one interaction with the healthcare system where a mental health concern was identified. This makes it a useful starting point for understanding diagnosed mental health conditions in the community and sets the stage for the next set of data, which focuses on more acute issues like hospitalizations, suicide, and substance-related crises.

Exhibit 16: Has a Medical Provider Ever Told You That You Have/Had a Depressive Disorder?, 2022 (Maricopa County)



Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

[17] CDC, 2024. Mental Health: About Behavioral Health.

To better understand how mental health challenges show up in more acute settings, Exhibit 17 and Exhibit 18 explore inpatient hospitalizations related to mental health disorders.

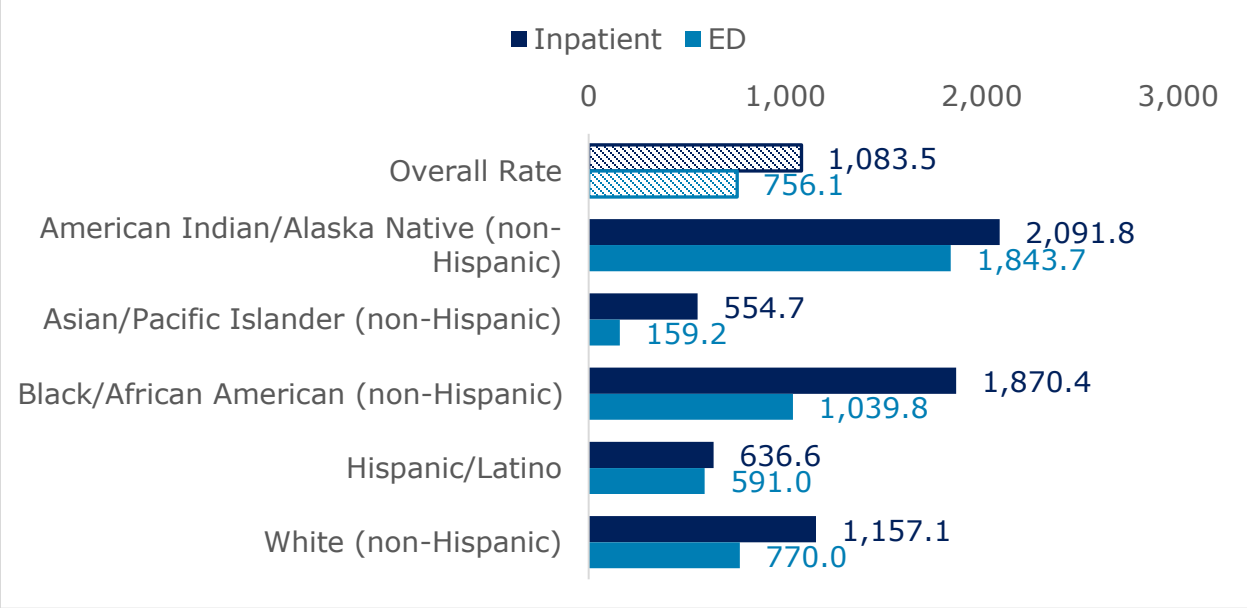
This data is broken out by race and ethnicity (Exhibit 17) and by gender (Exhibit 18) to help highlight differences in how various groups are accessing or experiencing hospital-based mental health care. This can offer insight into potential disparities in severity, access to outpatient treatment, or the availability of early intervention.

In 2023, American Indian/Alaska Native residents had the highest rates of mental health disorder diagnoses, with ED visits more than twice the overall rate and elevated inpatient use as well. Black/African American residents also had high rates in both settings.

On the lower end, Asian/Pacific Islander residents had the lowest rates overall, especially for ED visits. Hispanic/Latino residents were also below the overall rate in both settings. White residents were slightly above the overall rate for inpatient use and close to the average for ED visits.

Because some groups make up a smaller share of the population, small changes in visit numbers can lead to large shifts in rates.

Exhibit 17: Hospital Discharge Diagnosis: All Mental Health Disorders, 2023 Age-Adjusted Rates per 100,000, by Race/Ethnicity[18] (PSA)



Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

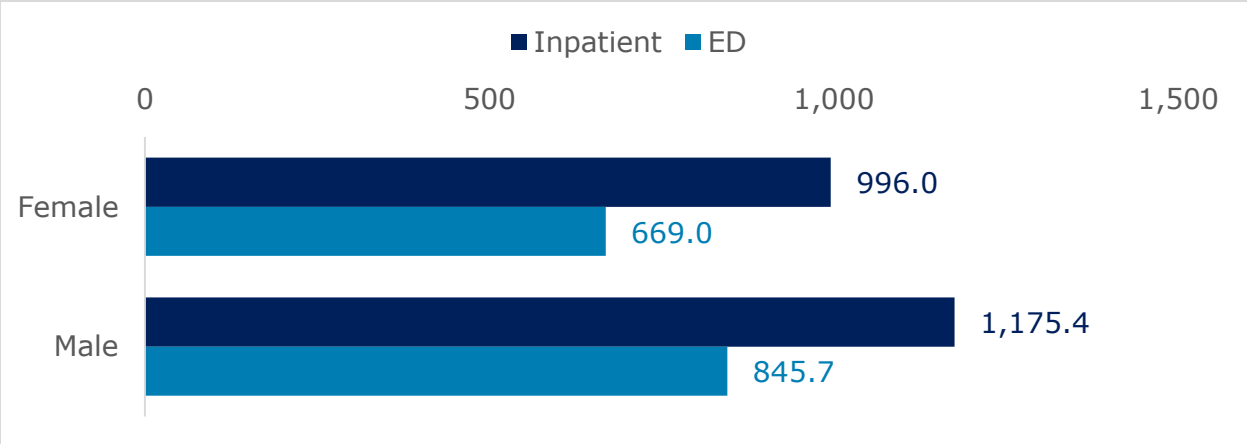
[18] Primary diagnosis of a mental, behavioral, or neurodevelopmental disorder using ICD-10-CM codes.

In 2023, across both inpatient and ED settings, males had higher rates of mental health-related hospitalizations than females.

Inpatient stays were especially higher for males, with a rate more than 15% above that of females. ED visits showed a similar pattern, though the difference was slightly smaller.

These trends may reflect differences in how and when people seek care or how symptoms show up and are addressed in different groups.

Exhibit 18: Hospital Discharge Diagnosis: All Mental Health Disorders, 2023 Age-Adjusted Rates per 100,000, by Gender[19] (PSA)



Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

[19] Primary diagnosis of a mental, behavioral, or neurodevelopmental disorder using ICD-10-CM codes.

While hospitalizations reflect serious mental health needs that result in clinical care, they don't tell the whole story. Mental health, substance use, and self-harm are often closely linked, and the lines between them can be hard to separate in real-world experiences.

Exhibit 19 looks at percent changes in hospitalization and death rates tied to alcohol use, drug-related conditions, opioid overdose, and self-harm from 2023 compared to the previous four-year period. These shifts offer a snapshot of how behavioral health issues are showing up across the healthcare system.

In the PSA, alcohol-related hospital visits rose in 2023, with inpatient stays increasing by 13.2% and ED visits up 19.1% compared to the previous four-year average. At the same time, deaths tied to alcohol use declined.

Opioid-related inpatient stays also increased, but ED visits dropped by more than 33%. Despite these mixed trends, deaths from opioid overdoses rose slightly.

All drug-related hospital visits declined overall, especially in the ED, and deaths dropped by nearly 5%. Deaths related to self-harm and suicide fell by nearly 20%, with fewer hospital visits in both settings.

These changes may reflect evolving behavioral health risks, care-seeking patterns, or access to services across the community.

Exhibit 19: Percent Change in Substance/Behavioral Health Risk Factor Related Hospitalizations and Deaths Between 2023 and 4-Year Averages (2019-2022)[20] (PSA)

	Inpatient	ED	Death
Alcohol Related	13.2	19.1	-9.6
All Drug Related	-0.1	-17.7	-4.9
Opioid Overdose	13.4	-33.4	2.3
Self-Harm/Suicide	-11.4	-15.8	-19.4

Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

[20] Color gradient indicates the direction and magnitude of change. Green cells reflect a decrease in rates (improvement), while red cells indicate an increase in rates (worsening outcomes). Darker shades represent larger changes.

Injury and Safety

These indicators reflect how often people go to the hospital or die because of injuries, such as falls or accidents. The data helps identify where prevention efforts might be needed.

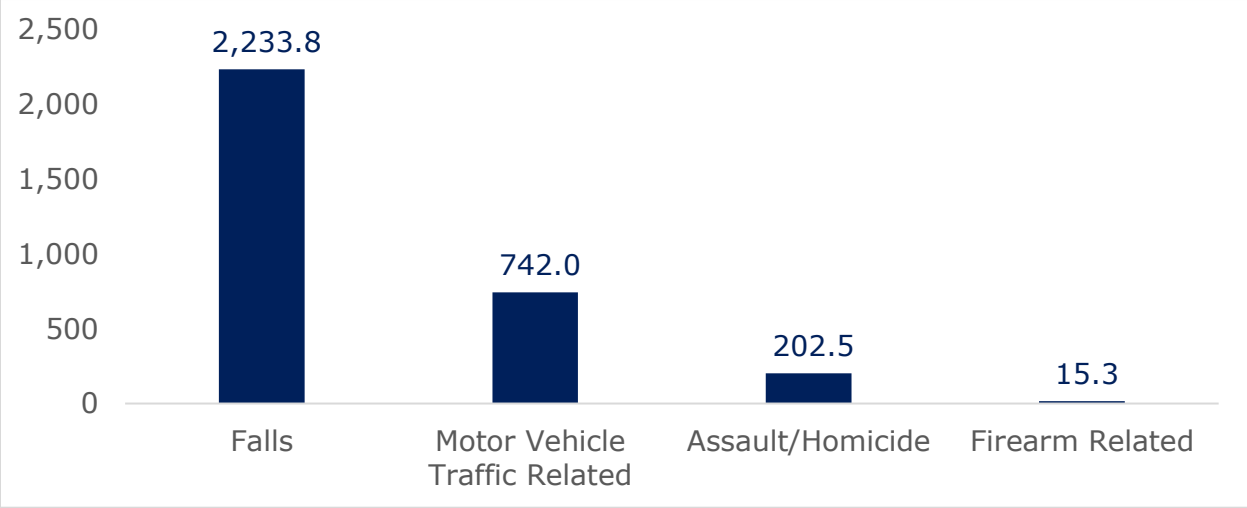
Injuries are a major public health concern in the U.S., accounting for more than 222,000 deaths in 2023 and over 40 million emergency department visits in 2022.[21,22] They often happen without warning and can cause lasting harm to individuals, families, and communities.

Injury-related emergency department visits offer a snapshot of how often people are seeking urgent care for accidents, falls, and other unintentional harm. Exhibit 20 shows how these visits vary by injury type. This data can help guide community efforts to reduce injury risks and improve safety for all residents.

In the PSA in 2023, falls were by far the most common reason for injury-related ED visits. The rate was more than three times higher than for motor vehicle injuries and about eleven times higher than for assaults or homicides. Firearm-related injuries made up only a small fraction of visits.

These patterns suggest that falls account for much of the local injury burden. At the same time, motor vehicle crashes and violence-related injuries still represent important areas for community prevention and safety efforts.

Exhibit 20: Injury-Related Emergency Department Visits, 2023 Age-Adjusted Rates per 100,000 (PSA)



Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

[21] CDC, 2025. Leading Causes of Death.
[22] CDC, 2025. Injuries.

Exhibit 21 compares 2023 rates of injury-related hospital visits and deaths to four-year averages from 2019 to 2022.

In the PSA, injury-related visits and outcomes moved in different directions depending on the cause. Firearm-related hospitalizations rose sharply, increasing by more than 40%, while deaths from firearm injuries declined slightly.

In contrast, assault-related inpatient stays dropped, but deaths rose by more than 21%. Fall-related injuries increased across all settings, including an 11% rise in deaths. Motor vehicle-related hospitalizations also climbed, even though related deaths decreased.

Exhibit 21: Percent Change in Injury Related Hospitalizations and Deaths Between 2023 and 4-Year Averages (2019-2022)[23] (PSA)

	Inpatient	ED	Death
All Injuries	4.8	6.7	1.6
Assault/Homicide	-19.5	9.2	21.3
Fall Related Injuries	8.1	9.8	11.1
Firearm Related	41.5	5.7	-0.9
Motor Vehicle Traffic Related	14.8	0.7	-8.7

Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

[23] Color gradient indicates the direction and magnitude of change. Green cells reflect a decrease in rates (improvement), while red cells indicate an increase in rates (worsening outcomes). Darker shades represent larger changes.

Maternal and Child Health

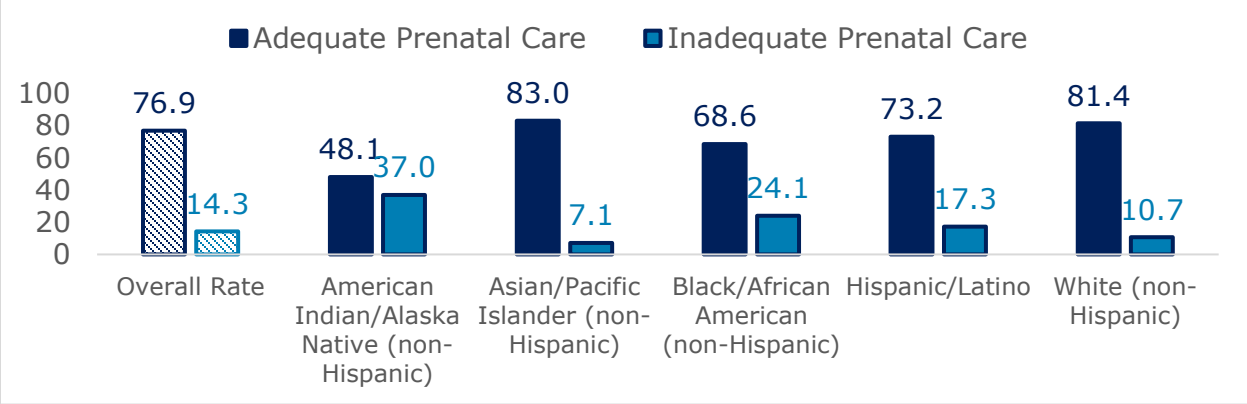
This section highlights key indicators related to the health of mothers and infants. It includes data on prenatal care, birth outcomes like low birthweight and preterm births, and teen birth rates.

Maternal and child health is a cornerstone of community well-being. When mothers receive the care they need before, during, and after pregnancy, it can lead to healthier outcomes for both parent and child. These outcomes shape not only the earliest stages of life but also long-term health and development. Looking at trends in maternal and child health helps identify where families may be facing barriers to care and highlights differences in birth outcomes that can guide efforts to support health equity.

Exhibit 22 shows rates of adequate and inadequate prenatal care by race and ethnicity. Prenatal care is a critical part of a healthy pregnancy. It helps detect and manage potential risks, ensures timely screenings, and connects families with important support and education.[24] Disparities in prenatal care access may point to broader gaps in healthcare coverage, availability of services, or cultural and language barriers within the healthcare system.

In the PSA in 2023, nearly one in five birthing parents received inadequate prenatal care. Rates were highest among American Indian/Alaska Native residents, with 37% receiving inadequate care. Black/African American and Hispanic/Latino residents followed, with rates around one in four and one in six, respectively. White and Asian/Pacific Islander residents had the lowest rates, both under 11%. Because population sizes vary, some differences may appear larger or smaller depending on the size of the group.

Exhibit 22: Prenatal Care, 2023 Crude Rates per 100 Live Births (PSA)



Source: Birth and death records, obtained from ADHS, cleaned and analyzed by MCDP

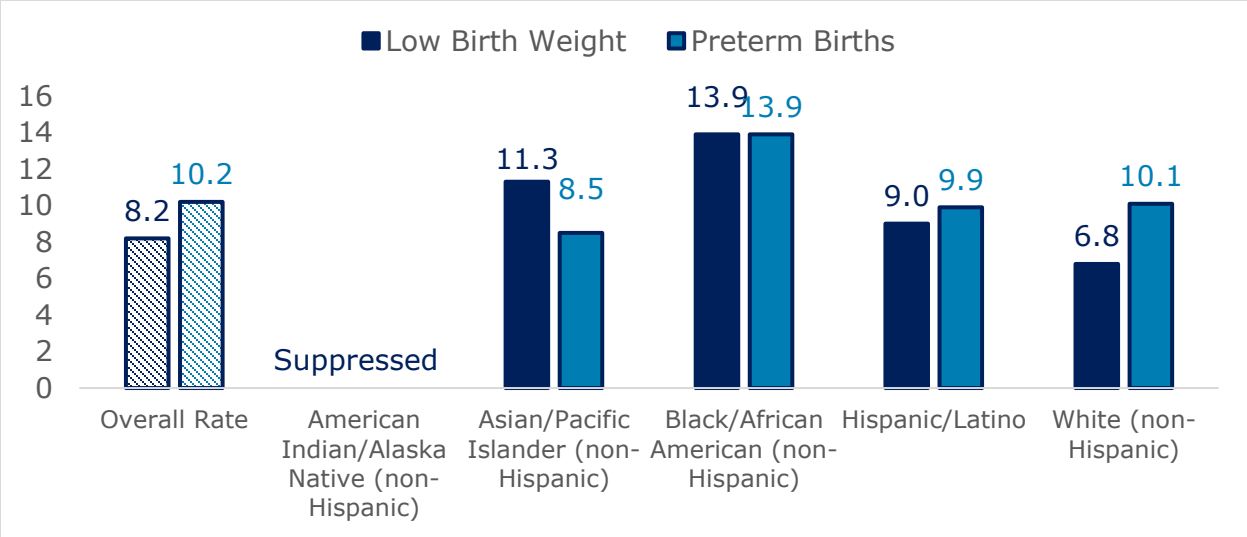
[24] Albarqi, 2025.

Access to early and consistent prenatal care can influence how pregnancies progress and how babies are born.

Exhibit 23 looks at rates of low birth weight and preterm birth, which are key indicators of newborn health.

In the PSA in 2023, Black/African American newborns had the highest rates of both low birth weight and preterm birth, well above the overall rate. Asian/Pacific Islander and Hispanic/Latino newborns also had rates slightly above the overall rate, though the gap was smaller. White newborns were slightly below the overall rate for low birth weight but slightly above it for preterm birth. Because population sizes vary, some of these differences may appear larger or smaller depending on the size of the group.

Exhibit 23: Low Birth Weight and Preterm Births, 2023 Crude Rates per 100 Live Births[25] (PSA)



Source: Birth and death records, obtained from ADHS, cleaned and analyzed by MCDP

[25] Data is suppressed if case count is between 1-4.

In addition to birth weight and prematurity, other maternal and infant health indicators can help show how conditions are changing over time. For example, teen birth rates reflect how often young people are becoming parents, which can carry added health, financial, and social risks. [26] Infant mortality, which is closely tied to maternal health, prenatal care, and broader social conditions, reflects the most serious outcomes for newborns. [27]

Exhibit 24 shows how these and other birth indicators shifted in 2022 compared to the previous four-year average.

Exhibit 24: Percent Change in Maternal and Infant Health Indicators Between 2022 and 4-Year Averages (2018-2021)[28] (PSA)

	Percent Change
Inadequate Prenatal Care	2.9
Low Birth Weight	16.7
Preterm Births	6.0
Teen Births	-12.3
Infant Mortality Rate	60.0

Source: Birth and death records, obtained from ADHS, cleaned and analyzed by MCDP

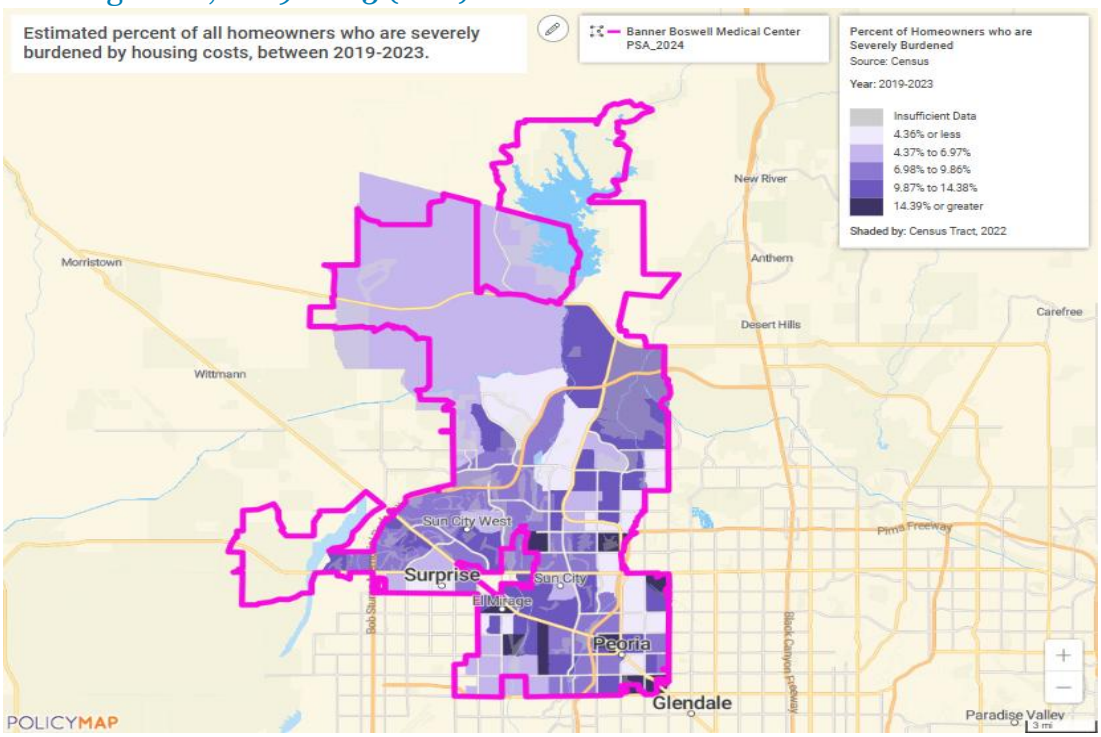
[26] CDC, 2015. Teen Childbearing Consequences.
[27] CDC, 2024. Infant Mortality.
[28] Color gradient indicates the direction and magnitude of change. Green cells reflect a decrease in rates (improvement), while red cells indicate an increase in rates (worsening outcomes). Darker shades represent larger changes. Birth rates are Crude Rates per 100 Live Births for Adequate/Inadequate Prenatal Care, Low Birthweight, and Preterm Birth. For Teenage Birth, rates are Crude Rates of Live Births Among Females Aged 15-19 Years per 1,000 Females Aged 15-19 Years. For Infant Mortality rates are Crude Rates per 1,000 Live Births.

Social and Environmental Drivers of Health

This section highlights community conditions that affect health over time, such as access to transportation, housing costs, and exposure to extreme heat. These factors influence people's ability to stay healthy and safe where they live.

Health is deeply connected to where and how people live. When housing costs take up a large portion of a household's income, it can make it harder to afford other essentials like food, transportation, and healthcare.[29] Exhibit 25 shows the estimated percentage of homeowners who are severely burdened by housing costs across the PSA. A household is considered severely cost burdened if it spends more than 50% of income on housing. The map reveals geographic differences in housing affordability, with higher rates of cost burden around Sun City. These areas are shaded in the darkest purple, indicating that more than 14.4% of homeowners spend a substantial portion of their income on housing.

Exhibit 25: Estimated Percent of All Homeowners Who Are Severely Burdened by Housing Costs; 2019-2023 (PSA)[30]



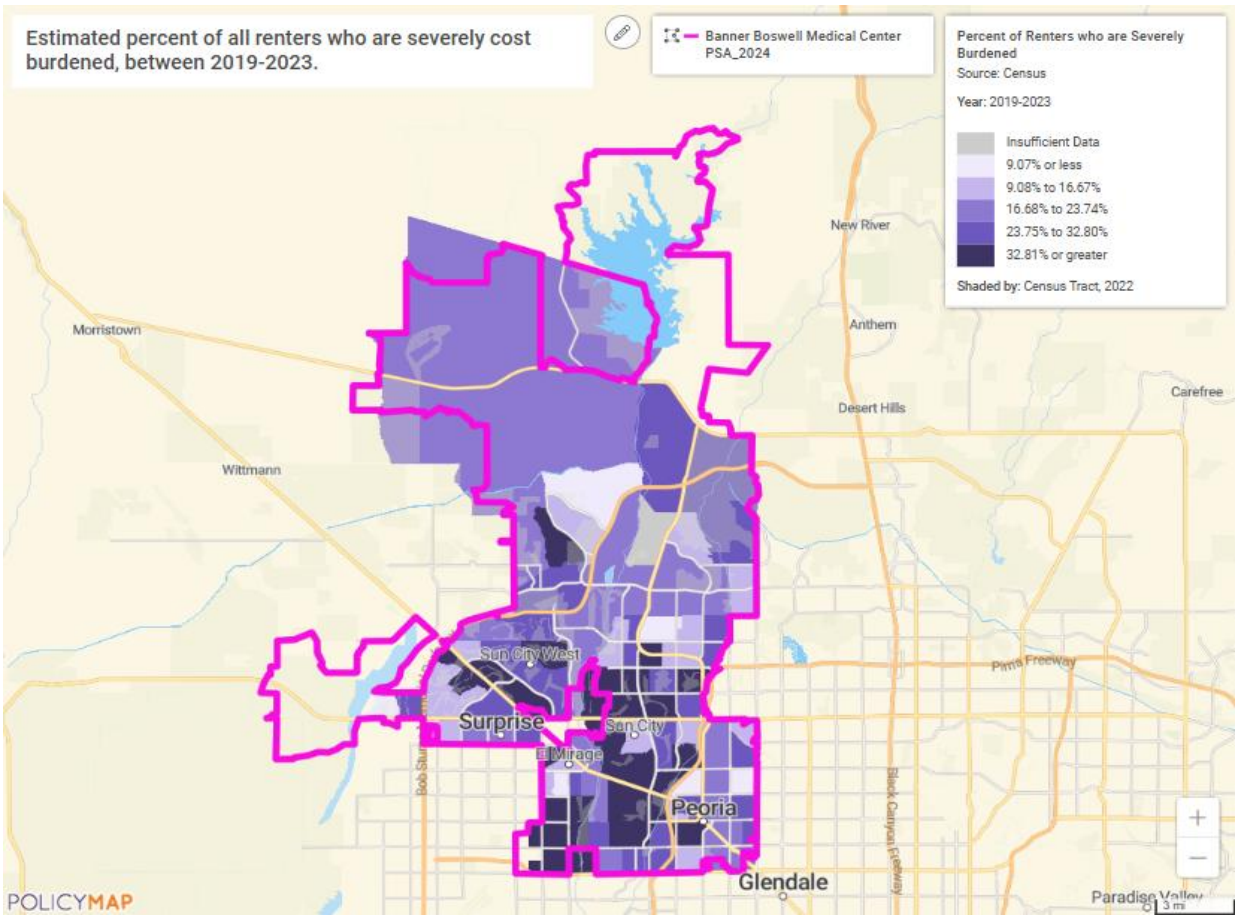
Source: PolicyMap; US Census

[29] Healthy People 2030. Social Determinants of Health.
[30] Estimated percent of owner households for whom selected monthly owner costs are 50% or more of household income, between 2019-2023. Owner housing costs include all mortgage principal payments, interest payments, real estate taxes, property insurance, homeowner fees, condo or coop fees and utilities (not including telephone or cable television).

While many homeowners experience financial strain, renters often face even greater housing cost challenges. Exhibit 26 shows the estimated percentage of renters across the PSA who are severely burdened by housing costs, spending more than half of their income on rent.

The map highlights especially high rates in the southern region of the PSA, surrounding Surprise and Peoria. These areas are shaded in the darkest purple, indicating that more than 32.8% of renters spend a substantial portion of their income on housing. These areas may face increased risk of housing instability, displacement, and related health impacts, particularly for lower-income residents who have fewer financial safety nets.

Exhibit 26: Estimated Percent of All Renters Who Are Severely Cost Burdened 2019-2023[31] (PSA)



Source: PolicyMap; US Census

[31] Percent of renter households for whom gross rent is 50% or more of household income, between 2019-2023. Gross rent is the contract rent plus the estimated average monthly cost of utilities (electricity, gas, water and sewer) and fuels (oil, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else). Gross rent is intended to eliminate differentials that result from varying practices with respect to the inclusion of utilities and fuels as part of the rental payment.

High housing costs can force difficult tradeoffs: when a large share of income goes to rent, there may be less left for essentials like food, medicine, or cooling. One way this strain shows up is through food insecurity.

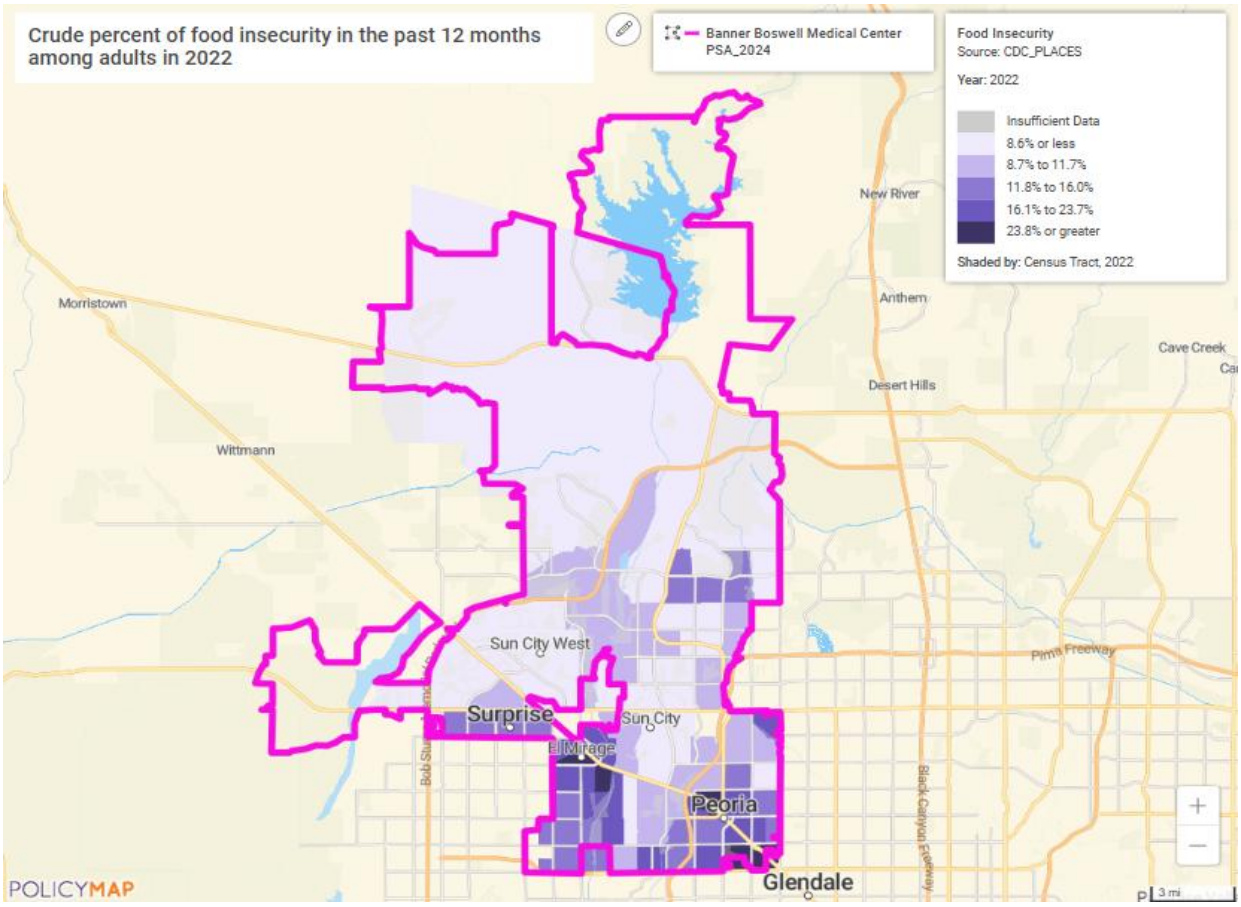
Food insecurity is closely linked to both short-term and long-term health problems, including stress, chronic disease, and poor nutrition outcomes.[32]

[32] HHS, n.d. Food Insecurity.

Exhibit 27 on the next page shows the estimated percent of adults in the PSA who experienced food insecurity in the past year. These estimates come from a national survey question asking whether people ran out of food and didn't have money to buy more. It reflects how many adults said this happened to them sometimes, usually, or always.

Areas of the PSA surrounding El Mirage and Peoria have a particularly high prevalence of food insecurity. These areas are shaded in the darkest purple, indicating that more than 23.8% of adults experienced food insecurity in the past year.

Exhibit 27: Access to Food: Crude Percent of Food Insecurity in the Past 12 Months Among Adults in 2022[33] (PSA)



Source: PolicyMap; CDC PLACES

The health risks tied to food insecurity often overlap with other challenges, especially during periods of extreme weather. In Maricopa County, rising temperatures have increased the risk of serious illness or death, particularly for older adults, people with chronic conditions, and those without stable housing or air conditioning.[34]

[33] A multi-level regression and post-stratification approach was applied to BRFSS and ACS data to compute a detailed probability among adults who reported that the food that they bought always/usually/sometimes did not last, and they didn't have money to get more. The probability was then applied to the detailed population estimates at the appropriate geographic level to generate the prevalence.
[34] CDC, 2023. Temperature Extremes.

Exhibit 28 shows the number of heat-related deaths in Maricopa County over the past decade. This is an increasing concern in Maricopa County, where rising summer temperatures have had a growing impact on health and safety.[35]

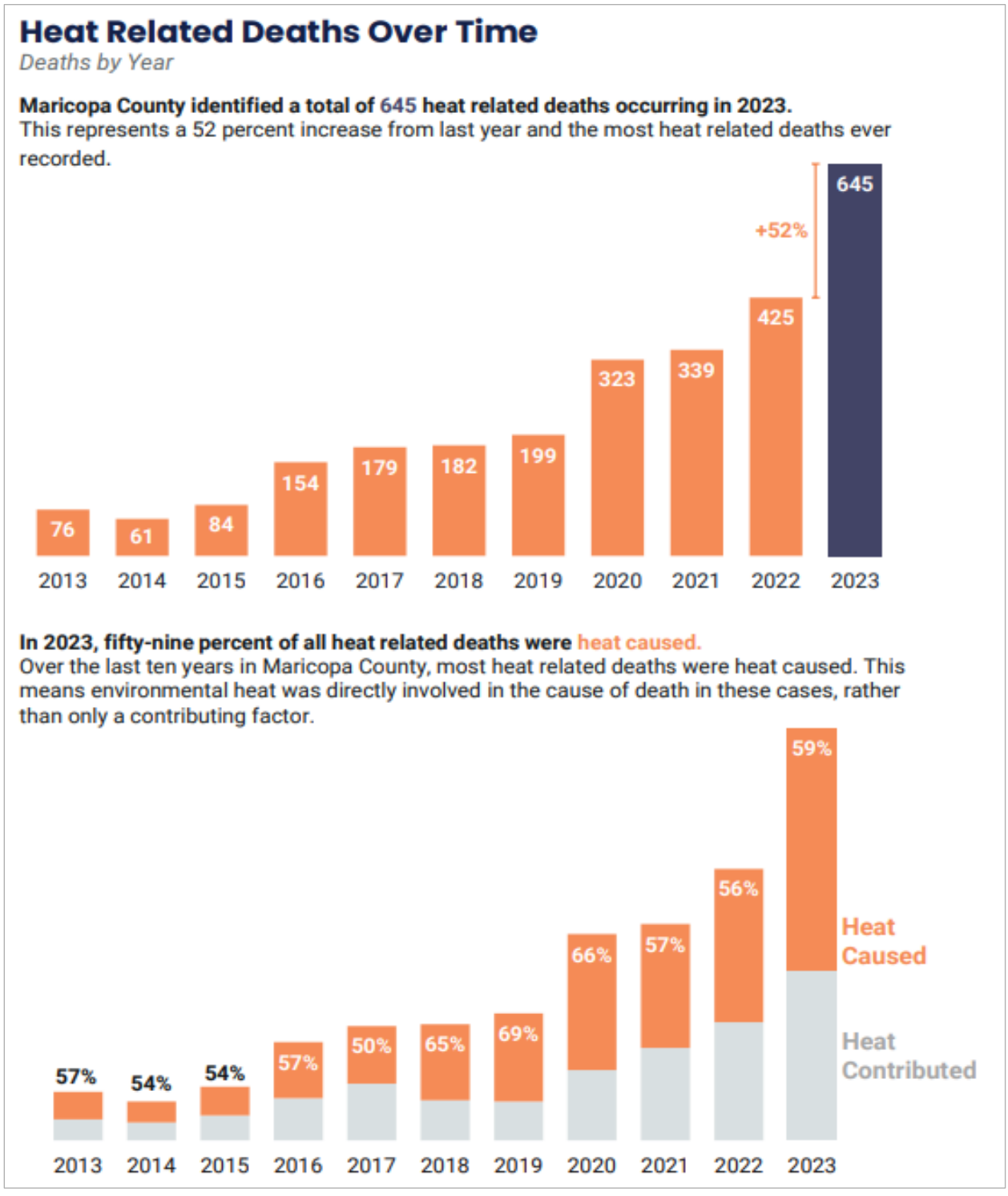
The data shows a sharp rise in heat-related deaths over time:

- In 2023, 645 deaths were attributed to heat - the highest on record and a 52% increase from the year before.
- More than half (59%) of these deaths were classified as heat caused, meaning heat was the direct cause of death, not just a contributing factor.
- Since 2016, the number of deaths has risen almost every year, highlighting a sustained public health trend.

This upward trend underscores the importance of heat response strategies, including access to cooling, safe housing, and outreach to at-risk populations.

[35] MacDonald-Evoy, 2025.

Exhibit 28: Heat Related Deaths Over Time (Maricopa County)



Source: MCDPH 2023 Heat Related Death Report

Qualitative Data Findings

Methodology

The qualitative findings presented in this report were derived from a previously conducted and published qualitative analysis found in the Community Health Needs Assessment 2024 Focus Group Findings and Appendix[36] and the Community Health Needs Assessment 2024 Key Informant Interviews.[37] The former is a result of a collaborative effort between the MCDPH and SIRC; together, they conducted 46 focus groups with 366 focus group participants from 15 priority populations. The latter is a result of a collaborative effort between the MCDPH and the Omni Institute, in which 24 key informants were interviewed. To ensure the integrity of the data and the analysis, all participant quotes, themes, subthemes, and narrative insights were used as they appeared in the original report, with minimal edits made for readability. This approach was used to respectfully represent the voices of the community and accurately portray the analysis conducted by MCDPH and its partners. A reinterpretation or reanalysis of the raw qualitative data was not conducted as part of this effort.

For the purposes of this report, the existing themes found in the CHNA 2024 Focus Group Findings and Appendix were organized into Strengths, Themes, and Needs.

Relevant insights from key informants were included in each section as appropriate. Visualizations were developed to concisely represent the original qualitative findings within these categories. The qualitative findings were consolidated to present a concise summary of the full analysis. Please refer to the original documents for a comprehensive qualitative analysis of the data.

> **Strengths** can serve as resources to address the needs identified.
>
> **Themes** are conceptual considerations that provide context so that needs are addressed in a way that is responsive to the culture and identity of the community.
>
> **Needs** are actionable areas that participants highlighted as the most pressing challenges, barriers, and concerns they face in their community.

These three concepts are intertwined and must be considered holistically to better understand and better utilize the data collected to make positive changes.

[36]Maricopa County CHNA 2023 Focus Group Findings: https://www.maricopa.gov/DocumentCenter/View/92376/2023-Focus-Group-Report-Findings ; Maricopa County CHNA 2023 Focus Group Findings Appendix: https://www.maricopa.gov/DocumentCenter/View/96246/2023-Focus-Group-Report-Appendices
[37] Maricopa County CHNA 2024 Key Informant Interviews: https://www.maricopa.gov/DocumentCenter/View/94150/2024-CHNA-Key-Informant-Interviews-Report_FINAL_52224

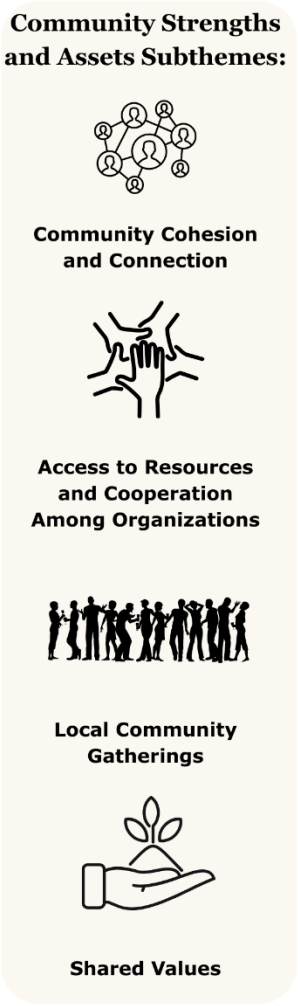
Strengths

Strengths are characteristics, resources, or other factors in a community that promote members' quality of life and community sustainability.

Community Members and Organizations

Across the focus groups and key informant interviews, many strengths were discussed relating to the participants' communities. Focus group participants discussed how they related to their neighbors and how community members affected them and their families. Answers from several groups described positive attributes such as a supportive environment, helpful neighbors, and a welcoming atmosphere.

> "You know your neighbors. You're able to share their life as well as theirs with you, a nice store, a nice church. You look out for each other. You feel safe. If you're not there, you know you still have a block watch around you in your neighborhood to where you all look out for each other."
>
> - *Low-Income Seniors Focus Group*



Key informants in the community shared similar views regarding the strengths of the community. Community members themselves were seen as a key strength, including their resiliency, resourcefulness, and commitment to protecting one another. According to participants, communities' knowledge, connections, pride, and cultural cohesion contribute to community well-being. Participants also highlighted various agencies, organizations, and programs within Maricopa County as a key strength.

> "We come out and help and support in any way that we can because of some of the work that they're doing with justice-involved folks, giving them employment, teaching them life skills and the life, could really mean their life [was] impacted for the better and [they do not have] to resort to old mindsets and behavior mistakes."
>
> - *Key Informant*

Themes

Themes are systemic factors that impact how a community functions and should be considered when leveraging strengths to meet the needs.

Systems of Power, Privilege, and Oppression

The theme systems of power, privilege, and oppression represent the root causes or structural drivers of inequity. Structural inequity is when one social group has a systematic disadvantage compared to other groups.[38] Focus group participants' perception of health, community representation, and racism was expressed during the focus group interviews. Racism, oppression, discrimination, and lack of community safety were uniquely experienced by minority ethnic groups and special populations. These experiences were categorized into eight subthemes:

- discrimination, racism, or oppression
- provider competency
- community safety
- neighborhood characteristics
- social connectedness
- community representation
- community care or mutual aid
- structural racism

> "When I finally saw the spinal surgeon, he said that if I had been diagnosed within the first three to four months of my symptoms, then I'd have an 80% chance of recovering full capabilities. Because it took so long to see the neurologist, and then the neurologist, even though I gave her my symptoms right away—and as a Black woman, they don't listen."
>
> - *Rural Focus Group*

Key informants also identified several disparities across community members as well as challenges and barriers to developing services and programming. These disparities were seen to impact historically marginalized communities, including communities of color, undocumented populations, and unhoused populations.

[38] Baciu et al., 2017

Education

Focus group discussions regarding education focused on the negative aspects of the state of education. The financial aspects of education were prevalent throughout. A participant from the low-income Hispanic focus group mentioned she was torn between wanting her daughter to attend college and the affordability of that education. In a similar vein, one of the participants from a general population focus group expressed the opinion that schools are unequally funded; with many lower-income schools struggling. Cost was also mentioned by a participant in a youth focus group who said that college classes were available to students in her high school, but the price of books alone was prohibitive. In keeping with this financial theme, a lower income Hispanic participant expressed a wish for an English language school for adults, and a fellow participant explains how that would help their community get better jobs.

> "Education in Arizona is one of the worst. I can statistically say, I got the bottom of the barrel. Having more funds for education, that could help us learn, cause I went to high school in Minnesota. I went to high school there, and it was a way different experience."
>
> - *Refugee/Immigrant/Migrant Focus Group*

Education as a Subtheme:

Costs of Postsecondary Education

Inadequate Public School Funding, Especially for High-Need Areas

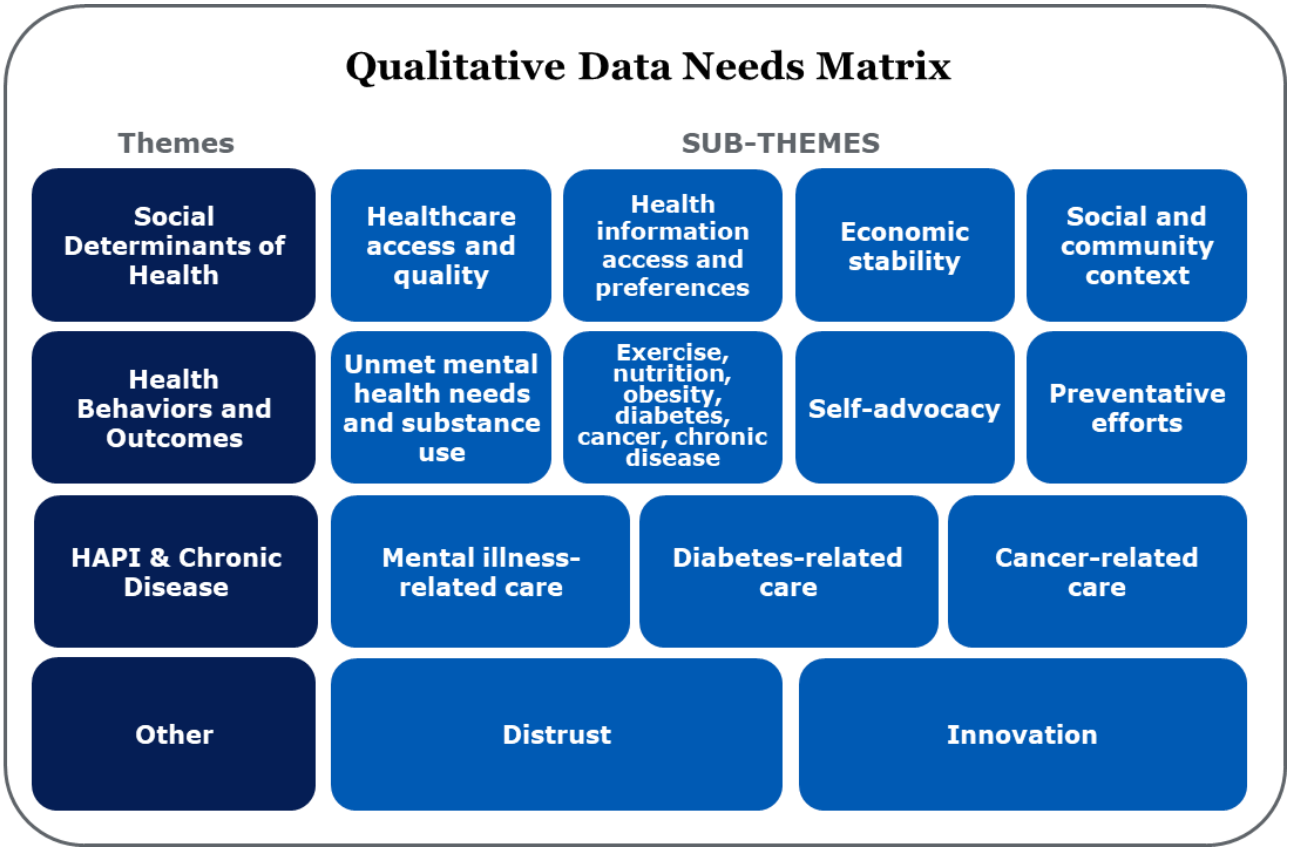
Unequal Access to Educational Resources

In contrast to the focus group discussions, key informants detailed the strengths of the education system in Maricopa County, specifically the strengths related to local universities and some of the public school districts, which participants noted are leading to positive change and growth. The options of public charter schools were also discussed and seen as an asset. A participant with two children, one in high school and one in elementary school, noted the educational opportunities afforded to youth in the community. Examples of such programs included an aeronautics/aerospace summer camp and additional language courses.

Needs

Needs are actionable areas that participants highlighted as the most pressing challenges, barriers, and concerns they face in their community.

Needs Matrix



Social Drivers of Health

The social drivers of health theme served to identify outside factors and occurrences that impact different aspects of a community's health and public health system. These factors, also known as social determinants of health, are a result of interrelated and often complex social and economic systems, and include characteristics such as socioeconomic status, access to health care, and the physical environment.[39] Four subthemes were identified under forces of change and are presented in order from most to least discussed:

- health care access and quality
- health information access and preferences
- economic stability
- social and community context

> "Sometimes places are too far away and you don't have the means to get there, so it's a problem."
>
> - *Low-Income Hispanic Focus Group*

Several key informants discussed that access to healthcare services can also vary across neighborhoods according to participants, with a scarcity of hospitals, clinics, and pharmacies in certain areas. In more outlying cities, healthcare access can be spread out, one participant noted for their community. The participant described one large hospital and a smaller hospital in their northwest city and mentioned that community members needed to travel to neighboring cities for more options. Another participant whose facility is in Phoenix described lack of healthcare options, coupled with lack of police presence, which leads to issues of public safety. Some informants noted that individuals who rely on

[39] CDC, 2024. SDOH.

public transportation or who have mobility issues experience increased difficulties in accessing medical appointments.

Health Behaviors and Outcomes

> "It is a wildly inequitable environment for those who are living with blindness and visual impairment because society isn't tilted towards them...I think that there needs to be healthcare that's really sensitive. And I think that the county is really well positioned to be able to work with ... hospitals in the area, as to how to provide that responsive healthcare."
>
> - *Key Informant*

The theme health behaviors and outcomes identified behaviors that can either work to improve health outcomes or put someone at increased risk for disease. Behaviors are an important factor to examine as they fall under a larger ability to control at the individual level, and certain behaviors such as healthy eating and exercise are known to be more commonly associated with positive health outcomes.[40] Health outcomes relate to those factors that impact the length and quality of life for community members. Eight subthemes of behavior and outcomes were identified and are presented in order from most to least discussed:

- prevention
- exercise
- self-advocacy
- unmet mental health needs

> "[...] If we could actually bring more of that to the classroom, bring this type of [health] education to students, I think that that would be helpful. More health-related stuff, more mental health-related stuff, physical and mental, building that into curriculums, versus relying on a health class, just one thing that not all students have to take but should. I think that would be helpful."
>
> - *General Population Focus Group*

[40] CDC, Healthy Weight 2023

- substance use
- poor nutrition
- obesity
- chronic disease

Some participants in key informant interviews shared that substance use impacts unhoused populations. They noted that individuals use substances in public locations because there is a lack of treatment centers. Others discussed preventive education as a means of reducing health issues, with a focus on younger communities. Several key informants described challenges and barriers related to mental health needs, as well as a number of issues related to resources, with a lack of service options and providers being the resource issue that was most described. Five participants also described a lack of funding in Maricopa County to ensure that spaces are navigable, accessible, and culturally aware. Key informants also discussed food deserts as a barrier for accessing nutritious food options. One innovative suggestion was that insurance coverage should include services like transportation to food banks.

> "Maricopa County did a really good job, especially during the pandemic, with really hearing the voices of the community…it was really community-driven, and I think that was really great. Our County Public Health Department is really focused on these upstream approaches to improving population and community health. And that often means engaging in advocacy and public policy and leveraging their voice is really critical because even though there has been some corrosion of trust with public health and things like vaccines and immunizations, they are still trusted community members."
>
> - – *Key Informant*

Health Behaviors and Outcomes Subthemes:

Prevention

Exercise, Poor Nutrition, Obesity, Diabetes, Cancer, Chronic Disease

Self-Advocacy

Unmet Mental Health Needs and Substance Use

Health in Arizona Policy Initiative (HAPI) and Chronic Diseases

The Health in Arizona Policy Initiative (HAPI) is an approach that aims to address population health needs by including health in all government and state policies. Multiple counties across Arizona participate in HAPI through the Arizona Department of Health Services to collaborate and enhance large-scale approaches to health. It is based on the idea that health is impacted not only by individual choices and factors, but by the interaction of various domains, including environment and local or statewide government policies.

This area focuses on what prevalent chronic diseases (diseases lasting more than one year) were commonly reported by focus group participants. The HAPI component of the focus group questions was added during the time that the focus groups were already being conducted. For this reason, there were no questions phrased specifically to elicit responses from the community directly related to prevalent chronic diseases. Despite this limitation, several subthemes emerged. Participants reported what diseases they personally had experienced and what they perceived to be more prevalent in their communities. Three subthemes of prevalent chronic diseases were identified and are presented from most to least discussed:

- mental illness
- diabetes
- cancer

> "I haven't mentioned skin cancer, which is on the rise and a real problem. Especially for people who are living alone or are unhoused, and they can't see, or they can't get to – they can't see the cancer, they can't get to care."
>
> - *Religious Minority Focus Group*

Participants in key informant interviews noted that stigma is a barrier for those with mental illness to receive treatment. Older adults are more likely to have mental health diagnoses that are overlooked, which leads to a lack of funding for specific populations in Maricopa County. One participant also shared a concern that anxiety is often underdiagnosed, and another expressed wishes for the development of treatments for diagnoses such as Alzheimer's. Some key informants noted the relationship between the lack of healthy outdoor space with health issues, such as cancer.

> "On Navajo [land], we are located on areas [that include] uranium, so there's a huge increase in cancer."
>
> - *Key Informant*

Additional Topics

The theme "additional topics" was included to capture topics that did not align with other themes but were notable topics of conversation. These topics of conversations were categorized into two subthemes. The two subthemes are in order from most to least discussed:

- innovation
- trust

> "For a similar idea, I suggested if there is a kinda of call center concerning our concerns about health issue, it'll be very helpful because in South Korea, if we put 119, Korean version of 911, we can ask a doctor real-time, 24 hours all the time about our issues, so there should be no debate. Like, "My son has a fever." I say something. My wife say something, but we all stay silent because doctor can say the answer."
>
> - *Asian Focus Group*

Participants in key informant interviews discussed trust in the context of immigrant communities and communities of color, particularly due to the anti-immigrant sentiment and complex trauma experienced by immigrants and in relations with law enforcement, which can contribute to self-isolation. Innovation was mentioned in key informant interviews in relation to Arizona State University, which focuses on research as well as the region's innovation and economic development.

> "There's plenty of research that backs up how the more anti-immigrant sentiment, the more isolated and the higher levels of PTSD and complex trauma people experience...even when we're bringing resources, people question why are we providing resources?"
>
> - *Key Informant*

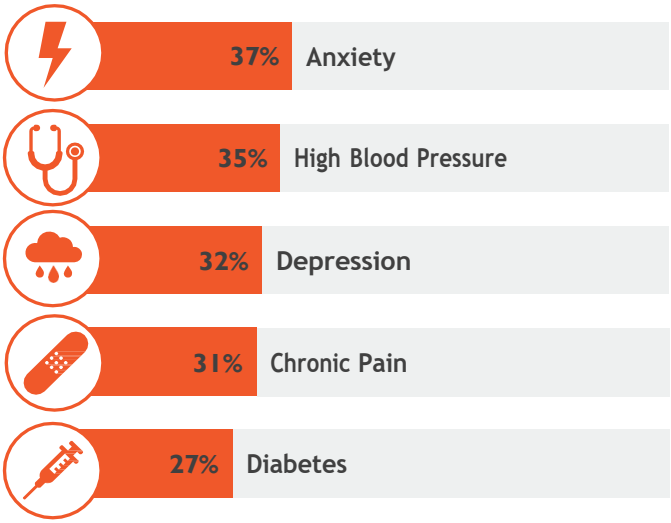
Survey Findings

Northwest Region Community Health Survey

About the Survey: *2,658 Northwest Maricopa County Region residents completed the survey during March – June 2023. Some survey questions were not completed by all survey participants, and the results might not reflect the opinions of the total Northwest Region population. Visit maricopahealthmatters.org to view all responses.*

Which health issues have the most impact on you and/or the people you live with or care for?

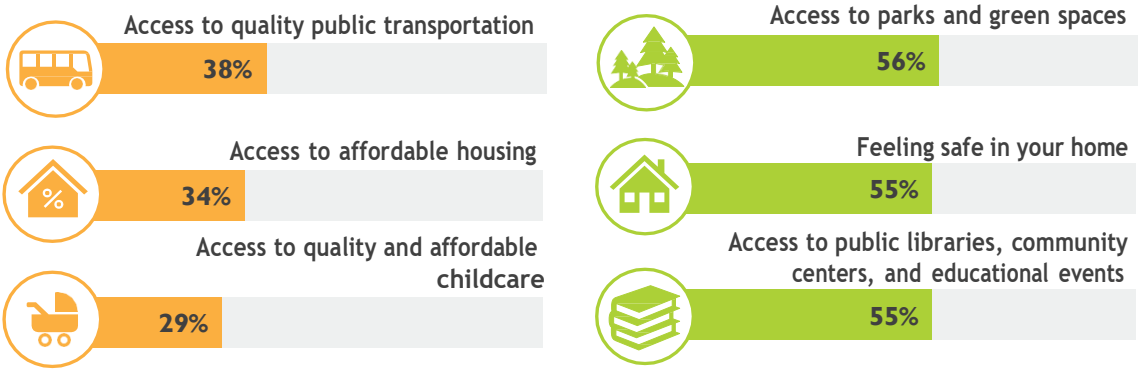
Many people said **anxiety, high blood pressure,** or **depression** were the health issues that have the most impact on someone they care for, live with, or themselves.



How would you rate these assets in your community?

The community assets most likely to be rated as poor included **public transportation** and **affordable housing**.

The highest rated community assets included **access to parks** and **feeling safe at home**.



How would you rate your physical and mental health?

Overall, few people reported poor personal health. However, certain groups rated their health as **poor** more often:

Poor Mental Health

9%	Overall
23%	Unhoused
20%	LGBTQ+
20%	Age 12-18 years

Poor Physical Health

9%	Overall
34%	Disabled
28%	Unhoused
23%	Homebound

How often could you get health care when needed?

Many people shared they had difficulty getting health care. Certain groups had even **more difficulty** getting needed care:

Difficulty Getting Mental Health Care

Overall	55%
Multiracial	73%
Refugee, Immigrant, Migrant	69%
Income $25k-$35k	65%

Difficulty Getting Medical Care

Overall	37%
Unhoused	50%
Refugee, Immigrant, Migrant	49%
Income $25k-$35k	48%

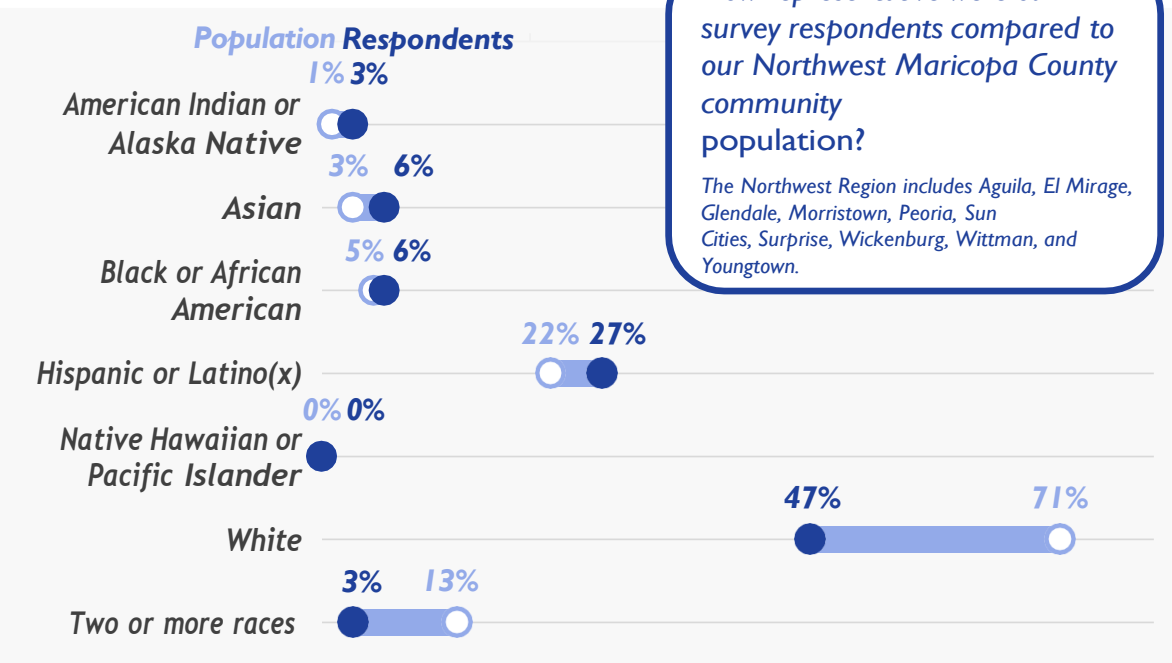
What would help you get the care you need?

- **49%** Evening or weekend appointments
- **42%** Lower out of pocket cost for services
- **39%** Multiple services at the same location

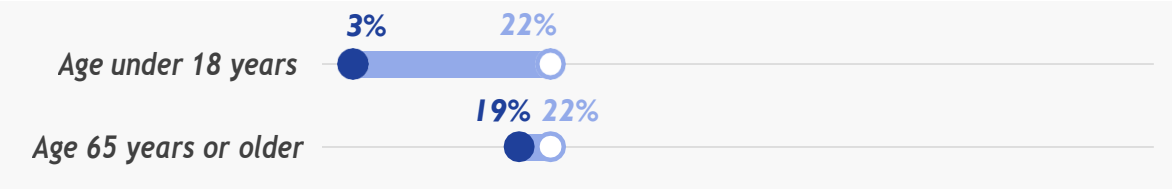
Community partners helped us achieve our largest and most inclusive survey yet.

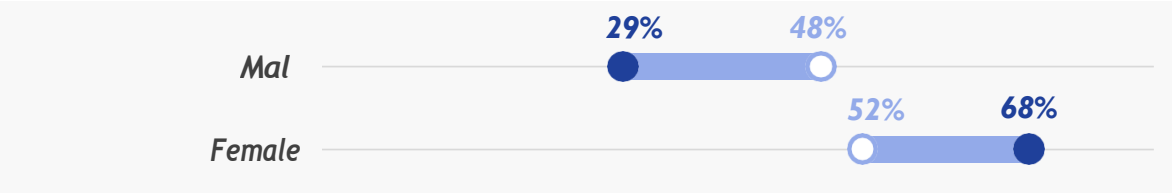
How representative were our survey respondents compared to our Northwest Maricopa County community population?

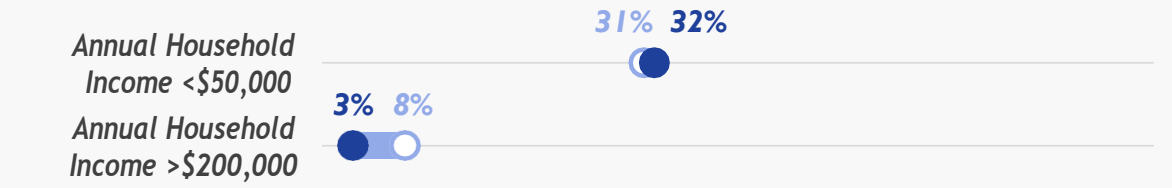
The Northwest Region includes Aguila, El Mirage, Glendale, Morristown, Peoria, Sun Cities, Surprise, Wickenburg, Wittman, and Youngtown.



Respondents selected the race / ethnicity they identified with most; Population race / ethnicity aligns with the 2022 American Community Survey







Sources: 2023 Maricopa County Community Health Survey, 2022 American Community

Prioritized Needs

Prioritization Process

The needs prioritization process is a critical step in finalizing the Community Health Needs Assessment. A prioritization session was conducted on July 28, 2025, with 9 BBWMC leaders. This was a 45-minute session facilitated by Banner staff. The meeting consisted of a data presentation, discussion of the data, community needs, and potential strategies.

An initial 18 health indicators were identified through primary and secondary data collection. Utilizing the Hanlon Method for setting criteria and ranking, 3 health indicators were identified to prioritize as significant health needs.

The Hanlon Method, objectively takes into consideration explicitly defined criteria and feasibility factors, utilizing the formula:

$(A+2B)\times C$

Criteria for the Hanlon Method is listed below.

A. Size of the Problem
B. Seriousness of the Problem
C. Effectiveness of the Problem

During the roundtable discussions topics included the magnitude and severity of the community need, potential barriers to addressing the needs, and what happens if the community need is not addressed in the hospital's service area. Following discussions, all participants were asked to rank each of the community needs on a scale for magnitude, severity, and feasibility. Using the Hanlon Method formula, a priority score was assigned to each community need. The results were provided to each local health system for consideration as they build their hospital Implementation Strategy. See Appendix E for the Needs Prioritization PowerPoint presentation.

Top Community Needs

The following community needs were prioritized as a result of the prioritization process:

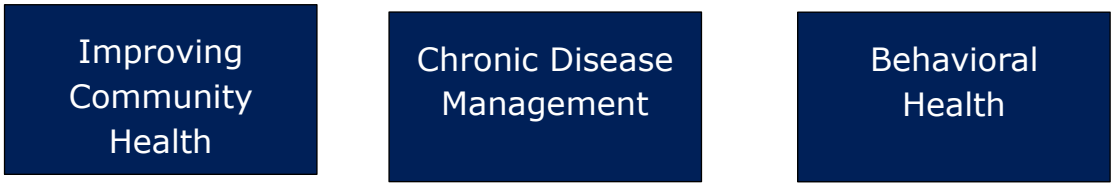
Exhibit 29: Top Community Needs

Rank	Community Need
1	Access to Primary Care
2	Access to Specialty Care
3	Access to Mental and Behavioral Health Services
4	Mental and Behavioral Health Conditions
5	Cardiovascular Disease
6	Diabetes
7	Obesity and Nutrition
8	Health Insurance
9	Cancer Prevention and Treatment
10	Maternal and Infant Health
11	Substance Use
12	Child and Adolescent Health
13	Mortality from Unintentional Injury
14	Access to Healthy Food
15	Environmental Health & Heat
16	Education Access and Quality
17	Housing and Homelessness
18	Discrimination / Racism / Oppression

Appendix A: 2022-2025 Implementation Strategy Update

The Community Health Needs Assessment process should be viewed as a three-year cycle to evaluate the impact of actions taken to address priority areas. This step affirms organizations' focus and targets efforts during the next CHNA cycle.

The top three health priorities for BBWMC from the 2022 Community Health Needs Assessment were:



Summary of Progress to Date

Significant Health Need: Improving the health of the communities we serve
Strategy: Increased utilization of Banner Health's care continuum through our clinics, hospitals, ambulatory settings, and post-acute settings of care.
Anticipated Outcome: Improve our communities' ease and access to the care continuum for all their health care needs.
• *Growth in utilization of ambulatory services, such as urgent care access, ambulatory surgical centers, and clinic access.* • *Improvement to online scheduling ease and navigation of Banner Health patient portal – this includes links to pre-approval text messages and communication via texting prior to the appointment.*
Strategy: Supporting our team members through internal wellness programs and employee benefits.
Anticipated Outcome: Inspire a healthy and productive work force.
• *Provide programs to medical staff to reduce burnout. Programs include Wellness in Nursing and Clinical Happiness in Medicine for physicians and advanced practice providers. This has resulted in year-over-year improvement in clinical providers' reduced burnout.* • *Improve Banner Health team member engagement and employee satisfaction via facility-led initiatives – annual survey data shows a 15% increase in employee satisfaction over a three-year trend.* • *Support employee wellness through well-being programs both in-person and virtual, focusing on physical, mental, and financial health.*
Strategy: Align Banner Health's strategies and processes with Social Determinants of Health practices.
Anticipated Outcome: Educate Banner Health team members and partners on incorporating Social Determinants of Health into our health care strategies.
• *Continue to identify areas of opportunity via community partnerships to address social determinants of health.* • *Provide care to over 1,500 annually via in-school clinics and mobile health clinics to low-income pediatric patients.* • *Provide ~1,300 vaccines to pediatric patients annually via in-school clinics and mobile health clinics to low-income patients.* • *Support seniors via food deliveries (~200 households annually), advocacy programs (~1,500 interactions annually), and grief support programs.*

Significant Health Need: Chronic Disease Management
Strategy: Increase access to Primary Care.
Anticipated Outcome: Improve ease of primary care utilization.
• *Improve year-over-year utilization of online scheduling for primary care visits by 2.5%* • *Utilization of ~10k annual telehealth visits to monitor chronic care conditions for patients.* • *Provide external resources to patients to support the management of health.*
Strategy: Support Banner Health communities in managing chronic diseases.
Anticipated Outcome: Improve chronic disease management through clinical support and patient education.
• *Improve patient management of high blood pressure, via primary care interventions and monitoring by 10% from 2022 to 2025.* • *Help patients monitor HbA1c levels with a target to below 16% for primary care visits – by 2025, facilities averaged 16%, a 4% decrease since 2022.*
Strategy: Increase awareness of and access to cancer screenings. **Increase awareness of and access to cancer screenings.**
Anticipated Outcome: Increase preventative cancer care.
• *Provide educational materials and resources to community members and patients for cancer awareness and prevention.* • *Increase patient compliance for routine colon screenings from 2022 to 2025, with a goal of 75% of patients being compliant (2025 half year at 79%).* • *Increase patient compliance for routine breast cancer screenings from 2022 to 2025, with a goal of 75% of patients being compliant (2025 half-year at 66%).*

Significant Health Need: Behavioral Health
Strategy: Provide awareness and access to mental health resources.
Anticipated Outcome: Reduce volume of acute mental health episodes through early interventions of education and access to preventative care.
• *Provide virtual education opportunities for mental health education and awareness of internal and external use.* • *Utilizing tele-behavioral services to provide resources to behavioral patients – growing from ~50 assessments annually to ~400 annually from 2022 to 2025.* • *Provide quick and easy access to Banner Health mental health resources for clinicians to share with patients.*
Strategy: Support communities in accessing substance prevention and intervention services.
Anticipated Outcome: Improve utilization of prevention and intervention services for substance use.
• *Utilize intervention best practices for addressing substance abuse and misuse, focusing on program utilization in clinics, emergency departments, and urgent cares.* • *Provide multi-interventional tobacco cessation support in all facilities for patients and their families.* • *Continue to provide inpatient detox and intensive outpatient services at all Banner Health acute health sites.*

Summary of Community Feedback

Banner Health welcomes community input and feedback on our Community Health Needs Assessment and our Implementation Plan. The public is invited to contact us on the Community Benefits webpage.

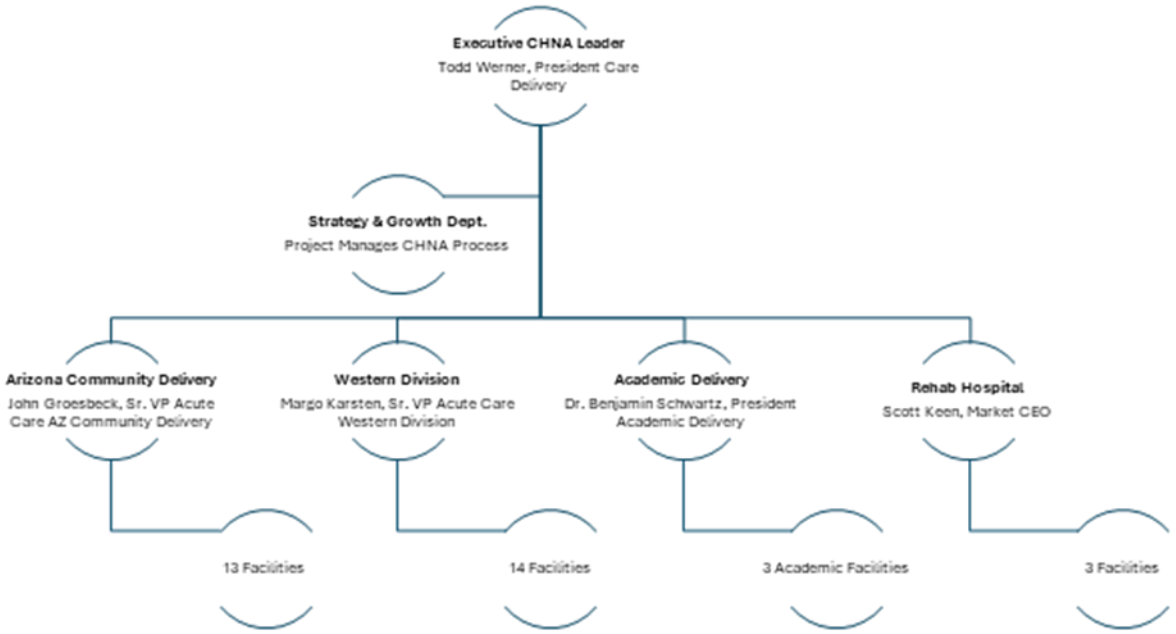
Since 2022, we have received a variety of communication via our Community Benefits webpage. Banner Health tracks comments received and addressed all comments where able. The table below is a summary of the themes of comments collected from 2023 to half year 2025.

To organize questions submitted, Banner Health utilizes a program called Form Stack to track feedback from community members. Banner Health CHNA Team Members routinely check the Form Stack account to be sure that all questions submitted to Banner Health are addressed in a timely manner.

	Feedback from Community
2023	• Comments on opportunities to align on the Behavioral Health strategies tactics. • Requests for recordings and notes from Colorado facilities annual Hospital Community Benefit Accountability Program. • Solicitation to participate in community collaboratives that align with Banner Health Implementation Plan.
2024	• Invitation to participate in local Community Health Fair. • Updates on changes to partner county org structure for CHIP and CHA work. • Solicitation to participate in community collaboratives that align with Banner Health Implementation Plan. • Request to participate in focus groups to understand alignment of Banner Health CHNA with city and county community health work.
Half Year 2025	• Questions, RSVPs, and follow ups to the CHNA Community Forums, Key Informant Interviews, Focus Groups, and Surveys. • Requests for recordings and notes from Colorado facilities annual Hospital Community Benefit Accountability Program. • Requests to understand the timeline on the 2025 CHNA Reports.

Appendix B: CHNA Organizational Structure

Banner CHNA Steering Committee



CHNA Facility-based Champions

Facility Leaders	Champion(s) -- 2025
Stan Holm, CEO	Stan Holm (CEO)
	Mandy Johnson (Director, Social Work Care Coordination)

Synapse Partners

CHNA Collaborators

Banner Health partners with Maricopa County Department of Public Health to conduct this CHNA, which was developed by Maricopa County Department of Public Health. Another key CHNA collaborator is Synapse, a coalition of non-profit and federally qualified health care providers that work together to collect data and conduct CHNAs to guide community investments. The following organizations are a part of the Synapse Coalition:

- Adelante Healthcare
- Banner Health
- City of Hope
- Circle the City
- Dignity Health
- Mayo Clinic
- Native Health
- Neighborhood Outreach Access to Health (NOAH)
- Phoenix Children's
- Valleywise Health
- Vitalyst Health Foundation

Assessment, Process, and Methods

Maricopa County health centers and hospitals play a vital role in enhancing the region's health and economy. Beyond providing high-quality medical care, these institutions implement programs that address community-specific needs. Many healthcare partners serve overlapping populations, leading to collaboration across Maricopa County. As a result, organizations such as Adelante Healthcare, Banner Health, City of Hope, Circle the City, Dignity Health, Mayo Clinic, Native Health, Neighborhood Outreach Access to Health, Phoenix Children's, and Valleywise Health partner with Maricopa County Department of Public Health through the Synapse Coalition to identify community strengths and address the most pressing needs through a coordinated CHNA.

Appendix C: Engagement

Sample Selection. Purposive sampling was used to recruit participants which involves the attraction and selection of individuals who meet certain inclusion criteria and do not meet certain exclusion criteria. Diversity in age, gender, race/ethnicity, physical ability, and other background factors were emphasized in recruitment. Inclusion criteria consisted of living in Maricopa County for at least six months of the year and meeting the criteria for the target population for that group. Target populations were recruited according to the priority populations identified by MCDPH and the Synapse partners. The 17 target populations included the following:

- Asian
- Black/African American
- Hispanic
- Native American
- Native Hawaiian/Pacific Islander
- Youth Ages 12-17 Years
- Seniors 65 Years and Older
- Low Income Individuals
- Religious Minorities
- Unsheltered
- Disabled
- Veterans
- LGBTQ+
- Refugee, Immigrant/Migrant
- Formerly Incarcerated
- People Living in Rural areas of Maricopa County

However, no specific groups were held with only Native Hawaiian/Pacific Islanders or disabled persons. Further, several focus groups were not of a specific priority population and were categorized as general population, allowing individuals from various backgrounds to participate at one time. Some individuals met the criteria of several priority populations. For example, one focus group was conducted with persons who identified as both low income persons and as seniors, and in another group, individuals identified as both low income and formerly incarcerated.

Geographic Region. Recently, MCDPH divided the county into five regions (Central Phoenix, Northeast, Northwest, Southeast, and Southwest) to help prioritize needs and resources in specific areas as Maricopa County is one of the fastest growing counties in the country. Participants were recruited from each of the five regions, and some focus groups were held which were not in a specific region and were thus

categorized as countywide, allowing individuals to participate from various regions at one time. The 46 focus groups were conducted across the regions as follows: Northeast (n=4), Southeast (n=6), Central Phoenix (n=12), Northwest (n=6), Southwest (n=5), and Countywide (n=13).

Recruitment. Marketing efforts included English and Spanish flyers (see Appendix J), social media posts (e.g. Facebook) and word of mouth by SIRC evaluators and partners. Recruitment materials were distributed by SIRC evaluators and partners across Maricopa County. Flyers were specifically tailored to the populations of interest and posted in some local businesses and organizations of community partners. Efforts were made to recruit through a wide range of networks and associations for each group with the assistance of MCDPH and its partners.

Registration. Prior to registration, interested individuals were screened to ensure they met the qualifying criteria using a set of questions developed. Participants were able to register for the groups via phone, email, paper sign-up sheets, or online through an online survey questionnaire platform. After registering for a focus group session, potential participants were sent reminders and a confirmation email that included logistical information such as time, date, and directions prior to their focus group. They were also asked to complete an online survey prior to attending the focus group (see Appendix O). Each participant was contacted by phone the day before the group to confirm participation, to clarify any logistical questions, and to minimize attrition.

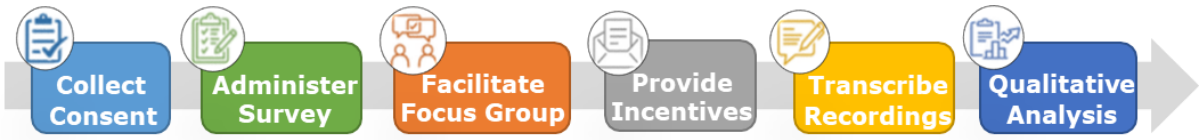
Venues. SIRC worked with new and existing community partners to identify and reserve appropriate locations for focus groups. All but one community partner volunteered their space. Those who volunteered their space were given a $45 Walmart gift card as a thank you for using their space. Venues selected were ADA compliant, convenient to the targeted participants, and located along public transportation routes to further minimize barriers to participation among the populations of interest. Venues were selected to ensure sufficient reach throughout Maricopa County. SIRC's Zoom platform was used for all virtual focus groups.

Participants. The target number of participants for Zoom focus groups was four to six individuals and six to 12 individuals for in person groups. Each group lasted approximately 90 minutes which was sufficient time for high quality data collection from the discussion while remaining respectful of participants' time. Most participants were 18 years of age or older, except in the groups in which youth participated; youth groups include persons as young as 12 years of age. A total of 397 individuals registered for a focus group; however, not all attended, which resulted in a total of 366 individuals participating in the focus groups. Participants had the options of signing up for an in person or Zoom focus group; 19 focus groups were conducted via Zoom and 27 in person.

Incentives and Supervision of Children. Individuals who participated in a focus group via Zoom received a $45 Tango e-card as a stipend. The Tango e-card was redeemable with over 500 vendors. Individuals who participated in person received a $45 Walmart gift card and in some cases were given the option to receive a Tango e-card instead. Additionally, individuals participating at the in person focus groups were also provided with a light meal and healthy beverages. The $45 incentive was deemed ethical as it was sufficient to achieve participation without being coercive (Grant and Sugarman, 2004). To minimize barriers to participation, supervision of children was provided as needed for each in person focus group by SIRC staff. Child supervision was conducted by a SIRC evaluator with an active Fingerprint Clearance card.

Consent. Per IRB requirements, participants were fully informed of any risks, benefits, and expectations associated with their participation. They were asked to sign an IRB-approved consent form prior to participating in the focus group. The signed consent forms were stored separately from any personal data provided by the focus group participants. Figure 1 shows a visual display of the focus group process.

Exhibit 30: Focus Group Process



Focus Group Schedule

FG #	Date in 2023	Region*	Population	Location
1	June 22 6:00 pm	NW	Veterans (n=3)	Zoom
2	June 24 12:00 pm	NW	General Population (n=3)	Zoom
3	June 28 12:00 pm	NW	General Population (n=7)	Zoom
4	June 28 6:00 pm	PHX	African American (n=11)	Tanner Community Development Corp. 700 E. Jefferson | Phoenix
5	June 29 10:00 am	CW	Seniors (n=4)	Zoom
6	June 29 2:00 pm	SW	Youth (n=8)	Dobbins Place Community Park 3400 W. Paseo Way | Laveen
7	June 30 5:00 pm	SW	African American (n=6)	Estrella Foothills Global Academy 5400 W. Carver | Laveen
8	July 8 12:00 pm	CW	General Population (n=4)	Zoom
9	July 11 12:00 pm	SE	Formally Incarcerated (n=8)	Streets of Joy 451 E. 4th Place | Mesa
10	July 12 6:00 pm	PHX	African American (n=14)	Tanner Senior Center 2150 E. Broadway Rd | Phoenix
11	July 15 1:00 pm	PHX	Youth (n=16)	Arizona State University 400 E. Van Buren St. | Phoenix
12	July 16 5:00 pm	CW	General Population (n=6)	Dobbins Place Community Park 3400 W. Paseo Way | Laveen
13	July 18 5:30 pm	SE	Formally Incarcerated (n=14)	Streets of Joy 451 E. 4th Place | Mesa
14	July 18 6:30 pm	PHX	LGBTQ+ (n=15)	Arizona State University 400 E. Van Buren St. | Phoenix
15	July 19 1:30 pm	CW	Youth (n=9)	Peer Solutions 2229 N. 22nd Street | Phoenix
16	July 19 5:00 pm	NE	Low Income (n=4)	Zoom
17	July 20 4:00 pm	NW	Youth (n=2)	Zoom
18	July 21 7:00 pm	SW	Low Income (n=9)	Cesar Chavez Park 8440 S. 35th Ave | Phoenix

FG #	Date in 2023	Region*	Population	Location
19	July 23 1:00 pm	CW	Hispanic (n=6)	Dobbins Place Community Park 3400 W. Paseo Way | Laveen
20	July 23 9:00 am	NE	Religious Minority (n=5)	Zoom
21	July 25 6:30 pm	PHX	LGBTQ+ (n=12)	Humble Brag Salon 4200 N. 7th Ave. | Phoenix
22	July 26 6:00 pm	PHX	Low Income 65+ Years (n=14)	Grand Families Community Center 5150 S. 18th Place | Phoenix
23	July 29 5:00 pm	CW	General Population (n=6)	Zoom
24	August 2 12:00 pm	NE	Low Income (n=8)	Paiute Neighborhood Center 6535 E. Osborn Rd. | Scottsdale
25	August 2 5:30 pm	NE	Low Income (n=5)	Paiute Neighborhood Center 6535 E. Osborn Rd. | Scottsdale
26	August 3 6:00 pm	CW	LGBTQ+ Transgender & Nonbinary (n=8)	Zoom
27	August 4 5:00 pm	SE	Asian Seniors (n=8)	Zoom
28	August 9 1:30 pm	PHX	Unsheltered Low Income (n=11)	Church of Christ Scientist 830 N. Central Ave | Phoenix
29	August 9 1:30 pm	PHX	Unsheltered Low Income (n=11)	Church of Christ Scientist 830 N. Central Ave | Phoenix
30	August 9 1:30 pm	PHX	Unsheltered Low Income (n=13)	Church of Christ Scientist 830 N. Central Ave | Phoenix
31	August 9 5:30 pm	PHX	Seniors Low Income (n=7)	Tanner Senior Center 2150 E. Broadway Rd | Phoenix
32	August 9 5:00 pm	SW	Rural Spanish Speakers (n=7)	ila Bend Family Resource Center 303 E. Pima Street | Gila Bend
33	August 9 5:00 pm	SW	Rural Spanish Speakers (n=5)	Gila Bend Family Resource Center 303 E. Pima Street | Gila Bend
34	August 9 12:00 pm	CW	Native American (n=8)	Zoom
35	August 11 10:30 am	SE	General Population (n=12)	Care 7 Confidential Address | Tempe

36	August 11 9:00 am	NW	Rural (n=5)	Wickenburg Community Hospital 520 Rose Lane | Wickenburg
37	August 14 5:00 pm	CW	Religious Minority (n=9)	Zoom

FG #	Date in 2023	Region*	Population	Location
38	August 14 5:00 pm	CW	Asian (n=6)	Zoom
39	August 15 3:00 pm	NW	Rural (n=5)	Zoom
40	August 17 5:30 pm	CW	Native American Youth (n=8)	Zoom
41	August 18 10:00 am	SE	Low Income Hispanic & Black (n=14)	Family Resource Center 5834 E. Calle Santos Bravo | Guadalupe
42	August 21 10:00 am	SE	Seniors (n=7)	Sun Lakes Oakwood Clubhouse 24218 S. Oakwood Blvd | Sun Lakes
43	August 23 12:00 pm	PHX	Former Foster Care Young Adults (n=5)	Zoom
44	August 28 6:00 pm	CW	Disability (n=3)	Zoom
45	August 30 5:30 pm	CW	LGBTQ+ Lesbian (n=4)	Zoom
46	August 30 3:00 pm	PHX	Refugee, Immigrant, Migrant (n=11)	Somali American United Council (SAUC) Community Center 2425 E. Thomas Rd. | Phoenix

* Region Note: CW=Countywide; NE=Northeast Region; NW=Northwest Region; PHX=Central Phoenix Region; SE=Southeast Region; SW=Southwest Region

Interview Guide

Introduction (5 minutes)

The Maricopa County Department of Public Health (the department) aims to better understand the health and well-being of Maricopa County community regions, service providers, and individual residents to determine priority health areas and barriers across Maricopa County. MCDPH has partnered with OMNI Institute, a non-profit social sciences consultancy, to conduct a qualitative assessment as part of a larger Community Health Needs Assessment (CHNA). Your feedback will be integrated into a larger CHNA report and will help to determine health priorities and design interventions for inclusion in a Community Health Improvement Plan (CHIP).

We are conducting 24 key informant interviews as part of this qualitative assessment. You have been invited to participate in this interview due to your key perspective on community strengths, challenges, and needs. The interview will take approximately 60 to 90 minutes, depending on your responses.

In our 1:1 interview, I'll ask around:

Your background/role: Your name, your organizational role/position, and what you do in the community.

Community strengths and assets: What strengths and resources there are in your community that support health and well-being.

Built environment: What physical and cultural assets are in the built environment in your community, how those may vary by neighborhood, and

Forces of change: What the current and historical forces of change are locally, regionally, and globally that have shaped the political, economic, and social conditions of the community.

Go Over Participant Rights (5 minutes)

Before we begin, I'd like to review a few things about your participation.

Participation in today's interview is completely **voluntary.** This means you do not have to answer any questions you feel uncomfortable answering, and you are free to leave anytime. There will be no penalty or consequence if you choose not to answer a question or participate in this discussion. You can also ask me any questions that you may have.

In terms of **privacy**, although your name will not be used, please be aware that information on the community sector in which you work, along with a summary of key informant findings will be provided to the public. Also understand that your identifying information including your name, organization, and title will be removed

from the transcript file when all transcripts are shared with MCDPH staff ONLY at the end of this project. However, because of your organizational/community role, there is a high risk or likelihood that you may be identifiable in the transcript. Finally, please know that the results of the study may be used in reports, presentations, or publications.

- Do you understand the purpose of the interview and give your consent to participate?

Lastly, I would like to record our interview. This allows me to focus on the conversation while making sure we capture your comments. No one outside of the OMNI evaluation team will hear the recording.

- Do you consent to be audio recorded?

********** *(START RECORDING)*********

Introduction (5 minutes)

1. First, can you please tell me your name and briefly introduce yourself?
    a. Probes: What is your job title and what do you do at your organization? How long have you been doing this work?
    b. What geographic regions do you serve?
        i. E.g., All of Maricopa County, All of Arizona, Central (Phoenix), Northwest Valley Southwest Valley, Northeast Valley, Southeast Valley, Rural West Maricopa County, Rural East Maricopa County, Native American Reservation
    c. What populations do you serve?
        i. E.g., Adults with Special Health Care Needs, African American / Black American, Indian / Native American, Asian / Pacific Islander, Children with Special Health Care Needs, Hispanic / Latinx, Homeless / Housing, Insecure Immigrants / Migrants, LGBTQ, Older Adults / Seniors, Recently Incarcerated Refugees / Asylum Seekers, Veterans, Other, All of the Above
    d. What age group(s) do you serve?
        i. E.g., Children (0-5), Children (6-11), Adolescents (12-17), Adolescents / Young Adult (18-24), Adults (25-34), Adults (35-64), Seniors (65-74), Seniors (75+), All Age Groups

Community Strengths and Assets (15 minutes)

Community strengths and assets are key resources (including community members) that are utilized to improve community health. Strengths can include skills, education, job experience, and community organizing as well as qualities not

typically considered valuable but which contribute greatly to community health such as resilience and local knowledge.

2. What strengths and assets do community members have?
    a. Probe: What resources and capabilities do individuals within the community possess that contribute to its well-being?
3. How do these community strengths and assets support/aid community health?
    a. Probe: Lift up examples from the previous response (for clarity as necessary)
4. Which strengths and assets can be used and strengthened to address health inequities?
    a. Probe: Are there any untapped resources within the community that could be mobilized to address specific health disparities?
5. [As time allows] What organizations and agencies are addressing [insert the sector(s)] needs in Maricopa County?
    a. Probes: What services do each provide? What more can they do to meet Maricopa County's needs, if anything?

Built Environment (15-20 minutes)

For this section, built environment is defined as the human-made surroundings that influence overall community health, including the individual behaviors that drive, promote, and/or hinder health and wellness.

6. What physical assets and resources exist in the built environment of your community around [insert relevant sector(s) of interest]?
    a. Probes: Infrastructure (roads, bridges, bike lanes, pedestrian pathways); public facilities (schools, hospitals, community centers, libraries); housing (affordable housing, homeless shelters and services); green spaces (parks, playgrounds, gardens); safety and security (policy, emergency services), cultural and historical assets (museums), etc.
    b. [As needed] How do community members view and interact with their built environment? How do these interactions impact community members' health?
7. How do these resources differ across neighborhoods, particularly in those experiencing the greatest health disparities?
    a. Reframe: Health inequities are focused on SDOH based caused by structural factors that affect some groups more than other (e.g., how do neighborhood resources differ by SES, racial/ethnic groupings, geographical location, etc.)

8. What barriers prevent community members from experiencing their built environment fully?
    a. Probe around accessibility (e.g., wheelchair accessibility), the physical design of the community (e.g., is there a highway cutting through certain neighborhoods?), etc.
9. What key aspects of the built environment in your community affect health inequities?
    a. Probe: How do they impact community health inequities? How can those aspects be improved or addressed to improve community health?

Forces of Change (15 minutes)

Forces of Change are defined as forces that can affect the community and local public health system. It can focus on occurrences in the past, present, or future, including forces in the past that contribute to structural inequities.

10. What is occurring or might occur that affects the health of your community or local public health system? (These can be both things within your community and things in the larger societal and economic context of your community.)
11. Which communities are disproportionately impacted by forces of change? How and why are they disproportionately impacted?
12. What is the local health department's role in addressing community health and wellness?
13. How have climate change and/or COVID-19 changed conditions in your community?
14. What forces can reinforce health equity in our community now and in the future? How can we take advantage of these forces?

Summary Question (2-5 minutes)

15. [As time allows] Is there anything else that you would like to share that you think is important and I haven't asked you about?

Focus Group Guide

Discussion Guide

Facilitator reads:

The goal of this focus group is to better understand the health and wellbeing of Maricopa County community regions, service providers, and individual residents to determine priority health areas and barriers across Maricopa County.

Opening Question (5 minutes)

To begin, why don't we go around the room and say one thing you like about your community.

General Quality of Life/ Community Questions (XX minutes)

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

1. What does quality of life mean to you?

   Prompt: How has your quality of life changed in the last year?

   Prompt: What would help improve your quality of life?

2. Take a moment to picture a healthy community. [Pause for reflection] Describe your picture of a healthy community.

   Prompt: How does your actual community compare with what you have described?

   Prompt: What is most important to you when it comes to living a healthy life?

3. In what ways does your community positively affect your health and others around you?

   Prompt: In what ways does your community negatively affect your health and the health of others around you?

Community Health Needs and Concerns (XX minutes)

Next, let's discuss any specific strengths, needs, and concerns about your community

4. When thinking about health, what are the greatest strengths in your community?
   Prompt: What is going well in your community?

5. What are the most common health problems affecting you and the people in your community?

   Prompt: Which of these health problems do you consider to be the most significant? Please explain.

6. What are the barriers to improving the health of your community?

   Prompt: How are these barriers affecting the health you and people close to you?

   Prompt: What is needed to remedy these health problems?

Access to Services, Information and Resources (XX minutes)

In this section, we will discuss access to health services, information, and resources.

Subsection: Health Services

We will first discuss access to services such as seeing a doctor, getting annual exams, getting prescription medication, and getting mental health services.

7. Take a moment to reflect back upon the last year. Was there a time when you (or someone close to you) had difficulty accessing needed health service(s)?

   Prompt: What, if anything, would have improved access to these needed resources?

8. Have you or others in your community experienced barriers to getting medical or physical health care, such as access to health providers, medications, and services? If so, what are those barriers?

9. Have you or others in your community experienced barriers to getting mental health care, such as treatment or support? If so, what are those barriers?

10. Are there any cost issues that keep you from caring for your health? (such as co-pays or high-deductible insurance plans)

    Prompt: If you are uninsured, what would help you get insurance?

11. To what degree, if at all, have you experienced or noticed any healthcare-related discrimination based on your identity (e.g. race, gender, income, education, disability, sexual orientation, etc. -depending on group)

    Prompt: 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.

Subsection: Health Information

Now we'll talk about access to health information and resources, such as information about where and how to get care, information about how to stay healthy or treat a health condition, and instructions from a care provider.

12. Where do you typically go to get health related material?

    Prompt: Which health related information and resources are most accessible to you and your community?

    Prompt: Do you consider these sources to be trusted and reliable?

13. How can health information and resources better reflect your culture and identities?
    Prompt: Do you feel heard or understood by your healthcare provider/s?

    Prompt: Do you understand what your healthcare provider tells you?

14. Can you think of anything else that may pose a barrier to accessing healthcare services, information or resources in your community?

Community Health Recommendations (XX minutes)

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

15. What are some ideas you have to help your community get or stay healthy and thrive?
    Prompt: What else do you and those close to you need to maintain or improve your health?
    [Additional prompts – 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)

16. Are there other services or resources (not already mentioned) that you and others need that aren't in your community?

Ending Question (X minutes)

17. 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 (X 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.

[Turn off recording devices.]

Gift Cards (X minutes)

Ensure we have the participants' correct email address for distribution Explain gift cards will be sent within the next 72 hours

Appendix D: Community Survey

Exhibit 31: Survey Questions

Maricopa County 2023 Community Health Assessment

In this survey, we want to hear your opinions and experiences related to your health and wellness. Your answers, alongside others', will shape community improvement goals and funding. No personally identifiable information will be collected, and all responses will be kept confidential. This survey is for residents of Maricopa County age 12 and above. Thank you for participating in this survey and supporting your community. If you have questions about the survey or need an alternative format, please email MaricopaHealthMatters@maricopa.gov.

This survey is for people who live in Maricopa County at least six months out of the year.

1. What Maricopa County zip code do you live in? _____

2. What city or town do you live in? _____

3. Please rate your health *(For each, choose only one)*:

3a. How would you rate your physical health, such as how your body feels day to day?	☐ Very Good	☐ Fair	☐ Poor	☐ Prefer not to answer
3b. How would you rate your mental health, such as your mood and how you handle stress day to day?	☐ Very Good	☐ Fair	☐ Poor	☐ Prefer not to answer
3c. How would you rate your connection with others, such as community, friendships, family, faith groups, etc.?	☐ Very Good	☐ Fair	☐ Poor	☐ Prefer not to answer

4. Please tell us about your experiences with healthcare *(Please read instructions carefully):*

4a. In the past 12 months, how often were you able to get medical care when you needed to? *(Choose only one)*

☐ Always	☐ Sometimes	☐ Never	☐ Not applicable

4b. In the past 12 months, how often were you able to get mental health care when you needed to? *(Choose only one)*

☐ Always	☐ Sometimes	☐ Never	☐ Not applicable

4c. What would help you get the care you need? *(Check all that apply)*

☐ More appointments available	☐ Services closer to where I live	☐ Lower out of pocket cost for services
☐ Evening or weekend appointments	☐ Transportation to appointments	☐ Clear prices for services
☐ Virtual/telehealth appointments	☐ Health care providers or interpreters who speak my native language	☐ Health care provider who specializes in the care I need
☐ Paid time off work *(sick time)*	☐ Health care providers who make me feel safe and respected	☐ Childcare or elder care
☐ Being able to get multiple services at the same location or practice	☐ Help with understanding and coordinating my care, such as finding services, filling out paperwork, using insurance, and scheduling appointments	☐ Not applicable
		☐ Other (please specify): _____

4d. How do you typically pay for your healthcare? *(Check all that apply)*

☐ Insurance from my employer or a family member's employer	☐ Travel to another country for healthcare
☐ Health insurance purchased through the marketplace	☐ Use my own money or pay out of pocket
☐ Indian Health Services	☐ Use free clinic(s)
☐ Medicaid/AHCCCS	☐ I do not use healthcare services
☐ Medicare *(Advantage plan, Parts A, B, etc.)*	☐ Other (please specify): _____
☐ Veterans Administration, TRICARE, or other military health care	☐ Prefer not to answer

5. Which health issues have the most impact on you and/or the people you live with or care for?*(Check all that apply)*

☐ Autoimmune disease *(lupus, MS, rheumatoid arthritis, etc.)*	☐ Long COVID *(COVID-19 symptoms lasting longer than 4 weeks)*	☐ Chronic stress
☐ Cancer	☐ HIV/AIDS	☐ Heat-related illness
☐ Chronic pain *(back pain, joint pain, fibromyalgia, etc.)*	☐ Sexually transmitted infections	☐ Sexual and reproductive health issues
☐ Dementia/Alzheimer's	☐ Other infectious diseases (*RSV, COVID-19, flu, common cold, etc.)*	☐ Racism, prejudice, or discrimination
☐ Diabetes	☐ Anxiety	☐ Intentional injury *(violence, domestic violence self-harm, suicide, weapon-related , etc.)*
☐ Heart disease	☐ Depression	☐ Unintentional/accidental injury *(falls, drowning, motor vehicle accidents, weapon-related, etc.)*
☐ High blood pressure/ hypertension	☐ Other mental health issues *(PTS schizophrenia, bipolar disorder, etc.)*	☐ No health issues
☐ Stroke	☐ Alcohol/substance misuse	☐ Other (please specify): _____
☐ Lung or respiratory issues *(asthma, COPD, etc.)*	☐ Tobacco or nicotine use *(Cigarettes, vaping, chew, etc.)*	☐ Other (please specify): _____

6. Have you experienced discrimination in the past 12 months due to the following: *(Check all that apply)*

☐ Race	☐ Gender	☐ Income
☐ National origin, ethnicity, or ancestry	☐ Sexual orientation	☐ Not applicable
☐ Primary language	☐ Disability	☐ Other (please specify): _____
☐ Spirituality, spiritual practices, or religion	☐ Education	☐ Prefer not to answer

7. Over the past 12 months, how often have you had enough money to pay for the following essentials:
***(For each, choose only one)*:**

Healthcare service	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Medications	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Mortgage or rent	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Food	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Utilities *(electricity, gas, water, etc.)*	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Clothing/Hygiene products *(soap, deodorant, etc.)*	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Childcare	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Tuition/Student Loans	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Phone	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Technology needed for work, school, or health care	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Internet	☐ Always	☐ Sometimes	☐ Never	☐ N/A
Transportation	☐ Always	☐ Sometimes	☐ Never	☐ N/A

5. How would you rate the following where you live? *(For each, choose only one)*:

Ability to communicate with local leadership and feel my voice is heard	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to safe spaces to exercise and be physically active	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to parks and green spaces	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to safe walking or biking paths	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to affordable healthy foods	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to places to stay cool during hot months	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to quality and affordable childcare	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to quality and affordable schools for children	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to affordable education after high school	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to quality public transportation	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to high-speed internet	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to affordable housing	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to quality medical care	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to quality mental health care	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to substance use treatment services	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to programs and activities for seniors 65+ *(senior community centers, etc.)*	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Access to public libraries, community centers, and educational events	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Accepting of all people *(different cultures, identities, etc.)*	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Feeling safe in public spaces *(not worrying about gun violence, terrorism, etc.)*	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Feeling safe in your home *(not worrying about burglary, domestic violence, etc.)*	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Feeling safe while driving *(few traffic accidents, safe drivers, good roadway design, etc.)*	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Opportunity to participate in religious, spiritual, or cultural events	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Services for residents in need or crisis *(food pantries, shelters, utility assistance, etc.)*	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Other (please specify):	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Other (please specify):	☐ Very Good	☐ Fair	☐ Poor	☐ N/A
Other (please specify):	☐ Very Good	☐ Fair	☐ Poor	☐ N/A

Demographics

Maricopa County residents come from very diverse backgrounds. We encourage you to fill out as many questions as you feel comfortable with so we can identify if any specific groups are experiencing certain issues more frequently than others. All responses to the survey are confidential. Some of these terms may be unfamiliar, but please pick the terms that best describe you.

6. Would you consider yourself to be a member of any of the following? *(Check all that apply)*

☐ Foster youth/former foster youth	☐ Military Member/Veteran
☐ Homebound	☐ Immigrant
☐ Senior living in a group setting with or without living assistance or medical care	☐ Refugee
☐ Disabled	☐ Other (please specify):_____
☐ Homeless / Houseless	☐ None of the above

7. What is your age? _____years

8. How many people live in your household (including yourself)?

Children (0-18 year-olds)	**#:**_____	Adults (19-64 year-olds)	**#:**_____	Seniors (65+ year-olds)	**#:**_____

12a. What is your race and ethnicity? *(Check all that apply)*

12b. If you had to choose only one, which race or ethnicity would you say that you identify with the most? ***(Choose only one)***

☐ American Indian, Alaska Native, or Native American	☐ Native Hawaiian or Other Pacific Islander
☐ Asian	☐ White
☐ Black or African American	☐ I identify as multiracial
☐ Hispanic, Latino(x)	☐ Prefer to self-describe: _____
☐ Middle Eastern or North African	☐ Prefer not to answer

13a. What is your gender identity? ***(Check all that apply)***

Some of the terms below may be unfamiliar, pick the terms that best describe you. All responses are confidential.

☐ Cisgender Man	☐ Transgender Man	☐ Non-binary/genderqueer	☐ Prefer to self-describe: _____
☐ Cisgender Woman	☐ Transgender Woman	☐ Don't know	☐ Prefer not to answer

13b. What was your assigned sex at birth? ***(Choose only one)***

☐ Female	☐ Male	☐ Don't know	☐ Prefer not to answer

13c. Are you intersex? ***(Choose only one)***

Intersex is an umbrella term that describes individuals with sex traits or reproductive anatomy that are different from strictly the male/female binary.

☐ Yes	☐ No	☐ Don't know	☐ Prefer not to answer

13d. What is your sexual orientation? ***(Check all that apply)***

☐ Straight (Heterosexual)	☐ Bisexual	☐ Pansexual	☐ Prefer to self-describe: _____
☐ Gay	☐ Queer	☐ Questioning or unsure	☐ Prefer not to answer
☐ Lesbian	☐ Asexual	☐ Don't know	

14. What is the highest level of education you have completed? ***(Choose only one)***

☐ Less than high school	☐ Vocational school
☐ Some high school, no diploma	☐ Bachelor's degree (e.g., BS, BA, BFA)
☐ High school diploma or GED	☐ Master's degree (e.g. MA, MS, MSW, MBA)
☐ Some college (1-4 years, no degree)	☐ Doctoral degree (e.g. PhD, EdD, MD, JD, etc.)
☐ Associate's degree (e.g., AS, AA)	☐ Other (please specify):_____

15. What is your current employment status? (*Check all that apply*)

☐ Employed	☐ Student	☐ Unable to work
☐ Self-employed	☐ Retired	☐ Out of work
☐ Work multiple jobs	☐ Homemaker or stay-at-home parent	☐ Other (specify): _____

16. What range is your annual household income? ***(Choose only one)***

Your household includes you and any family members or partners you live with who help pay for expenses.

☐ Less than $15,000	☐ $35,000 - $49,999	☐ $100,000 - $149,999	☐ I don't know
☐ $15,000 - $24,999	☐ $50,000 - $74,999	☐ $150,000 - $199,999	☐ Prefer not to answer
☐ $25,000 - $34,999	☐ $75,000 - $99,999	☐ $200,000 or more	

17. What additional thoughts and experiences would you like to share about your health and the health of your community?

Exhibit 32: Supplemental Survey Questions

CHNA 2023 Supplemental Survey

The purpose of this survey is to hear from you regarding your opinions and experiences related to your health and wellness. This survey will take approximately 10-15 minutes. This survey is optional and does not impact your eligibility for the focus group. You may skip any questions you do not wish to answer. The information you tell us could improve the programs and information offered. Please do not put your name anywhere on this survey.

This survey is for people who live in Maricopa County at least six months out of the year.

1. What Maricopa County zip code do you live in? _____

2. What city or town do you live in? _____

3. Please rate your health *(For each, choose only one)*:

3a. How would you rate your physical health, such as how your body feels day to day?	□ Very Good	□ Fair	□ Poor	□ Prefer not to answer
3b. How would you rate your mental health, such as your mood and how you handle stress day to day?	□ Very Good	□ Fair	□ Poor	□ Prefer not to answer
3c. How would you rate your connection with others, such as community, friendships, family, faith groups, etc.?	□ Very Good	□ Fair	□ Poor	□ Prefer not to answer

4. How does your current mental health compare to your mental health before the pandemic started? *(Choose only one)*

□ Better	□ Similar	□ Worse

5. Please tell us about your experiences with healthcare *(Please read instructions carefully)*:

5a. In the past 12 months, how often were you able to get medical care when you needed to? *(Choose only one)*

□ Always	□ Sometimes	□ Never	□ Not applicable

5b. In the past 12 months, how often were you able to get mental health care when you needed to? *(Choose only one)*

□ Always	□ Sometimes	□ Never	□ Not applicable

5c. What would help you get the care you need? *(Check all that apply)*

□ More appointments available	□ Services closer to where I live	□ Lower out of pocket cost for services
□ Evening or weekend appointments	□ Transportation to appointments	□ Clear prices for services
□ Virtual/telehealth appointments	□ Health care providers or interpreters who speak my native language	□ Health care provider who specializes in the care I need
□ Paid time off work *(sick time)*	□ Health care providers who make me feel safe and respected	□ Childcare or elder care
□ Being able to get multiple services at the same location or practice	□ Help with understanding and coordinating my care, such as finding services, filling out paperwork, using insurance, and scheduling appointments	□ Not applicable
		□ Other (please specify):

Sd. How do you typically pay for your healthcare? *(Check all that apply)*

□ Insurance from my employer or a family member's employer	□ Travel to another country for healthcare
□ Health insurance purchased through the marketplace	□ Use my own money or pay out of pocket
□ Indian Health Services	□ Use free clinic(s)
□ Medicaid/AHCCCS	□ I do not use healthcare services
□ Medicare ,*(Advantage plan Parts A, B, etc.}*	□ Other (please specify):
□ Veterans Administration, TRICARE, or other military health care	□ Prefer not to answer

6 Which health issues have the most impact on you and/or the people you **live** with or care *for? (Check all that apply)*

□ Autoimmune disease *(lupus, MS, rheumatoid arthritis, etc.)*	Long COVID *(COVID-19 symptoms lasting longer than 4 weeks)*	□ Chronic stress
□ Cancer	□ HIV/AIDS	□ Heat-related illness
□ Chronic pain *(back pain, joint pain, fibromyalgia, etc.)*	Sexually transmitted infections	□ Sexual and reproductive health issues
□ Dementia/Alzheimer's	Other infectious diseases *(RSV, COVID-19, flu, common cold, etc.)*	□ Racism, prejudice, or discrimination
□ Diabetes	□ Anxiety	□ intentional injury *(violence, domestic violence, self-harm, suicide, weapon-related, etc.)*
□ Heart disease	Depression	□ Unintentional/accidental **injury** *(falls, drowning, motor vehicle accidents, weapon-related, etc.}*
□ High blood pressure/ hypertension	Other mental health issues *(PTSD, schizophrenia, bipolar disorder, etc.)*	□ No health issues
□ Stroke	□ Alcohol/substance misuse	Other (please specify):
□ Lung or respiratory issues *(asthma, COPD, etc.)*	□ Tobacco or nicotine use *(Cigarettes, vaping, chew, etc.)*	□ Other (please specify):

7. **Have you experienced discrimination in the past 12 months due to the following:** ***{Check all that apply}***

□ Race	□ Gender	□ Income
□ National origin, ethnicity, or ancestry	□ Sexual orientation	□ Not applicable
□ Primary language	□ Disability	□ Other (please specify):
□ Spirituality, spiritual practices, or religion	□ Education	□ Prefer not to answer

7. . Over the past 12 months, how often have you had enough money to pay for the following essentials:
{For each, choose only one):

Healthcare service	□ Always	□ Sometimes	□ Never	N/A
Medications	□ Always	□ Sometimes	□ Never	□ N/A
Mortgage or rent	□ Always	□ Sometimes	□ Never	□ N/A
Food	□ Always	□ Sometimes	□ Never	□ N/A
Utilities *(electricity, gas, water, etc.)*	□ Always	□ Sometimes	□ Never	□ N/A
Clothing/Hygiene p:roducts *(soap, deodorant, etc.}*	□ Always	□ Sometimes	□ Never	N/A
Childcare	□ Always	□ Sometimes	□ Never	□ N/A
Tuition/Student Loans	□ Always	□ Sometimes	□ Never	□ N/A
Phone	□ Always	□ Sometimes	□ Never	N/A
Technology needed for work, school, or health care	□ Always	□ Sometimes	□ Never	N/A
Internet	□ Always	□ Sometimes	□ Never	□ N/A
Transportation	□ Always	□ Sometimes	□ Never	□ N/A

8. Do you spend more than half of your monthly income on housing (i.e., mortgage or rent)? *{Choose only one)*

J ☐Yes J No J O Don't know J O Not applicable

9. Where do you get most of your food? *,(Check all that apply)*

☐ Grocery store	0 Farmer's market	0 Sit down restaurant	0 Fast food restaurant
☐ Convenience store	D Food **bank** (including at **a** community organization/church)	D Other-Write In:	

10. What would help your community have better access to healthy food?

☐ **No** challenges	☐ More healthy food options in nearby stores or restaurants	D Lower cost	0 More time **to** shop **or** cook
☐ Better transportation access	☐ Don't know	0 Other -Write In:	

11. How much physical activity do you get per week? (this can include physical activity at your job) *(Choose only one}*

☐ Less thain1 hour D Between 1 and 2.5 hours 2.5 hours or more

12. What would make it easier to get at least 2.5 hours of physical activity per week? *{Check all that apply)*

☐ No challenges	☐ Safe neighborhood	☐ Parks or walking paths in my neighborhood	Transportation to parks or public recreation
☐ Cooler weather	☐ Equipment or space at home	☐ Better control of my health condition or injury	Childcare
☐ Affordable gym membership	0 More time to exercise	More indoor physical activity opportunities	Other - Write In:

7. How would you **rate** the following **where** you live? *{For each, choose only one):*

Ability to communicate with local leadership and feel my voice is heard	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to safe spaces to exercise and be physically active	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to parks and green spaces	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to safe walking or biking paths	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to affordable healthy foods	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to places to stay cool during hot months	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to quality and affordable childcare	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to quality and affordable sd1oolls for children	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to affordable education after high school	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to quality public transportation	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to high speed internet	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to affordable housing	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to quality medical care	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to quality mental health care	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to substance use treatment services	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to programs and activities for seniors 65+ *(seniorrommu,,itycenters, etc.}*	□ Very Good	□ Fair	□ Poor	□ **N/A**
Access to public libraries, community centers, a1t1d educational *events*	□ Very Good	□ Fair	□ Poor	□ **N/A**
Accepting of all people *(different cultures, identities, etc.)*	□ Very Good	□ Fair	□ Poor	□ **N/A**
!Feeling safe in public spaces *(not worrying about gun violence, terrorism, etc.}*	□ Very Good	□ Fair	□ Poor	□ **N/A**
!Feeling safe in your home *(not worrying about burglary, domesticviolence, etc.}*	□ Very Good	□ Fair	□ Poor	□ **N/A**
!Feeling safe **while** driving *(few tmfficacciderrts, safedrivers, goodraadwaydesign, etc.}*	□ Very Good	□ Fair	□ Poor	□ **N/A**
Opportunity to participate in religious, spiritual, or mltural events	□ Very Good	□ Fair	□ Poor	□ **N/A**
Services for residents in need or crisls *(foodpantries, shelters, utilityassistance; etc.}*	□ Very Good	□ Fair	□ Poor	□ **N/A**
Other (please speaify):	□ Very Good	□ Fair	□ Poor	□ **N/A**
Other (please speaify):	□ Very Good	□ Fair	□ Poor	□ **N/A**
Other (please speaify):	□ Very Good	□ Fair	□ Poor	□ **N/A**

Demographics

Maricopa County residents oome from very diverse backgrnunds. We encourage you to fill out as many questions as you feel comfortable with so we can identify if a,ny speoific groups are experiencing certain issues more frequentlly than others. Alli responses to the survey are confidential!.Some of these terms may be unfamiliar, but please pick the terms that best describe you. PLEASEONLY ANSWER IIF YOU ARE COMIFORTABILE.

7. Would you consider yourself to be a member of any of the following? *{Check all that apply)*

□ Foster youth/former foster youth	□ Immigirant
□ Homebound	□ Refugee
□ Senior living in a group setting with or without living assistance or medical care	□Formerly Incarcerated
□ Disabled	□ Religious Minority
□ Homeless/ Houseless	□ Other (please specify):__
□ Military Member/Veteran	□ INone of the above

8. **What is your age?** _____**years**

9. **How many pe,opl,e live** in **your household (including yourself}?**

Children I0-18 year-olds) #:_____ Adults 119-64 year-olds) #:_____ Seniors {65+ year-olds) #:___

18a. What is your **race** and ethnicity? *{Check all that apply)*

□ Ame1rica1n **Indian/Alaska Native/INative American**		
□ I don't know □ Ak-Chin Indian Community □ Apache (specify all):	□ Fort McDowellI Yavapai Nation □ Gila River Indian Community □ Havasupai □ Hopi	□ Navajo Nation □ Salt River !Pima-Maricopa Indian Community □ Tohono O'odham Nation □ Other(s} (specify}:
□ **Asian**		
□ I don't know □ Bangladeshi □ Cambodian □ Chinese □ Filipino	□ Hmong □ Indian □ Japanese □ Korean	□ Myanmar/Burmese (specify all): □ Pakistani □ Thai □ Vietnamese □ Other(s} [specify}:
□ **Black** or **African Amerkan**		
□ I don't know □ Afnica,n American □ Burundian □ Democratic Republic of the Congo	□ Ethiopian □ Ghanaian □ Haitian □ Jamaican □ Kenyan □ Nigerian	□ Rwandese □ Somali □ South African □ Tanzanian □ Ugandan □ Other(s} (specify}:
□ **Hispanic, Latiino(x)**		
□ I don't know □ Argentinian □ Brazilian □ Colombian □ Cuban	□ Dominican □ Guatemalan □ Honduran □ Mexican	□ Puerto Rican □ Salvadoran □ Spaniard □ Other(S} (specify}:
□ **Middle Eastern0Ir North African**		

□ I don't know □ Egyptian □ Ira1nian □ Iraqi	□ Israeli □ Kurdish □ Lebanese □ Moroccan	□ Syrian □ Tunisian □ Turkish □ Other(s} (specify):
□ **Native IHawaiian or Other Pacific Islander**		
□ I don't know □ Chamorro □ Chuukese □ Fijian	□ Marshallese □ Native Hawaiian □ Pa.lauan	□ Samoan □ Tahitian □ Tongan □ Other(sl (specify):
□ **White or Caucasian**		
□ I don't know □ Dutdh □ English □ French	□ German □ Irish □ Italian □ Norwegian	□ Polish □ Soottish □ Swedish □ Other(s} (specify):
□ **Other(s) (1please specify):** _____		
□ **I don't know**		
□ **P1refer not to answer**		

If you selected more than one race in question 18a please complete question 18b.

18b. If you had to choose only one., whkh race or ethnicity would you say that you identify with the most? ***{Choose only one}***

□ American Indian, Alaska Native, or Native American	□ Native Hawaiian or Other Pacific Islander
□ Asian	□ White
□ Blaok or African American	□ I identify as multiracial
□ Hispanic, Latino(xl	□ Prefer to sellf-describe:
□ Middlle Eastern or !North African	□ Prefer not to answer

19. What is the highest level of educaUon you have oompleted?'*(Chooseonlyone)'*

□ Less than high school	□ Vocational schodl
□ Some high school, no diploma	□ Bachellor's degree (e.g., BS, BA, BFA)
□ High schoolI diplloma or GED	□ Master's degree (e.g. MA, MS, MSW, MBA)
□ Some college (1-4 years, no degree)	□ Doctoral degree (e.g. PhD, EdD, MD, JD, etc.)
□ Assodate's degree (e.g., AS, AA)	□ Other (please specify):

20 What is yo11Jr current employment status? *(Check all that app{y)*

□ Employed	□ Student	□ Unable to worlk
□ Self-employed	Retired	Out of work
Work multiple jobs	□ Homemaker or stay-at-home parent	Other (specify):

21. Wlhat **range** is you ann11J al household income? *{Chooseonly one)*

Your household includes you and any family members or partners you live with who help pay for expenses..

□ Less than $15,000	□ $35,000 - $49,999	□ $100,000 - $149,999	□ I don't know
□ $15,000 - $24,999	□ $50,000 - $74,999	□ $150,000 - $199,999	□ Prefer not to answer
□ $25,000 - $34,999	□ $75,000 - $99,999	□ $200,000 or more	

Some of the terms below may be unfamiliar, pick the terms that best describe you. All responses are confidential.

22a. What is your gender identity? ***(Check all that apply)***

Cisgender refers to someone whose gender identity matches their sex assigned at birth.

□ Cisgender Man	□ Transgender Man	□ Non-binary/genderqueer	□ Prefer to self-describe: _____
□ Cisgender Woman	□ Transgender Woman	□ Don't know	□ Prefer not to answer

22b. What was your assigned sex at birth? ***(Choose only one)***

□ Female	□ Male	□ Don't know	□ Prefer not to answer

22c. Are you intersex? ***(Choose only one)***

Intersex is an umbrella term that describes individuals with sex traits or reproductive anatomy that are different from strictly the male/female binary.

□ Yes	□ No	□ Don't know	□ Prefer not to answer

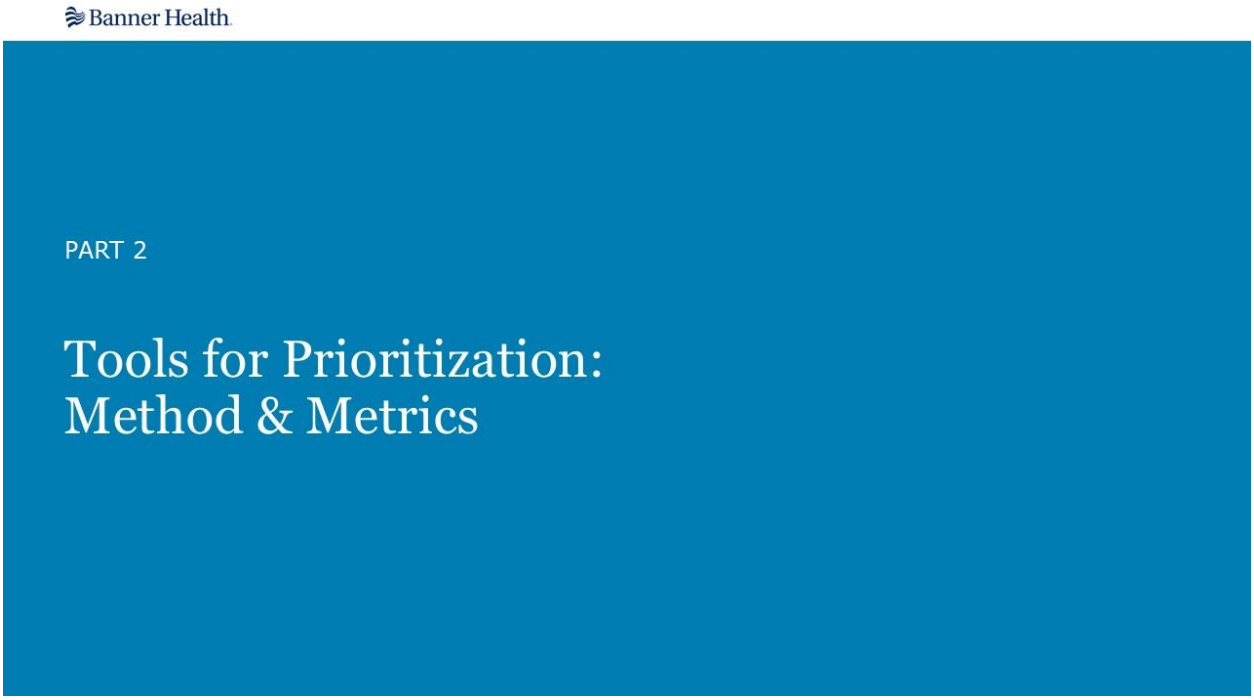
22d. What is your sexual orientation? ***(Check all that apply)***

□ Straight (Heterosexual)	□ Bisexual	□ Pansexual	□ Prefer to self-describe: _____
□ Gay	□ Queer	□ Questioning or unsure	□ Prefer not to answer
□ Lesbian	□ Asexual	□ Don't know	

Thank you!

Appendix E: Needs Prioritization Presentations

Exhibit 33: Needs Prioritization Presentation



Banner Health

Banner Health

The 18 Health Indicators

Access to Care	Behavioral Health	Chronic Disease Management	Other
• Access to Primary Care • Child and Adolescent Health • Health Insurance • Maternal and Infant Health • Mortality from Unintentional Injury • Access to Specialty Care	• Access to Mental and Behavioral Health Services • Mental and Behavioral Health Conditions • Substance Use	• Access to Healthy Food • Cancer Prevention and Treatment • Cardiovascular Disease • Diabetes • Obesity and Nutrition	• Discrimination, Racism, Oppression • Education Access and Quality • Environmental Health and Heat • Housing and Homelessness

Indicator list is based upon County Health Assessment process and grouped by themes

Banner Health

How the Scoring Works

Hanlon Method: objectively takes into consideration explicitly defined criteria and feasibility factors

$$(A + 2B) \times C$$

A = Size of Health Problem

% of Population Impacted

Based on data collected from the community (Census or community survey, State discharge data, etc.)

B = Seriousness of Health Problem

Does it require immediate attention?

Is there a public demand?

What is the economic impact?

What is the quality-of-life impact?

C = Effectiveness of Intervention

Highest weighted criteria

Is this an indicator that can be addressed by a Banner Health facility?

Banner Health

Banner Health

Top Scoring Indicators

Your survey results.

		A = Size of Health Problem	B = Seriousness of Health Problem	C = Effectiveness of Intervention	Total Score
1	Access to Primary Care	4.0	3.9	4.6	**53.7**
2	Access to Specialty Care	3.9	3.9	4.3	**50.6**
3	Access to Mental & Behavioral Health	3.4	4.0	4.8	**45.8**
4	Mental & Behavioral Health Conditions	3.8	3.9	3.6	**41.1**
5	Cardiovascular Disease	3.1	3.4	3.8	**37.8**
*	Diabetes	3.3	3.4	3.7	**37.5**
*	Obesity and Nutrition	3.3	3.4	3.6	**36.3**

Banner Health

Additional Health Indicators Noted

- Transportation & Built Environment and lack of parks and walking trails
- Prevention measures, women's health, community assessments to meet the needs of the changing communities, patient advocacy within the facilities.

Are we missing any health indicators?

Banner Health

Banner Health

PART 3

Determining our Health Priorities

Banner Health

Your Turn: Choose Your Top 3

In the following slides, we will review each of the Top 5 scored health indicators along with the supporting data.

At the end of the presentation, you'll be asked to rank your top three health indicators in order of priority.

Banner Health

Access to Primary Care

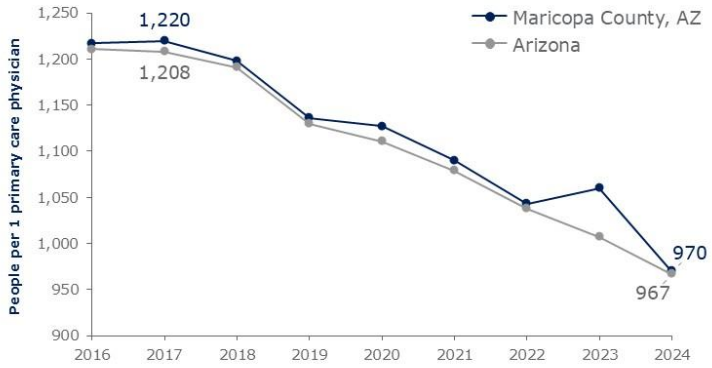
Ranked: #1

Maricopa County saw a decrease in the number of people per primary care physician from 2016-2024, suggesting better access to primary care physicians.

970:1
Primary Care Physician Ratio
Arizona: 967:1

72.4%
Routine Checkup in Past Year
(Adults Ages 18+)
Arizona: 72.1%

People per 1 primary care physician 2016-2024



Source: CDC BRFSS PLACES 2022, retrieved from MCDPH CHNA 2024-2026

Source: NPPES NPI, retrieved from MCDPH CHNA 2024-2026

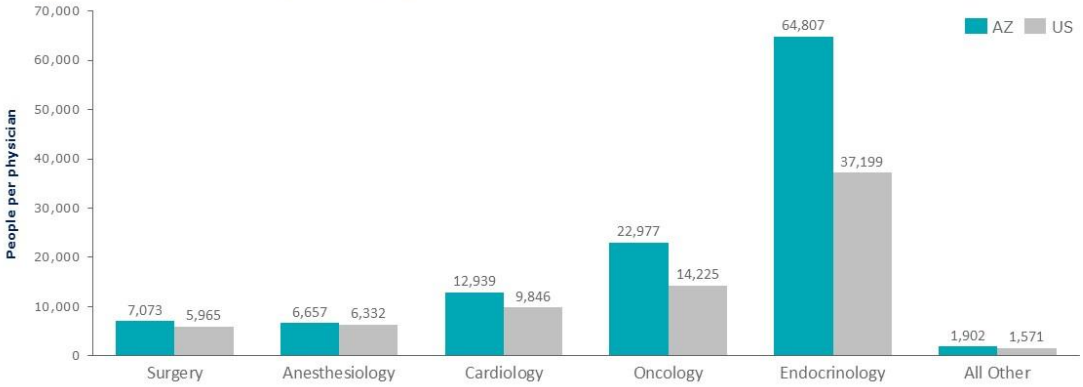
Banner Health

Access to Specialty Care

Ranked: #2

Note: Specialist provider rates are difficult to obtain at the county level because specialists often serve multiple counties and data is grouped broadly.

People per Specialist Physician (By Field)



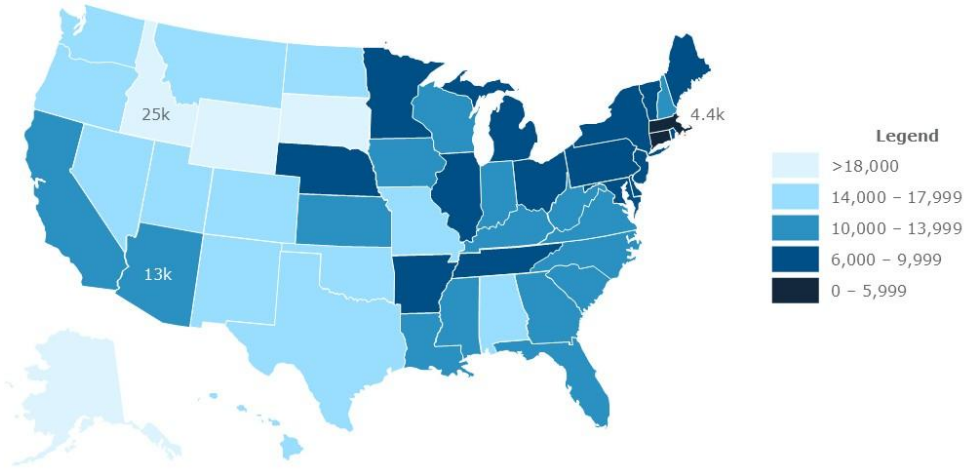
Source: Kaiser Family Foundation: special data request on State Licensing Information from Redi-Data Inc., April 2025. Population data: US Census, includes 50 states plus District of Columbia

Banner Health

Access to Specialty Care: Cardiologists

Ranked: #2

People per Cardiologist



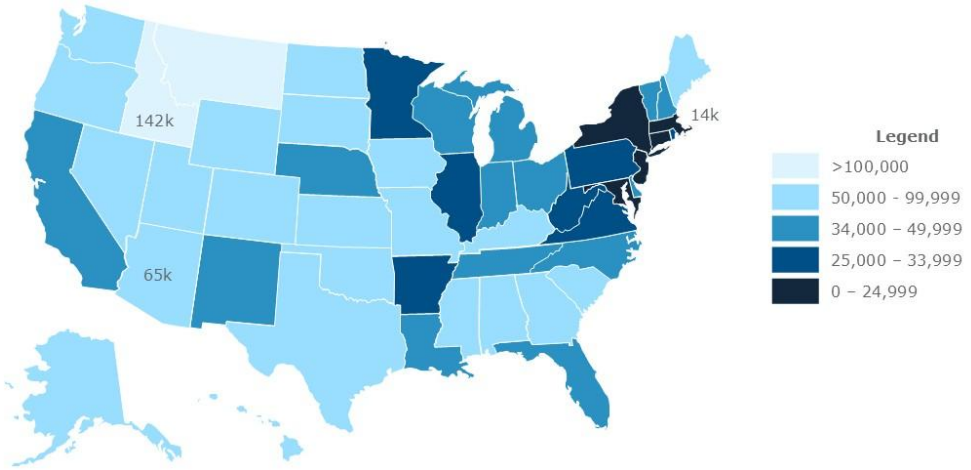
Source: Kaiser Family Foundation: special data request on State Licensing Information from Redi-Data Inc., April 2025. Population data: US Census July 2024 estimate

Banner Health

Access to Specialty Care: Endocrinologists

Ranked: #2

People per Endocrinologist



Source: Kaiser Family Foundation: special data request on State Licensing Information from Redi-Data Inc., April 2025. Population data: US Census July 2024 estimate

Banner Health

Access to Mental and Behavioral Health Care

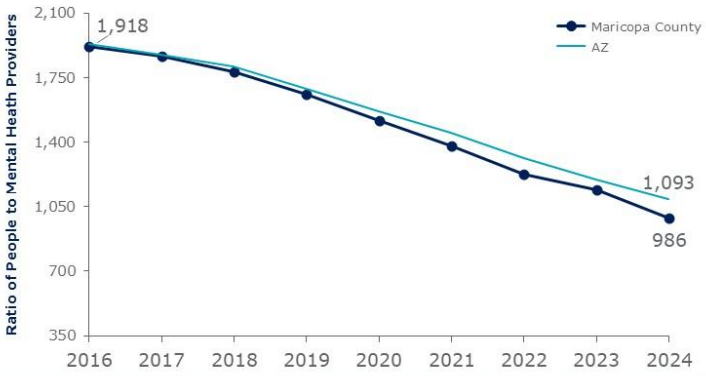
Ranked: #3

Maricopa has seen a significant decrease in the ratio of population to mental health providers from 2018-2024, suggesting better access to mental health care.

986:1
People per mental health provider
Arizona: 1093:1

21.8%
"Never" able to get mental health care when needed <12 months
2023 CHNA Survey

Ratio of People to Mental Health Providers



Source: NPPES NPI Retrieved from MCDPH CHNA

Banner Health

MARICOPA COUNTY PUBLIC HEALTH

Mental and Behavioral Health Conditions

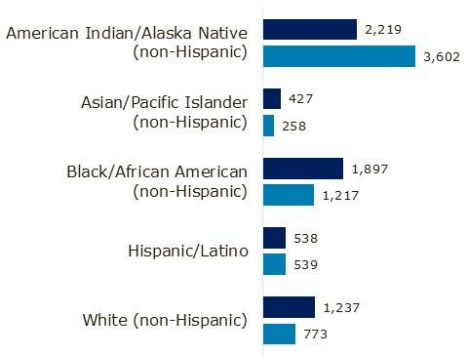
Ranked: #4

Includes mental, mood and depressive, and schizophrenic disorders

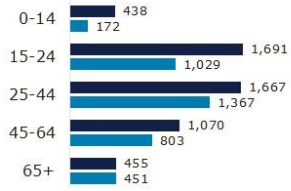
2023 Age-adjusted rates per 100,000 – Maricopa County PSA

■ Inpatient Hospitalizations (IP) ■ Emergency Department (ED)

Race/Ethnicity



Age (years)



IP Crude rates for those aged 15-24 were higher for Boswell & Del Webb PSAs.

Boswell: 2073
Del Webb: 2007

Sex

***Source:** 2023 Hospital Discharge Data*

Banner Health

MARICOPA COUNTY PUBLIC HEALTH

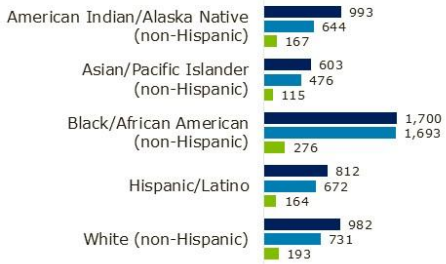
Cardiovascular Disease

Ranked: #5

2023 Age-adjusted rates per 100,000 – Maricopa County PSA

■ Inpatient Hospitalizations (IP) ■ Emergency Department (ED) ■ Death

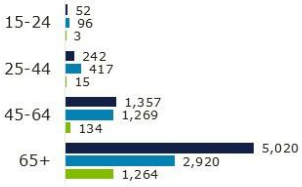
Race/Ethnicity



Rates for Black/African Americans were even higher for Boswell PSA:

Higher IP: 1,931
ED: 1,788
Death: 289

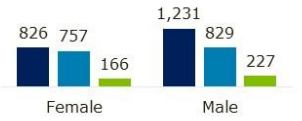
Age (years)



Crude rates for those aged 65+ yrs were even higher for the following Boswell and Del Webb PSAs:

Higher ED Rates:
BBWMC: 3,019
BDWMC: 3,090
Higher Death Rates:
BBWMC: 1,331

Sex



Rates for males were even higher for the Boswell and Del Webb PSAs

Higher IP Rates:
BBWMC: 1,238
Higher ED Rates:
BDWMC: 893
Higher Death Rates:
BBWMC: 245

Sources: *2023 Hospital Discharge Data and Death Data*

21

Banner Health

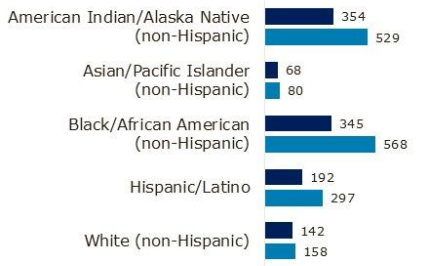
MARICOPA COUNTY PUBLIC HEALTH

Diabetes

2023 Age-adjusted rates per 100,000 – Maricopa County PSA

■ Inpatient Hospitalizations (IP) ■ Emergency Department (ED)

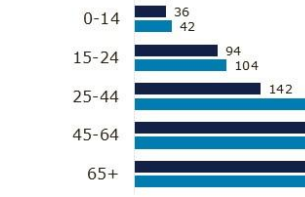
Race/Ethnicity



Rates for Black/African Americans were even higher for BBWMC PSA

Inpatient: 377
ED: 762

Age (years)



Sex

Sources: *2023 Hospital Discharge Data and Death Data*

Banner Health

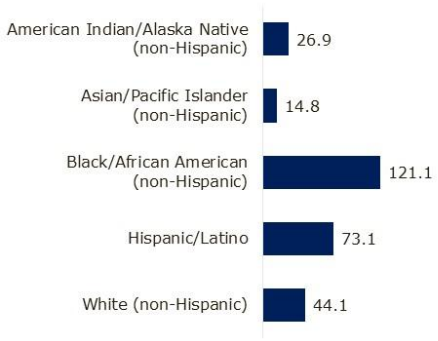
Banner Health MARICOPA COUNTY PUBLIC HEALTH

Obesity & Nutrition

2023 Age-adjusted rates per 100,000 – Maricopa County PSA

■ Inpatient Hospitalizations (IP)

Race/Ethnicity



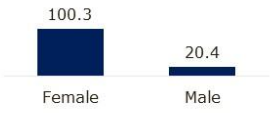
Age (years)

Crude rates for those aged 25-44 and 45-64 yrs were even higher for Boswell and Del Webb PSAs:

Higher IP Rates for 25-44:
BBWMC: 130
BDWMC: 125

Higher IP Rates for 45-64:
BBWMC: 102
BDWMC: 117

Sex



Rates for females were even higher for Boswell and Del Webb PSAs:

Higher IP Rates for females:
BBWMC: 107
BDWMC: 109

23

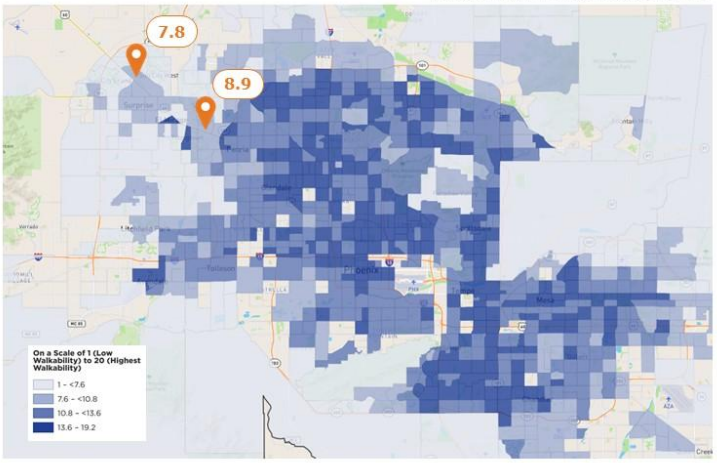
Sources: *2023 Hospital Discharge Data*

Banner Health

Transportation & Built Environment

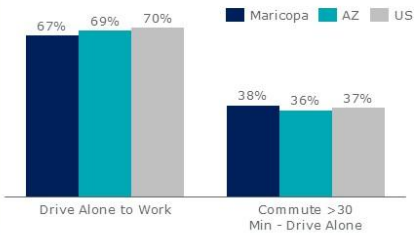
Walkability Index (Scale 1-20)

Includes factors like intersection density, land use mix, and access to public transit



Source: *EPA 2021, County Health Rankings 2019-2023*

Commute to Work



Access to Parks

56%

% of Population living within a half mile of a park

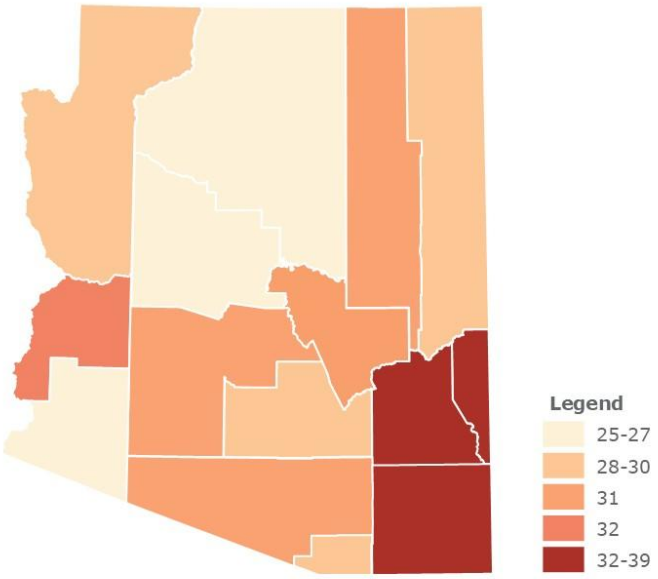
Arizona: 49%
United States: 51%

Banner Health

Environmental Health and Heat

2023 Number of Extreme Heat Days (May to September) by County

Extreme Heat Days are the number of days between May and September when the temperature is unusually hot - specifically, hotter than 90th percentile of historical daily temperatures.



Banner Health

Your Turn: Choose Your Top 3

		Total Score
1	Access to Primary Care	53.7
2	Access to Specialty Care	50.6
3	Access to Mental & Behavioral Health	45.8
4	Mental & Behavioral Health Conditions	41.1
5	Cardiovascular Disease	37.8
*	Diabetes	37.5
*	Obesity and Nutrition	36.3

Using your post it notes: Write your top 3 health indicators – **one indicator per post it note**

Appendix F: Resources

Exhibit 34: Resources Available to Address Prioritized Needs Identified Through the CHNA

Organization	Physical Address	Phone Number	Website Link
Senior Support Programs			
Alzheimers Association	340 E Palm Lane, Phoenix AZ 85004	602.528.0545	About the Desert Southwest Chapter | alz.org
Sun City CAN	10195 W Coggins Dr, Sun City AZ 85351	623-933-7530	Home - Sun City Community Assistance Network
Sun Health Foundation	14719 W Grand Ave, Surprise AZ 85374	623-471-9355	Sun Health
Olive Branch	13049 N 103rd Ave, Sun City, AZ, 85351	623-465-6000	Banner Olive Branch Senior Center in Sun City, AZ | N 107th Ave
Benevilla	16752 N Greasewood St, Surprise AZ 85378	623-584-4999	www.benevilla.org
Area on Aging	2950 N 7th St, Phoenix AZ 85014	602-264-4357	www.aaaphx.org
Behavioral Health			
Community Bridges	824 N 99th Ave, Avondale AZ 85323	877-931-9142	Arizona – CBI
Mind 24-7	10046 N Metro Pkwy W Phoenix, AZ 85051	1-844-646-3247	Walk-In Mental Health Clinics in Arizona - 24 Hour | MIND 24-7
Mercy Care	4750 S 44th Pl, Phoenix, AZ 85040	1-844-534-4673	Home | Mercy Care
Access to Care			

Organization	Physical Address	Phone Number	Website Link
Peoria Dial a Ride	8401 W Monore, Peoria AZ 85345	623-773-7435	Dial a Ride | City of Peoria
Foundation for Senior Living	1201 E Thomas Rd, Phoenix, AZ 85014	623-282-9300	Transportation | FSL.org
Chronic Disease Management			
Valleywise	8088 W Whitney Dr, Peoria AZ 85345	833-855-9973	Locations | Valleywise Health
MIssion of Mercy	1741 E Morten Ave, Phoenix, AZ 85020	602-486-7798	https://www.amissionofmercy.org/arizona/our-services/#clinic_location
Adelante Health Care	15351 W Bell Rd, Surprise AZ 85372	480-964-2273	Adelante Health Care | Behavioral Health Phoenix | WIC Program
Mountain Park Health Center	6975 W Glendale, AZ 85303	602-243-7277	Mountain Park Health Center Quality Healthcare for All
Housing & Homelessness			
Maricopa Emergency Assistance Program	301 W Jefferson St, Phoenix, AZ 85003	602-506-3011	Rental Assistance | Maricopa County, AZ
Peoria Community Assistance Program	9875 N 95th Ave, Peoria, AZ 85345	623-773-7070	Community Assistance | City of Peoria
Circle the City	210 S. 12th Ave, Phoenix, AZ 85007	602-254-4282	Healthcare services for the homeless | Circle the City
Contact Shelter Hotline	200 W Washington, Phoenix, AZ 85003	602-263-8900	www.phoenix.gov
Food Insecurity			
St Marys Food Bank	13050 W Elm St, Surprise	602-242-3663	www.firstfoodbank.org

Appendix G: Bibliography

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