2025

Banner Thunderbird Medical Center & Banner Children's at Thunderbird

Community Health Needs Assessment

Banner Health

Banner Children's

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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 Thunderbird Medical Center and Banner Children's at Thunderbird will focus in their 2025-2028 Implementation Strategy. The top three 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 in 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 Thunderbird Medical Center (BTMC) & Banner Children's at Thunderbird (BCT), Glendale. 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. BTMC, Glendale 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 the Banner Health's board in 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 Thunderbird Medical Center and Banner Children's at Thunderbird

Banner Thunderbird Medical Center (BTMC) is a Level I Trauma facility that originally opened in 1960 as Northwest Hospital. In 1999, it merged with the Lutheran and Samaritan health systems and was renamed Glendale Samaritan Hospital. It later became known as Banner Thunderbird Medical Center, the name it holds today. Banner Children's at Thunderbird opened in 2002 as the first pediatric unit in the west valley. In 2012, BTMC opened their Pediatric Emergency Department with a separate waiting and play area. Banner MD Anderson (BMDA) Cancer Center is also located on BTMC's campus.

Banner continually invests in the facility. In 2017 BTMC launched its Trauma program and added Pediatric Behavioral services in 2021. In 2024, construction began on a new five-story tower focused on Women and Infants services, with completion expected in 2026.

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

- BMDA medical oncology/infusion, radiation oncology
- Endoscopy
- Medical Imaging
- Heart Care
- Stroke Care
- Vascular Care
- Intensive Care
- Maternity Services
- Maternal Fetal Medicine
- Nutrition Services
- Rehabilitation Services
- Surgical Care
- Pediatric Care
- Advanced Neonatal Care
- Neurosurgery
- Behavioral Health

Among BTMC's accolades include being named the Best Place to Work and Best of the Best of Banner hospitals in 2024.

BTMC is proud to support and participate in the areas local Heart Walk, March of Dimes, and American Cancer Society-Making Strides events.

In 2024, BTMC employed 2,750 team members who were supported by 350 volunteers.

Description of Community Served

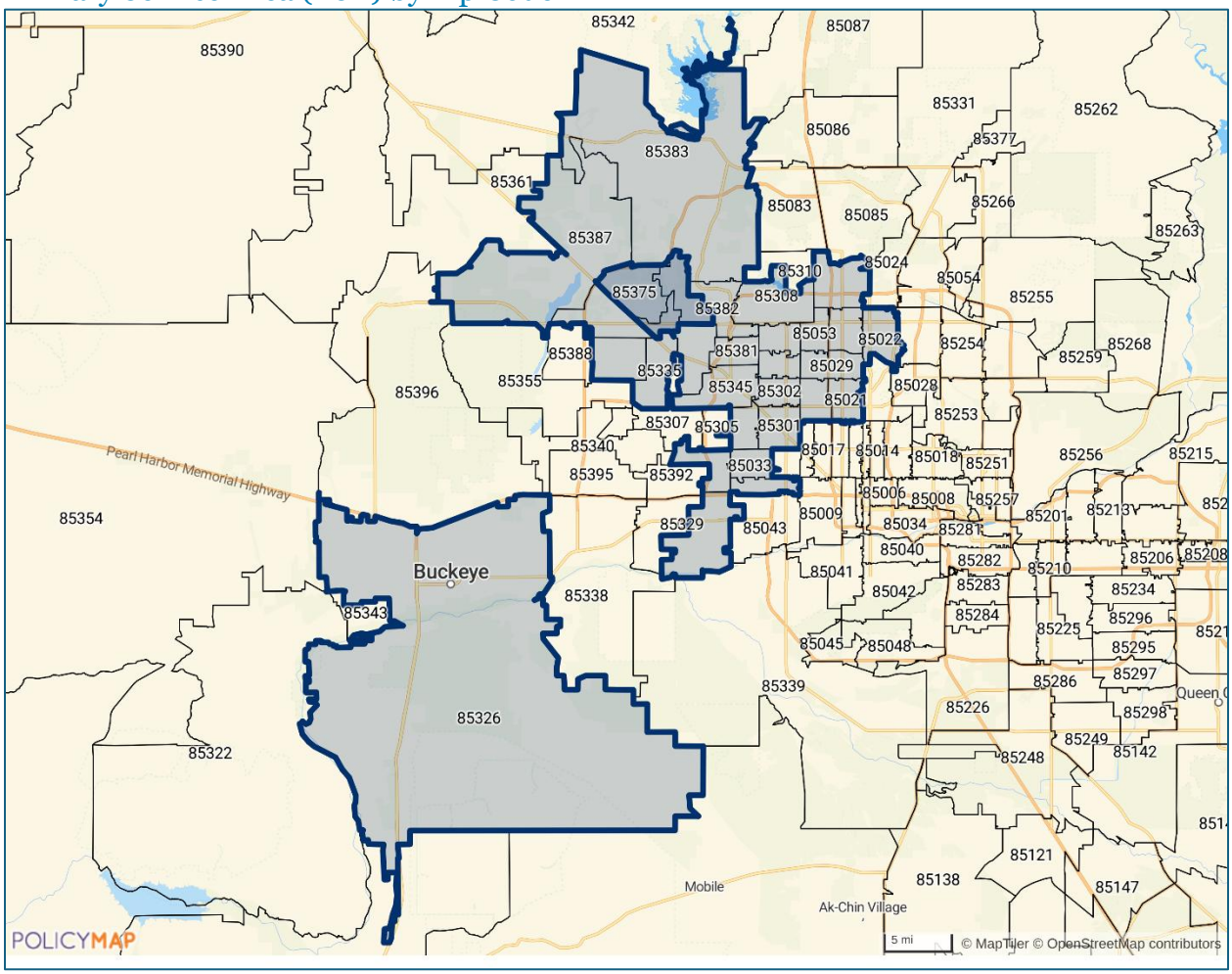
BTMC is in Glendale, Maricopa County, Arizona. Maricopa County is the fourth most populous county in the United States. BTMC serves the health care needs of those in west Phoenix, Glendale, Peoria and unincorporated areas of Maricopa County. With an estimated population of four million and growing, Maricopa 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 BTMC will also be provided when available. BTMC'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 BTMC's origins by zip code identified through BTMC's discharge data.

Facility Inpatient Origin by Zip Code Map

Exhibit 1: Banner Thunderbird Medical Center & Banner Children's at Thunderbird 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:

- Adelante Healthcare
- Banner Health
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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

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 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 surveys at the commencement of each focus group, with a total of 309 survey 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.

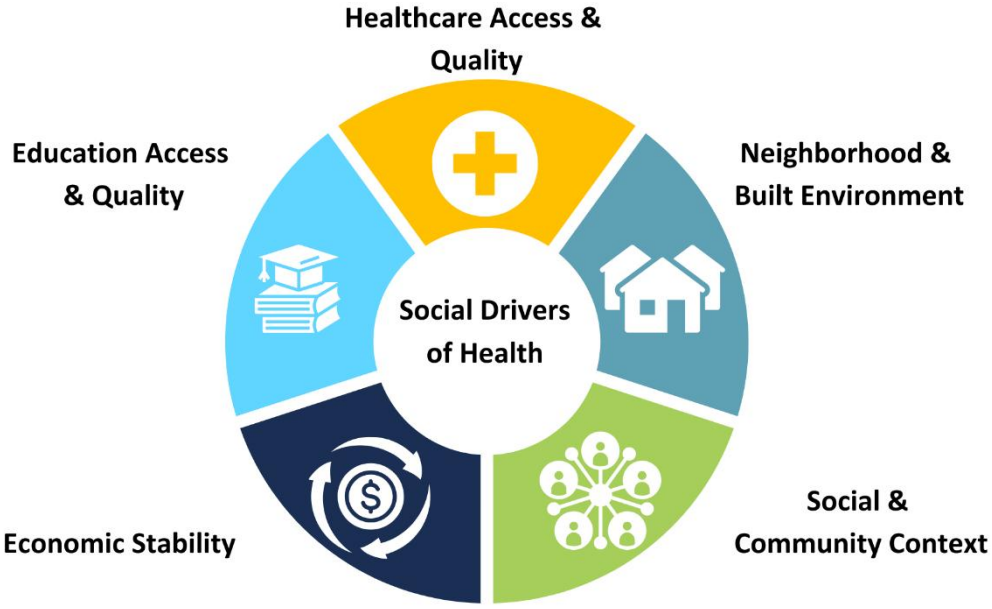
Not all survey respondents provided demographic information, and not all survey respondents answered each question.

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, 11 participants from Banner Thunderbird Medical Center and Banner Children's at Thunderbird 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 Banner Thunderbird Medical Center and Banner Children's at Thunderbird will focus in their 2025-2028 Implementation Strategy. A complete description of this process is provided on page 70. A list of those needs appears in the following section.

List of Prioritized Needs

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 the Synapse Coalition.

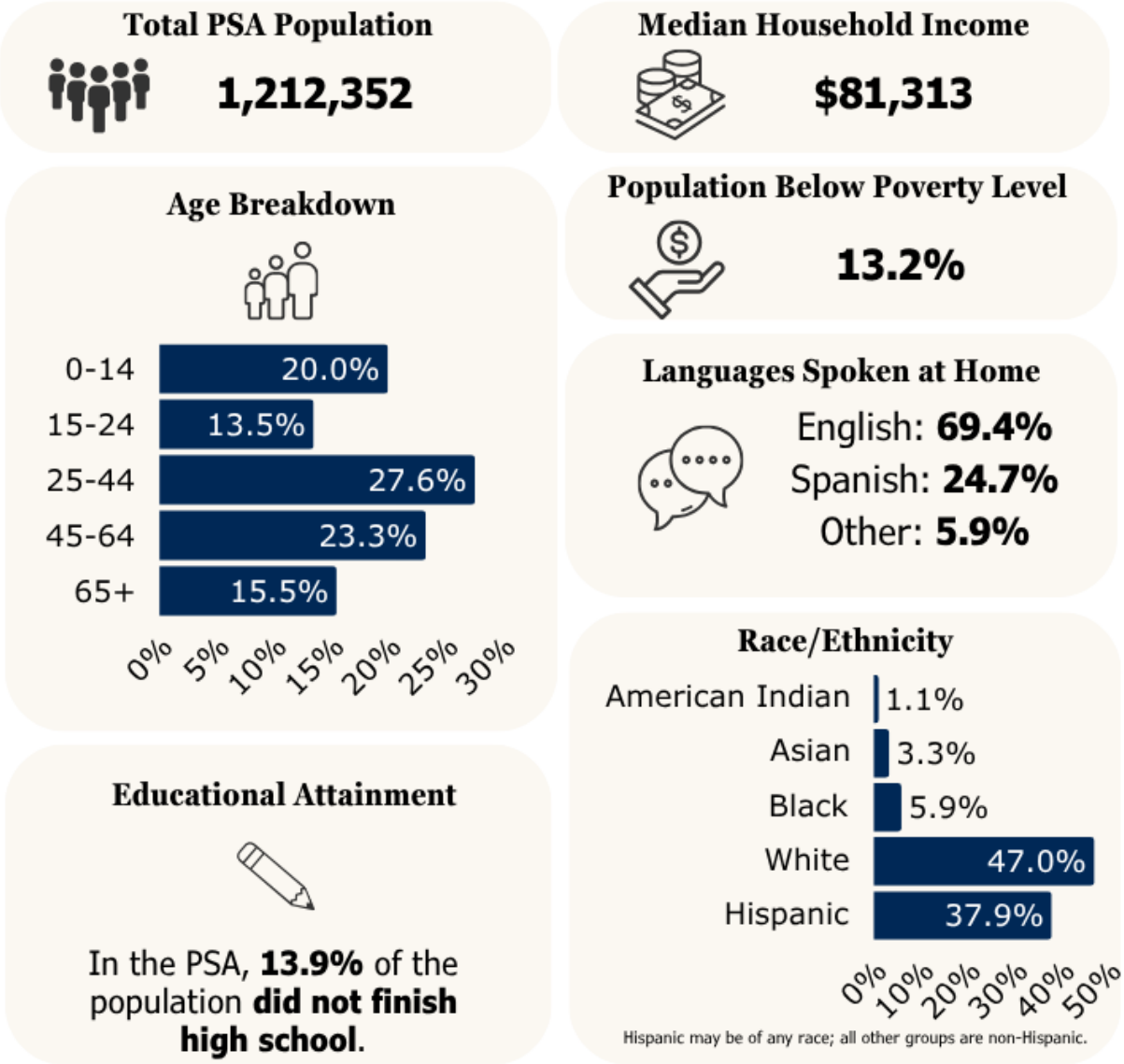
Most of the secondary data reflects conditions within the PSA. When PSA-level data is not available or when broader comparisons are helpful, data for Maricopa County or the state of Arizona is included and clearly noted.

Community survey data was collected across Maricopa County and analyzed by region. This report includes only the survey results from the region 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.

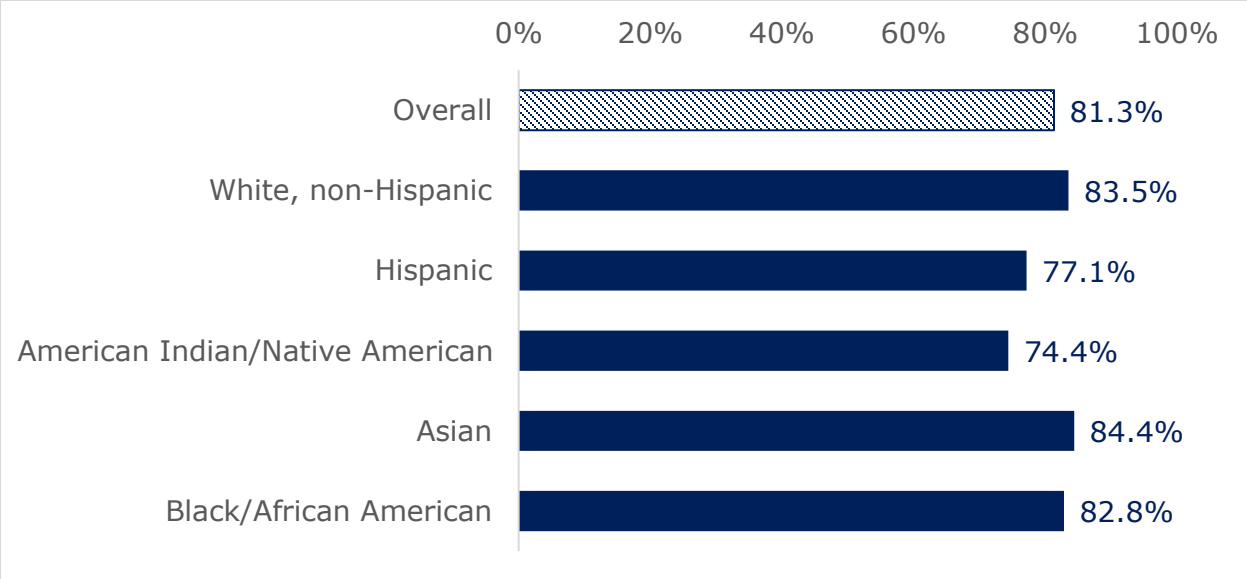
Self-rated health is widely used in public health research because it has been shown to predict outcomes such as hospitalization, disease incidence, and mortality.[4]

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.

To better understand what might be shaping how people view their own health, it helps to look at behaviors that influence long-term well-being.

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 in

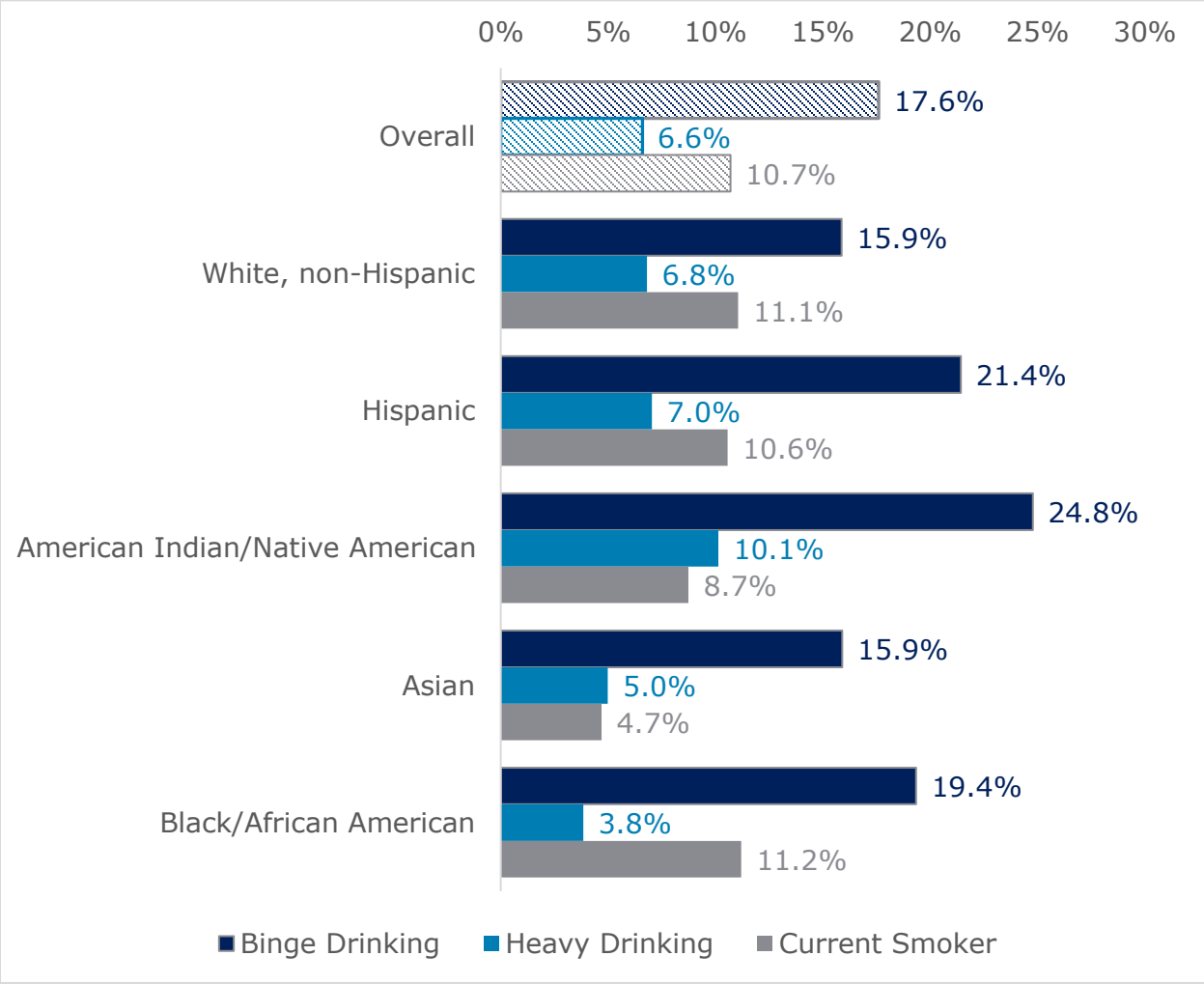
[5] CDC, 2024. About Chronic Diseases: Risk Factors.

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

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]

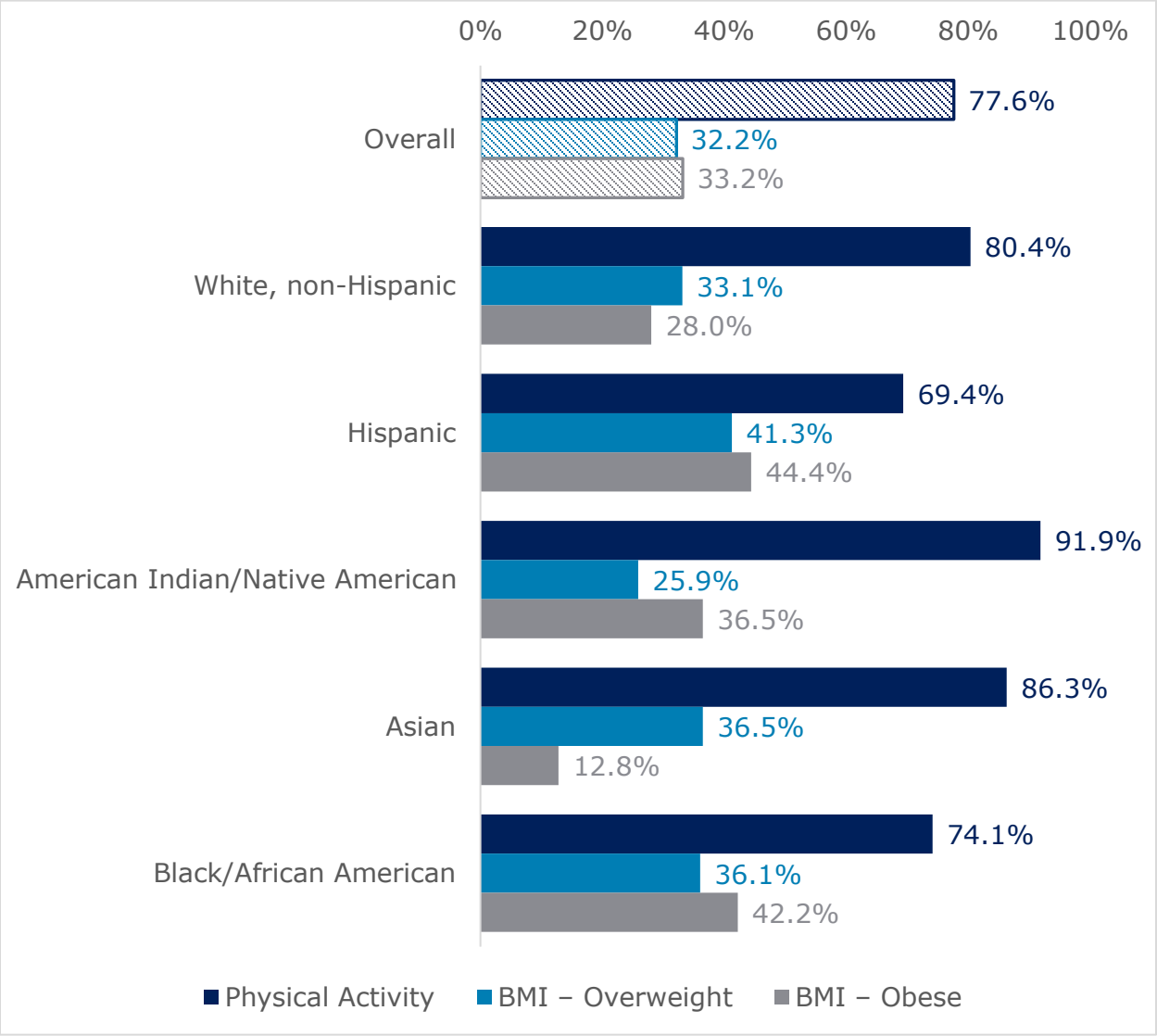
As seen in Exhibit 5, in 2022, 77.6% of Maricopa County adults reported getting some form of physical activity in the past month. However, activity levels and weight status varied by race and ethnicity:

- 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)



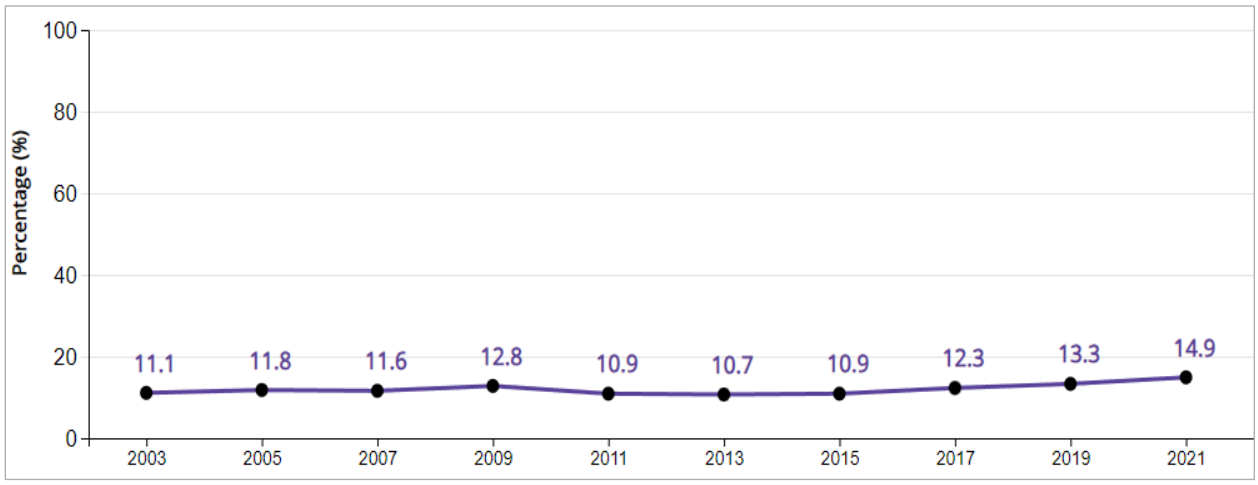
Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

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.

As seen in Exhibit 6, in 2021, 14.9% of Arizona high school students had obesity, the highest level reported since at least 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.[7]

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



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

[7] 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.

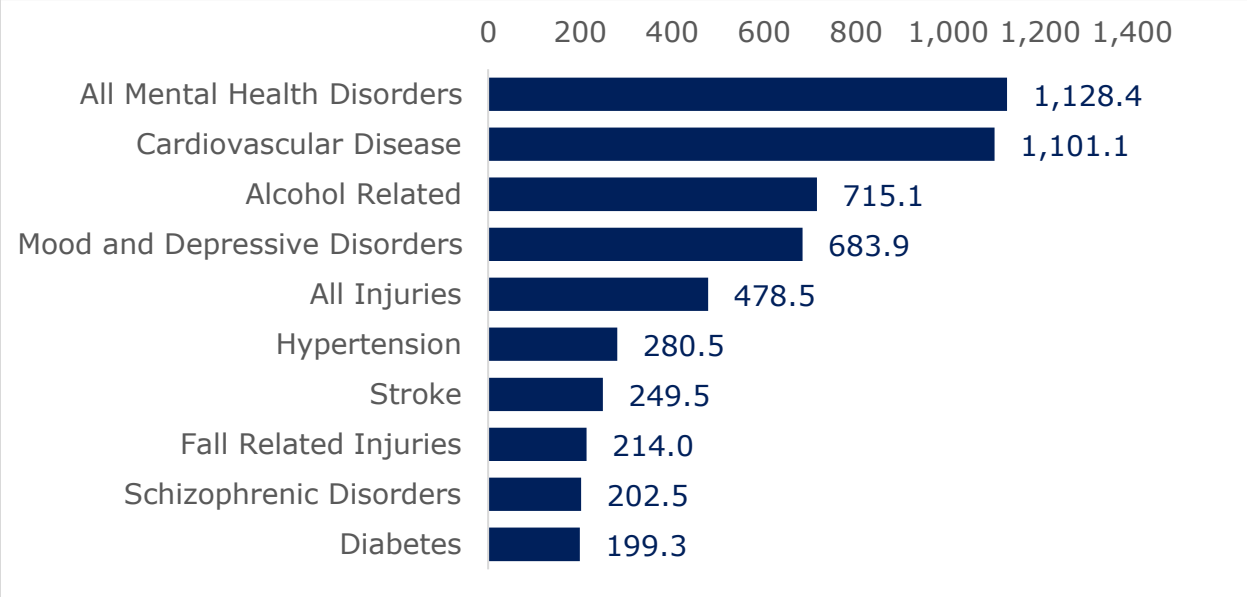
Understanding which conditions lead to hospital visits or early death helps paint a broader picture of health in the region. These outcomes are shaped by many factors, some clinical and some social, and they tell us what types of conditions are most frequently driving people in the PSA to seek care.

As shown in Exhibit 7, the top causes of inpatient hospitalization include mental health conditions, cardiovascular disease, and substance use.

Mental health disorders were the leading cause of inpatient hospitalizations, with a rate of 1,128.4 per 100,000 people. Cardiovascular disease was close behind. Alcohol-related hospitalizations and mood and depressive disorders also contributed significantly to inpatient stays.

Injuries, hypertension, and stroke followed, along with fall-related injuries and chronic conditions like diabetes and schizophrenia. The data highlights the wide range of health concerns that result in inpatient hospital admissions, including behavioral health needs, chronic disease, and acute medical events.

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.

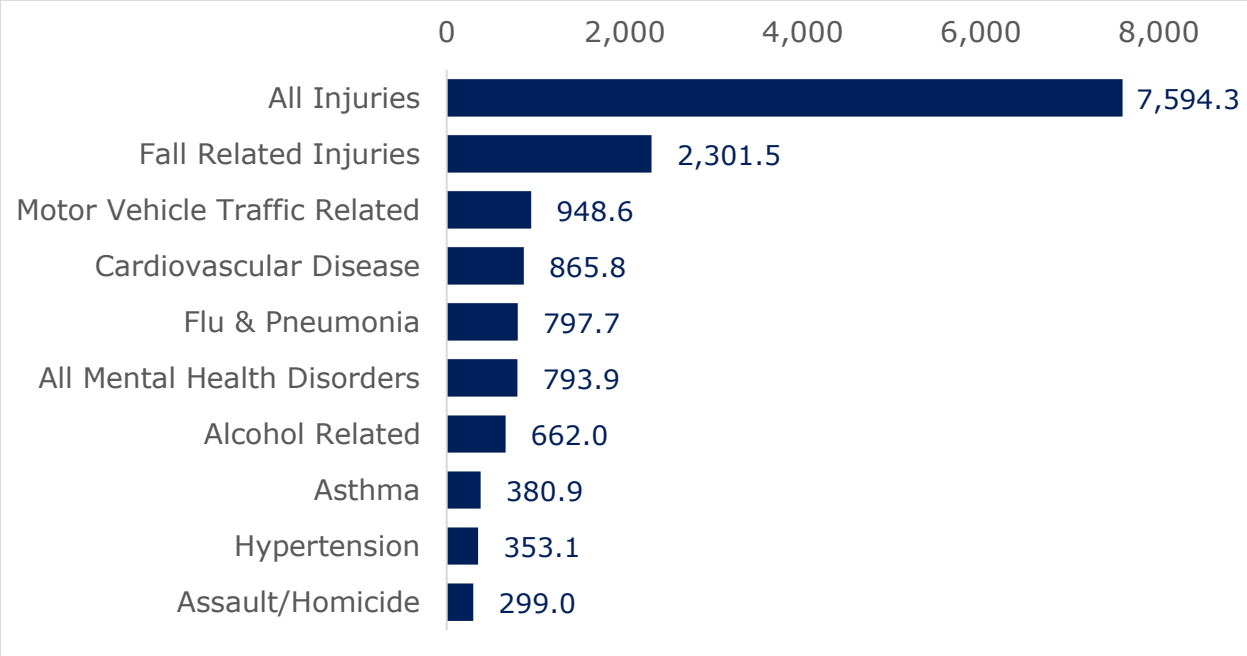
Exhibit 8 provides another part of the picture by showing the most common reasons people visit the emergency department, often for more immediate or urgent concerns. The top reasons include injuries, cardiovascular issues, and behavioral health concerns.

Injuries were the leading reason for ED visits, with a rate of 7,594.3 per 100,000 people. About one in three of those visits were related to falls.

Motor vehicle crashes and cardiovascular disease also contributed heavily to ED use, each with rates above 850 per 100,000. Respiratory infections like flu and pneumonia, along with mental health and alcohol-related concerns, were also common. Asthma, hypertension, and assault-related injuries appeared further down the list.

This mix of causes reflects the broad range of urgent needs driving people to seek emergency care, from accidents and illness to behavioral health and chronic 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.

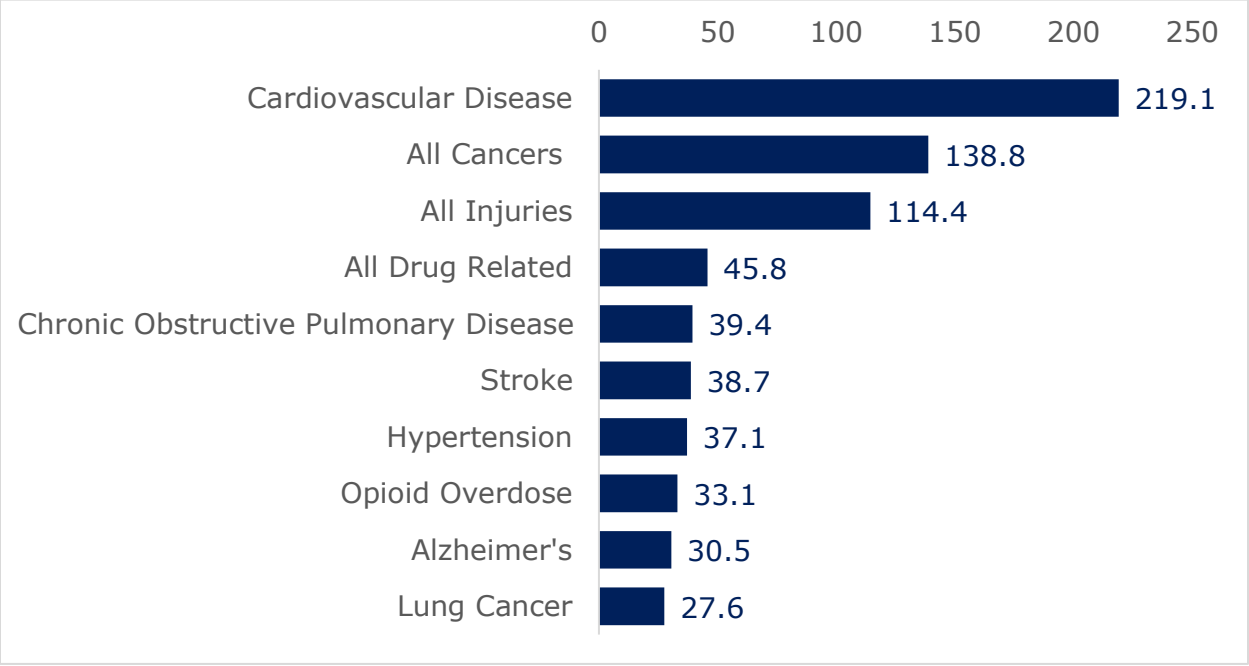
Exhibit 9 shows the leading causes of death in the PSA, adding another layer to understanding of community health. The top causes include cardiovascular disease, cancer, and injuries.

Cardiovascular disease was the leading cause of death, with a rate of 219.1 per 100,000 people. Cancer followed at 138.8, and injuries ranked third at 114.4 deaths per 100,000.

Drug-related deaths appeared next, followed by chronic conditions such as COPD, stroke, and hypertension. Opioid overdoses, Alzheimer's disease, and lung cancer also contributed to overall mortality.

The data reflects a mix of long-term illnesses, behavioral health-related deaths, and sudden events, offering a broad view of the factors contributing to loss of life in 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

Youth Health Outcomes

This section highlights major health concerns affecting children and adolescents, based on hospital and mortality data. It includes the top causes of inpatient stays and emergency department visits among youth ages 0–14, as well as trends in the leading causes of death among young people.

Understanding the health needs of children and adolescents is especially important in communities served by pediatric hospitals. Early-life health experiences can shape long-term physical, emotional, and social well-being.[8]

This section presents key data on youth health in the region, beginning with the top five causes of inpatient hospitalizations and emergency department visits among children ages 0 to 14. These indicators help highlight the most common reasons children seek acute care and can point to areas where community-based prevention, clinical care, or family support services may be needed.

Exhibit 10 shows that children in the PSA are hospitalized most often for mental health issues and respiratory conditions. Depressive disorders were the top reason for inpatient care, followed by respiratory failure and injuries.

On the emergency side, injuries were the most common reason for visits, along with upper respiratory infections, ear infections (otitis media), and abdominal pain. Together, these patterns point to both physical and behavioral health needs affecting local children.

Exhibit 10: Top 5 Causes of Inpatient Hospitalization and Emergency Department Visits for 0-14 Years Old, 2019-2023[9] (PSA)

Inpatient	ED
Depressive disorders	Injuries
Respiratory failure; insufficiency; arrest	Other specified upper respiratory infections
Injuries	Otitis media
Other specified and unspecified mood disorders	Abdominal pain and other digestive/abdomen signs and symptoms
Acute bronchitis	Nausea and vomiting

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

[8] Likhard, 2022
[9] Top indicators are based on frequencies by single primary/principal diagnosis or underlying cause of death.

it's also important to understand the leading causes of death among youth in the region. These outcomes offer a window into the most serious threats to child and adolescent health.

As shown in Exhibit 11, the top causes of death for individuals under 18 remained fairly consistent over the previous five-year period. Conditions related to the perinatal period and congenital abnormalities appeared every year, often in the top two. Unintentional injuries were also a persistent cause. Other leading causes included assault, drug overdose, malignant neoplasms, and in one year, intentional self-harm.

While the specific ranking of causes shifted slightly from year to year, the types of threats remained similar, underscoring the range of health and safety issues that affect youth in this community.

Exhibit 11: Top 5 Causes of Youth (<18) Deaths, 2019-2023[10]

2019	2020	2021	2022	2023
Certain conditions originating in perinatal period	Certain conditions originating in perinatal period	Certain conditions originating in perinatal period	Unintentional Injuries	Certain conditions originating in perinatal period
Congenital malformations, deformations & chromosomal abnormalities	Unintentional Injuries	Unintentional Injuries	Certain conditions originating in perinatal period	Unintentional Injuries
Unintentional Injuries	Congenital malformations, deformations & chromosomal abnormalities	Congenital malformations, deformations & chromosomal abnormalities	Congenital malformations, deformations & chromosomal abnormalities	Congenital malformations, deformations & chromosomal abnormalities
Malignant Neoplasms	Drug Overdose	Assault	Assault	Assault
Assault	Assault	Drug Overdose	Intentional Self Harm	Drug Overdose

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

[10] Top indicators are based on frequencies by single primary/principal diagnosis or underlying cause of death.

Healthcare Access and Utilization

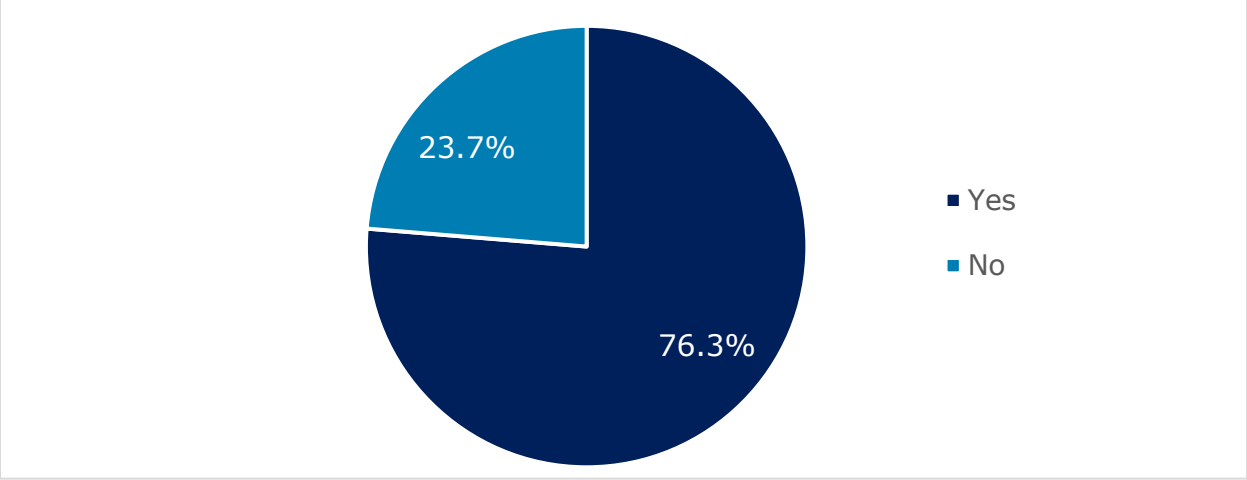
This section explores whether people have regular access to care and how often they use healthcare services. It includes information on insurance coverage, usual sources of care, and patterns in hospital visits by payer type.

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.[11]

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.[12]

Exhibit 12: People with a Usual Source of Care, 2022 (Maricopa County)



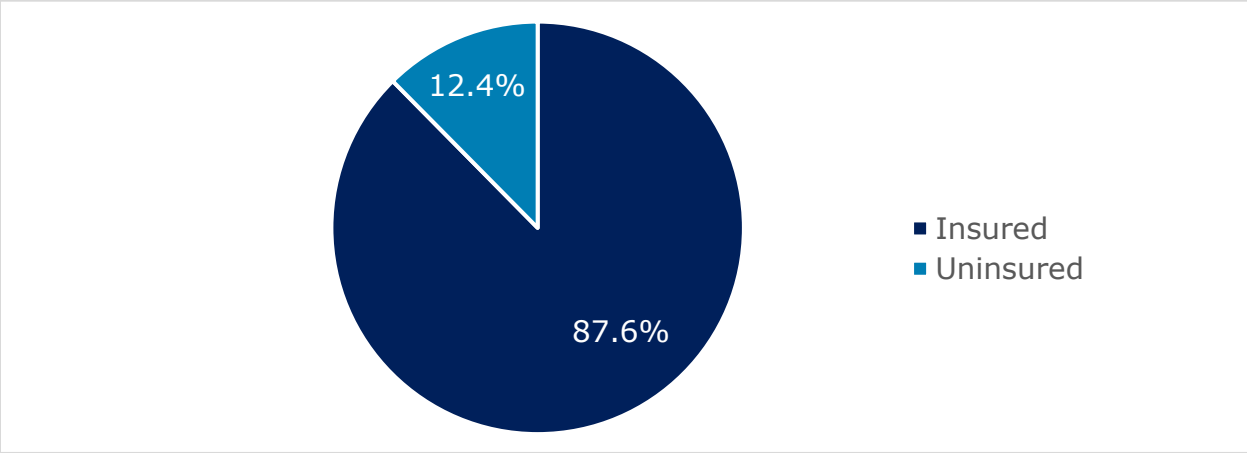
Source: Behavioral Risk Factor Surveillance System, 2022, Maricopa County

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

To better understand why some people may be going without a usual source of care, Exhibit 13 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, 12.4% of residents in the PSA were uninsured. While most had health coverage, this means about one in eight people lacked insurance, which may make it harder to access regular or affordable care when needed.

Exhibit 13: Health Insurance Status, 2023



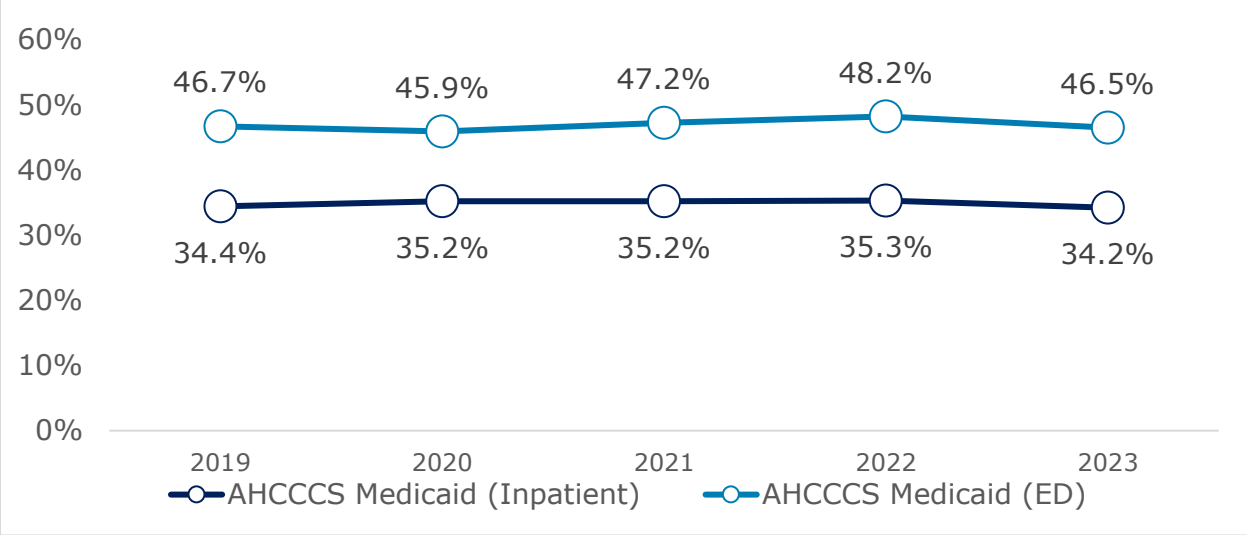
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

While Exhibit 13 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 14 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, about one in three inpatient stays in the PSA were covered by Medicaid, with rates holding fairly steady. ED visits were more likely to be billed to Medicaid, consistently covering just under half of all cases during this period. These patterns highlight the ongoing role of public insurance in helping lower-income residents access both emergency and inpatient care.

Exhibit 14: Trends in AHCCCS Medicaid Coverage Among Hospital Visits, 2019–2023 (PSA)



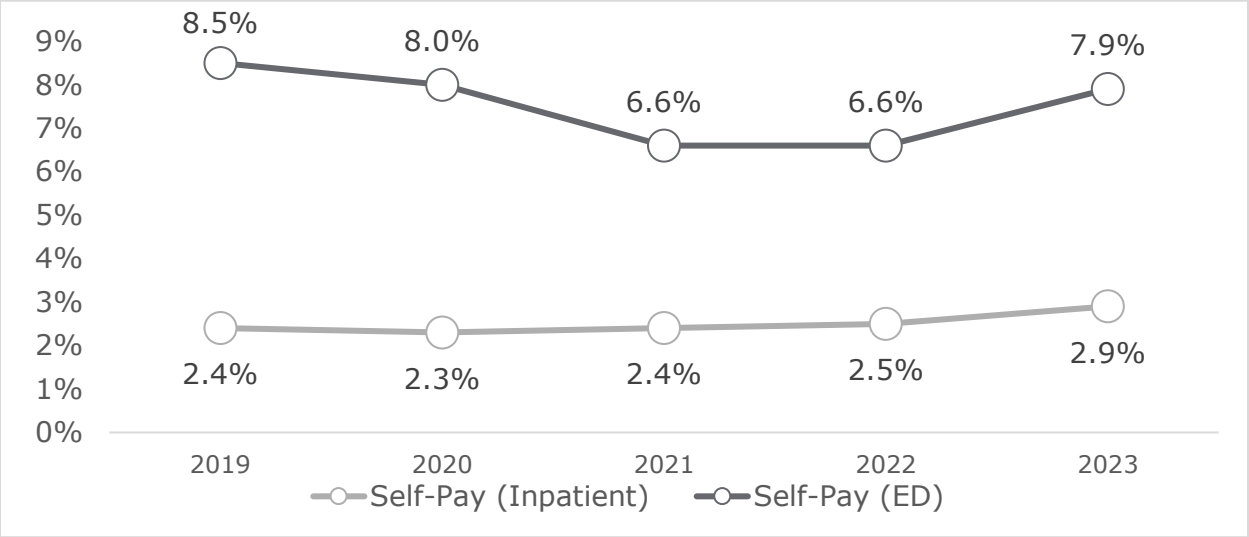
Source: Hospital Discharge Data, obtained from ADHS, cleaned and analyzed by MCDPH

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 15 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.[13]

Over the past five years, self-pay visits made up a small but consistent share of hospital use in the PSA, with ED visits notably higher than inpatient stays. ED rates declined from 2019 to 2021, held steady in 2022, then rose to 7.9% in 2023. Inpatient self-pay visits remained much lower, increasing slightly from 2.3 to 2.9%. These trends may reflect how some residents are accessing care without insurance or outside the traditional coverage system.

Exhibit 15: Trends in Self-Pay Hospital Visits, 2019–2023 (PSA)



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

[13] 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.[14]

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 16 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 hospitalizations declined for several conditions, including Alzheimer's disease and chronic obstructive pulmonary disease. Some conditions, such as diabetes and kidney disease, saw small increases in inpatient visits, while ED visits stayed relatively stable. A few indicators stood out: stroke-related ED visits rose sharply, and asthma-related deaths declined by more than 40%.

The largest change was in obesity-related ED visits, which climbed more than 85%. This aligns with national trends showing steady growth in severe obesity among U.S. adults.[15]

[14] CDC, 2023. About Chronic Disease
[15] Freedman & Ogden, 2024. Prevalence of Obesity.

Exhibit 16: Percent Change in Chronic Disease Related Hospitalizations and Deaths Between 2023 and 4-Year Averages (2019-2022)[16] (PSA)

	Inpatient	ED	Death
Alzheimer's	-16.2	-11.8	-14.0
Arthritis	-70.0[17]	8.2	
Asthma	6.3	4.1	-42.9
Cardiovascular Disease	4.9	7.9	0.1
Chronic Obstructive Pulmonary Disease	-14.1	-4.5	-2.0
Diabetes	3.7	1.1	-15.8
Flu & Pneumonia	-2.9	7.6	-14.6
Hypertension	3.6	4.3	-2.4
Kidney Disease	1.7	5.1	-4.1
Long COVID[18]	13.7	1.2	0.0
Overweight & Obesity	22.9	86.5	
Stroke	4.0	14.2	2.0

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

[16] 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.
[17] The decline in arthritis IP rates may stem from reduced osteoarthritis cases from 2019-2023, due to coding changes or a true population decline.
[18] 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.

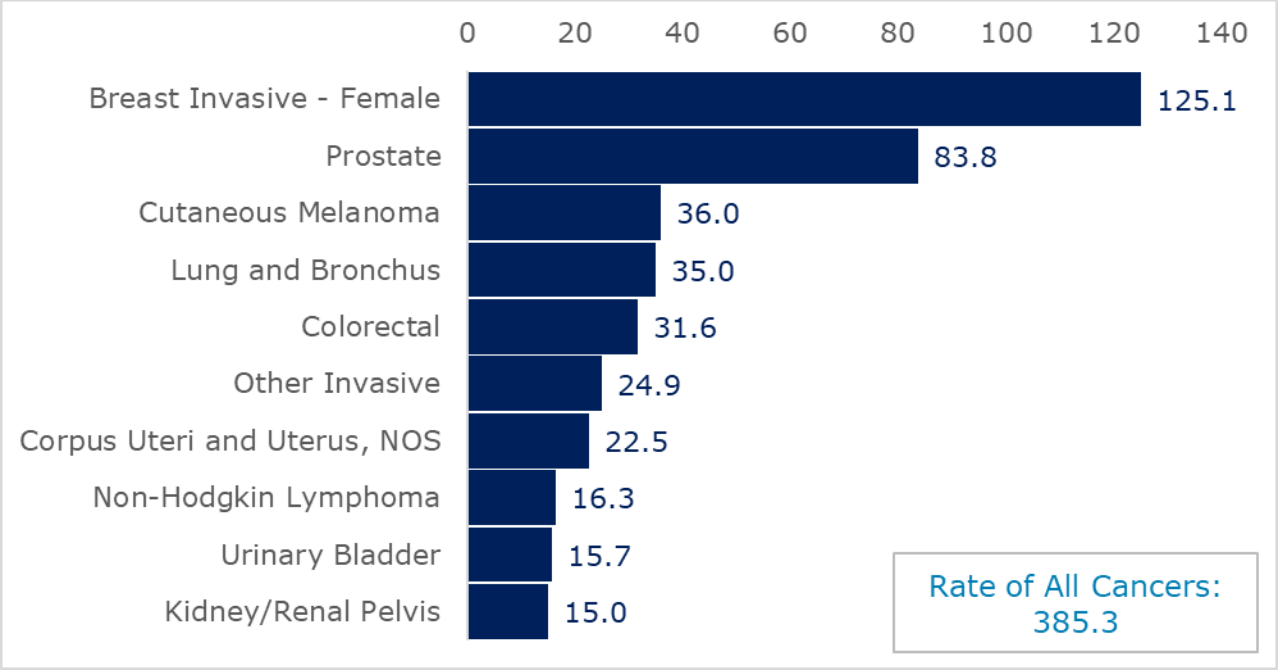
Cancer is another significant part of the chronic disease landscape in the community. Many of the same factors that influence conditions like diabetes or heart disease, including access to screening, early detection, and consistent care, can also affect cancer. Exhibit 17 highlights cancer incidence patterns 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 17: Cancer Incidence by Type, 2022 Age-Adjusted Rates per 100,000 (Maricopa County)[19]



Source: ADHS Cancer Registry

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

Mental Health and Substance Use

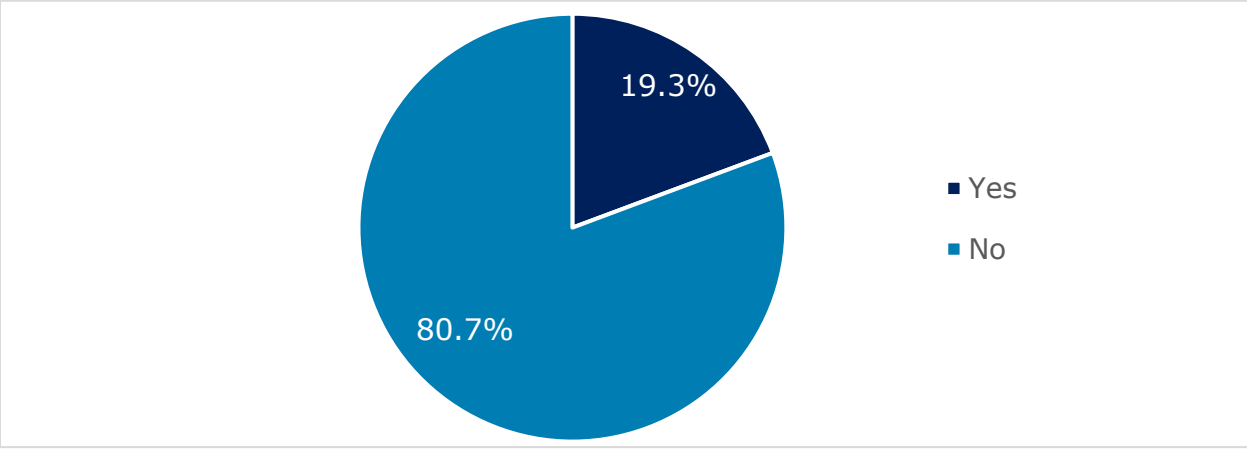
This section includes data on mental health diagnoses, hospital visits for mental health or substance use, and deaths related to suicide, alcohol, or drug use.

Mental health is an important part of overall well-being, affecting how people manage stress, maintain relationships, and engage with their communities.[20] Understanding the scope of mental health needs in the region begins with looking at how many people report living with a diagnosed condition.

Exhibit 18 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 18: 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

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

To better understand how mental health challenges show up in more acute settings, Exhibit 19 and Exhibit 20 explore inpatient hospitalizations related to mental health disorders.

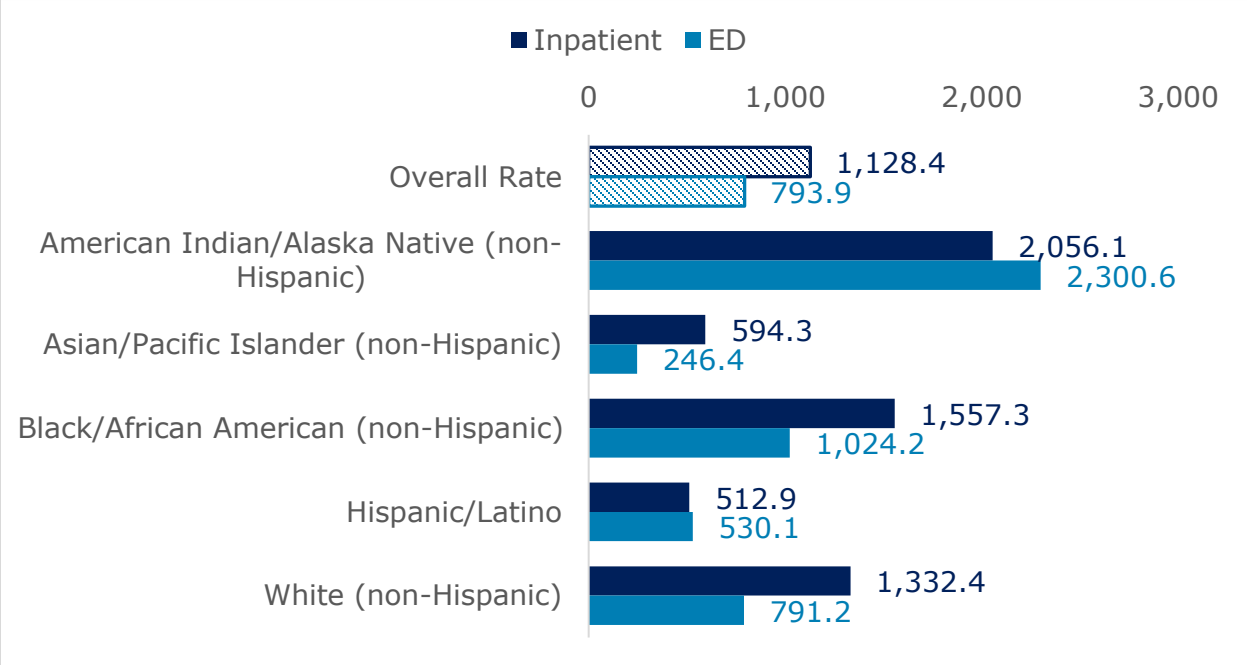
This data is broken out by race and ethnicity (Exhibit 19) and by gender (Exhibit 20) to help highlight differences in how various groups are accessing or experiencing hospital-based mental health care. This can offer insight into potential disparities in severity, access to outpatient treatment, or the availability of early intervention.

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

Asian/Pacific Islander and Hispanic/Latino residents had the lowest rates of inpatient and ED visits. White residents were close to the overall rate, with slightly higher inpatient use.

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

Exhibit 19: Hospital Discharge Diagnosis: All Mental Health Disorders, 2023 Age-Adjusted Rates per 100,000, by Race/Ethnicity[21] (PSA)



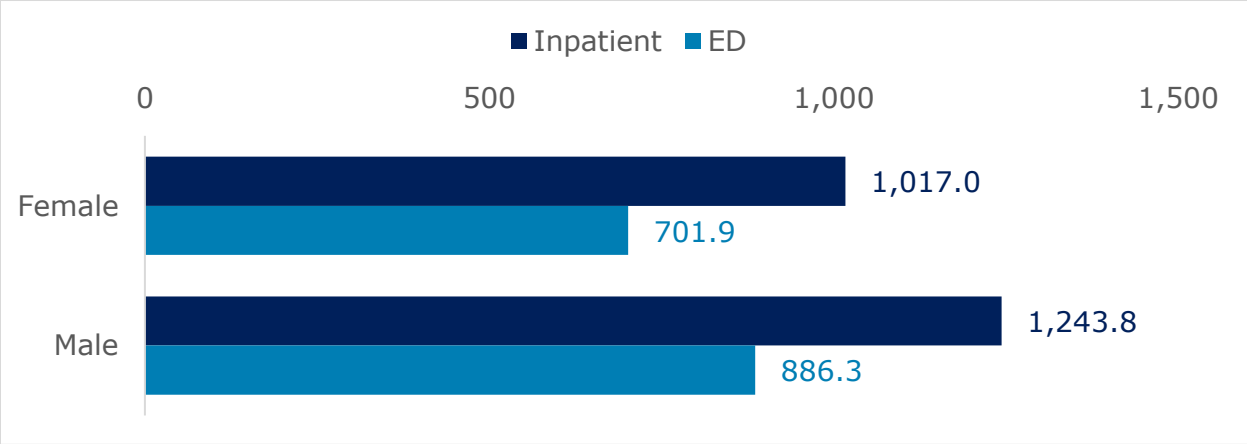
Source: Hospital discharge data and death records, obtained from ADHS, cleaned and analyzed by MCDPH

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

In the PSA in 2023, inpatient stays for mental health disorders were about 22% higher for males than females. ED visit rates were also higher among males, with a difference of roughly 26%.

These patterns may reflect differences in how mental health symptoms present, how care is accessed, or when individuals seek help.

Exhibit 20: Hospital Discharge Diagnosis: All Mental Health Disorders, 2023 Age-Adjusted Rates per 100,000, by Gender[22] (PSA)



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

[22] 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 21 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.

Alcohol-related hospitalizations and ED visits both increased, with ED visits up more than 17%. Opioid overdose hospitalizations also rose, while deaths linked to opioids increased by 10%. In contrast, hospitalizations, ED visits, and deaths connected to self-harm and suicide remained relatively steady or declined slightly. Overall, these trends suggest a growing burden from alcohol and opioid use in the community.

Exhibit 21: Percent Change in Substance/Behavioral Health Risk Factor Related Hospitalizations and Deaths Between 2023 and 4-Year Averages (2019-2022)[23] (PSA)

	Inpatient	ED	Death
Alcohol Related	9.2	17.5	5.4
All Drug Related	-1.2	-1.4	10.4
Opioid Overdose	13.5	0.2	10.1
Self-Harm/Suicide	-6.1	-7.3	-0.3

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.

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.[24,25] They often happen without warning and can cause lasting harm to individuals, families, and communities.

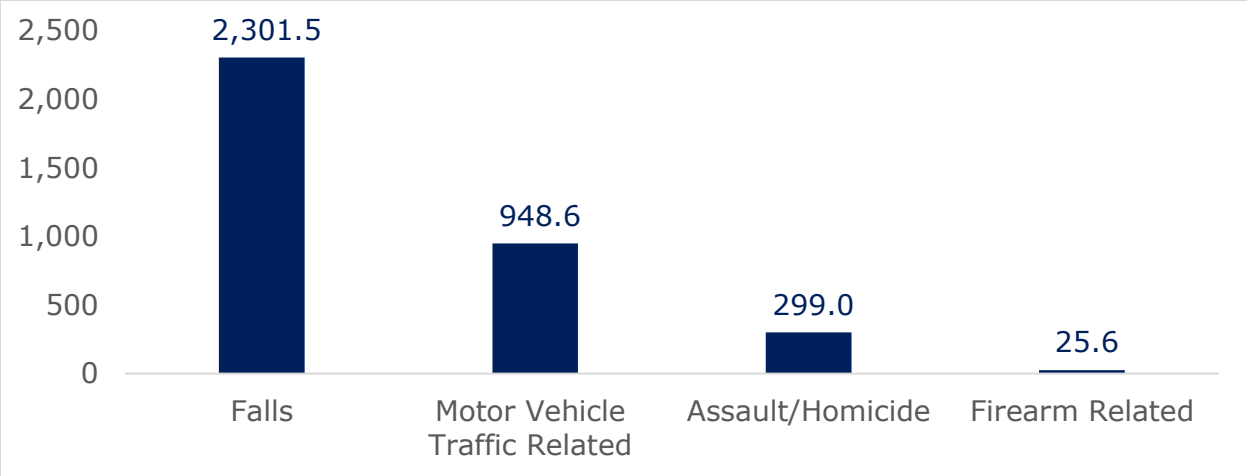
Injury-related emergency department visits offer a snapshot of how often people are seeking urgent care for accidents, falls, and other unintentional harm.

Exhibit 22 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 twice as high as for motor vehicle injuries and nearly eight times higher than for assaults or homicides. Firearm-related injuries made up only a small fraction of visits.

These patterns suggest that falls are 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 22: 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

[24] CDC, 2025. Leading Causes of Death.
[25] CDC, 2025. Injuries.

While emergency department visits help show the frequency of injury-related events, they don't capture the most serious outcomes.

Exhibit 23 compares 2023 rates of injury-related hospital visits and deaths to four-year averages from 2019 to 2022.

In the PSA, overall, injury-related inpatient stays declined slightly, while ED visits rose more than 6%, and deaths increased by 7%. Assault- and fall-related ED visits saw the largest increases, up 10% and 8% respectively. Meanwhile, inpatient stays for firearm injuries dropped nearly 12%, and deaths from motor vehicle-related injuries declined slightly.

Exhibit 23: Percent Change in Injury Related Hospitalizations and Deaths Between 2023 and 4-Year Averages (2019-2022)[26] (PSA)

	Inpatient	ED	Death
All Injuries	-3.5	6.3	7.3
Assault/Homicide	-14.8	10.3	-1.3
Fall Related Injuries	-5.0	8.3	3.5
Firearm Related	-11.5	-1.6	0.8
Motor Vehicle Traffic Related	1.9	3.1	-0.6

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

[26] 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

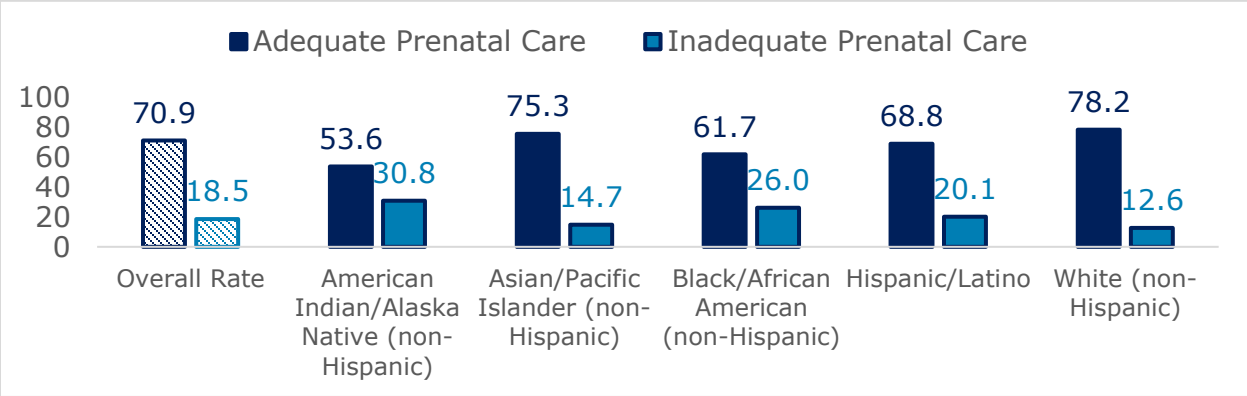
This section highlights key indicators related to the health of mothers and infants.
It includes data on prenatal care, birth outcomes like low birthweight and preterm births, and teen birth rates.

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 24 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.[27] 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 nearly one in three receiving inadequate care. Black/African American and Hispanic/Latino residents also had higher-than-average rates, while White and Asian/Pacific Islander residents had the lowest, both under 15%. Because population sizes vary, some differences may appear larger or smaller depending on the size of the group.

Exhibit 24: Prenatal Care, 2023 Crude Rates per 100 Live Births (PSA)



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

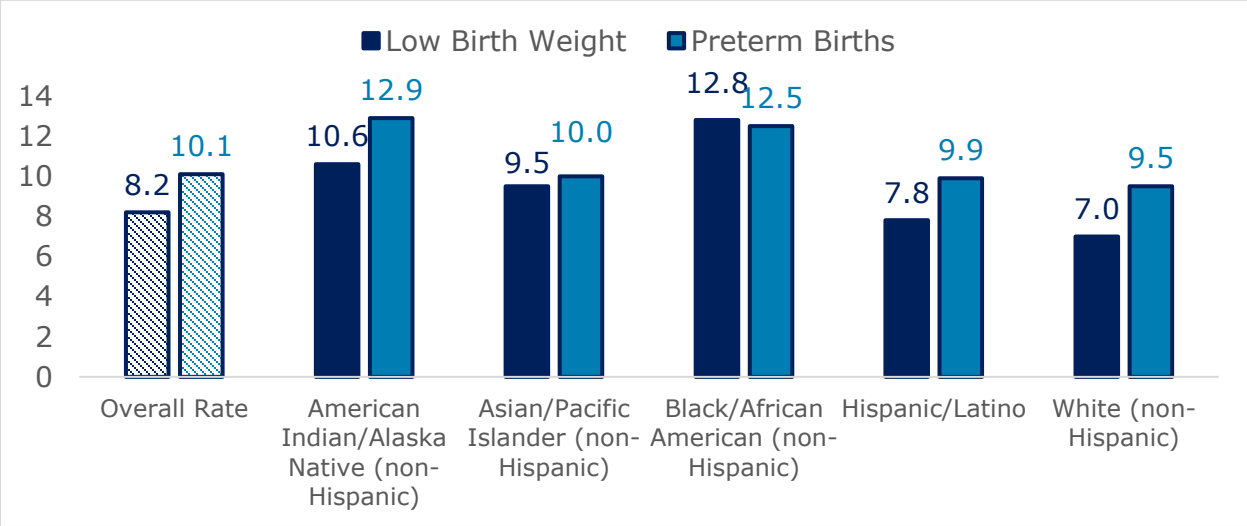
[27] Albarqi, 2025.

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

Exhibit 25 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 and American Indian/Alaska Native newborns had the highest rates of both low birth weight and preterm birth, with levels well above the overall rate. Most other groups were closer to the overall rate, with smaller differences between the two indicators. Because population sizes vary, some of these differences may appear larger or smaller depending on the size of the group.

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



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

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. [28] Infant mortality, which is closely tied to maternal health, prenatal care, and broader social conditions, reflects the most serious outcomes for newborns. [29]

Exhibit 26 shows shifts in several maternal and infant health indicators compared to the previous four-year averages across the PSA. The share of births with inadequate prenatal care rose slightly, along with small increases in low birth weight and preterm births. Teen births declined by more than 8%.

At the same time, the infant mortality rate climbed over 16%, marking one of the largest changes in this group of indicators. This mirrors the national trend: according to the CDC, the U.S. infant mortality rate rose by 3% between 2021 and 2022, the first statistically significant increase in two decades.[30]

Exhibit 26: Percent Change in Maternal and Infant Health Indicators Between 2022 and 4-Year Averages (2018-2021)[31] (PSA)

	Percent Change
Inadequate Prenatal Care	2.1
Low Birth Weight	6.8
Preterm Births	0.7
Teen Births	-8.3
Infant Mortality Rate	16.3

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

[28] CDC, 2015. Teen Childbearing Consequences.
[29] CDC, 2024. Infant Mortality.
[30] Arias et al., 2023. Infant Mortality in the U.S.
[31] 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.

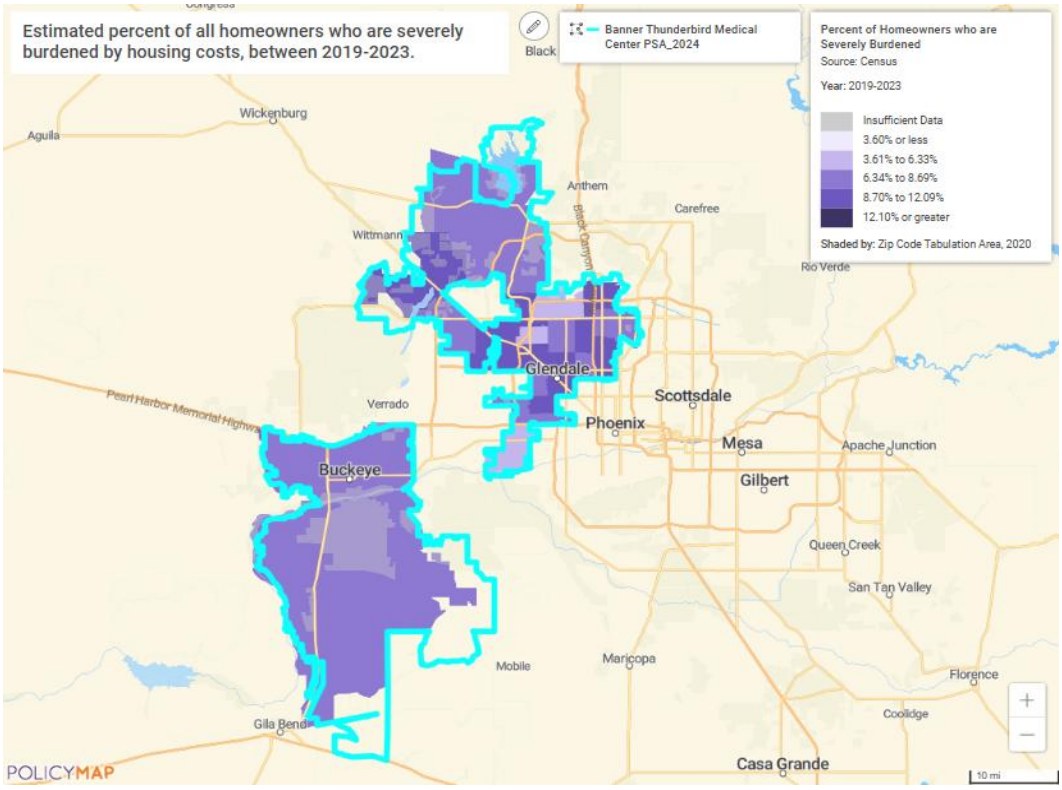
Social and Environmental Drivers of Health

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.[32]

Exhibit 27 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 concentrated around Glendale.

Exhibit 27: Estimated Percent of All Homeowners Who Are Severely Burdened by Housing Costs; 2019-2023[33] (PSA)



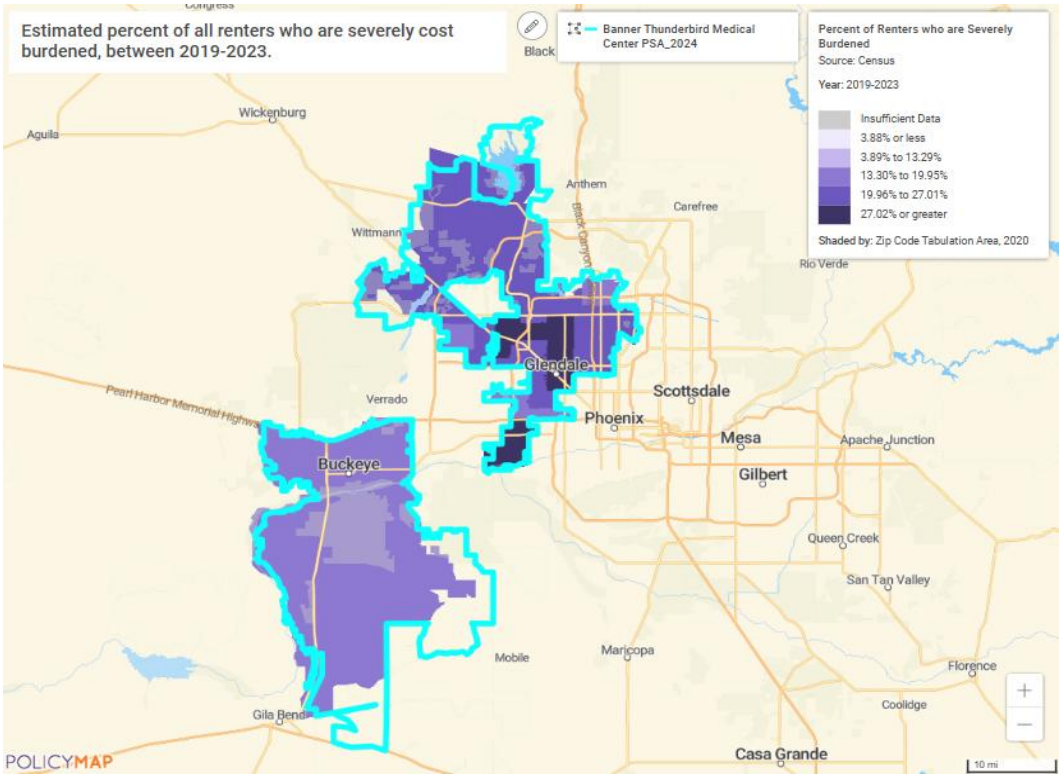
Source: PolicyMap; US Census

[32] Healthy People 2030. Social Determinants of Health.
[33] 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 28 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 areas surrounding Glendale. These areas are shaded in the darkest purple, indicating that more than 27.0% 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 28: Estimated Percent of All Renters Who Are Severely Cost Burdened 2019-2023[34] (PSA)



Source: PolicyMap; US Census

[34] 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.

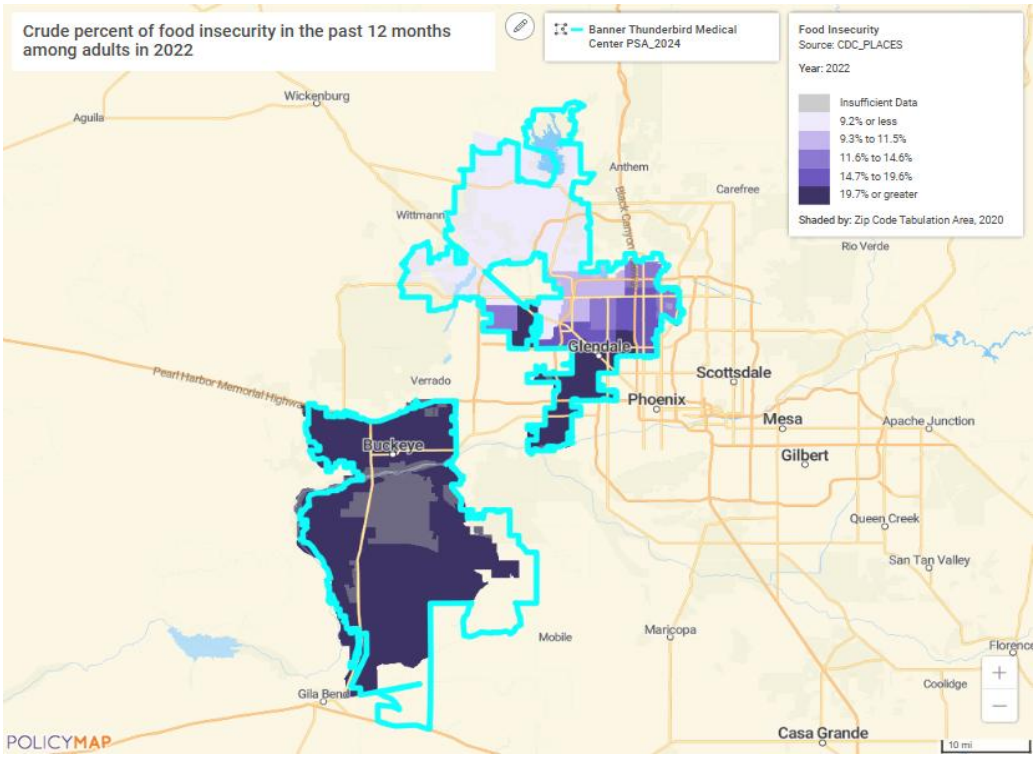
High housing costs can force difficult tradeoffs: when a large share of income goes to rent, there may be less left for essentials like food, medicine, or cooling. One way this strain shows up is through food insecurity.

Food insecurity is closely linked to both short-term and long-term health problems, including stress, chronic disease, and poor nutrition outcomes.[35]

Exhibit 29 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.

The southern region of the PSA surrounding Buckeye and the area south of Glendale has a particularly high prevalence of food insecurity. These areas are shaded in the darkest purple, indicating that more than 19.7% of adults experienced food insecurity in the past year.

Exhibit 29: Access to Food: Crude Percent of Food Insecurity in the Past 12 Months Among Adults in 2022[36] (PSA)



Source: PolicyMap; CDC PLACES

[35] HHS, n.d. Food Insecurity.
[36] 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.

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.[37]

[37] CDC, 2023. Temperature Extremes.

Exhibit 30 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.[38]

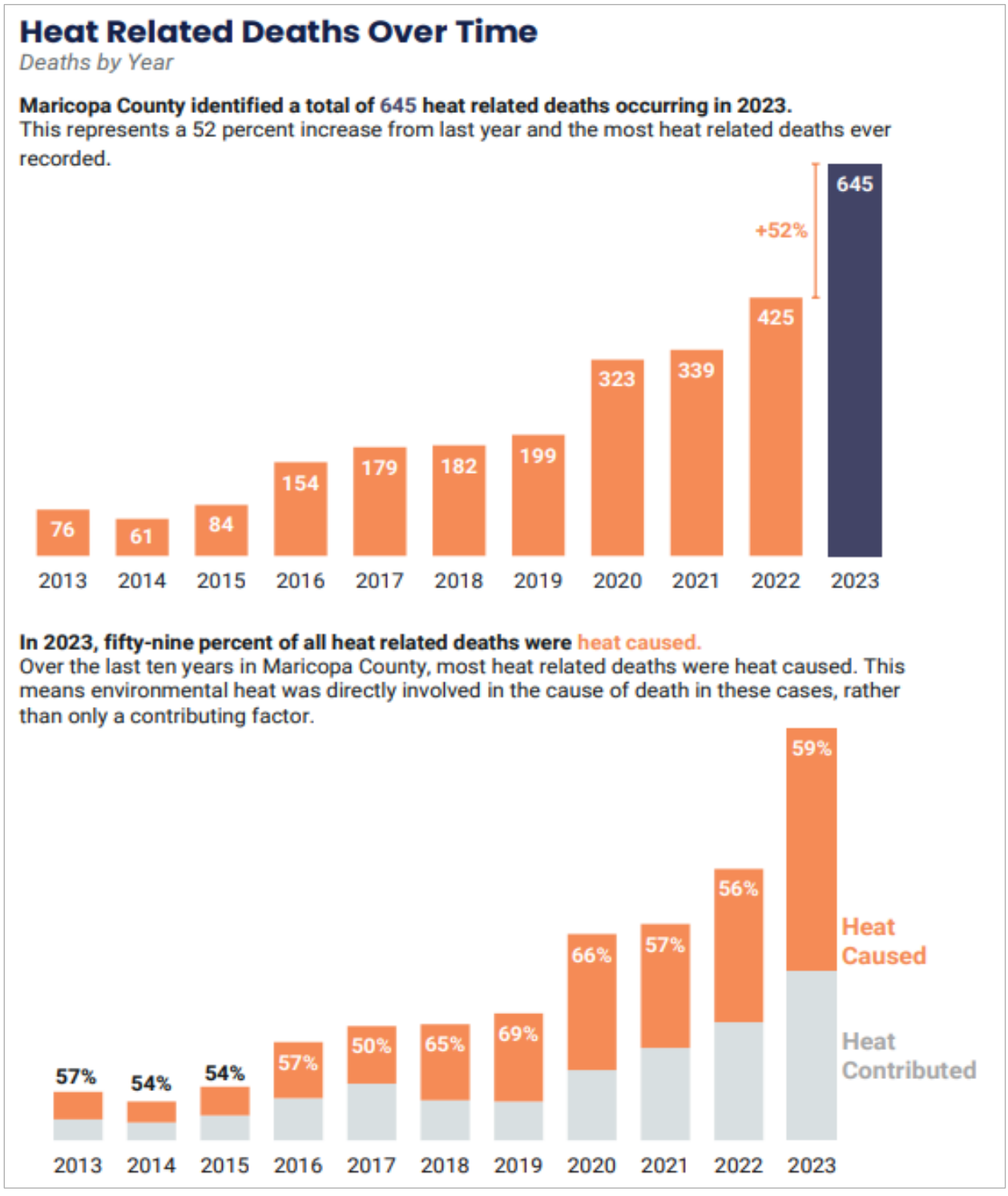
The data shows a sharp rise in heat-related deaths over time:

- 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.

[38] MacDonald-Evoy, 2025.

Exhibit 30: 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[39] and the Community Health Needs Assessment 2024 Key Informant Interviews.[40] The former is a result of a collaborative effort between 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.

[39]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

[40] Maricopa County CHNA 2024 Key Informant Interviews: https://www.maricopa.gov/DocumentCenter/View/94150/2024-CHNA-Key-Informant-Interviews-Report_FINAL_52224

Strengths

Community Members and Organizations

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

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 including youth described positive attributes such as activities for all ages, supportive environment, and a welcoming atmosphere.

> "...when we first opened we started having volleyball night, a volleyball open gym type of thing. It was so nice to see just a bunch of teenagers coming to play with just random adults who they've literally never met and build those connections. [...] I think that just really provides just a great place for just people to go. It doesn't even matter how old you are 'cause we have 12, 13, 14-year-olds playing with 30, 40-year- olds." - *Youth Focus Group*

Key informants in the community shared similar views regarding the strengths of the community and how they impact youth. 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 that support youth, including the education system, the new literacy lab, and the Summer Programs and Auxiliary Revenue Collaborative within Maricopa County as key strengths.

> "...she's a teacher in a neighboring district. And she's always telling me, 'Hey, did you get this resource? Can you take this into your schools?'[...]
>
> - *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[41]. 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. Youth shared experiences with providers who disregarded their ailments during an appointment because of their age.Youth also described emotional challenges such as discrimination and weapons at school, as well as some aspects like diverse communities that served as protective factors. Overall, 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

> "I've noticed that, specifically with Mexicans and Latinos, there's a lot of discrimination and a lot of people I know choose to wait to get their health checked and go to the hospital for the same reason, that they're immigrants, and they're scared that when they go there, and they try to pay out of pocket, they're gonna try and investigate them."
>
> - *Youth Focus Group*

[41] Baciu et al. (2017)

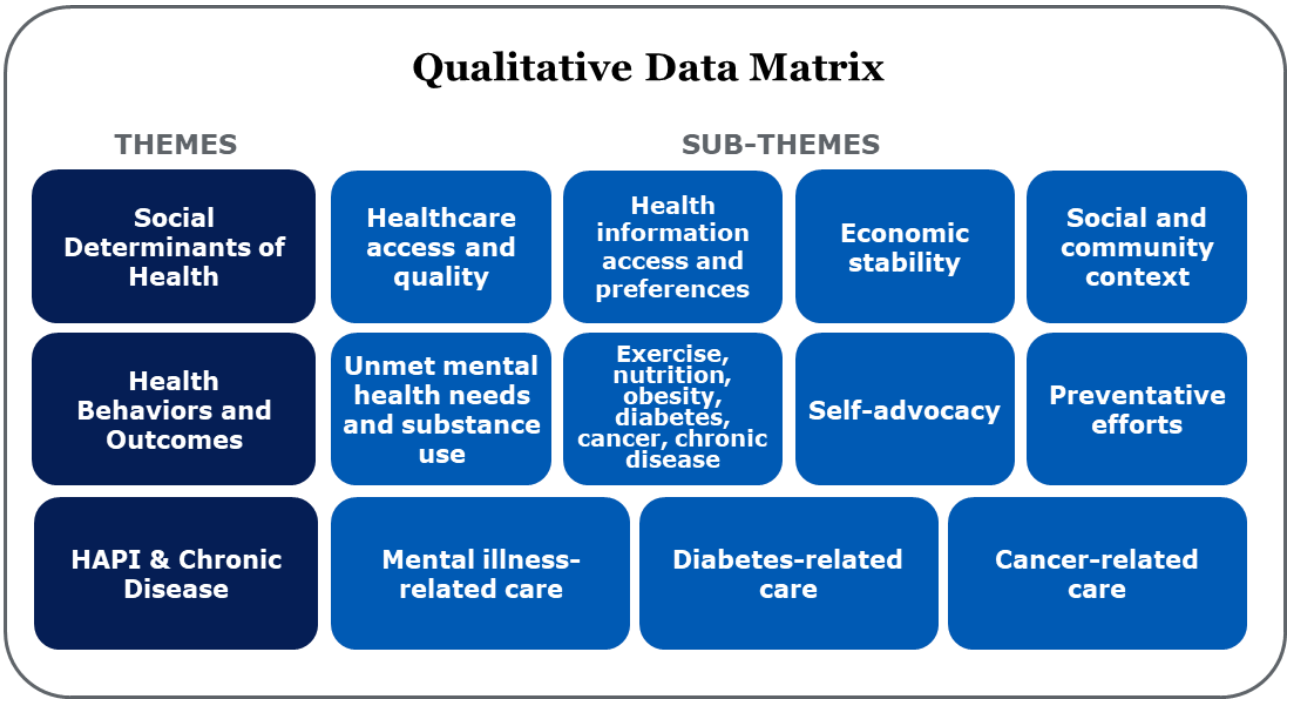
Key informants also identified several disparities among community members as well as challenges and barriers to developing services and programming. These disparities were seen to impact historically marginalized communities, including communities of color, undocumented populations, and unhoused populations. Specifically regarding age, one participant expressed concern about what they believed were high rates of anxiety and other mental diagnoses among youth. Key informants also echoed concerns about the need for increased school safety and described the disparities in different locations, such as South Phoenix.They noted that South Phoenix is a redlined area where there are fewer trees, usable parks, and sidewalks. Youth in these areas may be forced inside due to the poor quality of their physical environments.

> "There's a real disparity in the physical environment in Maricopa County where it's probably the same around the whole country, really, where the higher income neighborhoods have a lot more trees, a lot more usable parks, a lot more shade. The city even repairs the roads better than in the low-income parts of the city...if you go to South Phoenix, you could see entire neighborhoods that, I mean, they don't have any shade trees along the streets. They have fewer sidewalks. The roads are torn up and not chip-sealed. And so it's less walkable and bikeable. That's where the food deserts are. So I mean, the strengths are in the wealthy parts, and the weaknesses are in those lower-income neighborhoods that don't have a built environment that helps nudge and allow people to make the healthy choice the easy choice."
>
> - *Key Informant*

Needs

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

Needs Matrix



Impact of 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.[42] One youth participant expressed appreciation for the diversity of their community. Adult participants shared concerns about financial and insurance barriers to accessing healthcare, which impact youth. Additionally, those in rural areas noted the limited availability of local healthcare services. Overall, four subthemes were identified 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

> "I would say some type of community get together for the younger kids, because let's start it when they're young so they can know what a community is. To feel what a community is. Offer help or just be there for each other, because when they get older, it's too late by then."
>
> - *Low-Income Focus Group*

[42] CDC, 2022.

Several key informants discussed the varying levels of access that exist based on location or neighborhood, with a scarcity of hospitals, clinics, and pharmacies in certain areas. One participant noted that in more outlying cities, healthcare access can be spread out. 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 public transportation or who have mobility issues are likely to struggle more. Single-parent families experience additional financial pressure, as one crisis can lead to the loss of other basic needs, deeply impacting any youth involved.

> "[W]e need a crisis assistance fund… [for example] when a family loses their car and most car repairs are not cheap anymore…And if a family can't come up with $400, they may lose their job, which then leads to [the loss of] other things we need…there's a lot of pressure if you're a single parent household…They can't afford one thing to go wrong. And so, a crisis assistance fund is a potential solution with parameters to help pay for one month's rent or childcare, or transportation repair."
>
> - *Key Informant*

Education and School Needs

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 that 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.

> "I think that we should have more access to be able to rent out books, 'cause at our school, we take college classes, and the college classes are free, but I had to buy a book that was a hundred-and-something dollars, and I feel like if we had more accessibility to rent them out, or buy them for cheaper, it would've been easier."
>
> - *Youth Focus Group*

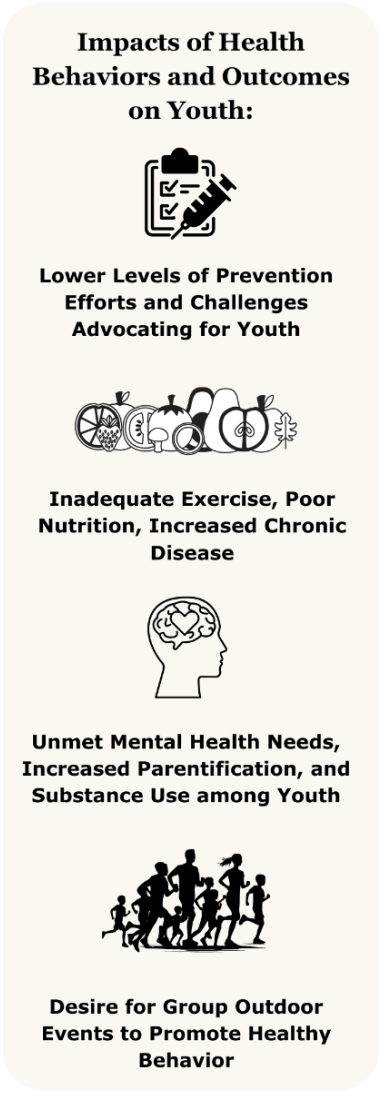
In contrast to the focus group discussions, key informants detailed the strengths of the education system in Maricopa County, specifically the strengths related to local universities and some of the public school districts, which participants noted are leading to positive change and growth. The options 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.

> "...go to the Capitol and ask them to include the newer generations, completely. That's where the strength lies, making use of the time and minds that are more accessible at this moment, cleaner, and more transparent. In my opinion, it's the inclusion of new generations entirely. I think that even for a new generation, a five-year-old bot, you can start showing him certain activities or games that could attract his mind to avoid things like tobacco, drugs, and alcohol, and strengthen that with all sorts of services or programs...Forming leaders at an early age is going to give us communities with leadership in the future."
>
> - *Key Informant*

Youth Health Behaviors and Outcomes

The theme about 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 health outcomes[43]. Health outcomes relate to those factors that impact the length and quality of life for community members, with participants discussing the desire to see more preventive health education taught in schools. Community members also shared concerns about how often kids exercise with suggestions to develop free fitness programs in the community. In addition, families shared stories about challenges they experienced while advocating for their children's needs. Overall, 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
- substance use
- poor nutrition
- obesity
- chronic disease



[43] CDC, Healthy Weight 2023.

> "For example, with my kids in Mexico–if you want a podiatrist or something, they'll send one right away. But it's very difficult here. I remember when my son needed a helmet and they would tell me, 'No, come back in a year, he's not there yet.' And we went several times but it didn't happen. And with my girl it was the same, she had something on her finger and they told me she was too little to get treatment. So, that's something that can't be treated no and they just let it advance…So, you do have to insist and persist so they can refer you to a specialist.[…] and it was the same with both of my kids. I had to insist over and over and when they finally listened and referred me to a specialist, the specialist said it was too late."
>
> - *– Low-Income Hispanic Focus Group*

Like the issues discussed in focus group discussions, key informants also noted challenges in accessing healthy foods, with food swamps and convenience stores prevalent in low-income areas. Key informants further explained that culture and lived experience can deter people from seeking preventive treatment or medical care for health issues, with one participant suggesting increased efforts to educate the community about adverse childhood experiences (ACEs). Additionally, some participants expressed desire for community or city-hosted outdoor events that would allow for more community connection and promote healthy behavior.

Impact of 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. As part of the subthemes, participants reported that their children are experiencing higher levels of stress than ever before, which were leading to mental health concerns. Regarding mental health treatment, one youth participant noted that mental illness resources are available, but more emphasis is needed to increase awareness. Navigating the healthcare system and receiving treatment in a timely fashion were frequently reported, while others discussed the impact of stigma. Overall, three subthemes emerged from the discussions, in order of most discussed to least discussed:

- mental illness
- diabetes
- cancer

> "Someone I was close to was going through a lot mentally and it was really affecting him and he didn't even know where to go. He wanted to admit himself somewhere into a mental facility just to help him with it, but he didn't even know how to go about it. He was calling, trying to call places but it just wasn't really–they expected him to already know everything and so he wasn't able to really get that help at the center that he needed to go to."–
>
> - *Youth Focus Group*

Participants in key informant interviews discussed stigma as well; they noted that stigma is a barrier for those with mental illness to receive treatment. One participant shared how their fear of deportation impacts their child that was born in the United States. Similarly, another participant described how trauma and stigma that is caused by previous political acts is passed down within families and communities. Another participant discussed the removal of KidsCare, another negative repercussion impacting youth.

> "...there is fear accessing healthcare services due to public charge, fear of being deported or their information being shared with the public entity that will then put them at risk of losing the ability to stay in this county....there's fear of accessing public benefits. 'My child was born here and they have legal status and they can get on public benefits. If I were to apply for my child, I'm fearful that I may be deported and therefore will not access public benefits.' So, a lot of stigma that was built as a relation to the public, the political landscape and bills being passed...that seem a little bit more punitive..."
>
> - *Key Informant*

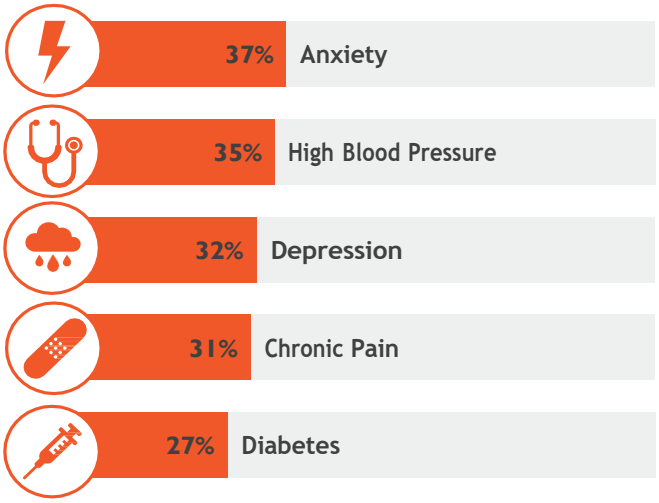
Survey Findings

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?

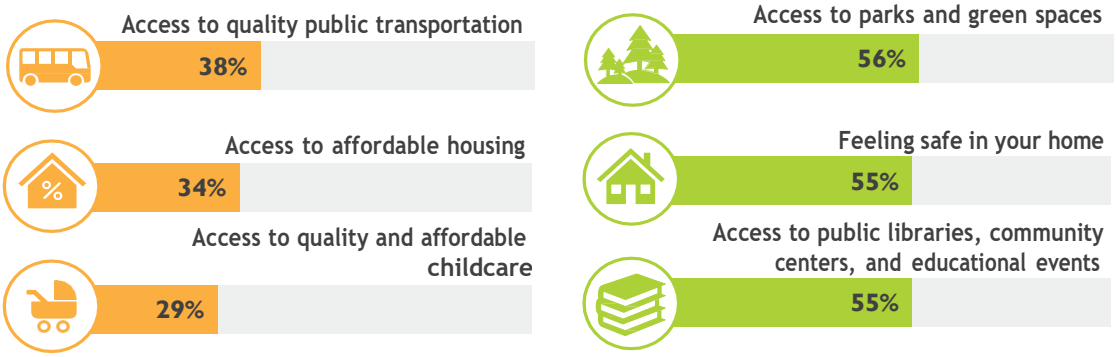
Many people said **anxiety, high blood pressure,** or **depression** were the health issues that have the most impact on someone they care for, live with, or themselves.



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

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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:

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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

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 11 BTMC 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 31: Top Community Needs

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

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 BTMC 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 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 of clinical provider 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 provide resources to behavioral patients – growing from ~50 assessments annually to ~400 annually from 2022 to 2025.* • *Provide quick and easy access of 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.

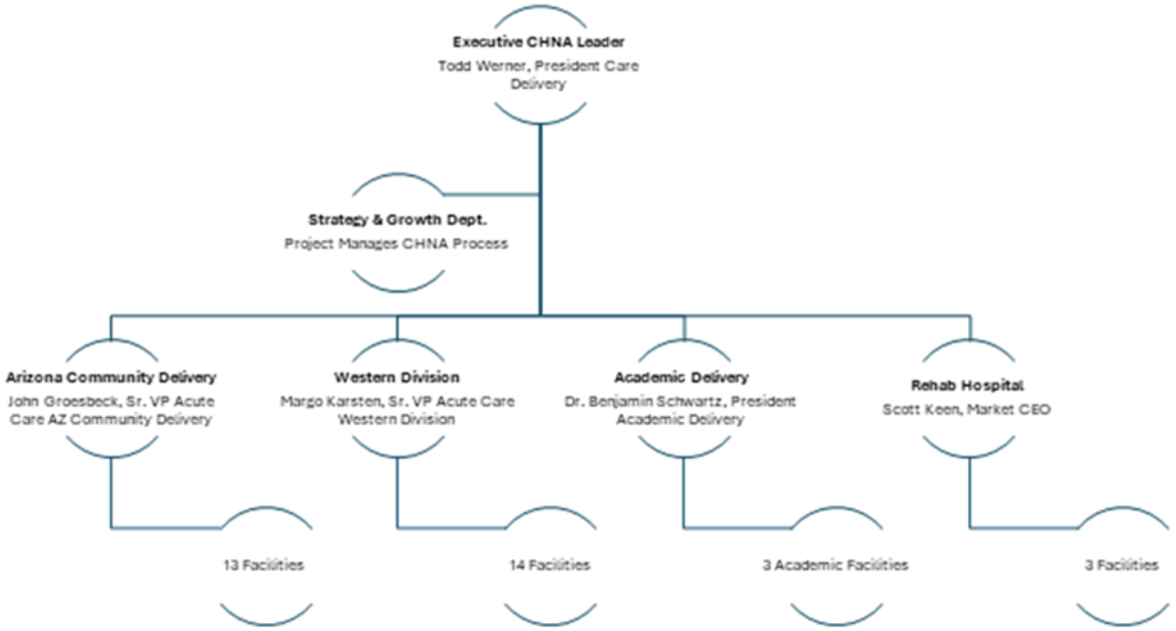
Since 2022, we have received a variety of communication via our Community Benefits webpage. Banner Health tracks comments received and addressed all comments where able. The table below is a summary of the themes of comments collected from 2023 to half year 2025.

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
Debbie Flores, CEO	Kristen Franklin (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 32: 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

FG #	Date in 2023	Region*	Population	Location
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

FG #	Date in 2023	Region*	Population	Location
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 33: 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 <u>you</u> and/or the <u>people you live with or care for</u>?*(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 34: 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 app{y}***

□ 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)*

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

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

☐ Grocery store	☐ Farmer's market	☐ Sit down restaurant	☐ Fast food restaurant
☐ Convenience store	☐ Food **bank** (including at a community organization/church)	☐ 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	☐ Lower cost	☐ More time **to** shop **or** cook
☐ Better transportation access	☐ Don't know	☐ 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 ☐ 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	☐ 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 colllege (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 35: Needs Prioritization Presentation

Banner Health

PART 2

Tools for Prioritization: Method & Metrics

Banner Health

The 18 Health Indicators

Access to Care

- Access to Primary Care
- Child and Adolescent Health
- Health Insurance
- Maternal and Infant Health
- Mortality from Unintentional Injury
- Access to Specialty Care

Behavioral Health

- Access to Mental and Behavioral Health Services
- Mental and Behavioral Health Conditions
- Substance Use

Chronic Disease Management

- Access to Healthy Food
- Cancer Prevention and Treatment
- Cardiovascular Disease
- Diabetes
- Obesity and Nutrition

Other

- 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

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	3.7	3.7	4.2	**45.8**
2	Mental and Behavioral Health Conditions	3.8	4.0	3.7	**43.4**
3	Access to Mental and Behavioral Health Services	3.8	3.8	3.7	**42.2**
4	Access to Specialty Care	3.7	3.5	3.8	**40.9**
5	Substance Use	3.5	3.8	3.3	**37.2**
*	Child and Adolescent Health	3.5	2.8	3.8	**35.1**
*	Maternal and Infant Health	3.2	2.8	3.7	**32.4**

Are we missing any health indicators?

PART 3

Determining our Health Priorities

Your Turn: Choose Your Top 3

In the following slides, we will review each of the Top **5** 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

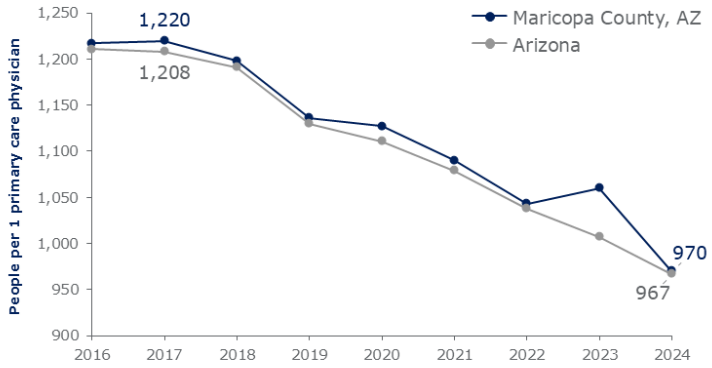
Ranked: #1

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

MARICOPA COUNTY PUBLIC HEALTH

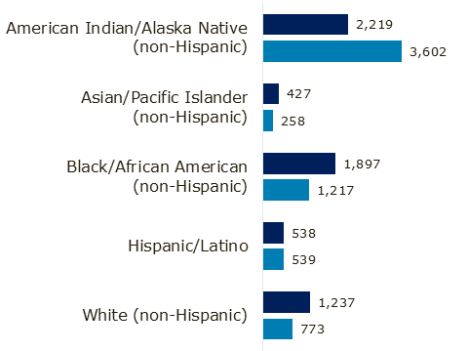
Mental and Behavioral Health Conditions

Ranked: #2

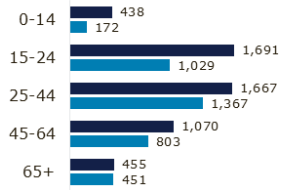
2023 Age-adjusted rates per 100,000 – Maricopa County PSA

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

Race/Ethnicity



Age (years)



Crude rates for those aged 15-24 and 25-44 yrs were even higher for BTMC PSA:

Higher IP Rates:
15-24: 1,705
25-44: 1,635

Sex

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

Banner Health

Access to Mental and Behavioral Health Services

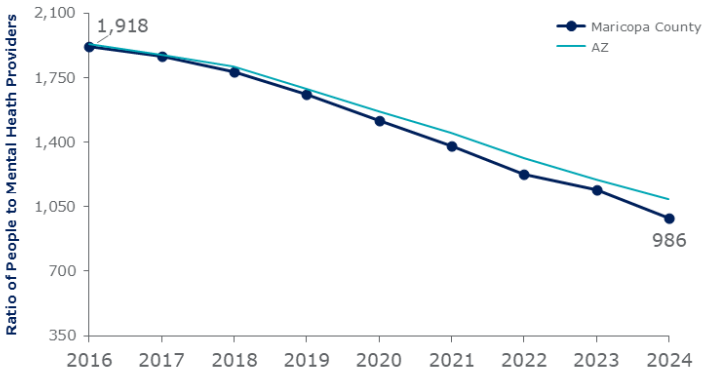
Ranked: #3

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

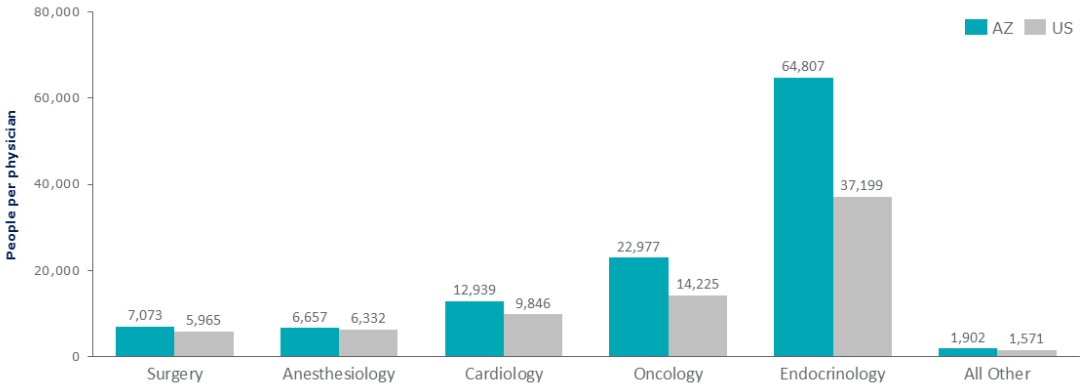
Banner Health

Access to Specialty Care

Ranked: #4

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)



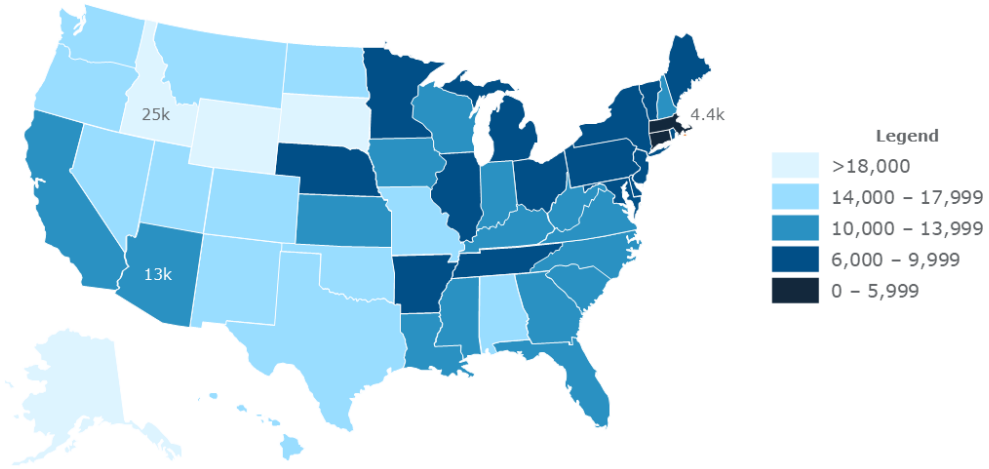
Source: Kaiser Family Foundation: special data request on State Licensing Information from Redi-Data Inc., April 2025. Population data: US Census, includes 50 states plus District of Columbia

Banner Health

Access to Specialty Care: Cardiologists

Ranked: #4

People per Cardiologist



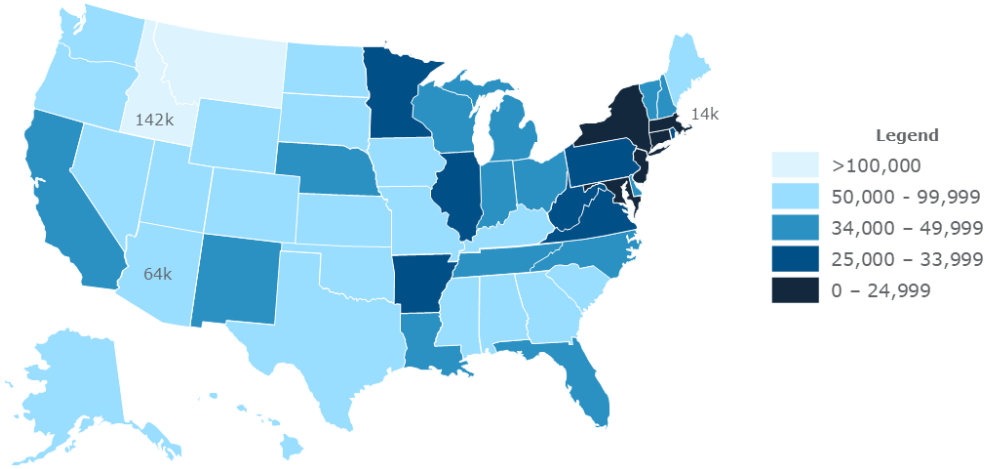
Source: Kaiser Family Foundation: special data request on State Licensing Information from Redi-Data Inc., April 2025. Population data: US Census July 2024 estimate

Banner Health

Access to Specialty Care: Endocrinologists

Ranked: #4

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

MARICOPA COUNTY PUBLIC HEALTH

Substance Use

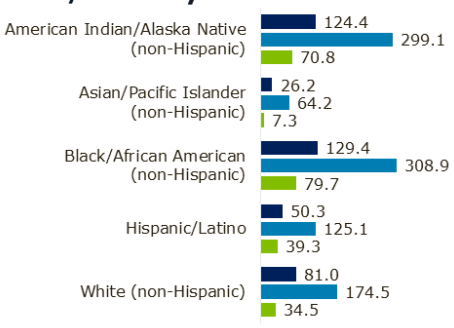
All Drug Related

Ranked: #5

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

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

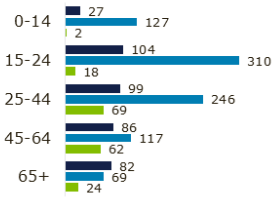
Race/Ethnicity



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

Higher Death Rate: 81.3

Age (years)

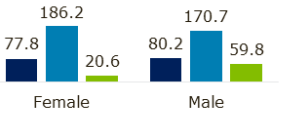


Crude rates for those aged 15-24 and 25-44 yrs were even higher for the following PSAs:

Higher IP Rates:
15–24: 124
25-44: 102

Higher Death Rates:
15 – 24: 15.2
25 – 44: 80

Sex



Rates for females and males were even higher for BTMC PSA:

Higher IP:
Males: 94.1
Females: 84.4

ED Rates:
Males: 177
Females: 201

Source: *2023 Hospital Discharge Data and Death Data*

Banner Health

MARICOPA COUNTY PUBLIC HEALTH

Substance Use

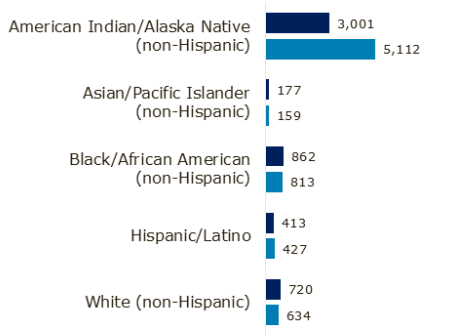
Alcohol Related

Ranked: #5

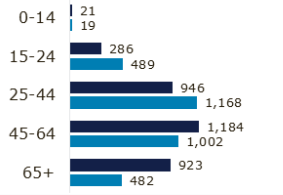
2023 Age-adjusted rates per 100,000 – Maricopa County PSA

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

Race/Ethnicity



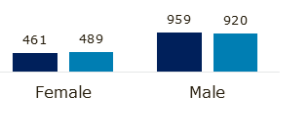
Age (years)



Crude rates for those aged 45-64 yrs were even higher for BTMC PSA:

Higher IP Rates: 1,226

Sex



Rates for males were even higher for the BTMC PSA:

Higher IP Rates: 989

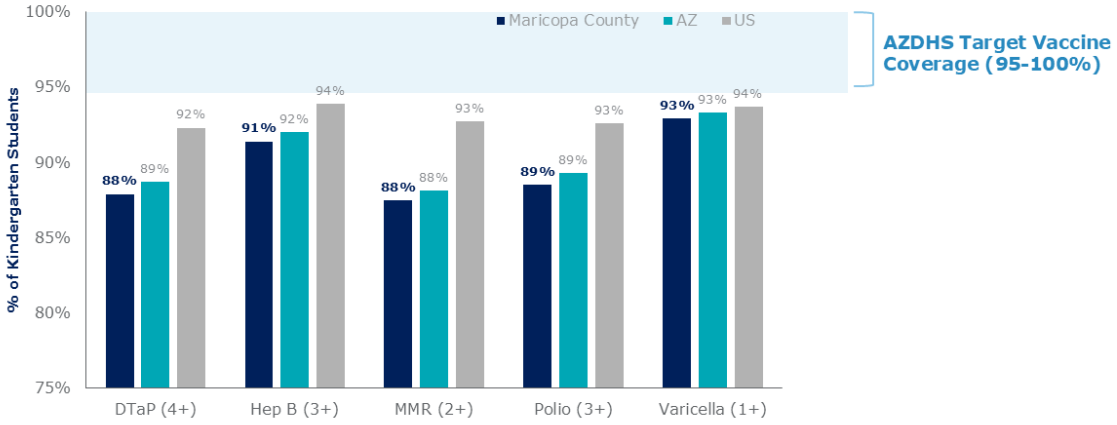
21

Source: *2023 Hospital Discharge Data and Death Data*

Banner Health

Child and Adolescent Health: Vaccinations

Shows total percentage of kindergarten students that are fully immunized with the following vaccines (series length varies)



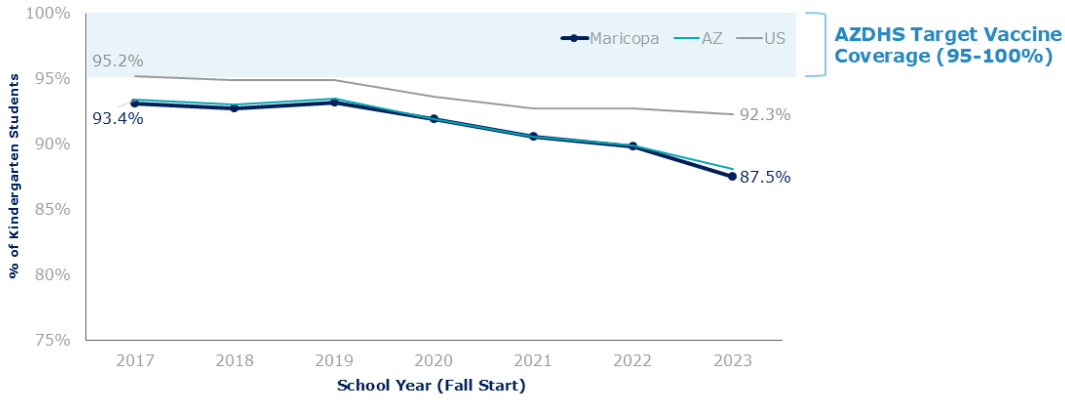
Source: AZDHS Immunization Data Report 2023-2024 School Year. US Data is from the National Center for Immunizations and Respiratory Diseases

Banner Health

Child and Adolescent Health: Vaccinations

Shows trended percentage of kindergarten students that are fully immunized with 2+ MMR vaccines.

MMR Vaccination Rate: Kindergarten Students

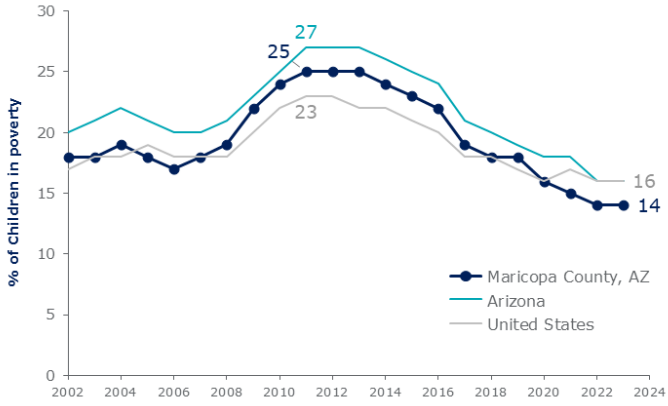


Source: AZDHS Immunization Data Report 2017-2018 to 2023-2024 School Year. US Data is from the National Center for Immunizations and Respiratory Diseases

Banner Health

Child and Adolescent Drivers of Health

Children in Poverty 2006 - 2023



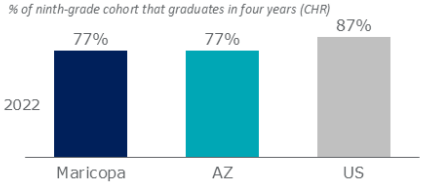
Preschool-Age Children Enrolled in School

35%
Children ages 3-4
Arizona: 35.7%

Source: US Census Bureau ACS 5-year 2019-2023

High School Graduation Rate

% of ninth-grade cohort that graduates in four years (CHR)



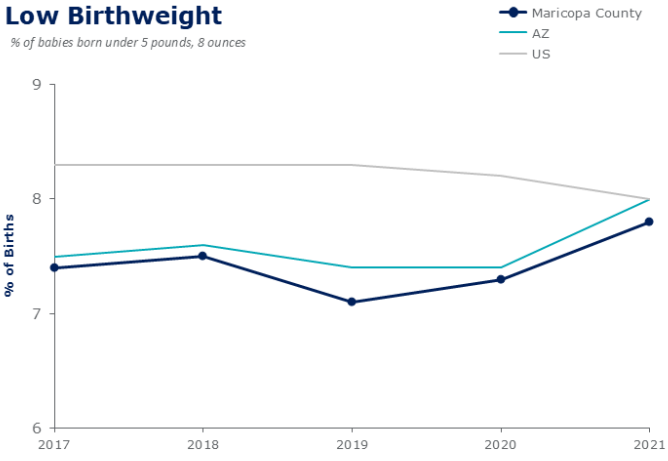
Source: County Health Rankings

Banner Health

Maternal & Infant Health

Low Birthweight

% of babies born under 5 pounds, 8 ounces

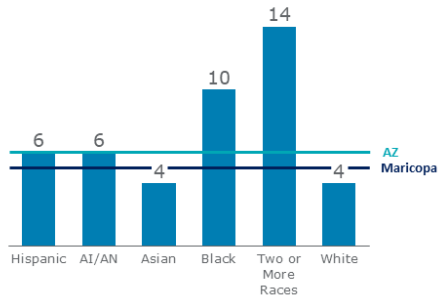


75.6%
% of women 18+ received PAP screening <3 years
Arizona: 74.4%

75.5%
% of women 50-74 had mammogram <2 years
Arizona: 75.1%

Infant Mortality

Number of infant deaths (<1 year) per 1,000 live births



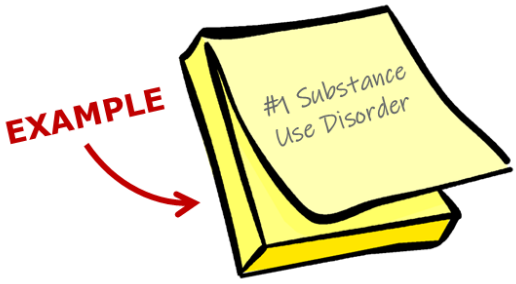
Source: MCDPH CCHNA Population Data Report, 2022 County Health Rankings

Banner Health

Your Turn: Choose Your Top 3

		Total Score
1	Access to Primary Care	**45.8**
2	Mental and Behavioral Health Conditions	**43.4**
3	Access to Mental and Behavioral Health Services	**42.2**
4	Access to Specialty Care	**40.9**
5	Substance Use	**37.2**
*	Child and Adolescent Health	**35.1**
*	Maternal and Infant Health	**32.4**

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



Appendix F: Resources

Exhibit 36: Resources Available to Address Prioritized Needs Identified Through the CHNA

Organization	Physical Address	Phone Number	Website Link
Senior Support Programs			
Benevilla	8133 W Cactus Rd, Peoria AZ 85361	623-679-7126	www.benevilla.org
Foundation for Senior Living	6010 W Northern Ave, Glendale AZ 85301	602-532-2983	www.fsladultdayservices.org
Duet	10000 N 31st ave, Phoenix, AZ 85051	602-285-0543	www.duetaz.org
Area on Aging	2950 N 7th St, Phoenix AZ 85014	602-264-4357	www.aaaphx.org
Valley West Senior Center	8561 N 61st Ave, Glendale AZ 85302	623-931-7436	Ywca Metropolitan Phoenix Senior Program - Senior Center in Glendale
Behavioral Health			
Mercy Care	4750 S 44th Pl, Phoenix, AZ 85040	1-844-534-4673	Home | Mercy Care
Access to Care			
City Peoria Dial a Ride	8401 W Monore, Peoria, AZ 85345	623-773-7435	Dial a Ride | City of Peoria
Glendale Dial a Ride	6210 W Myrtle Ave, Glendale AZ 85301	623-930-3500	Transit Services - City of Glendale
Chronic Disease Management			
MIssion of Mercy	1741 E Morten Ave, Phoenix, AZ 85020	602-486-7798	https://www.amissionofmercy.org/arizona/our-services/#clinic_location

Organization	Physical Address	Phone Number	Website Link
HUG Clinic	555 N 18th St, Phoenix, AZ, 85006	602-268-8511	HUG Clinic | GateWay Community College
Adelante Health Care	9610 N Metro Parkway West, Phoenix, AZ 85051	877-809-5092	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			
Foundation for Senior Living	1201 E Thomas Rd, Phoenix, AZ 85014	623-979-3911x405	FSL | Affordable Senior Housing & Care Services Phoenix
Circle the City	210 S. 12th Ave, Phoenix, AZ 85007	602-254-4282	Healthcare services for the homeless | Circle the City
Peoria Community Assistance Program	9875 N 95th Ave, Peoria, AZ 85345	623-773-7070	Community Assistance | City of Peoria
Glendale Community Assistance	5850 W Glendale Ave, AZ 85301	623-930-2854	Housing Stability Services - City of Glendale
Glendale Community Housing Services	6842 N 61st ave, Glendale AZ 85301	623-930-2180	www.glendaleaz.com
Contact Shelter Hotline	200 W Washington, Phoenix, AZ 85003	602-263-8900	www.phoenix.gov
Food Insecurity			
Desert Mission	9229 N 4th St, Phoenix, AZ 85020	602-870-6062	HonorHealth Desert Mission - Phoenix, AZ
St Marys Food Bank	3131 W Thomas Rd. Phoenix, AZ 85017	602-242-3663	www.firstfoodbank.org

Appendix G: Bibliography

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