

**2013 Community Health Needs Assessment  
Scottsdale Healthcare  
Thompson Peak Hospital**



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## OVERVIEW AND BACKGROUND

Scottsdale Healthcare (SHC) has completed this community health needs assessment study in an effort to identify the unmet health care needs within the Thompson Peak Hospital (Thompson Peak) Service Area. The purpose of this report is to provide findings and recommendations for prioritizing community health needs as a basis for developing a SHC system-wide implementation plan to meet the needs of the community.

## STUDY OBJECTIVES

The overall goal of this study is to identify the unmet health needs for those who live in the Thompson Peak Service Area. In order to achieve this goal, data collection and research were focused around five specific objectives:

- To understand the demographic make-up of the Thompson Peak Service Area.
- To understand the health and wellness issues facing the Thompson Peak Service Area residents.
- To understand the healthcare issues from the perspective of healthcare leaders in the community.
- To understand the healthcare habits, attitudes, and needs of the community.
- To understand ED and hospital utilization, mortality rate, and disease prevalence of the community.

## METHODOLOGY

The Community Health Needs Assessment (CHNA) process used both quantitative and qualitative research strategies. The investigation involved analysis and reporting from secondary data sources as well as three different approaches to primary data collection:

### Primary Data Sources

1. Focus group interviews, 2011
2. Household telephone survey, 2011
3. Community leader interviews, 2011

### Secondary Data Sources

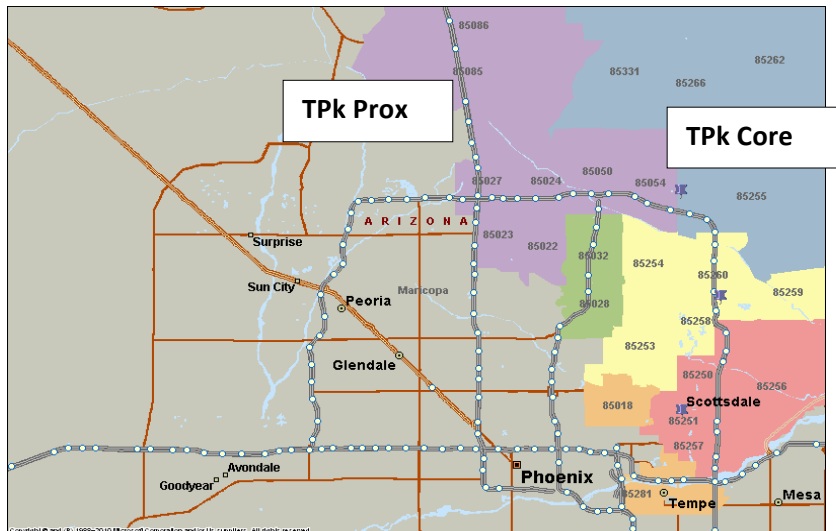
1. Demographic data, 2011
2. Community Vital Statistics, Arizona, 2010
3. Health Status Report for Cities and Towns in Maricopa County, 2007-2010
4. Arizona Health Survey Data, 2010
5. Hospitalization and ED Data, 2009-2011

## STUDY AREA

The study area consists of the ZIP codes that make up the Thompson Peak core and proximate Service Area as displayed in Table 1 and geographic area displayed in Figure 1.

**Table 1** Study Area ZIP Codes

Service Area (Core and Proximate)	ZIP Codes
Thompson Peak	85255, 85262, 85266, 85331, 85050, 85054, 85022, 85023, 85024, 85027, 85085, and 85086

**Figure 1** The Thompson Peak Service Area's Geography


## KEY FINDINGS

The ultimate goal of not-for-profit health care organizations is to improve the health of the communities they serve. The findings of this report draw attention to five important themes that affect the health of the Thompson Peak Service Area:

- 1. Mortality rate is higher in the City of Scottsdale versus other cities in Maricopa County (except Sun City and Sun City West)**
  - Next to Sun City & Sun City West, the City of Scottsdale's overall crude death rate is the highest in Maricopa County. The crude death rate equates to the total number of deaths per year per 100,000 people and is not adjusted for age.
  - The City of Scottsdale has the second highest percentage of population 65 years old and older in Maricopa County. Areas with older populations generally have higher rates of death from cancers, cardiovascular, and heart disease resulting in higher total death rates.
  - The City of Scottsdale's rate of death due to cancer, diabetes, Alzheimer's, cardiovascular diseases, influenza and pneumonia, and chronic lower respiratory are higher than Maricopa County, Arizona, and US rates.
- 2. The entire SHC Service Area (Thompson Peak Service Area sampling size is too small to be reportable) has a higher prevalence of diabetes, high blood pressure, and heart disease than both Maricopa County and Arizona.**
  - Results from the Arizona Health Survey show that SHC Service Area has a higher percentage of adults who reported yes when asked if their doctor diagnosed them with diabetes, high blood pressure, and heart disease than Maricopa County and Arizona.

3. **More than 50% of the entire SHC Service Area (Thompson Peak Service Area sampling size is too small to be reportable) residents are overweight or obese. The SHC Service Area mean value of BMI is 26.8 kg/m<sup>2</sup> which is defined as overweight.**
4. **Social determinants that define the Thompson Peak Service Area priority populations include age, income, insurance coverage, and employment status. Data show that priority populations have difficulty accessing quality care in a timely manner and exhibit poor health-related behaviors.**
  - Survey results show that individuals who fall in the younger age group, lower income level, or lack proper insurance coverage are more likely to:
 

<ul style="list-style-type: none"> <li>▪ Not have a PCP</li> <li>▪ Not have regular checkups</li> <li>▪ Have difficulty receiving a health service</li> <li>▪ Use the ED/Urgent Care for care</li> <li>▪ Have difficulty affording a medication prescribed or recommended to them and will either find a way to pay for it or not take the medication</li> <li>▪ Not be able to afford to eat balanced meals</li> <li>▪ Not exercise at all</li> <li>▪ Sleep less than 7 hours</li> <li>▪ Use tobacco</li> </ul>	<ul style="list-style-type: none"> <li>▪ Indicate stress and depression kept them from doing usual activities such as self-care, work or recreation put off dental care</li> <li>▪ Have difficulty figuring out how to find the right doctors to address their medical needs</li> <li>▪ Put off medical treatment</li> <li>▪ Have poor perception of overall health</li> <li>▪ Have had a physician tell them they need to lose weight</li> </ul>
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5. **Community leader interviews emphasize the need for preventive healthcare, reducing obesity, early detection of autism, elderly care, access to quality care for developmentally disabled children, and access to quality care for children from lower income backgrounds.**

## CONCLUSION

Following the CHNA, a Steering Committee was formed to respond to each of the community concerns identified in the assessment. The Committee reviewed and discussed the findings to select priority needs. Criteria that were used to select priority needs include the magnitude of the problem, the severity of the problem, the impact of the problem on vulnerable populations, the importance of the problem in the community, feasibility, and consequences of inaction. Through this process the Committee identified five Focus Areas:

1. Cardiovascular Disease
2. Heart Failure
3. Diabetes
4. Obesity
5. Cancer

As for the rest of the community concerns identified in the assessment (Alzheimer's disease, influenza and pneumonia, chronic lower respiratory disease, suicides, dehydration, urinary tract infections, and autism) that did not make it to the top five Focus Areas, the CHNA Steering Committee, nonetheless, acknowledges the importance of those other needs and plans to collaborate with community partners



to address them. In addition, there are areas that SHC is currently working on and plans to continue these efforts because they serve a great value to the community. These areas include childhood immunization, children with disabilities, and dental care.

The CHNA and five Focus Areas were also presented to the Community Stewardship Advisory Council to review and approve. With the five Focus Areas identified, the next steps are to develop implementation strategies to effectively improve the health of the community.



## **INTRODUCTION**

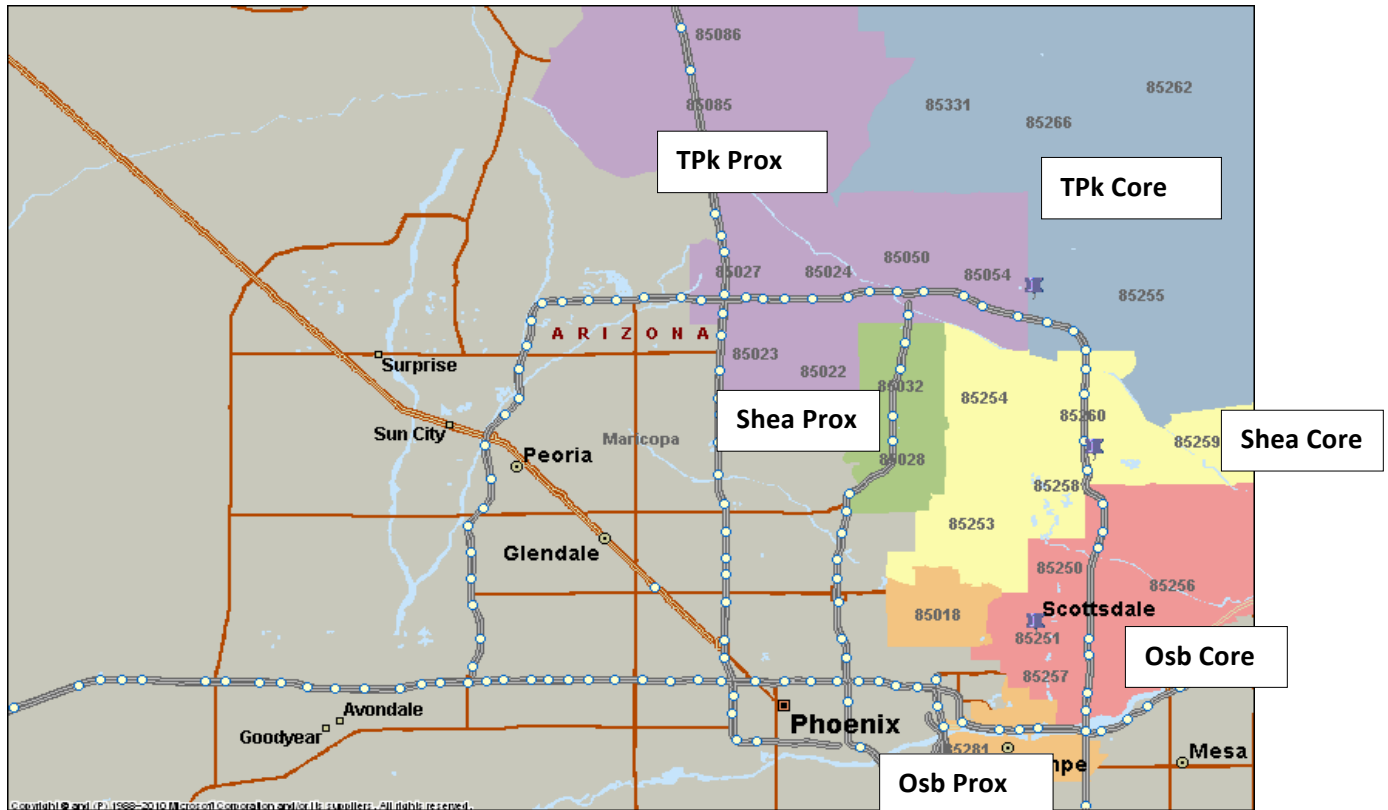
Scottsdale Healthcare (SHC) is a not-for-profit organization led by a volunteer board of directors from the local community. Recognized as one of Maricopa County's leading health care facilities dedicated to meeting the needs of those living in the community, SHC has a mission to provide the highest quality and most compassionate care for all individuals. SHC was founded in 1962 and today serves the entire Northeast Valley and beyond through two comprehensive medical centers (Osborn and Shea), one hospital (Thompson Peak) and one surgical specialty center (Greenbaum). Among the services offered by SHC are hospital based medical services and programs, outpatient surgery centers, home health services, and a wide range of community health education and outreach services. One way SHC fulfills its mission of providing quality and compassionate care to all individuals in the community is through the Community Health Services Department by providing strategies and programs that are adapted to meet the needs of the community. Also SHC collaborates with the Neighborhood Outreach Access to Health (NOAH) to ensure that programs such as prevention of medical problems and promoting health by offering well-care visits, immunizations, prenatal care, dental care and medical management of chronic diseases reach the uninsured and underinsured.

Thompson Peak is a 64-bed community medical-surgical hospital providing emergency, cardiovascular, orthopedic and oncology services. It is home to one of three hospitals in SHC and is located in the northernmost part of the SHC Service Area. SHC has completed this community health needs assessment study, in an effort to identify the unmet health care needs within the Thompson Peak Service Area. The purpose of this report is to provide findings and recommendations for prioritizing community health needs as a basis for developing a SHC system-wide implementation plan to meet the needs of the community. As stated by the Community Preventive Services Task Force, "It has become clear that critical population health improvements depend not just on quality medical care but on effective community preventive services reaching Americans where they live, learn, work, worship, and play" (1). Therefore the goal of this process is to identify effective ways to improve the overall health of the community.

## **BACKGROUND**

Thompson Peak is recognized for the care and services it provides to residents throughout its core service area in Scottsdale and Cave Creek (zip codes 85255, 85262, 85266, and 85331) and proximate service area that extends out to Phoenix (zip codes 85050, 85054, 85022, 85023, 85024, 85027, 85085, and 85086). Refer to Figure 1. This geographic area is SHC largest core and proximate service area and covers a wide range of diverse socio-economic groups and living conditions. Given the need to examine health information on a number of levels, data, when available, were collected and analyzed at three primary levels: 1) at the ZIP code level within the study area (Thompson Peak Service Area and SHC Service Area) 2) Maricopa County, and 3) Arizona. Where ZIP code data was not available, all efforts were put into finding comparable data such as city level data to use in place of SHC data. While this is not a perfect replacement, it gives us an estimated idea of the health conditions of the SHC Service Area.

**Figure 1** SHC Service Areas Geography



## OBJECTIVES

The overall goal of this study is to identify the unmet health needs for those who live in the Thompson Peak Service Area. In order to achieve this goal, data collection and research were focused around five specific objectives:

- To understand the demographic make-up of the Thompson Peak Service Area.
- To understand the health and wellness issues facing Thompson Peak Service Area residents.
- To understand the healthcare issues from the perspective of healthcare leaders in the community.
- To understand the healthcare habits, attitudes, and needs of the community.
- To understand ED and hospital utilization, mortality rate, and disease prevalence of the community.

## METHODOLOGY

The Community Health Needs Assessment (CHNA) process used both quantitative and qualitative research strategies. The investigation involved analysis and reporting from secondary data sources as well as three different approaches to primary data collection:



## Primary Data Sources

The core focus of the CHNA was to understand the unmet health needs of the community members in the region. These include many distinct groups such as low or limited income residents, uninsured and underinsured individuals and families, immigrants with limited or no English language ability. The intention was to obtain input from community members and leaders of SHC.

### 1. Focus group interviews, 2011

SHC commissioned WestGroup Research to conduct two 2-hour qualitative focus groups to discuss health and wellness issues facing SHC Service Area residents. As it is qualitative in nature, findings were not used to reflect the opinions of the greater Scottsdale population. The findings were used as directional information to understanding perceptions present in the community in order to design the quantitative telephone survey. (See Appendix A for questions asked during the interview and results.)

### 2. Household telephone survey, 2011

WestGroup Research conducted 403 telephone surveys with community residents living in the Thompson Peak Service Area. Residents were randomly selected from a random digit dial sample of phone numbers within the Thompson Peak Service Area zip codes. The overall sample has a margin of error +/- 5% at the 95% level of confidence. (See Appendix B for questions asked during the interview and demographic makeup.)

Data was viewed through several different demographic 'data cuts' to identify, from a macro perspective, which issues may affect certain demographics significantly more. These 'cuts' include the following demographics and subgroups:

- Gender (male, female)
- Age (18 to 34, 35-54, 55 and older)
- Income (<\$40,000, \$40,000-\$80,000, and > \$80,000)
- Respondents with children under the age of 18 living in the home vs. those without
- Employment status (full time, part time, retired, house-spouse, student, unemployed)
- Health insurance status (private, Medicare, AHCCCS/Medicaid, self-insured, military, none)
- Respondents who did have difficulty receiving a healthcare service in the last 12 months, vs. those who did not

When the phrase "more likely" or "less likely" is used, this implies statistical significance at the 95% confidence level in order to call out only statistically meaningful differences.

### 3. Community leader interviews, 2011

WestGroup Research conducted seventeen qualitative interviews with a variety of healthcare leaders in the Valley, many of whom work primarily within the Scottsdale community. Interviews were generally around 15 minutes long and designed to gather in-depth perspectives



about key issues facing Valley residents, and suggestions for SHC. As the research is qualitative in nature, the findings could not be used to represent the views of a larger population.

Respondents represented several organizations, including:

- Maricopa County Department of Public Health
- Arizona Department of Health Services
- American Heart Association—Arizona Branch
- Autism Speaks
- NE Valley / Scottsdale YMCA
- Scottsdale Community College
- City of Scottsdale, including Scottsdale Fire Department and Scottsdale Police Department
- Area Agency on Aging
- Balsz Unified School District
- Southwest Human Development
- Scottsdale Training & Rehabilitation Services (STARS)
- Beatitudes Campus Assisted Living
- Salt River Indian Community
- Coyote Crisis Collaborative
- Scottsdale Unified School District

### **Secondary Data Sources**

#### **2. Demographic data**

Demographic data for the year 2011 for the Thompson Peak Service Area, the entire SHC Service Area, County and State data were provided by the SHC Business Strategic Department and obtained from Claritas Inc. 2011 and Thomson Reuters' Demographics Expert 2.7.

#### **3. Community Vital Statistics, Arizona, 2010 (2)**

Community Vital Statistics, Arizona, 2010 provides public data at the community-level on live births and deaths in Arizona 2010. Information on live births and deaths is compiled from the original documents (i.e., certificates of live birth and certificates of death) filed with the Arizona Department of Health Services. As noted in the report, many percentages or rates calculated from the data would be based on a small number of events. The rates based on fewer than 10 events are not statistically reliable. Caution must be exercised when interpreting data based on small number of events and/or events occurring in small populations. Data is reported for the City of Scottsdale, Maricopa County and Arizona. Because ZIP code level data is not available, City of Scottsdale data is used as a proxy for SHC Service Area to get a sense for the health issues in the region. City of Scottsdale's ZIP codes cover a large portion of SHC Service Area (11 out of 15 City of Scottsdale ZIP codes are in the SHC core Service Area).

4. Health Status Report for Cities and Towns in Maricopa County, 2007-2010 (3)

This report was prepared by the Maricopa County Department of Public Health, Office of Epidemiology on health status for cities and towns in Maricopa County. The population estimates used in this report are from the U.S. Census and are based on the Census 2000 population. It includes diseases and health indicators as well as information on the size and age distribution of the population. All city, town, Maricopa County and Arizona health data in this report are for calendar years 2007, 2008, 2009, 2010. Population estimates may underestimate or overestimate the true population due to migration. Therefore, the true burden of disease may be underestimated or overestimated. Again, data is reported for the City of Scottsdale, Maricopa County and Arizona.

5. Arizona Health Survey Data (4)

The Arizona Health Survey (AHS), sponsored by St. Luke's Health Initiatives, is a population-based random-digit dial telephone survey of Arizona's population conducted biennially. Data in this report contain results from surveys conducted in the first half of 2010. It was designed to collect data on individual indicators of health status, health care access, health-related behaviors and various demographic and social/environmental factors related to health. It is a comprehensive research effort developed to foster new insights and deepen our understanding of health and well-being in Arizona with interviews representing 8,200 adults and 2,100 children in 2010. AHS is a telephone survey of adults in households with landline telephone numbers using a random digit dialing (RDD) sample. The sample was geographically stratified to represent Maricopa County and the remainder of Arizona. In Maricopa County, children and adolescents were also sampled when present in a household. All data were collected using a computer-assisted telephone interviewing (CATI) system, with interviewing in English and Spanish. The data were weighted to represent the Arizona household population.

6. Hospitalization and ED Data

SHC holds state-specific hospital admissions data via the WIN-Stat Analyst software. Hospital admissions data was obtainable for each SHC hospital as well as Maricopa County and Arizona. Emergency department (ED) data was only available for SHC facilities. Following the Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicators (PQIs) were analyzed using hospitalization and ED data (5).

AHRQ is 1 of 12 agencies within the Department of Health and Human Service. AHRQ supports research that helps organization make more informed decisions and improves quality of health care services. The Quality Indicators (QI) are measures of health care quality that make use of the readily available hospital inpatient administrative data. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time. One AHRQ QI module that is reported here is the Prevention Quality Indicators (PQIs) which identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care or for which early



intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community.

The PQIs stated in this report include adult asthma, pediatric asthma, heart failure, COPD, dehydration, urinary tract infection, long-term complications of diabetes, short-term complications of diabetes, uncontrolled diabetes, and bacterial pneumonia for people who live in the Thompson Peak Service Area admitted to any facilities in Arizona from 2009 to 2011. These rates are age adjusted using the 2000 US standard population in order to compare them to the Osborn Service Area, the Shea Service Area, Maricopa County, and Arizona. The population data used to calculate rate is from Claritas Inc. 2011 and Thomson Reuter’s Demographics Expert 2.7, as reported in the demographic section of this report. Crudes rates are also reported for the Thompson Peak Service Area residents to understand the magnitude of the problem for each measure. All rates represent cases per 10,000 of population.

**FINDINGS**

**Demographics**

Population

The tables below display the demographics of the Thompson Peak Service Area compared to the SHC Service Area, Maricopa County and Arizona for the year 2011.

**Table 1** Total Population and Percent Growth of the Thompson Peak Service Area and Selected Geographic Areas

<b>Geographic Area</b>	<b>Population (2011)</b>	<b>Population Estimate (2016)</b>	<b>% Change</b>
Thompson Peak Service Area	325,227	368,872	13.4%
SHC Service Area	783,927	861,543	9.9%
Maricopa County	3,991,065	4,430,550	11.0%
Arizona	6,544,462	7,238,005	10.6%

The Thompson Peak Service Area population is projected to grow at a faster pace than the SHC Service Area, Maricopa County and Arizona.

**Table 2** Percent Males, Females, and Females in Child Bearing Age of the Thompson Peak Service Area and Selected Geographic Areas

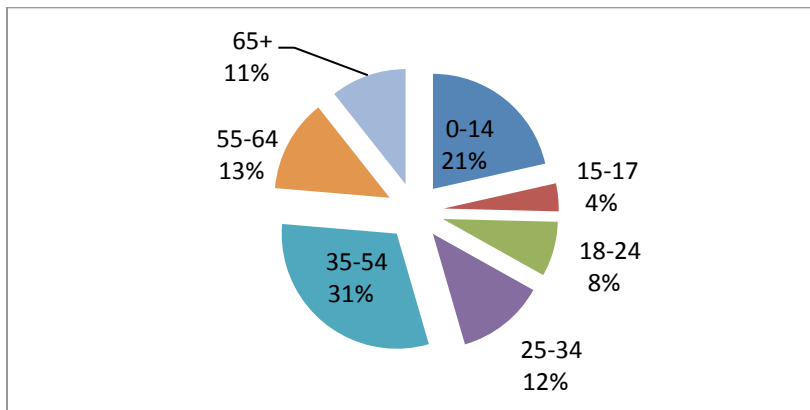
	Thompson Peak Service Area (N = 325,227)	SHC Service Area (N = 783,927)	Maricopa County (N = 3,991,065)	Arizona (N=6,544,462)
Total Male Population	50%	50%	50%	50%
Total Female Population	50%	50%	50%	50%
Females, Child Bearing Age (15-44)	19%	20%	20%	19%

The Thompson Peak Service Area percent male and female population is about 50-50; the same as the other geographic areas. The Thompson Peak Service Area percent female in child bearing age is about the same as the other geographic areas.

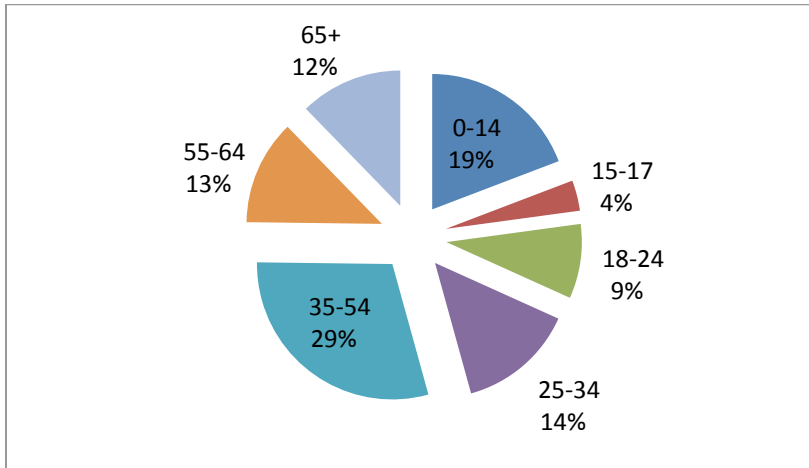
#### Age

The Thompson Peak Service Area population over the age of 65 is about the same compared to the SHC Service Area and Maricopa County but slightly less than Arizona. The following figures show the age distribution for the Thompson Peak Service Area and selected geographic areas. In 2011, 11% of the Thompson Peak Service Area was over the age of 65 compared to 12% in the SHC Service Area, 11% in Maricopa County and 13% in Arizona. Twenty one percent was under the age of 15 in the Thompson Peak Service Area compared to 19% in the SHC Service Area, 24% in Maricopa County, and 22% in Arizona.

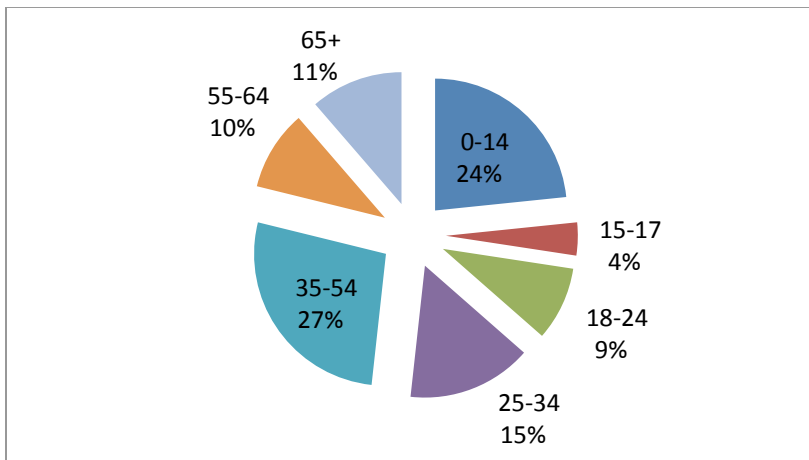
**Figure 2** Age Distribution, Thompson Peak Service Area, 2011 (N=325,227)



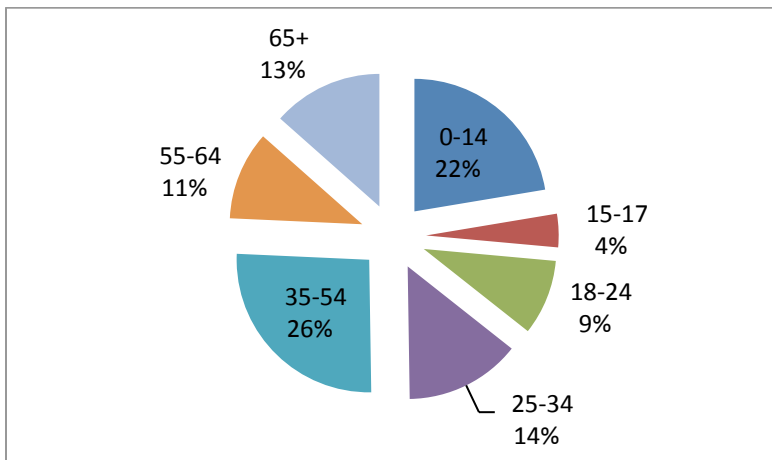
**Figure 3** Age Distribution, SHC Service Area, 2011 (N=783,927)



**Figure 4** Age Distribution, Maricopa County, 2011 (N=3,991,065)



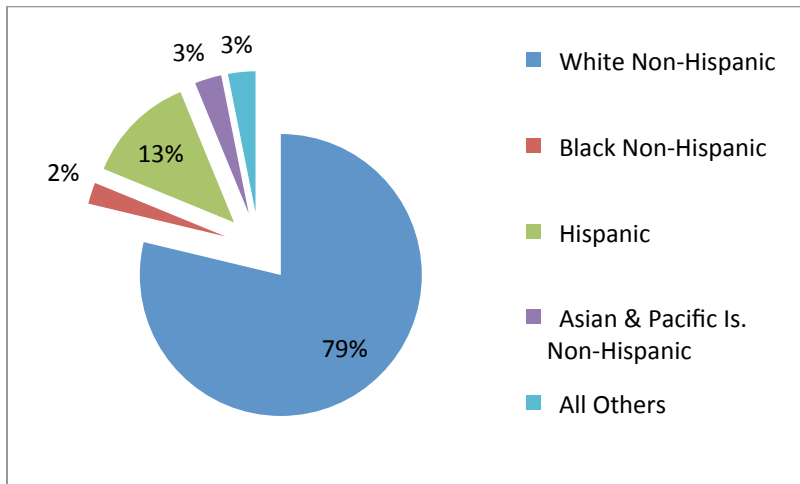
**Figure 5** Age Distribution, Arizona, 2011 (N=6,544,462)



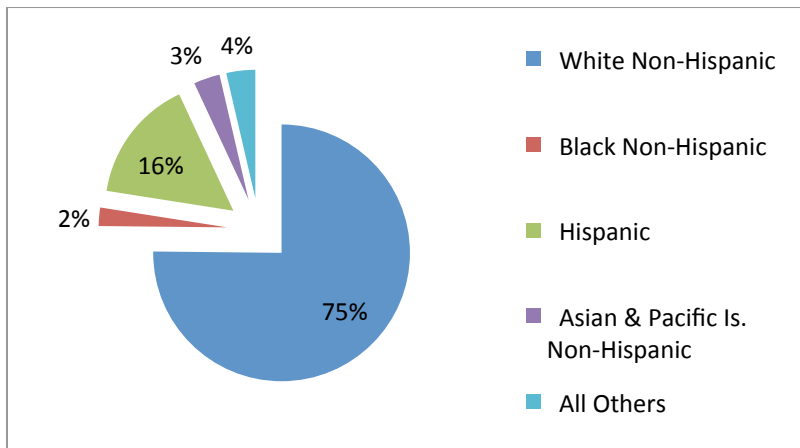
Race/Ethnicity

The Thompson Peak Service Area White Non-Hispanic population is 79% compared to 75% in the SHC Service Area, 56% in Maricopa County, and 56% in Arizona. The following figures display the racial and ethnicity distribution of the Thompson Peak Service Area and selected geographic areas.

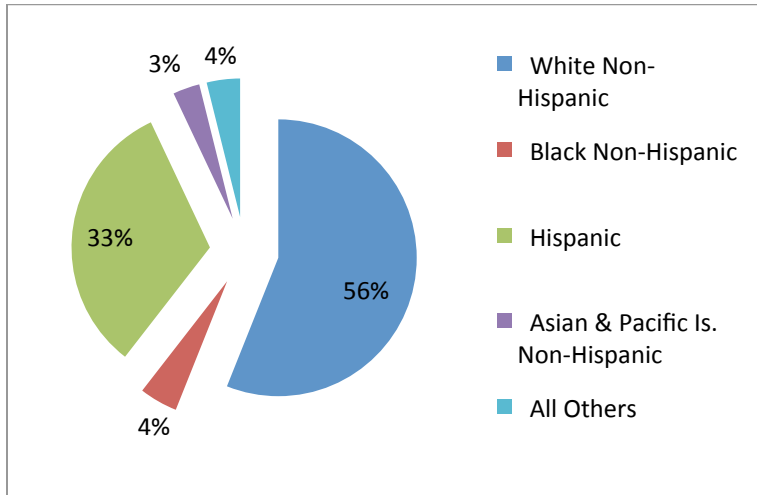
**Figure 6** Thompson Peak Service Area Population by Race, 2011 (N=325,227)



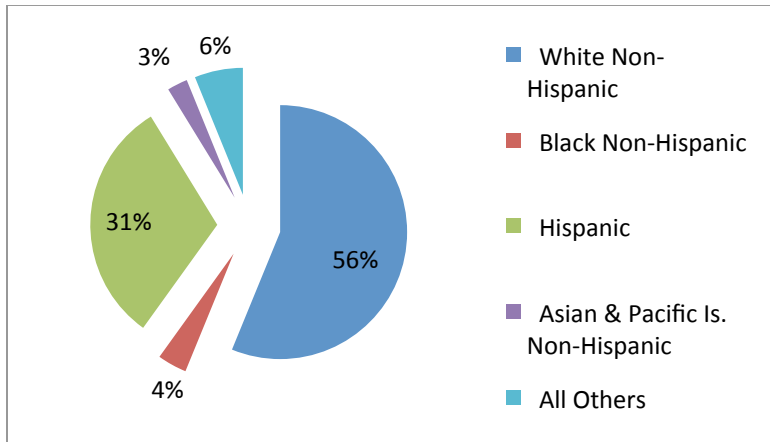
**Figure 7** SHC Service Area Population by Race, 2011 (N=783,927)



**Figure 8** Maricopa County Population by Race, 2011 (N=3,991,065)



**Figure 9** Arizona Population by Race, 2011 (N=6,544,462)



### Education Level

Table 3 displays the education level for adults 25 years and older for the Thompson Peak Service Area and selected geographic areas. Compared to Maricopa County, and Arizona, the Thompson Peak Service Area has a higher percentage of adults who have a Bachelor's degree or greater but slightly lower than the SHC Service Area as a whole.



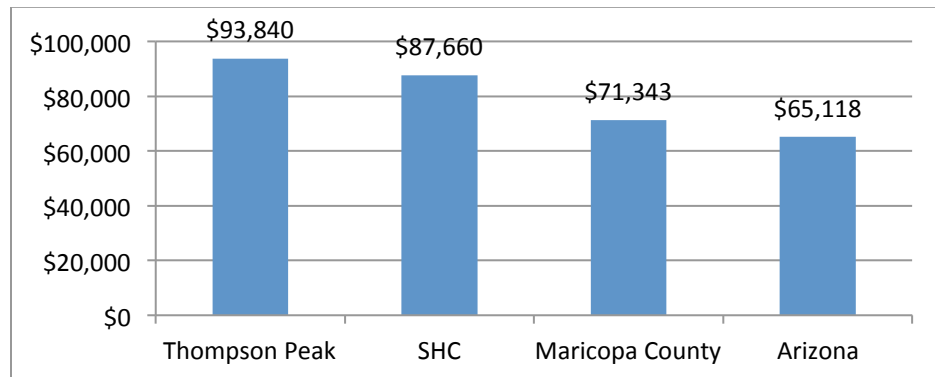
**Table 3** 2011 Adult Education Level Distributions for the Thompson Peak Service Area and Selected Geographic Areas

<b>2011 Adult Education Level Distribution</b>	<b>Thompson Peak Service Area (N=325,227)</b>	<b>SHC Service Area (N=535,054)</b>	<b>Maricopa County (N = 2,535,796)</b>	<b>Arizona (N=4,212,050)</b>
Less than High School	2%	3%	7%	7%
Some High School	5%	5%	8%	9%
High School Degree	22%	20%	24%	25%
Some College/Assoc. Degree	34%	32%	32%	33%
Bachelor's Degree or Greater	37%	40%	28%	26%

#### Household Income Distribution

The average household incomes for the Thompson Peak Service Area is \$93,840—higher than the SHC Service Area, Maricopa County and Arizona’s average household income, as illustrated by in Figure 10.

**Figure 10** Average Household Income for the Thompson Peak Service Area and selected geographic areas.



The income distribution for the Thompson Peak Service Area and selected geographic areas is displayed in table 4. Note that the Thompson Peak Service Area has the highest percentage of households earning over \$100,000 per year compared to the other geographic areas. The largest distribution of household income for the Thompson Peak Service Area is also over \$100,000 per year.

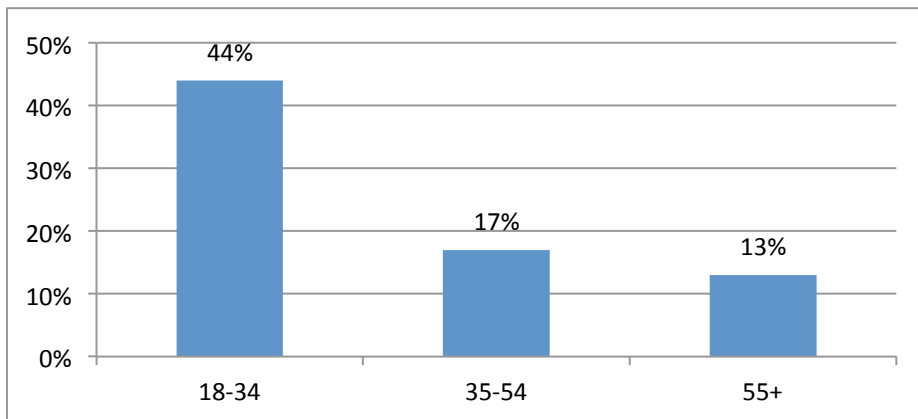
**Table 4** 2011 Household Income Distributions for the Thompson Peak Service Area and Selected Geographic Areas.

2011 Household Income	Thompson Peak Service Area (N=126,394)	SHC Service Area (N = 316,419)	Maricopa County (N = 1,411,729)	Arizona (N=2,374,853)
<\$15K	6%	8%	10%	12%
\$15-25K	7%	8%	10%	11%
\$25-50K	22%	24%	27%	29%
\$50-75K	19%	19%	21%	20%
\$75-100K	14%	13%	13%	12%
Over \$100K	31%	27%	20%	17%

### Telephone Surveys

Approximately 83% of the Thompson Peak Service Area residents indicated they have a primary care doctor (PCP). Groups more likely to indicate that they do not have a primary care doctor include males, those ages 18 to 34, those with children under the age of 18 in the home, and those with no health insurance. Figure 11 illustrates the percentage of residents in each age group who indicated that they do not have a PCP. About 44% of those in the age group 18-34 indicated that they do not have a PCP compared to 17% in the age group 35-54 and 13% in the age group 55+. And 48% of those who do not have insurance indicated that they do not have a PCP compared to a range of 12% to 14% who have other insurance sub-groups.

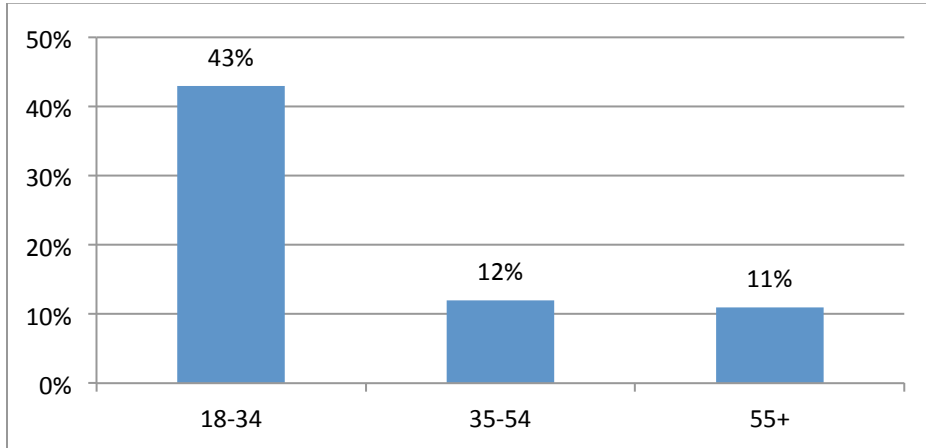
**Figure 11** Percent of Residents in Each Age Group Who Indicated That They Do Not Have a Primary Care Doctor



Among those with primary care doctors, 86% indicated that they go to the doctor for regular checkups. Groups more likely to indicate that they do not go for regular checkups include those ages 18 to 34 and AHCCCS/Medicaid recipients. Figure 12 shows that those in the age group of 18-54 do not go for regular checkups as often as age groups 35-54 and 55+. One hundred percent of AHCCCS/Medicaid recipients

indicated that they do not go for regular checkups compared to a range of 64% to 91% with other insurance sub-groups.

**Figure 12** Percent of Residents in Each Age Group Who Do Not Go for Regular Checkups.



Survey results show that only 8% of the Thompson Peak Service Area residents indicated that they had encountered difficulty receiving a health service in the last 12 months. Of those who indicated they had encountered difficulty, approximately 50% attributed this to lack of proper insurance coverage. Groups more likely to indicate having difficulty receiving health services are females and those earning less than \$40k per year vs. those earning \$80 or more (18% vs. 5%).

Approximately 22% of the Thompson Peak Service Area residents indicated having used an ER/Urgent Care Clinic in the last 12 months for a problem that more commonly is treated in a doctor's office. There were no statistically meaningful differences among the different demographic groups.

Two thirds (67%) of the Thompson Peak Service Area residents indicated that they take at least one prescription drug. Approximately 17% of them indicated having difficulty affording a medication prescribed or recommended to them. Table 5 shows the course of actions taken by those who have difficulty affording the medication. The majority indicated that they find a way to pay for it or do not take the medication at all. Groups more likely to indicate having had difficulty in this regard include those earning less than \$80,000 per year, those who indicated they did have difficult receiving a health service in the last 12 months, those who are unemployed, and those with no health insurance.

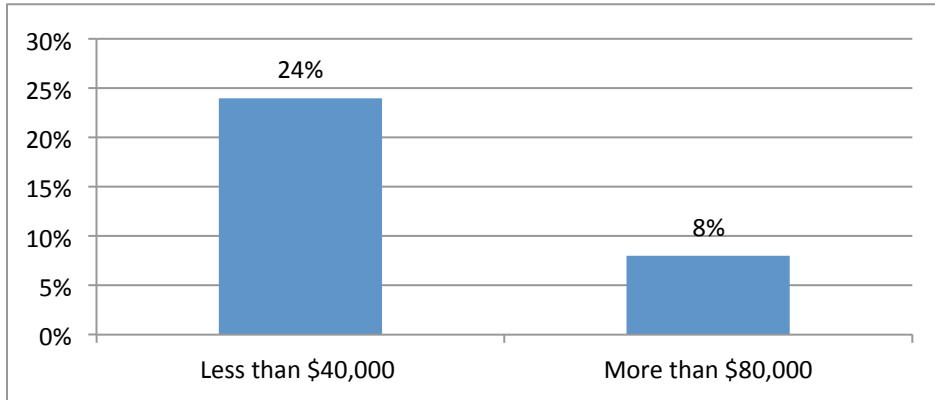
**Table 5** Actions Taken by the Thompson Peak Service Area residents Who Have Difficulty Affording Medications

	<b>Thompson Peak Service Area (N=83)</b>
Find a way to pay for it/do what it takes to get the money/credit cards	30%
Not take the medication	30%
Ask the doctor for a less expensive option	14%
Ask for generic	10%
Take it less often than prescribed	9%
Discount cards/other coupons	7%
Substitute an over-the-counter medication	4%
Ask for free samples	4%
Buy them in a different country/Mexico/Canada	3%
Cut back on other expenses/bills/food/utilities	1%
Attempt to get insurance to pay	1%
Find medication discounts online	1%
Ask the drug companies for help/assistance program	1%
Other	4%
Don't Know	1

Approximately 13% the Thompson Peak Service Area residents indicated that, in the last 12 months, it was either often or sometimes true that they were unable to afford to eat balanced meals. Groups more likely to select often or sometimes true include those earning less than \$80,000, those with children under the age of 18 in the home, those who indicated they did have difficulty receiving a health service in the last 12 months, those who are unemployed, and those receiving AHCCCS/Medicaid.

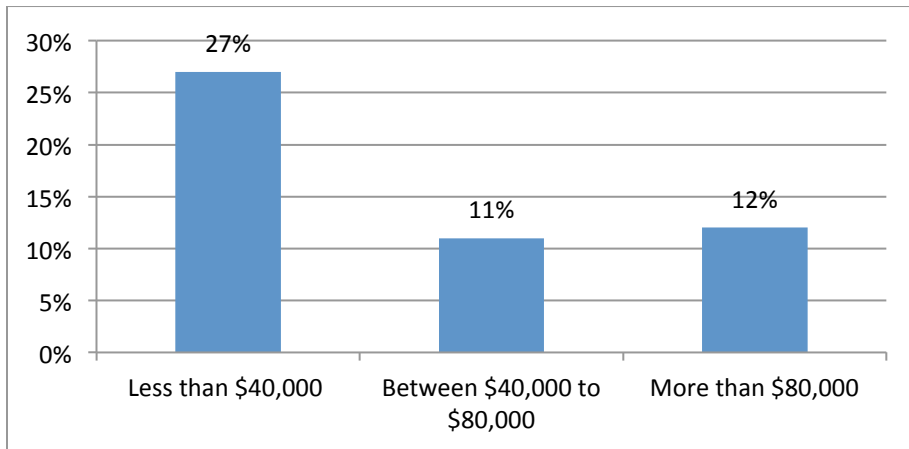
The average time the Thompson Peak Service Area residents indicated is spent exercising each week is 3.6 hours. Approximately 13% indicated that they do not exercise at all during the average week. The group that is more likely to indicate that they do not exercise at is those earning less than \$40,000 per year. Figure 13 shows the percentage of residents who do not exercise at all by income.

**Figure 13** Percent of Residents in Each Income Group Who Do Not Exercise at All



Two thirds (66%) indicated that they sleep seven hours or more on most nights. Approximately 13% indicated that they use tobacco products. Groups more likely to use tobacco products are males, those earning less than \$40,000 per year, those who indicated they did have difficulty receiving a health service in the last 12 months, and AHCCCS/Medicaid recipients. Figure 14 shows percent of tobacco by earning groups.

**Figure 14** Percent of Residents in Each Income Group Who Use Tobacco

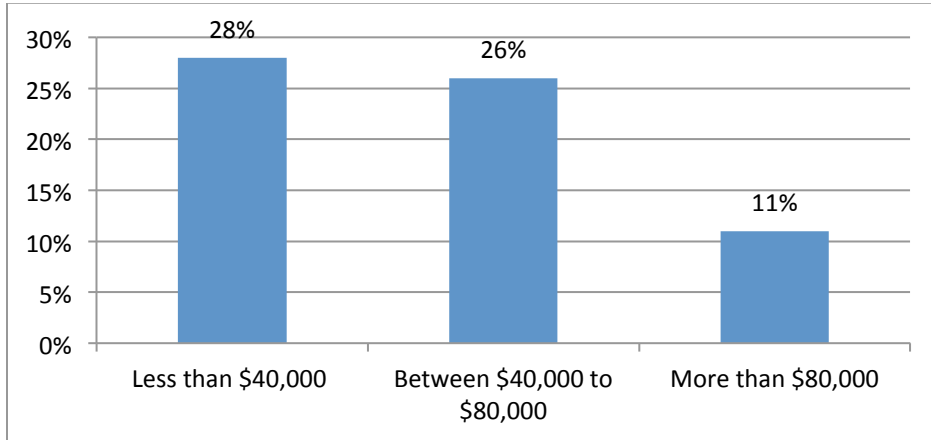


Approximately 16% indicated stress or depression kept them from doing usual activities such as self-care, work or recreation in the last 30 days. Groups more likely to indicate this is the case include females, those earning less than \$40,000 per year, those who indicated they did have difficulty receiving a health service in the last 12 months, those who are unemployed, and AHCCCS/Medicaid recipients .

One in five (19%) indicated that poor physical health kept them from doing usual activities such as self-care, work or recreation in the last 30 days. Groups more likely to indicate this is the case include females, those ages 55 and older, those earning less than \$80,000 per year, those who indicated they did have difficulty receiving a health service in the last 12 months and those who are unemployed.

Figure 15 illustrates the percentage of residents who indicated poor physical health kept them from doing usual activities stratified by earning groups.

**Figure 15** Percent of Residents in Each Income Group Who Indicated Poor Physical Health Kept Them from Doing Usual Activities



Approximately half (45%) reported receiving a flu vaccine in the last 12 months. Groups more likely to indicate that they did not receive a flu vaccine include those under the age of 55, those with children under the age of 18 in the home, and those with no health insurance. Ninety percent of those with no health insurance indicated that they did not receive a flu vaccine.

Among those with children under the age of 18 in their households, approximately 40% of the Thompson Peak Service Area residents indicated that at least one of their children received a flu vaccine in the last 12 months.

The vast majority (97%) of those with children under the age of 18 in the home indicated that their children received all recommended immunizations. Among those with children under the age of 18 in the home, approximately 12% reported that at least one child in the household has special needs such as autism, a physical disability, or something else.

Table 6 lists the aided health issues that affected residents the most (from the highest percentage of often true + sometimes true responses to lowest percentage). Difficulty navigating the rules and regulations of insurance policies was a primary challenge among the Thompson Peak Service Area residents.



**Table 6** Percent of Residents Who Reported Often True or Sometimes True to the Following Aided Health Issues

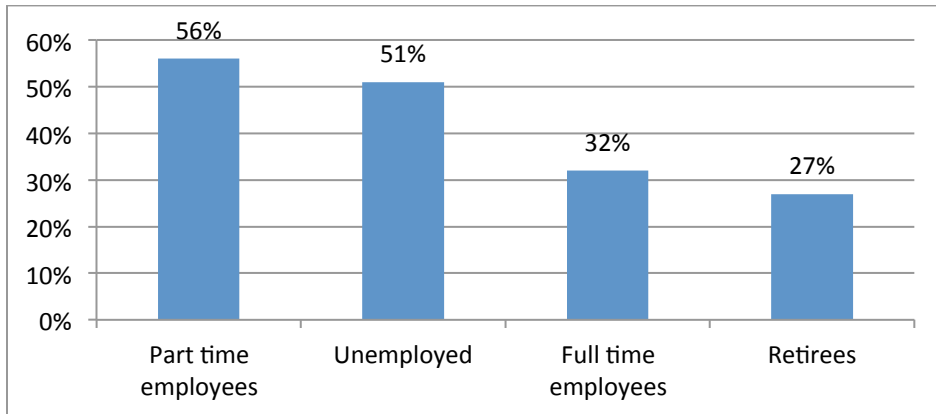
<b>Net: Often True + Sometimes True</b>	<b>Thompson Peak Service Area (N=403)</b>
I/We have difficulty navigating the rules and regulations of my/our health insurance policy	42%
I/We do not get all recommended health screenings	36%
I/We have put off receiving dental care because I/we could not afford it	34%
I/We have difficulty figuring out how to find the right doctors to address my/our medical needs	28%
I/We put off medical treatment because I/we could not afford it	24%
I/We have put off receiving vision care because I/we could not afford it	22%

Groups more likely to indicate they do not get all recommended health screenings are those females, those earning less than \$40,000 per year, those who indicated they did have difficulty receiving a health service in the last 12 months, part time employees, those who are unemployed, and those with no health insurance. Table 7 shows the percentages that do not get health screenings for each group. Note that part time employees and those who are unemployed are more likely not to get health screenings compared to full time employees and retirees (Figure 16).

**Table 7** Percent of Residents in Selected Groups Who Indicated That They Do Not Get Health Screenings

	<b>Do Not Get Health Screenings</b>
Females	40%
Males	29%
	<b>Do Not Get Health Screenings</b>
Less than \$40,000	52%
More than \$80,000	30%
	<b>Do Not Get Health Screenings</b>
Indicated did have difficulty receiving health service	72%
Indicated did not have difficulty receiving health service	33%
	<b>Do Not Get Health Screenings</b>
Part time employees	56%
Unemployed	51%
Full time employees	32%
Retirees	27%
	<b>Do Not Get Health Screenings</b>
No health insurance	72%
Most other insurance sub-groups	32%-44%

**Figure 16** Percent of Residents in Each Employment Group Who Indicated That They Do Not Get Health Screenings



Groups more likely to indicate that they put off dental care are females, those earning less than \$80,000 per year, those with children under the age of 18 in the home, those who indicated having difficulty receiving a health service in the last 12 months, part time employees, those who are unemployed, and those who are AHCCCS/Medicaid recipients. Table 8 shows the percentage that put off dental care for each group.

**Table 8** Percent of Residents in Selected Groups Who Put Off Dental Care

	<b>Put Off Dental Care</b>
Females	38%
Males	26%
<b>Annual Income</b>	<b>Put Off Dental Care</b>
Less than \$40,000	57%
Between \$40,000 to \$80,000	43%
More than \$80,000	22%
	<b>Put Off Dental Care</b>
Those with children under the age of 18 in the home	41%
Those without	30%
	<b>Put Off Dental Care</b>
Indicated did have difficulty receiving health service	81%
Indicated did not have difficulty receiving health service	30%
	<b>Put Off Dental Care</b>
Part-time employees	59%
Those who are unemployed	60%
Most other employment subgroups	24%-29%
	<b>Put Off Dental Care</b>
Those who are AHCCCS/Medicaid recipients or have no health insurance	100%



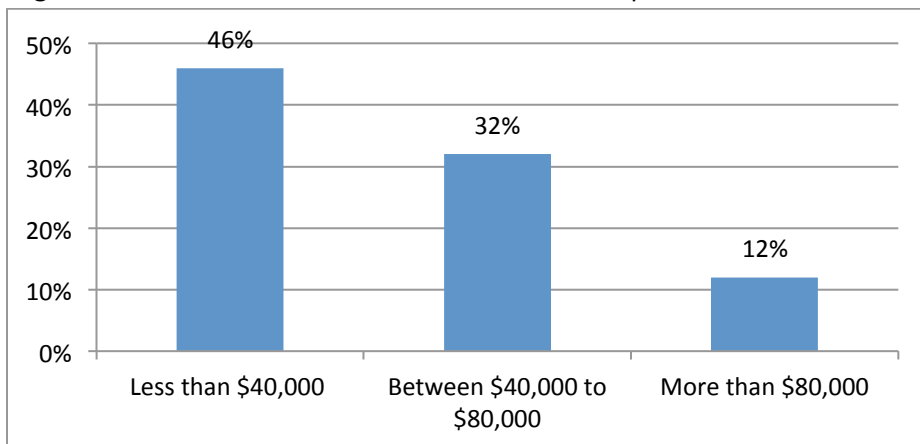
Those with most other insurance subgroups	28% to 76%
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Groups more likely to indicate they put off medical treatment are females, those earning less than \$80,000 per year, those with children under the age of 18 in the homes, those who indicated they did have difficulty receiving a health service in the last 12 months, those who are unemployed, and AHCCCS/Medicaid recipients. Table 9 shows the percentage for each group who put off medical treatment. Figure 17 illustrates the difference by earning groups.

**Table 9** Percent of Residents in Selected Groups Who Put Off Medical Treatment

	<b>Put off Medical Treatment</b>
Females	27%
Males	18%
	<b>Put off Medical Treatment</b>
Unemployed	51%
Most other employment sub-groups	15%-22%
<b>Annual Income</b>	<b>Put off Medical Treatment</b>
Less than \$40,000	46%
Between \$40,000 to \$80,000	32%
More than \$80,000	12%
	<b>Put off Medical Treatment</b>
AHCCCS/Medicaid	88%
No Health Insurance	86%
All other insurance sub-groups	17% to 33%
	<b>Put off Medical Treatment</b>
Indicated did have difficulty receiving health service	69%
Indicated did not have difficulty receiving health service	20%
	<b>Put off Medical Treatment</b>
Those with children under the age of 18 in the home	34%
Those without	20%

**Figure 17** Percent of Residents in Each Income Group Who Put Off Medical Treatment

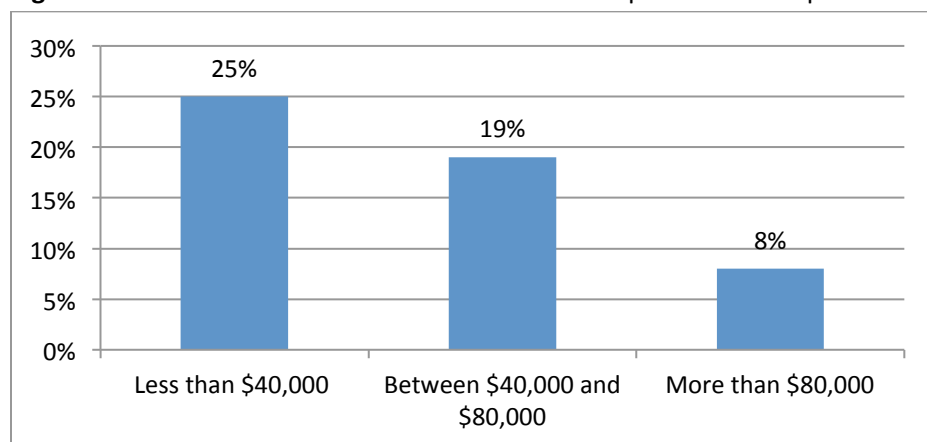


Approximately 63% of the Thompson Peak Service Area residents indicated that their overall health is excellent or very good. Approximately 14% indicated that their overall health was either fair or poor. Groups more likely to select fair or poor include those ages 55 and older, those earning less than \$80,000 per year, those who indicated having difficulty receiving a health service in the last 12 months, and those who are unemployed. Table 10 shows the percentages for each group. Figure 18 illustrates the responses by each income group.

**Table 10** Percent of Residents in Selected Groups Whose Perception of Overall Health is Fair or Poor

	<b>Perception of Overall Health is Fair or Poor</b>
Ages 55 and older	17%
Ages 18 to 34	4%
	<b>Perception of Overall Health is Fair or Poor</b>
Unemployed	32%
Most Other employment sub-groups	7%-12%
<b>Annual Income</b>	<b>Perception of Overall Health is Fair or Poor</b>
Less than \$40,000	25%
Between \$40,000 and \$80,000	19%
More than \$80,000	8%
	<b>Perception of Overall Health is Fair or Poor</b>
Difficulty receiving a health service in the last 12 months	31%
Did not have difficulty receiving a health service in the last 12 months	12%

**Figure 18** Percent of Residents in Each Income Group Whose Perception of Overall Health is Fair or Poor



Just over half (53%) indicated that, in the last 12 months, their physician has told them that their weight is just fine. Approximately 29% indicated that their doctor told them they needed to lose weight. The



groups more likely to indicate having been told by their doctor that they needed to lose is males vs. females (36% vs. 25%)

### **Community Leaders Interviews**

While respondents were diverse in terms of backgrounds and roles within the community, there were a few themes that were repeatedly mentioned in discussions and can be viewed from an overall perspective.

**Partnerships** – the concept of partnership and working together is something many respondents believe to be part and parcel of effectively addressing healthcare needs in the community. Many respondents spontaneously praised SHC as a community leader in this regard, and emphasized strength through partnership as SHC moves forward in 2012 and beyond.

**General Wellness** – The idea of general wellness and preventive healthcare is a big-picture topic that respondents repeatedly mentioned. A few respondents in particular indicated that issues like obesity and its related conditions must receive high priority from the community in the future, given the severe effects on the healthcare system (which look to worsen if not addressed). In terms of Scottsdale’s ability (as a city) to offer residents resources to live healthy lives, many respondents spontaneously indicated that Scottsdale does offer its residents these things if residents are able to and choose to pursue healthy lifestyle choices. For example, one respondent said, “Scottsdale as a city has marvelous opportunities for people to move and get out.” The challenge lies in improving education and awareness.

**Lack of Resources** – Whether from the perspective of a state department dealing with a lower percentage of funding dollars than ever before, or a non-profit organization trying to prioritize its own efforts based on dwindling dollars, it is clear that stretching available funds is something that community leadership deals with on a regular basis. Outside of the funding issue, there are also human capital shortages. For example, one respondent indicated that the state, in general, lacks enough qualified physician to adequately diagnose patients with Autism. The primary suggestion provided was to ensure that an adequate number of trained and certified personnel are working within their facilities. If possible, SHC should attract one or two more developmental pediatricians. Trying to achieve synergies and efficiencies through partnerships, creativity, and more upstream efforts (i.e. preventive healthcare) is an area where SHC’s position as a leader can be used to address some of these issues.

When discussing key health issues facing Valley residents, respondents spoke from a variety of contexts depending on their roles within the community. Thus, discussions ranged across a wide variety of topics. The following are key issues that face Valley residents.

### **Autism**

Community leaders mentioned the topic of autism as an issue. Autism requires expensive and dedicated care. In order to receive state services for Autism, however, a person must receive a proper diagnosis. Receiving a diagnosis is problematic because there is a shortage of physicians who are able to diagnose. Wait time to see a qualified physician are generally around six months. Once diagnosed, working with

the state to receive state services is an extensive and exhaustive process. The community is deficient in resources for adult autism. Most of the focus is on children with the condition. After diagnosis, finding a good therapist who fits with the family/patient is often very difficult. Some families go through multiple therapists before they identify one who will fit their needs. In the absence of finding an outside therapist, some families opt to certify their own family members as therapists. Suggestions for SHC include providing adequate number of trained and certified personnel are working in their facilities. If possible, SHC should attract one or two more developmental pediatricians. Examples of model resources available to community residents outside of SHC include organizations such as Southwest Human Development, Phoenix Children's Hospital, Southwest Autism Research Support Center, and the Hope Group.

### **Elderly Residents/Retirement Living**

The topic of elderly residents/retirement living was discussed. For elderly residents entering or living in a retirement community (whether in an independent community or in a skilled nursing/assisted living setting), one of the main overarching challenges is the increased incidence of comorbid conditions which impact these residents' abilities to function smoothly and independently. The lack of affordable and/or subsidized housing is seen as a key obstacle to obtaining placement in a retirement community. In order to be eligible for AHCCCS coverage, residents are required to meet both a financial and functional (physical) threshold. While many applicants pass the financial requirements, many are "not quite frail enough" to qualify for state services. Elderly residents are less mobile and thus find it more difficult to access facilities/resources they need. For residents looking to avoid moving into a facility/retirement community and maintain their independence, a primary obstacle is that many of these residents live alone. For these residents, obtaining support/services often requires outside help. Due to lack of funding, wait lists for services are extensive in some cases. Often, residents will opt not to wait and will get placement in a facility or struggle/worsen in their current home condition. The need for improvement regarding smooth transition periods was commonly mentioned by respondents. In one respondents' perspective, there exists a service gap between the care offered by assisted living facilities, and the care offered by emergency rooms. In other words, there is a lack of middle-ground care for certain residents. The challenges of less-than-adequate resources and the ability of resident' to identify those resources is seen as a problem that is not unique to our community. A suggestion is to create tighter networks between provider types, for example, SHC working more closely with other senior providers in communities so that when seniors move from one facility to another, those transitions get smoothly coordinated. Another suggestion is to improve transition policies for elderly residents from hospital visits to home.

### **General Wellness/Obesity/Cardiac Health**

A number of respondents, when asked about key issues facing the Valley, referred to topics which fall under the large umbrella topic of wellness and healthy lifestyle. While multiple respondents highlighted the severity of Valley residents' poor health in general, some pointed to preventive healthcare measures that can help "right the ship." Obesity (and associated conditions) was offered repeatedly as a high priority issue, and it is generally agreed among respondents that the problem is getting worse, and is not

unique to our community. In addition to being a public health burden, it was noted that obesity is contributing to a larger financial burden for healthcare in general. High cost of, or low access to nutritious foods and sedentary lifestyles among residents are some of the primary factors attributed to the rise in obesity. Declining physical education in schools, lack of knowledge about nutrition, and lack of discipline in pursuing an active lifestyle are also contributing factors. Cardiac disease, while recognized as a serious affliction among both males and females, is not as often perceived to be associated with females due to lack of awareness.

The need to move toward preventive healthcare in general was also a common theme among respondents. Some issues that respondents identified as pressing issues include residents not going to their doctors' offices enough, sedentary lifestyles due to technology, life and work culture, and the absence of adequate health education from a young age. Many respondents believe that, as a well-respected and credible voice in the Valley, SHC is in a prime position to help educate and "get the word out" about the importance of healthy lifestyle and preventive health maintenance. Promoting healthier life choices is seen to some as an effort to be undertaken by the whole community, not just a health system such as SHC. However, SHC can credibly take a leadership role when partnering with various parts of the community. This echoes comments from many respondents around the idea of strength through partnership.

A suggestion was mentioned that at the time of discharge, obese patients may benefit from receiving a "did you know" piece of literature, or instruction which represents a step-by-step pathway to better health. Some respondents believe SHC can play an effective role at the policy level when it comes to developing policies which can promote and encourage a healthier population. Public schools, for example, are places where some of these concerns can be addressed from an early age. One respondent suggested SHC, as much as possible, have a seat at the table in regard to school advisory health councils to ensure things like nutrition and physical education are high priorities in the curriculum. Work with the city council and mayor's office to provide resources as the city makes planning decisions, so that principles of physical activity can be employed to make the community more walkable and friendly for physical activity (an example was given from one respondent about a recently conducted health assessment prior to the execution of a new transit initiative in Tempe). Work with city to make it easier to zone and site farmers markets and encourage community gardens.

### **Developmental Issues**

Two key issues that children with developmental disabilities face are access to care and quality of care. Cost, proximity to home/work, and transportation are often problematic for families. If care is received, it may not be from a skilled pediatrician. Many foster care children, for example, are treated by general practice physicians rather than pediatricians. The lack of qualified pediatricians is seen by one respondent as more pronounced in the Valley than in other places. Adult with developmental disabilities face a difficult transition from high school age into the "real world." For these residents, employment and independent living are difficult to attain. The lack of Valley resources available to these residents is identified by one respondent as "appalling." By the time these residents reach



adulthood, some families are too exhausted to continue being strong advocates for them. In the absence of advocates, this demographic becomes what one respondent refers to as a “forgotten population.”

### **Emergency Preparedness**

One obstacle to the community being optimally prepared for handling unforeseen crises is the idea that competitive groups (i.e., competitive hospitals or other organizations) have to be able to effectively work together during a disaster situation. Linked to this is the idea that there needs to be a strong capability of healthcare organizations in both rural and urban areas to work together during an emergency. Some traditional barriers to both of these key issues are unengaged municipalities, or cities that do not want to nor cannot utilize dwindling dollars to engage in preparation exercises, etc. Identifying all of the stakeholders that must be involved in the event of a crisis is also a key consideration. If an organization will be involved in the response component, then involvement in the planning processes is also critical, according to one respondent. Hospitals, therefore, must play a key role in planning processes. One respondent noted that hospitals are required to be involved in preparations, exercises and training, but may do the bare minimum stated in their requirements, rather than taking measures to go above and beyond. The respondent also indicated that, although emergency preparedness is high a priority when it is talked about, when funding realities hit it often becomes a low priority. This leads to the question of whether hospital systems are truly ready to accommodate a large scale disaster. One respondent indicated that SHC should priorities developing relationships not just with non-profit and city organizations, but also with key corporations to form a working coalition in the community. One respondent sees an opportunity for organizations like SHC to be more involved with emergency managers and going to regional meetings more often. Participating in table-top exercises and full-scale preparedness exercises more often was another suggestion for SHC to assist the community in being better prepared.

### **Schools**

A respondent with a firsthand perspective of healthcare issues among children from lower-income backgrounds indicated that with poverty comes a long list of healthcare concerns; “you name it, with poverty you get everything.” Many students’ families have no healthcare coverage. Physical health as well as mental health is adversely affected among these children. Language can be another barrier to accessing services/information, with a large percentage of these students learning English as a second language. For impoverished students, the lack of healthcare resources is evident, although one respondent did provide an example of one very positive resource in the community, and that is the Educare Clinic which is managed by SHC. Another respondent, speaking about students in the Scottsdale School District, indicated that one key topic of concern is preventive healthcare in general especially among students from lower income backgrounds. Physical education, if competing with other curriculum within tight budgets, is one of the first things to get cut. Additionally, mental and behavioral health care are also high priorities. For example, a student who is suspected to have some kind of deficit cannot be diagnosed by a school psychologist or counselor, so notifying parents and helping them navigate the system is a critical process in order to make sure students receive proper care. Current efforts to keep parents aware of healthcare concerns include sending home literature or other information a=with students. The topics may range from anxiety, resiliency, bullying, stress, dieting, and a number of other topics. Assuming SHC is granted Federally Qualified Health Center (FQHC) status, the district is hoping to move toward a system where schools are staffed with SHC



registered nurses who are essentially “leased.” For example, there are many special education students who require a significant amount of medical care that the school is otherwise unable to bill for. By having federal dollars available to offset some of these costs, this would help the school system maintain and/or expand health services offered to students. A number of respondents (not just those who are involved intimately in a school system), called out that, when it comes to promoting preventive healthcare, starting from a young age is critical, and SHC’s efforts with school systems moving forward will play a large role in addressing some of the community’s under-met health needs.

**Community Vital Statistics and Health Status Report for Cities and Towns in Maricopa County**

Table 11 shows selected characteristics of newborns and mothers by community reported in the Community Vital Statistics, Arizona, 2010 for Arizona, Maricopa County and the City of Scottsdale. Data is available by city and not by zip code therefore the City of Scottsdale data is used to get a general understanding of the characteristics of the SHC Service Area as a whole. Note that the City of Scottsdale has a lower percentage of mothers 19 years old or younger compared to Arizona and Maricopa County. The City of Scottsdale also has a higher rate of babies who receive prenatal care in the 1<sup>st</sup> trimester compared to Arizona and Maricopa County. The percentage of babies with no prenatal care in City of Scottsdale is lower than Arizona and Maricopa County. Low birth weights in newborns are about the same in the City of Scottsdale compared to Arizona and Maricopa County.

**Table 11** Selected Characteristics of Newborns and Mothers by Community

Community	Total births	Mother 19 years old or younger	Prenatal care in the 1st trimester	No prenatal care	Public payer for birth	LBW newborns (<2,500 grams at birth)	Unwed mother
Arizona	87,053	10.8%	81.9%	1.6%	55.3%	7.1%	44.7%
Maricopa County	54,236	9.8%	85.9%	1.3%	53.6%	7.1%	43.4%
City of Scottsdale	2,231	4.2%	86.9%	0.9%	25.9%	7.2%	26.8%

Table 12 shows selected characteristics of newborns and mothers trended from 2007-2010 for the City of Scottsdale reported in the Health Status Report for Cities and Towns in Maricopa County. Maricopa County, Arizona, and U.S. data as well as Healthy People 2020 goals (when available and comparable) are listed for comparison. Low weight births and infant mortality decreased in 2010 in the City of Scottsdale. The percentage of low weight births in the City of Scottsdale improved since 2009 and is now equal to Maricopa County and Arizona and less than the U.S and the Healthy People 2020 goal. Infant mortality rate has improved since 2009 and is less than Maricopa County, Arizona, the U.S. and the Healthy People 2020 goal.





**Table 12** Selected Characteristics of Newborns and Mothers Trended From 2007-2010 for the City of Scottsdale and Selected Geographic Areas

	City of Scottsdale						Comparisons					
	2007		2008		2009		2010		Maricopa County, 2010	Healthy People 2020	Arizona 2010	U.S. 2010
	N	% or Rate	N	% or Rate	N	% or Rate	N	% or Rate				
Low weight births (under 2,500 grams) - % of live births	177	7.3%	149	6.3%	191	8.5%	160	7.2%	7.1%	7.8%	7.1%	8.2%
Infant mortality per 1,000 live births	11	4.5	6	2.5	14	6.2	9	4.0	5.8	6.0	6.0	6.1
Total Births	2,423		2,378		2,258		2,230		54,235		87,053	4,000,279

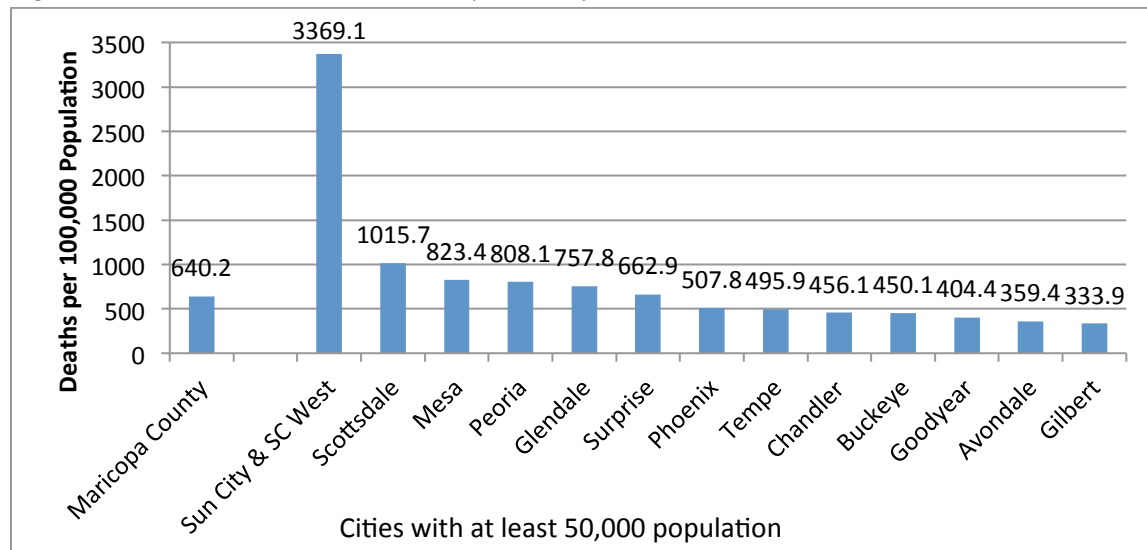
Table 13 shows the rate of death for selected causes reported in the Health Status Report for Cities and Towns in Maricopa County. The top two causes of death are cancer and cardiovascular disease. Rate of death from cancer in the City of Scottsdale has increased and remains higher than Maricopa County, Arizona, and the U.S. Rate of death from cardiovascular disease has also increased and remains higher than Maricopa County, Arizona and the U.S rate. Alzheimer and chronic lower respiratory are the next two highest causes of death. The City of Scottsdale’s rate of death from Alzheimer’s is climbing and about doubles Maricopa County rate. Chronic lower respiratory disease has declined since 2008 but remains higher than the Maricopa County, Arizona and U.S. rates.

**Table 13** Rate of Death for Selected Causes the For City of Scottsdale And Selected Geographic Areas

Underlying Cause of Death	City of Scottsdale								Comparisons		
	2007		2008		2009		2010		Maricopa County, 2010	Arizona 2010	U.S. 2010
	N	Rate per 100,000	N	Rate per 100,000	N	Rate per 100,000	N	Rate per 100,000			
Malignant Neoplasms (cancer)	519	221.5	521	220.3	510	213.6	532	244.7	144.3	163.1	185.9
Diabetes	40	17.1	50	21.1	44	18.4	58	26.7	18.4	21.5	22.3
Alzheimer's	147	62.7	136	57.5	161	67.4	178	81.9	43.6	36.2	27.0
Major Cardiovascular Diseases	628	268.0	646	273.2	605	253.4	632	290.7	178.3	199.5	251.8
Influenza & Pneumonia	42	17.9	56	23.7	43	18.0	26	12.0	7.8	11.4	16.2
Chronic Lower Respiratory	103	44.0	129	54.5	135	56.6	111	51.1	38.3	45.2	44.6

The following graphs were highlighted in the Health Status Report for Cities and Towns in Maricopa County. Figure 19 shows crude death rate in Maricopa County and selected cities and Figure 20 shows the percent of population 65 years old and older. As stated in the report, these charts are included to show cities with relatively older populations. Areas with older populations generally have higher rates of death from cancers, cardiovascular, and heart disease resulting in higher total death rates.

**Figure 19** Crude Death Rates in Maricopa County and Selected Cities, 2010



**Figure 20** Percent of Population 65 Years Old and Older, Maricopa County and Selected Cities, 2010

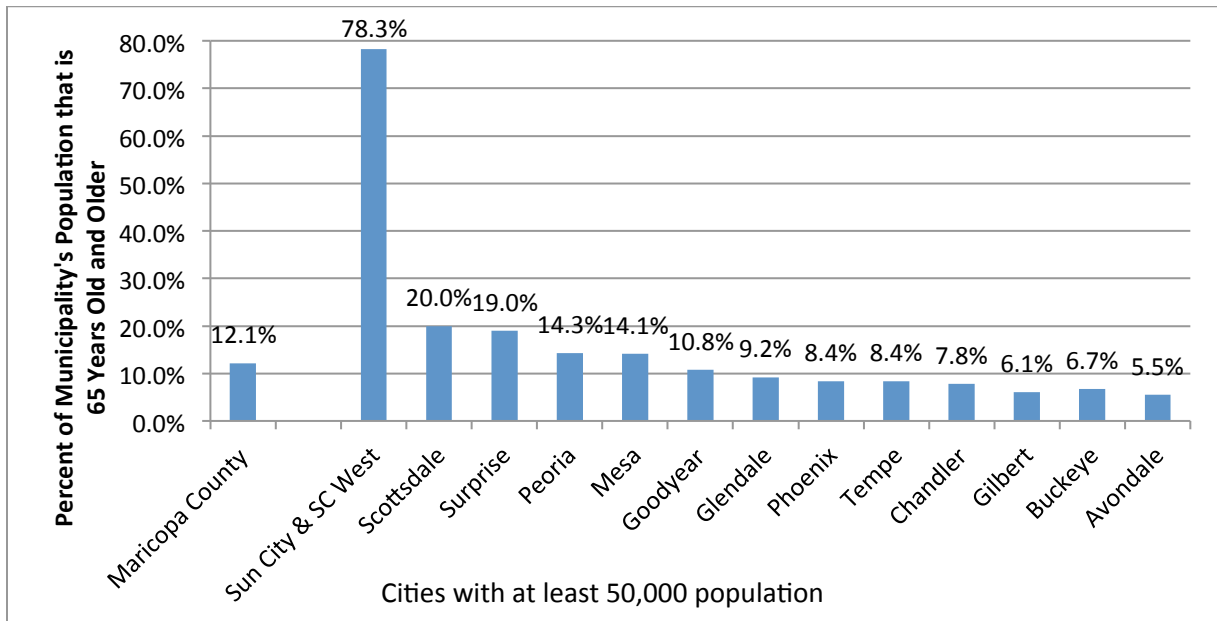
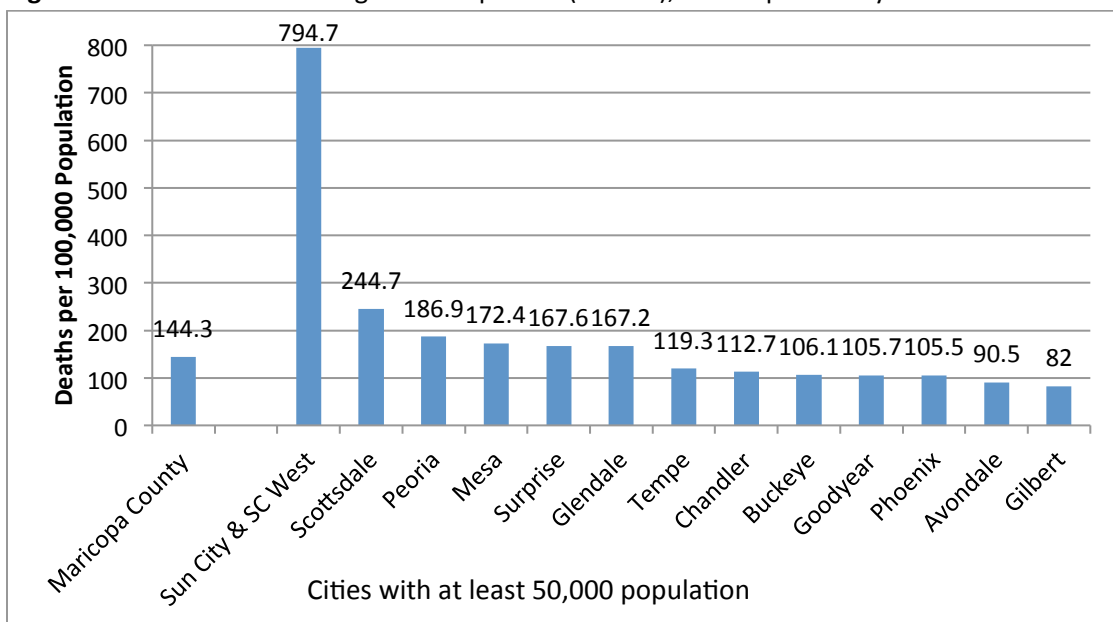
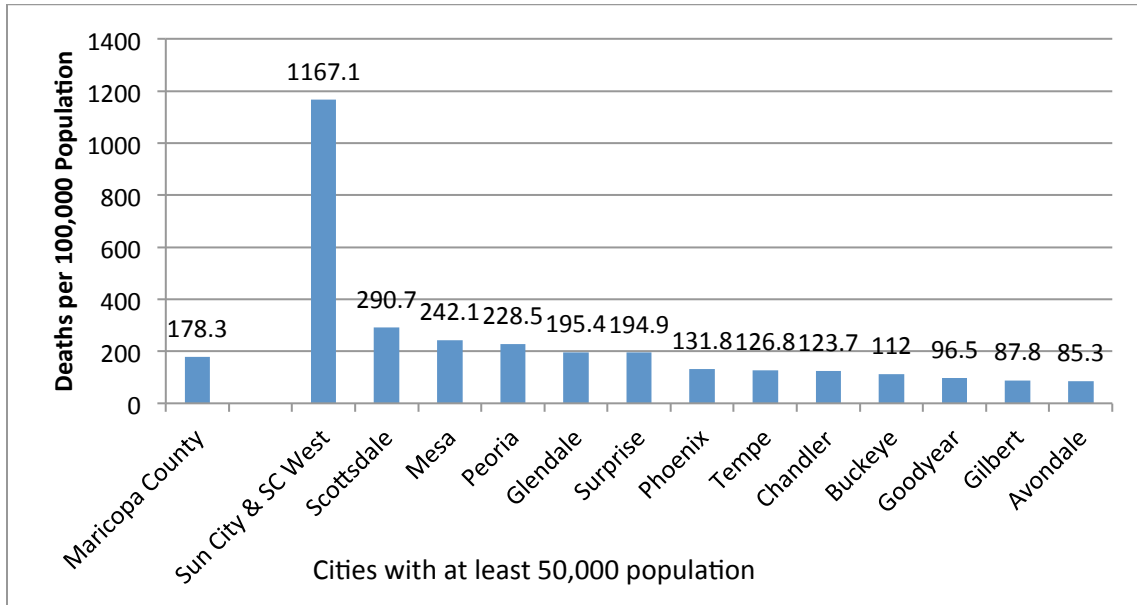


Figure 21-23 shows the rate of death from the selected diseases for Maricopa County and selected cities. Note that next to Sun City and SC West, the City of Scottsdale has one of the highest rates of death from cancer, cardiovascular disease, and heart disease.

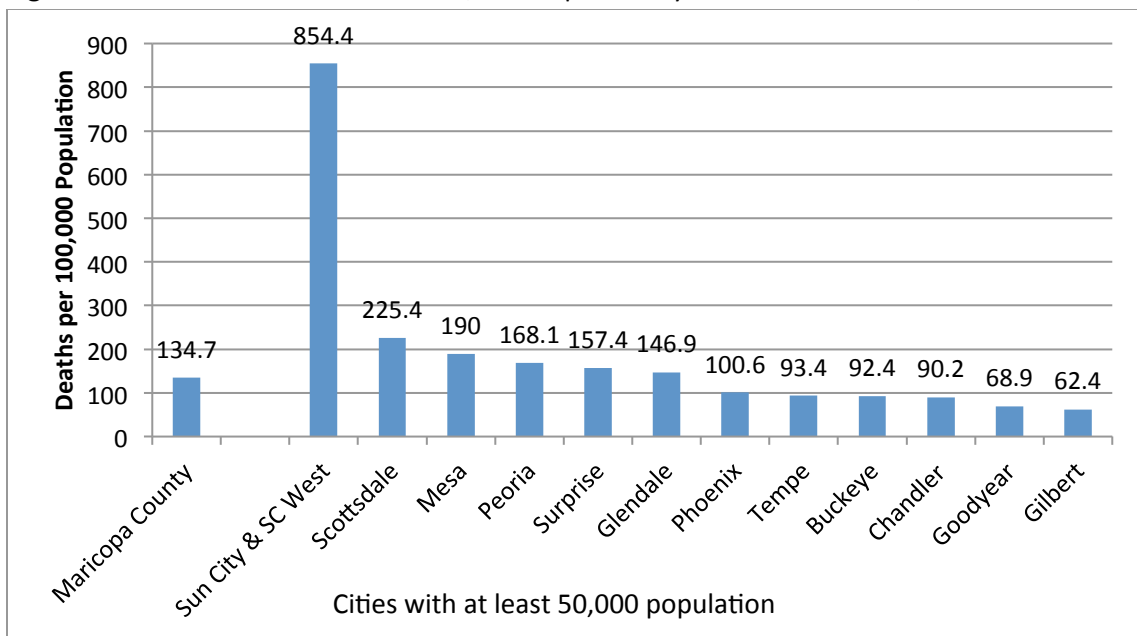
**Figure 21** Deaths Due to Malignant Neoplasms (Cancer), Maricopa County and Selected Cities, 2010



**Figure 22** Deaths Due to Cardiovascular Disease, Maricopa County and Selected Cities, 2010



**Figure 23** Deaths Due to Heart Disease, Maricopa County and Selected Cities, 2010



### Arizona Health Survey Data

Arizona Health Survey conducted a 271-question survey to 8,200 adults in 2010. Table 14 shows results for a few selected questions on disease prevalence that were not included in the survey conducted by WestGroup Research. Note that the SHC Service Area has a higher prevalence of diabetes, high blood pressure, and heart disease than both Maricopa County and Arizona.

**Table 14** Percent Of Adults Who Reported Yes When Asked If Their Doctor Diagnosed Them With The Following Conditions.

	Thompson Peak Service Area * (N=193)	SHC Service Area (N=475)	Maricopa County (N=2,723)	AZ (N=8,251)
Diabetes	11.4	11.4	10.5	11.0
High BP	29.0	33.1	26.1	28.0
Asthma (adults)	15.0	16.0	16.0	16.2
Heart Disease	19.4	16.6	13.0	13.8

\*For reporting purposes only as sampling size is too small (190) with error rate of +/-7%. Data is not projectable.

Overweight and obesity data are also available through the AZ Health Survey by calculating respondents' height and weight for body mass index (BMI). Table 15 shows that the SHC Service Area percent overweight, percent obese and BMI are lower than that of Maricopa County and Arizona. Nonetheless, over 50% of the SHC Service Area residents are overweight or obese. The SHC Service Area mean value of BMI is 26.8 kg/m<sup>2</sup> which is defined as overweight.

**Table 15** Percent Of Adults Who Are Overweight and/or Obese and the Average BMI

	Thompson Peak Service Area*(N=193)	SHC Service Area (N=475)	Maricopa County (N=2,723)	AZ (N=8,251)
<b>% Overweight</b>	28.6%	30.3%	34.8%	34.9%
<b>% Obese</b>	25%	23.2%	27.8%	28.1%
<b>% Obese &amp; Overweight</b>	53.6%	53.5%	62.6%	67%
<b>Average BMI</b>	26.9	26.8	28.8	28.6

\*For reporting purposes only as sampling size is too small (190) with error rate of +/-7%. Data is not projectable.

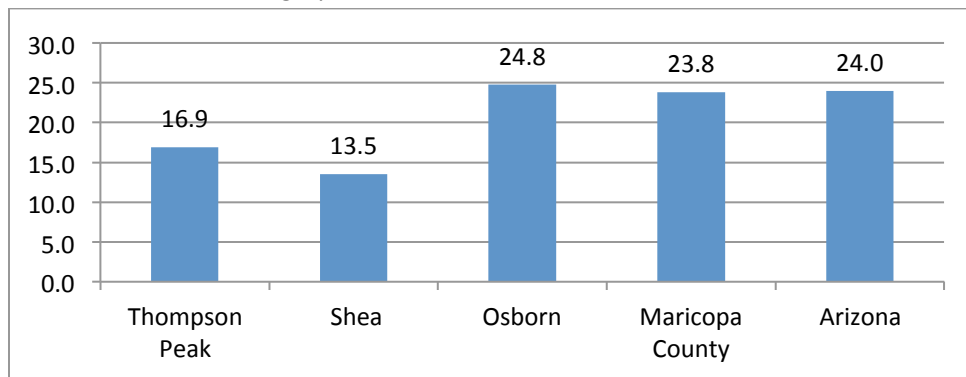
### Hospitalization Data

The following are Prevention Quality Indicators (PQIs) for the Thompson Peak Service Area and selected geographic areas which identify hospital admissions that evidence suggests may have been avoided through access to high-quality outpatient care or for which early intervention can prevent complications or more severe disease. Tables 16-25 and figures 24-33 show crude and age-adjusted hospital admissions rate per 10,000 of population for the Thompson Peak Service Area residents who were admitted to any facilities in Arizona from 2009 to 2011. The conditions reported include adult asthma, pediatric asthma, heart failure, COPD, dehydration, urinary tract infection, long-term complications of diabetes, short-term complications of diabetes, uncontrolled diabetes, and bacterial pneumonia.

**Table 16** Hospital Admissions per 10,000 Due to **Adult Asthma** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	16.9	13.5	24.8	23.8	24.0
Crude Rate	22.8	18.4	32.1	31.6	32.7

**Figure 24** Age-Adjusted Admission Rate per 10,000 Due to **Adult Asthma** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

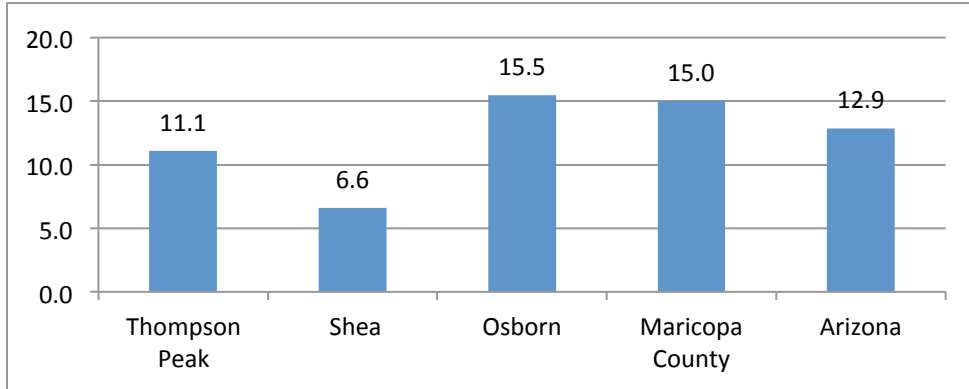


Note that next to the Shea Service Area, the Thompson Peak Service Area has the lowest rate of admission due to adult asthma compared to the Osborn Service Area, Maricopa County and Arizona.

**Table 17** Hospital Admissions per 10,000 Due to **Pediatric Asthma** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	11.1	6.6	15.5	15.0	12.9
Crude Rate	43.5	25.3	61.8	59.3	50.5

**Figure 25** Age-Adjusted Admission Rate per 10,000 Due to **Pediatric Asthma** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

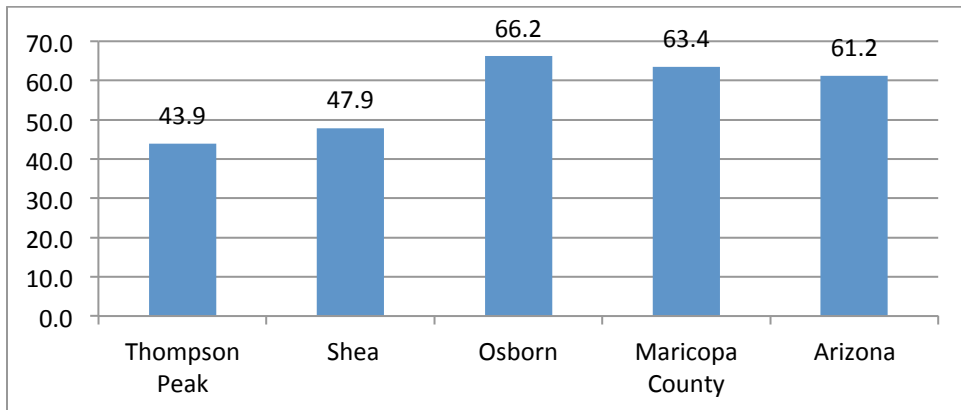


Again, note that next to the Shea Service Area, the Thompson Peak Service Area has the lowest rate of admission due to pediatric asthma compared to the Osborn Service Area, Maricopa County and Arizona.

**Table 18** Hospital Admissions per 10,000 Due to **Heart Failure** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	43.9	47.9	66.2	63.4	61.2
Crude Rate	54.0	67.5	85.8	81.0	88.2

**Figure 26** Age-Adjusted Admission Rate per 10,000 Due to **Heart Failure** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011



Note that the Thompson Peak Service Area has the lowest rate of admission due to heart failure compared to the Shea and Osborn Service Areas, Maricopa County and Arizona.

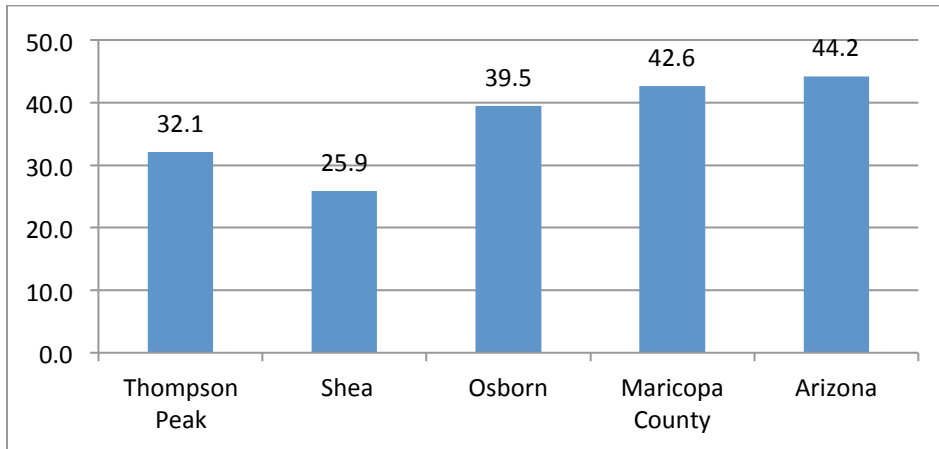
**Table 19** Hospital Admissions per 10,000 Due to **COPD** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011



	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	32.1	25.9	39.5	42.6	44.2
Crude Rate	41.0	36.8	51.1	55.3	63.8



**Figure 27** Age-Adjusted Admission Rate per 10,000 Due to **COPD** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

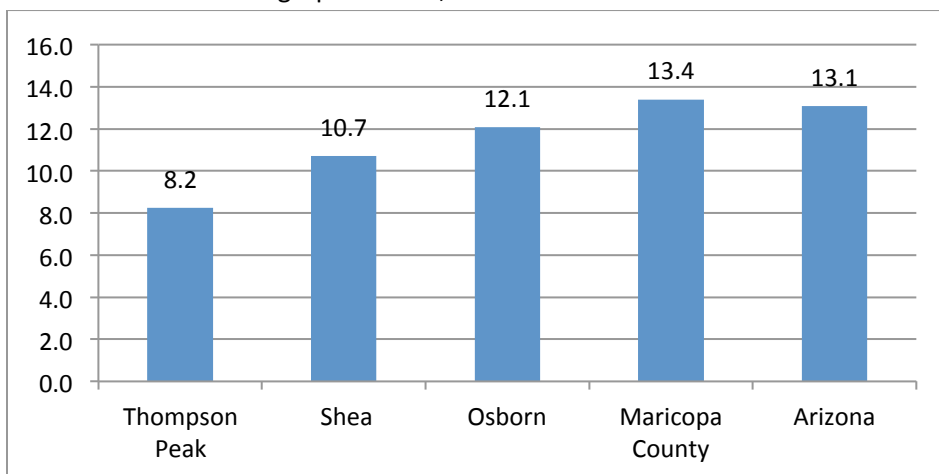


Again, note that the Thompson Peak rate of admission due to COPD is lower compared to the Osborn Service Area, Maricopa County and Arizona.

**Table 20** Hospital Admissions per 10,000 Due to **Dehydration** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	8.2	10.7	12.1	13.4	13.1
Crude Rate	10.8	21.0	15.8	17.4	18.4

**Figure 28** Age-Adjusted Admission Rate per 10,000 Due to **Dehydration** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

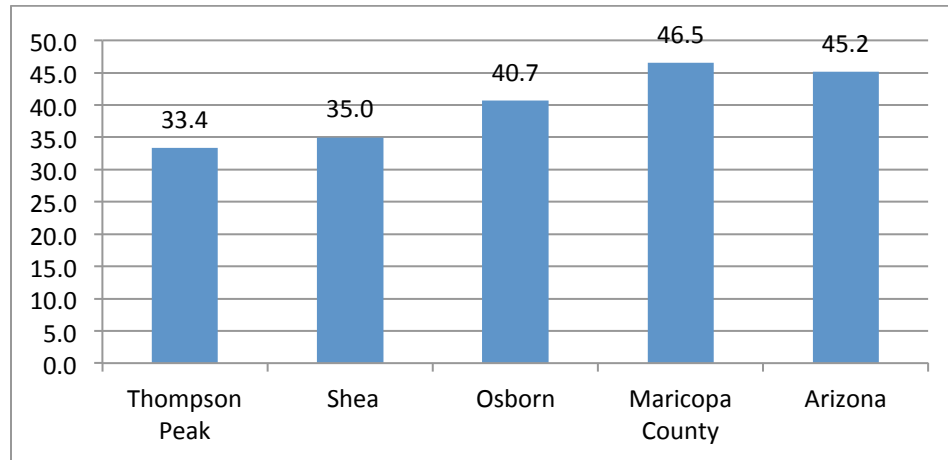


Note that the Thompson Peak Service Area has the lowest rate of admission due to dehydration compared to the Shea and Osborn Service Areas, Maricopa County and Arizona.

**Table 21** Hospital Admissions per 10,000 Due to **Urinary Tract Infection** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	33.4	35.0	40.7	46.5	45.2
Crude Rate	41.8	52.8	53.6	60.2	63.5

**Figure 29** Age-Adjusted Admission Rate per 10,000 Due to **Urinary Tract Infection** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

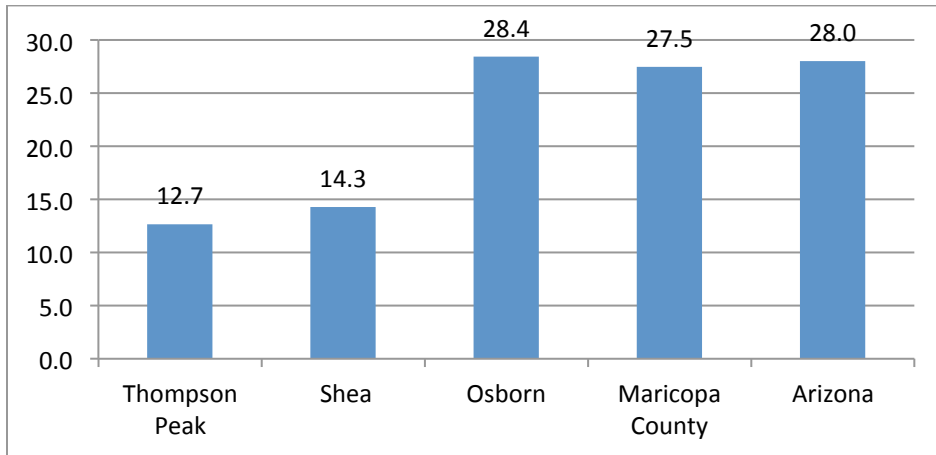


Note that the Thompson Peak Service Area has the lowest rate of admission due to urinary tract infection compared to the Shea and Osborn Service Areas, Maricopa County and Arizona.

**Table 22** Hospital Admissions per 10,000 Due to **Long-Term Complications of Diabetes** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	12.7	14.3	28.4	27.5	28.0
Crude Rate	17.8	20.5	36.2	36.4	38.9

**Figure 30** Age-Adjusted Admission Rate per 10,000 Due to Long-Term Complications of Diabetes for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

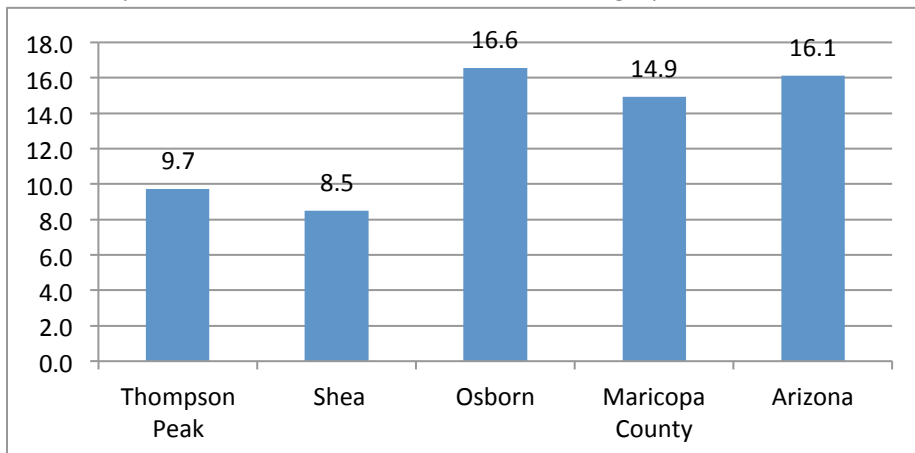


Note that the Thompson Peak Service Area has the lowest rate of admission due to long-term complications of diabetes compared to the Shea and the Osborn Service Areas, Maricopa County and Arizona.

**Table 23** Hospital Admissions per 10,000 Due to Short-Term Complications of Diabetes for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	9.7	8.5	16.6	14.9	16.1
Crude Rate	12.4	12.3	22.2	20.1	21.3

**Figure 31** Age-Adjusted Admission Rate per 10,000 Due to Short-Term Complications of Diabetes for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

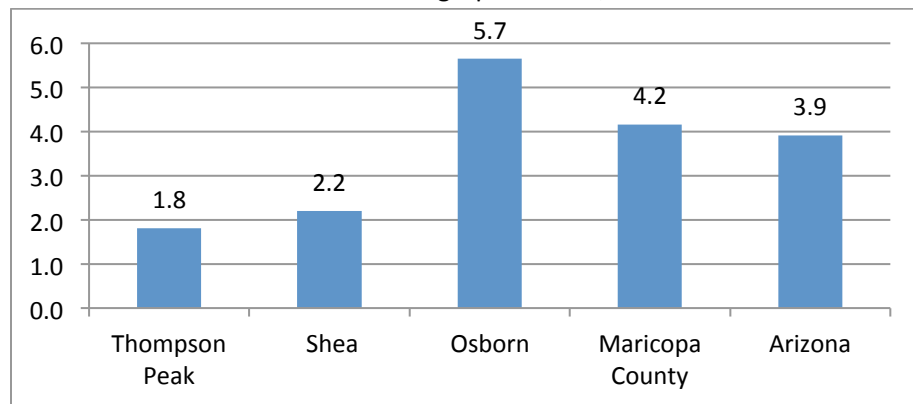


Note that next to the Shea Service Area, the Thompson Peak Service Area has the lowest rate of admission due short-term complications of diabetes compared to the Osborn Service Area, Maricopa County and Arizona.

**Table 24** Hospital Admissions per 10,000 Due to **Uncontrolled Diabetes** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	1.8	2.2	5.7	4.2	3.9
Crude Rate	2.4	3.1	7.2	5.5	5.3

**Figure 32** Age-Adjusted Admission Rate per 10,000 Due to **Uncontrolled Diabetes** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

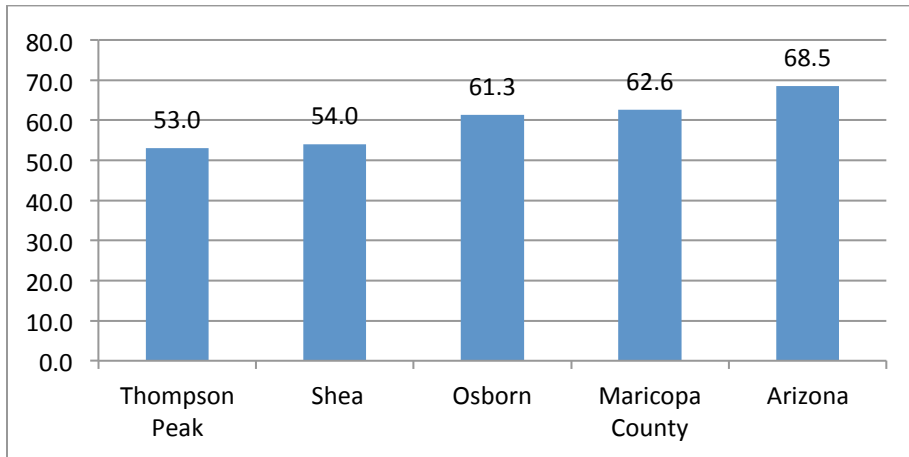


Note that the Thompson Peak Service Area the lowest rate of admission due to uncontrolled diabetes compared to the Shea and Osborn Service Areas, Maricopa County and Arizona.

**Table 25** Hospital Admissions per 10,000 Due to **Bacterial Pneumonia** for Residents of the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011

	Thompson Peak Service Area	Shea Service Area	Osborn Service Area	Maricopa County	Arizona
Age-Adjusted Rate	53.0	54.0	61.3	62.6	68.5
Crude Rate	67.5	84.6	79.7	82.1	97.0

**Figure 33** Age-Adjusted Admission Rate per 10,000 due **Bacterial Pneumonia** for the Thompson Peak Service Area and Selected Geographic Areas, 2009-2011



The Thompson Peak Service Area has the lowest rate of admission due bacterial pneumonia compared to the Shea and Osborn Service Areas, Maricopa County and Arizona.

#### Emergency Department Data

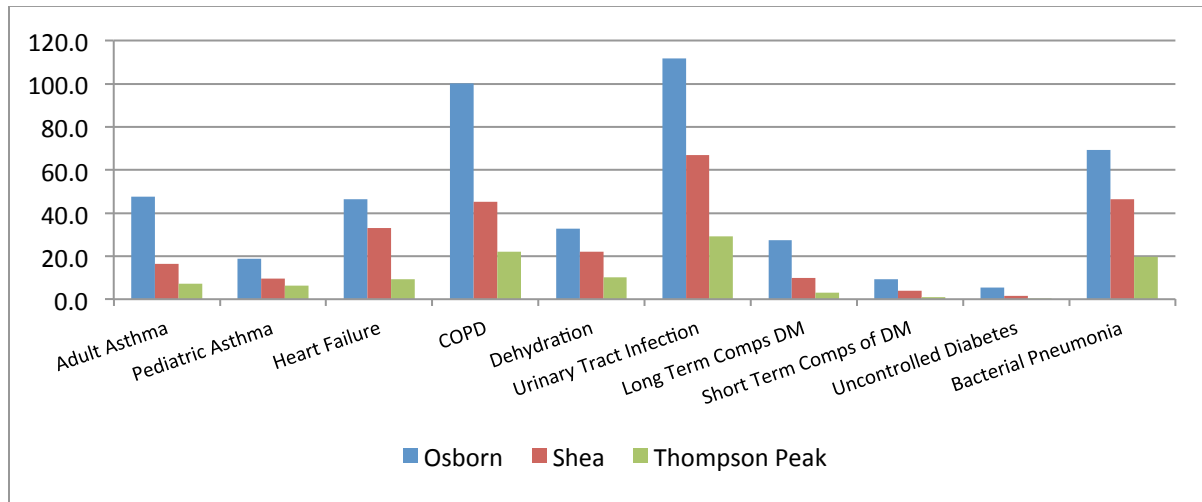
A similar perspective can be taken for emergency department (ED) data where visits to the ED may have been avoided through access to high-quality outpatient care or for which early intervention can prevent complications or more severe disease. Provided below are ED visits data for the same sets of problems, however, due to data limitations, it is restricted to only patients who were seen at SHC facilities who live in the Thompson Peak, Shea, and Osborn Service Areas. Only crude rates are available but because this report seeks to understand severity of the health issues in the SHC Thompson Peak community, crude rates are appropriate.

**Table 26** ED Visit Rate per 10,000 for Selected Conditions for the Thompson Peak, Osborn, and Shea Service Areas, 2009-2011

	Thompson Peak Service Area	Osborn Service Area	Shea Service Area
Adult Asthma	7.3	47.5	16.5
Pediatric Asthma	6.2	18.6	9.5
Heart Failure	9.1	46.3	33.0
COPD	21.9	100.2	45.3
Dehydration	10.1	32.6	21.9
Urinary Tract Infection	29.0	111.9	66.9
Long Term Comps DM	3.0	27.5	9.9
Short Term Comps of DM	0.9	9.3	3.8
Uncontrolled Diabetes	0.4	5.5	1.7

Bacterial Pneumonia	19.7	69.3	46.4
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**Figure 34** ED Visit Rate per 10,000 for Selected Conditions for Thompson Peak, Osborn, and Shea Service Areas, 2009-2011



Note that the Osborn Service Area residents have the highest rate of ED visits for all conditions while the Thompson Peak Service Area has the lowest visit rate of ED for all three areas.

## DISCUSSION AND RECOMMENDATIONS

The ultimate goal of not-for-profit health care organizations is to improve the health of the communities they serve. The findings of this report draw attention to five important themes that affect the health of the Thompson Peak Service Area:

**1. Mortality rate is higher in the City of Scottsdale versus other cities in Maricopa County (except Sun City and Sun City West)**

- Next to Sun City & Sun City West, the City of Scottsdale’s overall crude death rate is the highest in Maricopa County. The crude death rate equates to the total number of deaths per year per 100,000 people and is not adjusted for age.
- The City of Scottsdale has the second highest percentage of population 65 years old and older in Maricopa County. Areas with older populations generally have higher rates of death from cancers, cardiovascular, and heart disease resulting in higher total death rates.
- The City of Scottsdale’s rate of death due to cancer, diabetes, Alzheimer’s, cardiovascular diseases, influenza and pneumonia, and chronic lower respiratory are higher than Maricopa County, Arizona, and US rates.

**2. The entire SHC Service Area (Thompson Peak Service Area sampling size is too small to be reportable) has a higher prevalence of diabetes, high blood pressure, and heart disease than both Maricopa County and Arizona.**

- Results from the Arizona Health Survey show that SHC Service Area has a higher percentage of adults who reported yes when asked if their doctor diagnosed them with diabetes, high blood pressure, and heart disease than Maricopa County and Arizona.

**3. More than 50% of the entire SHC Service Area (Thompson Peak Service Area sampling size is too small to be reportable) residents are overweight or obese. The SHC Service Area mean value of BMI is 26.8 kg/m<sup>2</sup> which is defined as overweight.**

**4. Social determinants that define the Thompson Peak Service Area priority populations include age, income, insurance coverage, and employment status. Data show that priority populations have difficulty accessing quality care in a timely manner and exhibit poor health-related behaviors.**

- Survey results show that individuals who fall in the younger age group, lower income level, or lack proper insurance coverage are more likely to:
 

<ul style="list-style-type: none"> <li>▪ Not have a PCP</li> <li>▪ Not have regular checkups</li> <li>▪ Have difficulty receiving a health service</li> <li>▪ Use the ED/Urgent Care for care</li> <li>▪ Have difficulty affording a medication prescribed or recommended to them and will either find a way to pay for it or not take the medication</li> <li>▪ Not be able to afford to eat balanced meals</li> <li>▪ Not exercise at all</li> <li>▪ Sleep less than 7 hours</li> <li>▪ Use tobacco</li> </ul>	<ul style="list-style-type: none"> <li>▪ Indicate stress and depression kept them from doing usual activities such as self-care, work or recreation put off dental care</li> <li>▪ Have difficulty figuring out how to find the right doctors to address their medical needs</li> <li>▪ Put of medical treatment</li> <li>▪ Have poor perception of overall health</li> <li>▪ Have had a physician tell them they need to lose weight</li> </ul>
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5. **Community leader interviews emphasize the need for preventive healthcare, reducing obesity, early detection of autism, elderly care, access to quality care for developmentally disabled children, and access to quality care for children from lower income backgrounds.**

## CONCLUSION

Following the CHNA, a Steering Committee was formed to respond to each of the community concerns identified in the assessment (see Appendix E for list of members). The Committee reviewed and discussed the findings to select priority needs. Criteria that were used to select priority needs include the magnitude of the problem, the severity of the problem, the impact of the problem on vulnerable populations, the importance of the problem in the community, feasibility, and consequences of inaction. Through this process the Committee identified five Focus Areas:

1. Cardiovascular Disease
2. Heart Failure
3. Diabetes
4. Obesity
5. Cancer

As for the rest of the community concerns identified in the assessment (Alzheimer's disease, influenza and pneumonia, chronic lower respiratory disease, suicides, dehydration, urinary tract infections, and autism) that did not make it to the top five Focus Areas, the CHNA Steering Committee, nonetheless, acknowledges the importance of those other needs and plans to collaborate with community partners to address them. In addition, there are areas that SHC is currently working on and plans to continue these efforts because they serve a great value to the community. These areas include childhood immunization, children with disabilities, and dental care.

The CHNA and five Focus Areas were also presented to the Community Stewardship Advisory Council to review and approve (see Appendix F for list of members). With the five Focus Areas identified, the next steps are to develop implementation strategies to effectively improve the health of the community.



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## APPENDIX A—Focus Group Questions, Demographics, and Results

### Questionnaire

\*\*\*GUIDE ONLY – QUALITATIVE IN NATURE. DISCUSSION MAY DEVIATE FROM THE LIST OF TOPICS BELOW AS APPROPRIATE DURING THE INTERVIEWS.

Hi Mr./Ms. [\_\_\_\_\_],

This is [\_\_\_\_\_] calling from WestGroup Research on behalf of Scottsdale Healthcare. Thank you so much for speaking with me today – I have some questions that will take about 15 minutes of our time to go through.

As you may already know, Scottsdale Healthcare is conducting a community assessment to understand the health needs of the residents they serve. This includes understanding barriers prohibiting residents from living healthy lifestyles and receiving appropriate healthcare, and generally understanding the top issues facing valley residents in these regards. Part of this process is speaking with community leaders such as you who bear eye witness each day to some of the key issues facing various parts of the community. [STATEMENT REGARDING ANONYMITY AND RECORDING]

1. Please tell me a little bit about your title/role/daily responsibilities?
2. What do you feel are the primary issues that impede or prevent the residents or community groups you serve from living a healthy life and/or accessing the healthcare services they need? Can you provide an example of that? What do you think are the causes of these issues?
  - a. Do you think these issues are unique to this community? Are they more or less severe? Why?
  - b. Does your organization attempt to provide assistance to address some of these issues? Why or why not?
  - c. IF THEY DO: Please describe some of the activities you undertake to address these issues?
  - d. IF THEY DO NOT: Where do the residents or constituencies turn to for assistance on these issues?
3. As a local healthcare provider, what do you think Scottsdale Healthcare could do to provide assistance in the areas we discussed before? Is there anything in particular they are currently doing that stands out to you? What can they be doing more effectively?
4. What programs or services offered by other local hospitals are you aware of that are particularly helpful? Please explain
5. What other suggestions or recommendations would you make for Scottsdale Healthcare as it seeks to identify and address any gaps that exist in the area that are affecting the ability of individuals in the community to be healthy?

**Focus Group Respondents Demographic Makeup**

A high level overview of group demographics is below:

	Thompson Peak <b>Group 1</b> <b>(N=9)</b>	Thompson Peak <b>Group 2</b> <b>(N=10)</b>
Male	3	5
Female	6	5
Age 21-54	8	5
Age 55-75	1	5
High School Education	-	1
Some College Education	1	4
College Graduate	6	3
Post Graduate	2	2
Caucasian	9	9
African-American	-	-
Hispanic	-	1
Other Group Characteristics	All parents with children in home	No children in home

One group was comprised only of participants with children in the home, and the other comprised only of participants without children in the home. The non-children group skewed to a slightly older age demographic. The demographic attributes of the groups are: 40% males to 60% females, mix of age, employment status, and type of health insurance. Respondents were recruited by zip-code to ensure correct geographic representation.

### Focus Group Interview Results

A total of 19 individuals participated in the focus group interviews. Again, given the qualitative nature of this research, the findings were only used as directional information to understand perceptions present in the Thompson Peak Service Area. Table 1 is a compiled list of issues which residents indicated affect their ability to have the quality of life they would like.

The top issues facing the community expressed by both groups are financial stress/economy, personal health, education (access and cost), family/friends/pets, transportation, access to quality food/restaurants/groceries, foreclosures/mortgages, entertainment/recreation, safety/crime, and weather.

**Table 1** List of Issues Which Residents Indicated Affect Their Ability to Have The Quality of Life They Would Like.

	Thompson Peak Group 1	Thompson Peak Group 2
Financial Stress/Economy	X	X
Personal health	X	X
Education (access & cost)	X	X
Family/Friends/Pets	X	X
Stress of work/life		X
Transportation	X	X
Cost of medical care	X	
Access to quality food/restaurants/groceries	X	X
Environment (air quality, water, general)		X
Foreclosures/mortgages	X	X
Stress/Mental health		
Entertainment/Recreation	X	X
Politics/Media	X	
Safety/Crime	X	X
Weather	X	X
Local sports teams	X	
Alternative fuel / fuel prices	X	
City resources (first responders, infrastructure)	X	
Population/Overpopulation		
Senior citizen services	X	
Children (wellbeing/health)		
Diet/living habits (exercise, active lifestyle)	X	
Homeless shelters/families		
SB1070/Discrimination		

Drugs/substance abuse		X
Language barrier		

Note: specific responses were grouped together if similar in category

Table 2 is a compiled list of issues which residents indicated affect their ability to live healthy lives. Participants in each group were also asked to select the top issues with the most impact on their ability to be healthy. Those cells are highlighted. Note that Group 1 prioritized access/timely access to medical care, cost of prescriptions, quality of doctors/care, and financial stress/economy while Group 2 prioritized stress of work/life, insurance costs and access, and diet/living habits.

**Table 2** List of Issues Which Residents Indicated Affect Their Ability to Live Healthy Lives

	<b>Thompson Peak Group 1</b>	<b>Thompson Peak Group 2</b>
Stress of work/life	X	X
Insurance costs and access	X	X
Diet/living habits (exercise, active lifestyle)		X
Insurance rules and regulations	X	
Lack of health education	X	
Access/timely access to medical care	X	X
Cost of prescriptions	X	
Quality of doctors/care	X	X
Access to quality food/restaurants/groceries	X	X
Financial stress/Economy	X	
Cost of medical care		
Environment		
Culture		
Medicare reimbursement/acceptance		
Lack of free places to exercise		
Obesity		
Disabilities		
Children (wellbeing/health)		
Support groups		
Fear of doctors		
Specific services available (ex: Autism, Cancer)	X	
Senior services/retirement home costs	X	
Genetics		X

WestGroup Research noted that it became apparent during the focus group interviews that residents' lives are often too "full" to pursue proper healthcare to the extent they know they should. When

prompted, most residents agreed that there are plenty of things they could be doing to improve their health—a better diet, more active lifestyle, and generally more preventive health maintenance practices. While participants mentioned a myriad of potential factors that may impact healthy living, some of the most consistently impactful and commonly referenced issues included: life/work stress, barriers/access to healthcare, and health insurance status. Notably, many residents talked about not having enough hours in the day or dollars in their savings accounts to seek even preventive healthcare maintenance. There is also the perception that going to the doctor is unpleasant and setting an appointment with a physician gets in the way of their schedules therefore “if it ain’t broke, don’t fix it.” Some mentioned displeasures in seeing a physician due to unreasonable wait times, sickly environment of patient waiting lobbies, lack of ability to see the same physician, and the feeling of being rushed out the door after seeing the physician.

Among the residents with health insurance, there was a strong sense of frustration related to navigating the rules and stipulations of their insurance policies including in-network vs. out-of-network limitations, understanding coverage plans, and shrinking coverage. And among the residents without insurance, many do not seek for health care except in the event of a serious illness or injury. Most residents did not know of free or low-cost clinics and some perceived that free clinics are poorer quality healthcare providers. Some even mentioned that they go to Mexico for healthcare/medications due to the cost differential. Dental care was specifically mention a couple of times.

Residents were asked to rate on a scale of 1 to 5 (5 being significantly affected) how the listed key health indicators affected them personally. Table 3 displays the results of these questions.

**Table 3** Results of How Residents Rate Key Health Indicators Affected Them Personally (on a scale of 1 to 5; 5 being significantly affected)

Personally Affected	Thompson Peak Group 1 (N=9)		Thompson Peak Group 2 (N=10)	
	1-3	4-5	1-3	4-5
Access to Health Services	5	4	7	3
Cancer	6	3	5	5
Food Safety	7	2	7	3
Heart Disease and Stroke	4	5	7	3
Immunization and Infectious Diseases	5	4	8	2
Injury and Violence Prevention	7	2	9	1
Maternal, Infant and Child Health	1	8	6	4
Mental Health and Mental Disorders	7	2	7	3
Nutrition and Weight Status	4	5	7	3
Tobacco Use	9	0	6	4
Substance Abuse	8	1	7	3

Notes: Tallies are not projectable.



Residents were also asked to rate how the same health indicators affected the residents in the community where they live. Table 4 displays these results.

**Table 4** Results of How Residents Rate Key Health Indicators Affected the Residents in the Community Where They Live (on a scale of 1 to 5; 5 being significantly affected)

Community Affected	Thompson Peak Group 1 (N=9)		Thompson Peak Group 2 (N=10)	
	1-3	4-5	1-3	4-5
Access to Health Services	5	4	5	5
Cancer	4	5	5	5
Food Safety	7	2	6	4
Heart Disease and stroke	2	7	5	5
Immunization and Infectious Diseases	7	2	5	5
Injury and Violence Prevention	6	3	8	2
Maternal, Infant and Child Health	3	6	6	4
Mental Health and Mental Disorders	5	4	6	4
Nutrition and Weight Status	1	8	6	4
Tobacco Use	5	4	6	4
Substance Abuse	4	5	4	6

Notes: Tallies are not projectable.

High ratings for access to health services were found in both groups for the community perception. Most residents had some sort of health coverage, and thus did not necessarily consider themselves completely unable to get health services, but noted that cost and other barriers often prevent them from fully pursuing proper healthcare.

Residents provided high community ratings for cancer, indicating that cancer incidence rates are increasing, particularly skin cancer in Arizona. Nutrition received both high personal and community perception ratings. Residents mentioned the increasing cost of healthy foods, easy access to junk foods, and sedentary lifestyles that they and the community have become accustomed to. Substance abuse received low personal ratings but high community rating indicating a high concern for substance abuse in the community as a whole.

Residents are largely unaware of the vast resources available to them by SHC and other entities in the valley. Many residents indicated a strongly positive perception of the quality of healthcare that is available to them in Scottsdale, but when pressed to recall specific programs or messages being promoted in the community, they struggled to remember many. It is clear that increasing awareness and effective self-promotion should be goals for SHC.



**APPENDIX B-WestGroup Telephone Survey Respondents Demographics**

Service Area	N	Zip Codes
Thompson Peak	403	85255, 85262, 85266, 85331, 85050, 85054, 85022, 85023, 85024, 85027, 85085, 85086

Demographics	Thompson Peak Service Area (N=403)
<b>Gender</b>	
Male	35%
Female	65%
<b>Education</b>	
Less than high school	2%
High school graduate	13%
Some college	28%
Bachelor’s degree	33%
Post graduate degree	24%
<b>Income</b>	
Under \$15,000	6%
\$15,000 - \$24,999	4%
\$25,000 - \$39,999	7%
\$40,000 - \$59,999	10%
\$60,000 - \$79,999	12%
\$80,000 - \$100,000	12%
Over \$100,000	29%
Don’t know/refused	21%
<i>Mean Income</i>	\$80,680
<b>Number of Children</b>	
None	65%
One	14%
Two	15%
Three or more	5%
Refused	<1%
<b>Arizona resident status</b>	
Year round	95%
Part time	3%
Don’t Know/refused	2%
<b>Primary Insurance</b>	
Private	67%
Medicare/Medicare Advantage	16%



AHCCCS	2%
Self-insured	6%
Military	2%
No insurance	5%
Other	1%
Don't know/Refused	1%
<b>Employment Status</b>	
Full-time	47%
Part-time	8%
Retired	25%
House-spouse	8%
Student	<1%
Unemployed	9%
Don't know/Refused	2%



**APPENDIX C—Scottsdale Healthcare CHNA Steering Committee Members**

<p><b>Wendy Armendariz</b> Executive Director Neighborhood Outreach Access to Health(NOAH)</p>	<p><b>Marialena Murphy</b> Clinical Director, Perioperative Services Scottsdale Healthcare</p>
<p><b>Gary Baker</b> Executive Vice President, Healthcare Operations Scottsdale Healthcare</p>	<p><b>Chris O'Mara, MSN, RN</b> Supervisor, Community Health Services Scottsdale Healthcare</p>
<p><b>David Barber</b> Vice President, Marketing Scottsdale Healthcare</p>	<p><b>Michelle Pabis</b> Executive Director, Gov. &amp; Public Affairs Scottsdale Healthcare</p>
<p><b>Marvin Bell, M.D., MPH</b> Associate Director, Family Practice Scottsdale Healthcare</p>	<p><b>Kimberly Post, DNP, MBA/HCM, RN, NEA-BC</b> Vice President, Administration Thompson Peak Hospital</p>
<p><b>James Burke, M.D., M.B.A.</b> Senior Vice President, Chief Physician Executive Scottsdale Healthcare</p>	<p><b>Bobbi Presser, MPH</b> Executive Director, Clinical Integration Scottsdale Healthcare</p>
<p><b>Evonda Copeland, MLIS</b> Supervisor, Library Services &amp; HealthConnect Scottsdale Healthcare</p>	<p><b>Peggy Reiley, RN, Ed.D.</b> Executive Director, Clinical Integration Scottsdale Healthcare</p>
<p><b>Jess DeJesus, Pharm. D., MBA/HCM</b> Associate Vice President, Department of Pharmacy Scottsdale Healthcare</p>	<p><b>Irving M. Rollingher, M.D.</b> Chief Medical Information Officer Scottsdale Healthcare</p>
<p><b>Karen Ford, RN, MSN</b> Director, Case Management Scottsdale Healthcare</p>	<p><b>Lisa Sandoval, MPH</b> Director, Marketing Scottsdale Healthcare</p>
<p><b>Pauline Hrenchir, BS, MSN, MSL, RNC, RNFA</b> Clinical Director, Women's Services Scottsdale Healthcare</p>	<p><b>Tracey Schalscha, MPH</b> Consultant Scottsdale Healthcare</p>
<p><b>Mary Kopp, RN, BSN, MS</b> Associate Vice President, Administration Scottsdale Healthcare Shea</p>	<p><b>Richard Silver, M.D.</b> Vice President, Chief Medical Officer Scottsdale Healthcare</p>
<p><b>Rena Larcus, Ph.D.</b> Manager, Community Health Services Scottsdale Healthcare</p>	<p><b>Brian Steines, CPA</b> Vice President of Finance Scottsdale Healthcare</p>
<p><b>Diane Legum, MHA</b> Director, Ambulatory Services Scottsdale Healthcare</p>	<p><b>James Stelzer</b> Executive Director Scottsdale Health Partners</p>
<p><b>Jim Marshall</b> Director, Human Resources Scottsdale Healthcare</p>	<p><b>Dean Thomas, MBA, MHSA</b> Vice President, Clinical Services Scottsdale Healthcare</p>
<p><b>Barbara Martindale, MS-NL, RN</b> Project Manager, Community Health Services Scottsdale Healthcare</p>	<p><b>Lindsay Thomas, RN, MSN, OCN</b> Director, Cancer Center Scottsdale Healthcare</p>
<p><b>Peggy Morehouse, RN, BSN, MSL</b> Director, Clinical Nursing Services Scottsdale Healthcare</p>	



**APPENDIX D—Scottsdale Healthcare Community Stewardship Advisory Council Members – 2013**

<p><b>David Barber</b> Vice President, Marketing Scottsdale Healthcare</p>	<p><b>Tracey Schalscha, MPH</b> Consultant Preventive Health Consulting</p>
<p><b>Marvin Bell, M.D., MPH</b> Associate Director, Family Medicine Scottsdale Healthcare</p>	<p><b>Brian Steines, CPA</b> Vice President, Finance Scottsdale Healthcare</p>
<p><b>James Bertz, DDS, M.D.</b> Past President Thompson Peak Hospital</p>	<p><b>Brent Stockwell</b> Director, Strategic Initiatives City of Scottsdale</p>
<p><b>Tim Bray</b> President Southwest Community Resources</p>	<p><b>Trisha Stuart</b> President Giving Solutions</p>
<p><b>Evonda Copeland, MLIS</b> Supervisor, Library Services Scottsdale Healthcare</p>	
<p><b>Jan Gehler, Ed.D</b> President Scottsdale Community College</p>	
<p><b>Laura Grafman</b> Executive Vice President Scottsdale Healthcare Foundation</p>	
<p><b>Bruce Johnson</b> Pastor Scottsdale Presbyterian Church</p>	
<p><b>Virginia Korte, Chair</b> President/CEO Scottsdale Training &amp; Rehabilitation Services(STARS)</p>	
<p><b>Christine Kovach</b> Community Activist McDowell Sonoran Conservancy</p>	
<p><b>Renaë Larcus, Ph.D</b> Manager, Community Health Services Scottsdale Healthcare</p>	
<p><b>Barbara Martindale, MS-NL, RN</b> Project Manager, Community Health Services Scottsdale Healthcare</p>	
<p><b>Michelle Pabis</b> Director, Government Relations Scottsdale Healthcare</p>	
<p><b>Milissa Sackos</b> Executive Director Student and Community Services</p>	