2024 COMMUNITY HEALTH NEEDS ASSESSMENT

HonorHealth Sonoran Crossing Medical Center (SCMC) Service Area

Sponsored by
HonorHealth Sonoran Crossing Medical Center

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Prepared by
www.PRCExcellence.com

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INTRODUCTION

PROJECT OVERVIEW

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This Community Health Needs Assessment — a follow-up to a similar study conducted in 2021 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of HonorHealth Sonoran Crossing Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment was conducted on behalf of HonorHealth by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

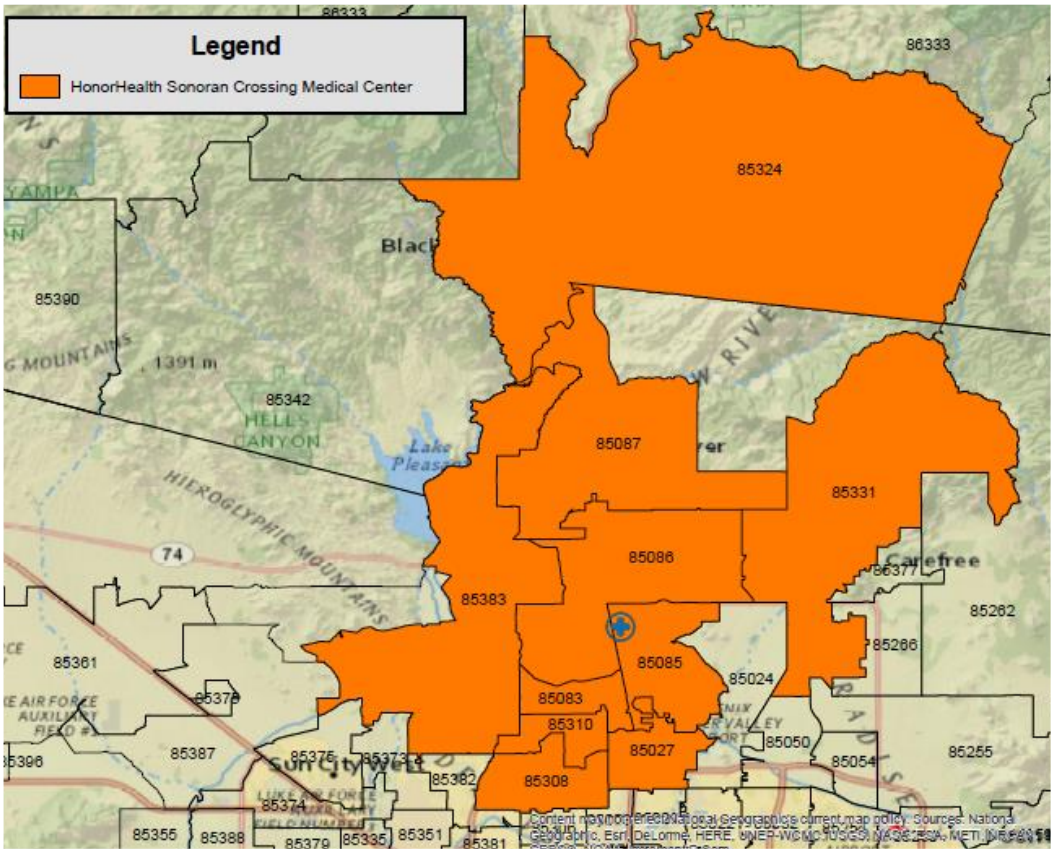
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by HonorHealth and PRC and is similar to the previous survey used in the area, allowing for data trending.

Community Defined for This Assessment

For the purposes of the survey effort, the HonorHealth Sonoran Crossing Medical Center service area (referred to as the “SCMC Service Area” in this report) was determined based on the top 10 residential ZIP Codes contributing to patient volume and is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 310 individuals age 18 and older in the SCMC Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the SCMC Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

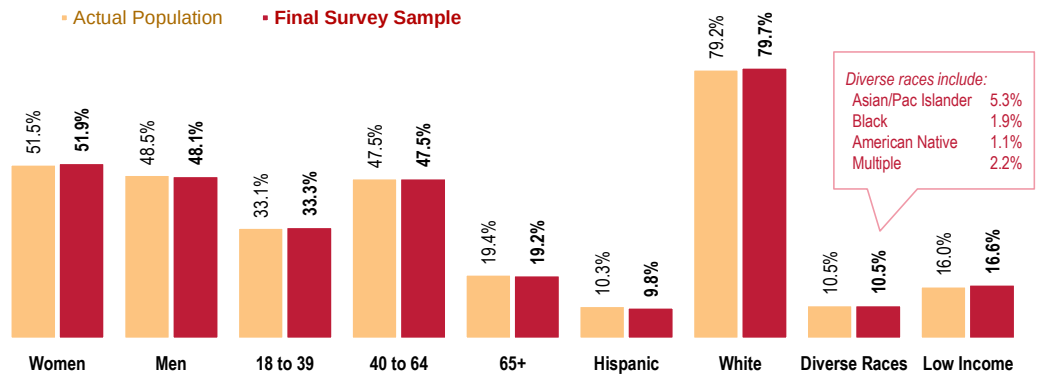
For statistical purposes, the maximum rate of error associated with a sample size of 310 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the SCMC Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older.]

Population & Survey Sample Characteristics
(SCMC Service Area, 2024)



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by HonorHealth; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Here, input was drawn from key informants working in the City of Phoenix and throughout Maricopa County. In all, 67 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	11
Public Health Representatives	5
Other Health Providers	14
Social Services Providers	17
Other Community Leaders	20

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Advanced Health Care of Mesa
- American Heart Association, Greater Phoenix Division
- APS
- Area Agency on Aging, Region One
- Arizona Department of Health Services
- Arizona Public Broadcasting System
- Arizona State University
- Aspen Infusion
- AZ ACES Consortium
- Camelback Fiduciary
- CarePatrol Of Scottsdale
- Circle the City
- City of Phoenix
- City of Phoenix, Public Transit
- Community PCP
- Cypress Home Care Solutions
- Deer Valley Unified School District
- Department of Economic Security
- Desert Hills Presbyterian Church
- Desert Mission
- Dougherty Foundation
- Duet: Partners In Health & Aging
- Emblem Home Health
- Encompass Home Health Care
- ENSIGN–Coronado Care Center
- Faith Hospice
- Foothills Food Bank
- Foothills Sports Medicine & PT
- Friendly House
- Goodwill of Central and Northern Arizona
- Hickey Family Foundation
- Home Care Resources
- Hospice of the Valley
- Human Services Campus
- Jewish Family & Children's Service
- Maricopa County Department of Public Health
- Maricopa Association of Governments
- Neighborhood Ministries
- New Pathways for Youth
- Neighborhood Outreach Access to Health (NOAH)
- Phoenix Chamber of Commerce
- Phoenix Rescue Mission
- Recovia
- Saint Vincent de Paul
- Salvation Army
- Tempe Community Action Agency
- The Flinn Foundation
- theHUB
- Valley of the Sun YMCA
- Virtis Health
- Washington Elementary School District

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Throughout this report, secondary data reflect Maricopa County as a whole.

Benchmark Data

Trending

A similar survey was administered in the SCMC Service Area in 2021 by PRC on behalf of HonorHealth. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Arizona Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

HonorHealth Sonoran Crossing Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, HonorHealth Sonoran Crossing Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. HonorHealth Sonoran Crossing Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	25
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	116
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	123

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Difficulty Finding a Physician – Lack of Transportation – Culture/Language ▪ Lack of Transportation Prevented Work or Appt Access ▪ Primary Care Physician Ratio ▪ Specific Source of Ongoing Medical Care ▪ Emergency Room Utilization
CANCER	▪ Leading Cause of Death
DIABETES	▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Activity Limitations ▪ Caregiving
HEART DISEASE & STROKE	▪ Leading Cause of Death
HOUSING	▪ Key Informants: *Social Determinants of Health (especially Housing & Homelessness)* ranked as a top concern.
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Fall-Related Deaths [Age 65+]
MENTAL HEALTH	▪ Symptoms of Chronic Depression ▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Difficulty Accessing Fresh Produce ▪ Overweight & Obesity

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
RESPIRATORY DISEASE	▪ Pneumonia/Influenza Deaths
SEXUAL HEALTH	▪ Chlamydia Incidence ▪ Gonorrhea Incidence
SUBSTANCE USE	▪ Unintentional Drug-Induced Deaths ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Smoking Cessation

Prioritization of Health Needs

On May 21, 2024, the HonorHealth CHNA Steering Committee (representing multiple HonorHealth hospitals) held an online meeting to review, evaluate, and discuss the significant health issues identified for each of the hospital service areas and for the region overall, based on findings of this Community Health Needs Assessment (CHNA). The committee also considered community feedback on prioritization received from community stakeholders in the Online Key Informant Survey process. Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA. Following the data review, PRC answered any questions and participated in a discussion of the issues raised.

On June 18, 2024, the committee reconvened a second online meeting to take part in a process to prioritize identified health issues based on the data review and input from community stakeholders. In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting platform was used in which each participant was able to register their ratings using a mobile device or web browser.

The participants were asked to evaluate each health issue along two criteria:

SCOPE & SEVERITY ► The first rating was to gauge the magnitude of the problem in consideration of the following:

- How many people are affected?
- How does the local community data compare to state or national levels, or Healthy People 2030 targets?
- To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered using a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

ABILITY TO IMPACT ► A second rating was designed to measure the perceived likelihood of having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Mental Health
2. Nutrition, Physical Activity & Weight
3. Access to Health Care Services
4. Heart Disease & Stroke
5. Diabetes
6. Cancer
7. Substance Use
8. Sexual Health
9. Injury & Violence
10. Respiratory Disease
11. Tobacco Use
12. Disabling Conditions
13. Oral Health

Hospital Implementation Strategy

HonorHealth Sonoran Crossing Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, SCMC Service Area results are shown in the larger, gray column.

The columns to the right of the SCMC Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the SCMC Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2021. Note that survey data reflect the ZIP Code-defined SCMC Service Area.

OTHER (SECONDARY) DATA INDICATORS:

Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect Maricopa County data.

SOCIAL DETERMINANTS	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	3.1 [County-Level Data]	3.1	3.9		
Population in Poverty (Percent)	11.5 [County-Level Data]	13.1	12.5	8.0	
Children in Poverty (Percent)	16.0 [County-Level Data]	17.9	16.7	8.0	
No High School Diploma (Age 25+, Percent)	10.8 [County-Level Data]	11.3	10.9		
Unemployment Rate (Age 16+, Percent)	3.3 [County-Level Data]	3.8	3.6		8.5
% Unable to Pay Cash for a $400 Emergency Expense	19.0		34.0		19.6
% Worry/Stress Over Rent/Mortgage in Past Year	34.0		45.8		32.0
% Unhealthy/Unsafe Housing Conditions	9.1		16.4		5.8
% Worried About Paying Utility Bills in the Past Year	29.8				26.9
% Lack of Transportation Prevented Work or Appointment Access	18.8				8.9
Population With Low Food Access (Percent)	20.8 [County-Level Data]	26.8	22.2		
% Food Insecure	29.2		43.3		21.3
		better	similar	worse	

OVERALL HEALTH	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	15.2	19.2	15.7		13.7
		better	similar	worse	

ACCESS TO HEALTH CARE	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**7.1**	14.0	8.1	7.6	8.2
% Difficulty Accessing Health Care in Past Year (Composite)	**56.2**		52.5		52.9
% Cost Prevented Physician Visit in Past Year	**19.3**		21.6		14.9
% Cost Prevented Getting Prescription in Past Year	**17.2**		20.2		12.0
% Difficulty Getting Appointment in Past Year	**36.0**		33.4		29.6
% Inconvenient Hrs Prevented Dr Visit in Past Year	**21.0**		22.9		20.2
% Difficulty Finding Physician in Past Year	**21.7**		22.0		14.4
% Transportation Hindered Dr Visit in Past Year	**12.9**		18.3		7.3
% Language/Culture Prevented Care in Past Year	**2.4**		5.0		0.3
% Stretched Prescription to Save Cost in Past Year	**14.0**		19.4		13.1
Primary Care Doctors per 100,000	**90.9** [County-Level Data]	96.0	111.7		
% Have a Specific Source of Ongoing Care	**70.5**		69.9	84.0	77.3
% Routine Checkup in Past Year	**66.1**	73.3	65.3		61.2
% Two or More ER Visits in Past Year	**15.7**		15.6		9.3
% Rate Local Health Care "Fair/Poor"	**13.7**		11.5		10.9

better similar worse

CANCER	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	**127.0** [County-Level Data]	130.2	146.5	122.7	145.9
Lung Cancer Deaths per 100,000 (Age-Adjusted)	**25.3** [County-Level Data]	26.2	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)	**17.9** [County-Level Data]	17.7	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)	**16.7** [County-Level Data]	17.0	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)	**12.1** [County-Level Data]	12.2	13.1	8.9	
Cancer Incidence per 100,000 (Age-Adjusted)	**380.2** [County-Level Data]	376.6	442.3		
Lung Cancer Incidence per 100,000 (Age-Adjusted)	**41.5** [County-Level Data]	41.6	54.0		
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	**117.6** [County-Level Data]	113.0	127.0		
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	**77.8** [County-Level Data]	76.4	110.5		
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	**30.1** [County-Level Data]	30.8	36.5		
% Cancer	**11.1**	13.8	7.4		9.6
% [Women 50-74] Breast Cancer Screening	**78.7**	74.9	64.0	80.5	77.3
% [Women 21-65] Cervical Cancer Screening	**76.5**		75.4	84.3	82.2
% [Age 50-75] Colorectal Cancer Screening	**72.0**	65.3	71.5	74.4	75.0
		better	similar	worse	

DIABETES	SCMC	SCMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000 (Age-Adjusted)	**23.1** [County-Level Data]	24.1	22.6		23.9
% Diabetes/High Blood Sugar	**10.3**	12.7	12.8		8.3
% Borderline/Pre-Diabetes	**17.4**		15.0		15.8
Kidney Disease Deaths per 100,000 (Age-Adjusted)	**6.6** [County-Level Data]	7.8	12.8		2.6
% Kidney Disease	**4.7**	4.1	4.1		2.1
		better	similar	worse	

DISABLING CONDITIONS	SCMC	SCMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	**33.8**		38.0		32.7
% Activity Limitations	**33.9**		27.5		28.3
% High-Impact Chronic Pain	**22.5**		19.6	6.4	16.8
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	**36.3** [County-Level Data]	32.7	30.9		40.5
% Caregiver to a Friend/Family Member	**33.0**		22.8		19.7
		better	similar	worse	

HEART DISEASE & STROKE	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000 (Age-Adjusted)	135.3 [County-Level Data]	138.4	164.4	127.4	136.5
% Heart Disease	7.4	7.0	10.3		4.2
Stroke Deaths per 100,000 (Age-Adjusted)	31.3 [County-Level Data]	31.3	37.6	33.4	28.4
% Stroke	3.8	3.8	5.4		2.7
% High Blood Pressure	34.8	30.9	40.4	42.6	35.8
% High Cholesterol	34.2		32.4		38.8
% 1+ Cardiovascular Risk Factor	83.1		87.8		83.9
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	23.9 [County-Level Data]	26.5	22.3		23.8
Teen Births per 1,000 Females 15-19	21.1 [County-Level Data]	22.3	19.3		
Low Birthweight (Percent of Births)	7.0 [County-Level Data]	7.3	8.2		
Infant Deaths per 1,000 Births	4.8 [County-Level Data]	5.2	5.5	5.0	5.7
		better	similar	worse	

INJURY & VIOLENCE	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	**58.7** [County-Level Data]	61.1	51.6	43.2	42.3
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	**10.9** [County-Level Data]	13.1	11.4	10.1	
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)	**88.0** [County-Level Data]	81.6	67.1	63.4	
Homicide Deaths per 100,000 (Age-Adjusted)	**6.3** [County-Level Data]	6.5	6.1	5.5	5.6
Violent Crimes per 100,000	**447.8** [County-Level Data]	482.6	416.0		
% Victim of Violent Crime in Past 5 Years	**5.1**		7.0		4.7
% Victim of Intimate Partner Violence	**17.2**		20.3		17.3
% Household Member Threatened w/Violence in the Past Year	**7.6**				9.4
		better	similar	worse	

MENTAL HEALTH	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**24.2**		24.4		21.9
% Diagnosed Depression	**27.1**	20.2	30.8		27.5
% Symptoms of Chronic Depression	**43.2**		46.7		35.6
% Typical Day Is "Extremely/Very" Stressful	**16.6**		21.1		18.3
Suicide Deaths per 100,000 (Age-Adjusted)	**15.7** [County-Level Data]	18.5	13.9	12.8	15.7

MENTAL HEALTH (continued)	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Mental Health Providers per 100,000	**98.6** [County-Level Data]	106.9	172.3		
% Felt Out of Control Over the Important Things in the Past Year	**38.8**				40.7
% "Sometimes/Rarely/Never" Have Someone to Turn To	**26.8**				25.7
% Receiving Mental Health Treatment	**22.6**		21.9		19.3
% Unable to Get Mental Health Services in Past Year	**12.0**		13.2		9.6
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	**23.4**		30.0		12.4
% 5+ Servings of Fruits/Vegetables per Day	**31.1**		29.1		26.5
% No Leisure-Time Physical Activity	**20.9**	23.4	30.2	21.8	20.7
% Meet Physical Activity Guidelines	**29.2**	25.5	30.3	29.7	27.6
Recreation/Fitness Facilities per 100,000	**11.7** [County-Level Data]	10.6	11.9		
% Overweight (BMI 25+)	**66.6**	66.7	63.3		65.6
% Obese (BMI 30+)	**30.1**	33.2	33.9	36.0	31.2
		better	similar	worse	

ORAL HEALTH	SCMC	SCMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
% Have Dental Insurance	**73.2**		72.7	75.0	73.9
% Dental Visit in Past Year	**60.7**	60.7	56.5	45.0	63.6
		better	similar	worse	

RESPIRATORY DISEASE	SCMC	SCMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000 (Age-Adjusted)	**36.2** [County-Level Data]	38.6	38.1		43.2
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	**10.9** [County-Level Data]	11.4	13.4		6.9
COVID-19 Deaths per 100,000 (Age-Adjusted)	**81.8** [County-Level Data]	87.6	85.0		
% Asthma	**15.2**	9.7	17.9		10.6
% COPD (Lung Disease)	**5.3**	6.7	11.0		4.2
		better	similar	worse	

SEXUAL HEALTH	SCMC	SCMC vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**328.6** [County-Level Data]	296.4	382.2		287.5
Chlamydia Incidence per 100,000	**634.6** [County-Level Data]	570.3	495.5		
Gonorrhea Incidence per 100,000	**311.4** [County-Level Data]	253.2	214.0		
		better	similar	worse	

SUBSTANCE USE	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	12.9 [County-Level Data]	15.1	11.9		12.7
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	12.0 [County-Level Data]	15.7	12.5	10.9	
% Excessive Drinking	23.1	18.7	34.3		26.4
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	26.8 [County-Level Data]	25.8	21.0		12.4
% Used an Illicit Drug in Past Month	3.2		8.4		4.2
% Used a Prescription Opioid in Past Year	18.5		15.1		16.4
% Ever Sought Help for Alcohol or Drug Problem	5.9		6.8		5.8
% Personally Impacted by Substance Use	42.8		45.4		40.9
		better	similar	worse	

TOBACCO USE	SCMC	SCMC vs. BENCHMARKS			
		vs. AZ	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	14.7	12.7	23.9	6.1	14.2
% Someone Smokes at Home	14.2		17.7		10.7
% Use Vaping Products	13.4	9.0	18.5		10.7
% [Smokers] Received Advice to Quit Smoking	65.9		57.8	58.1	56.3
% [Smokers] Have Quit Smoking 1+ Days in Past Year		53.0	53.1	65.7	
		better	similar	worse	

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density. [COUNTY-LEVEL DATA]

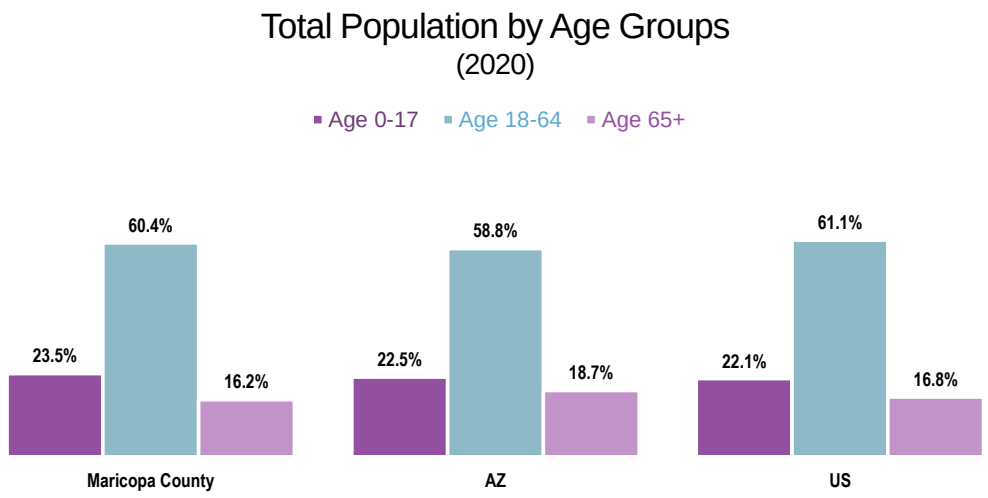
Total Population
(Estimated Population, 2020)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Maricopa County	4,420,568	9,201.74	480
Arizona	7,151,502	113,652.78	63
United States	331,449,281	3,533,018.38	94

Sources:
- US Census Bureau Decennial Census, 2020.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]



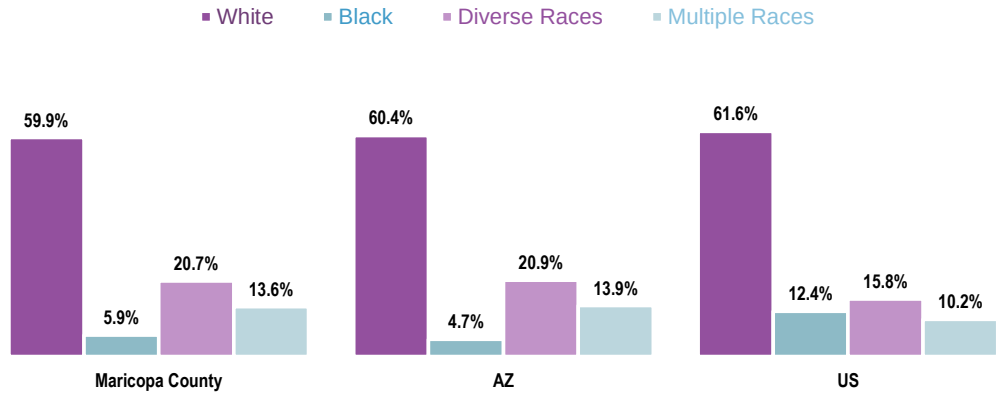
Sources:
- US Census Bureau Decennial Census, 2020.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Race & Ethnicity

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

The following charts illustrate the racial and ethnic makeup of our community. [COUNTY-LEVEL DATA]

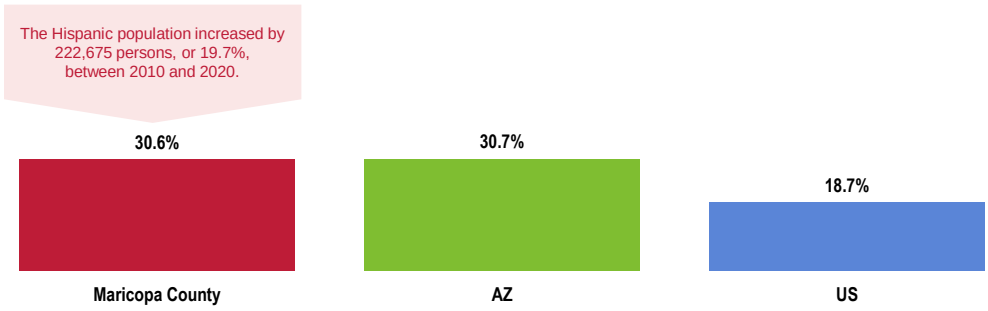
Total Population by Race Alone
(2020)



Sources:
- US Census Bureau Decennial Census, 2020.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Hispanic Population
(2020)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

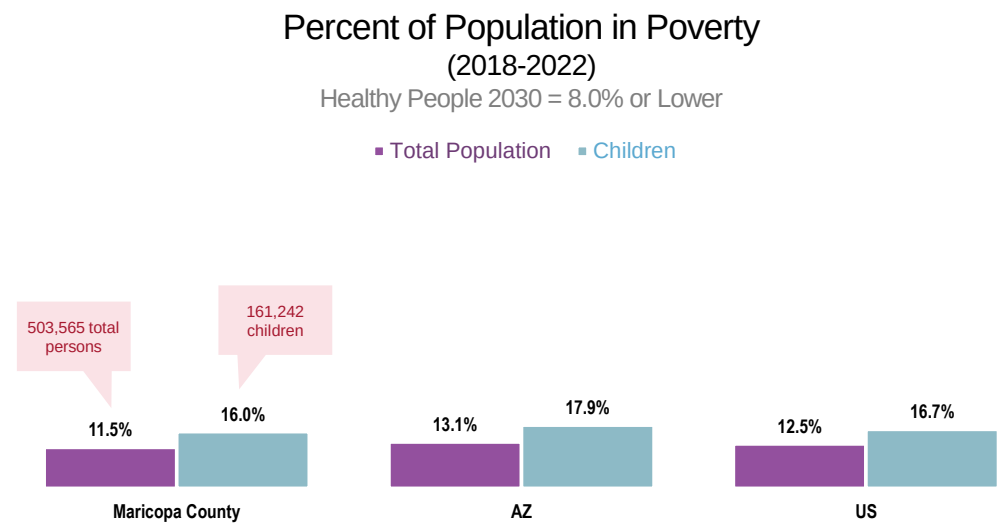
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]

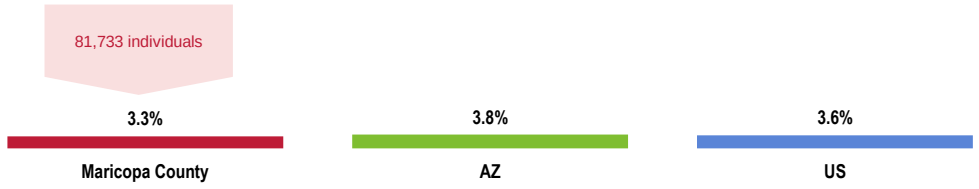


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following unemployment data derived from the US Department of Labor. [COUNTY-LEVEL DATA]

Unemployment Rate



Sources:
- US Department of Labor, Bureau of Labor Statistics, December 2023.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

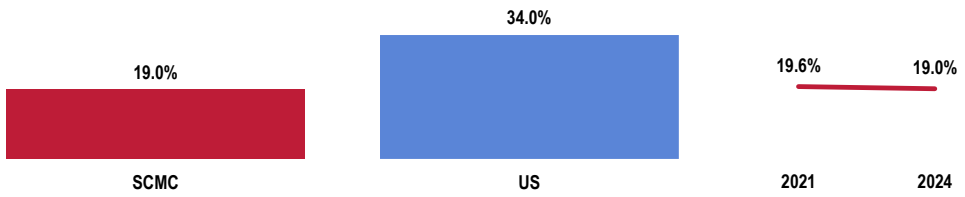
Financial Resilience

PRC SURVEY ► "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following charts detail "no" responses in the SCMC Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status] and race/ethnicity.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

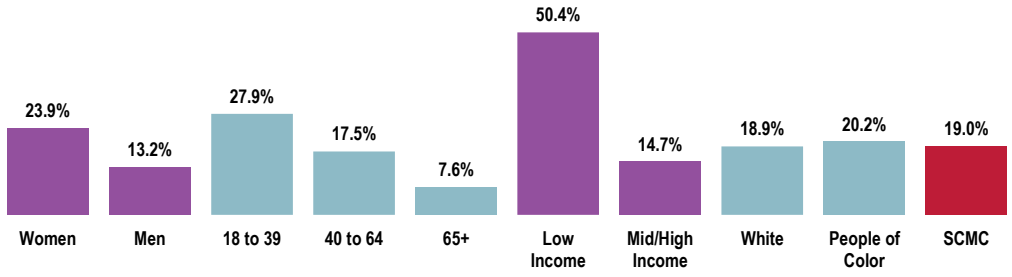
SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(SCMC Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

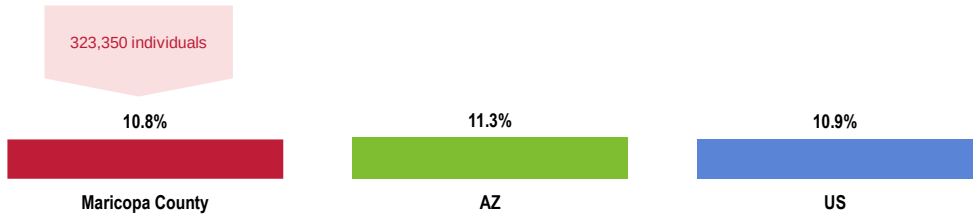
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2022 guidelines place the poverty threshold for a family of four at $27,750 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. “White” reflects those who identify as White alone, without Hispanic origin. “People of Color” includes those who identify as Hispanic, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Adults Age 25 and Older; 2018-2022)



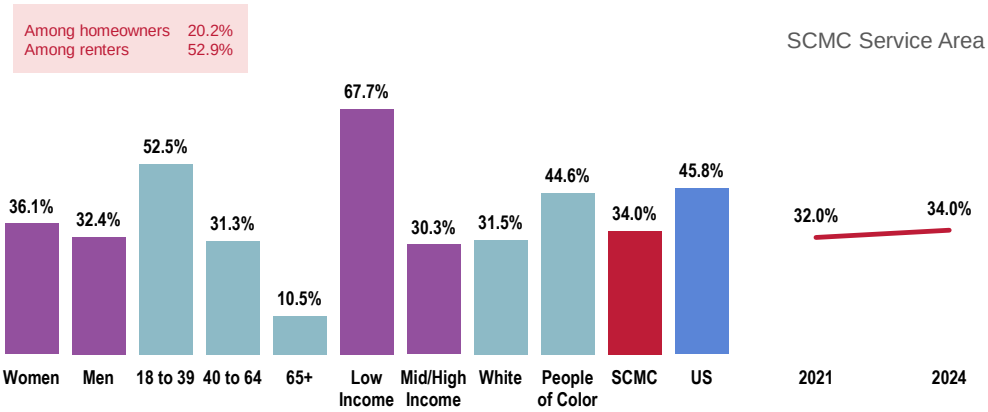
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

PRC SURVEY ► "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

"Always/Usually/Sometimes" Worried About Paying Rent or Mortgage in the Past Year
(SCMC Service Area)

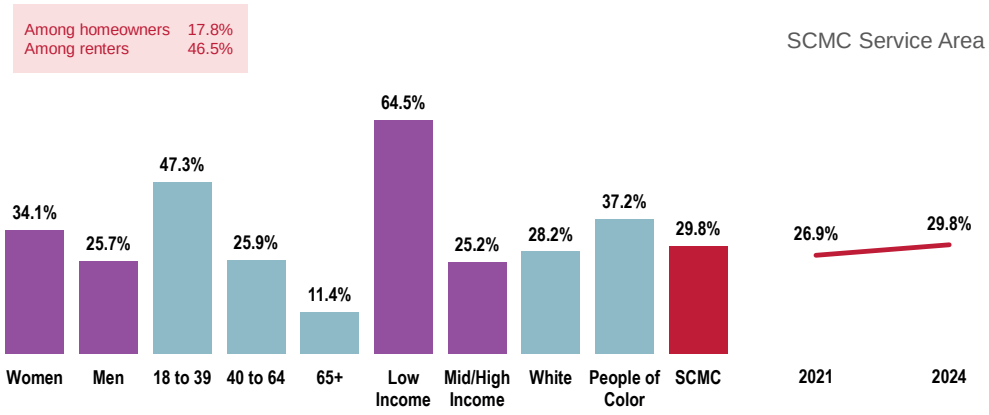


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► "In the past 12 months, how often were you worried or stressed about having enough money to pay your utility bills, such as water, electric, gas, etc.? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

"Always/Usually/Sometimes" Worried About Paying Utility Bills in the Past Year
(SCMC Service Area)

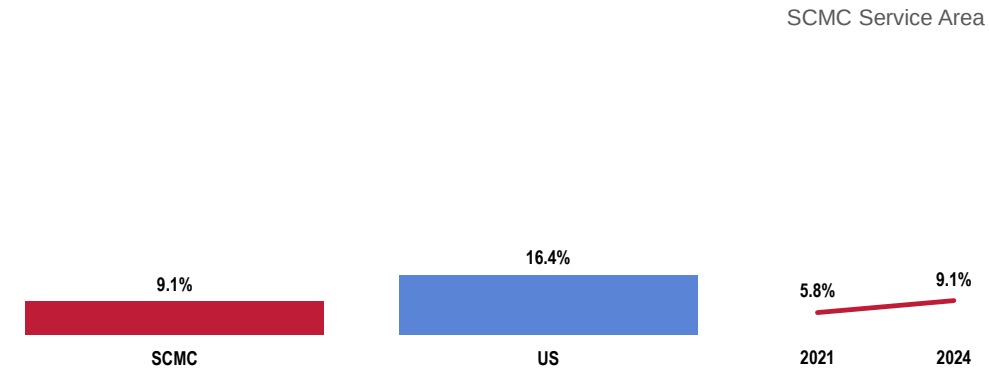


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ► "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(SCMC Service Area, 2024)

Among homeowners 6.0%
Among renters 11.3%

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 55]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Insecurity

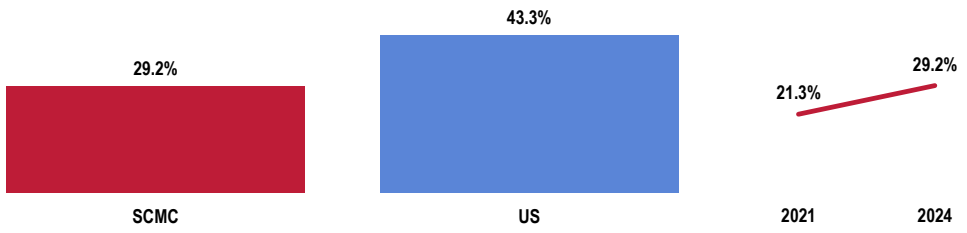
PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecure

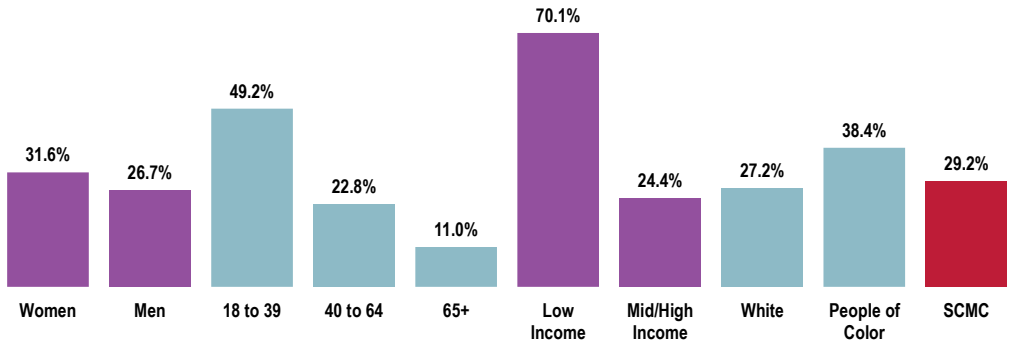
SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecure
(SCMC Service Area, 2024)

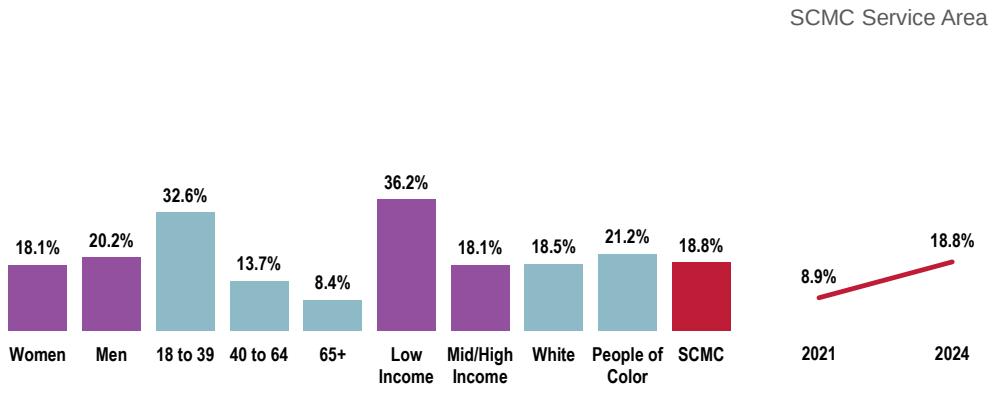


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: • Asked of all respondents.
• Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Lack of Transportation

PRC SURVEY ► "Was there a time during the past 12 months when a lack of transportation made it difficult or prevented you from going to work or getting to a scheduled appointment?"

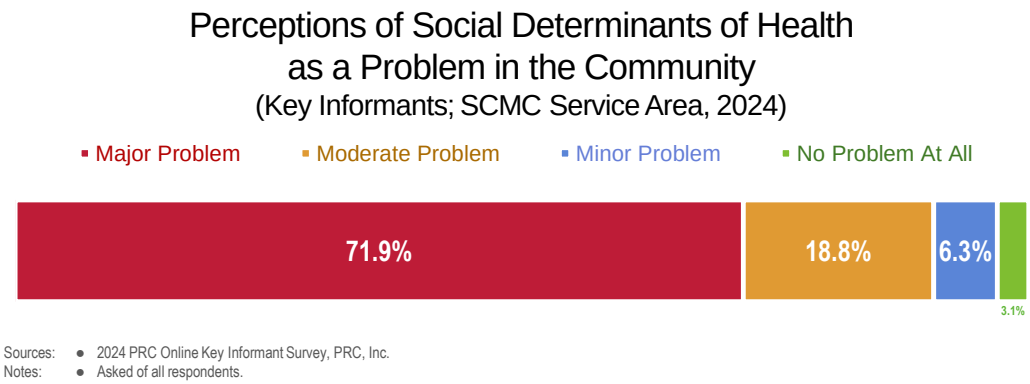
Lack of Transportation Prevented Going to Work or Getting to a Scheduled Appointment in the Past Year
(SCMC Service Area)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Housing

> Many older adults are struggling with the high cost of rent and utilities. They have to chose between paying housing costs, prescriptions and food. – Social Services Provider (Phoenix)
>
> Lack of affordable housing for families and seniors. I don't mean just shelters. Market rate is so high that the average person can't buy a home. Rent is crazy. As an educator, the cost of living is forcing families to move more frequently, this affects their education. – Community Leader (Phoenix)
>
> Housing is unaffordable. Air quality is poor and worsening. Food deserts persist. Hate is rising. – Physician (Maricopa County)
>
> Affordable housing, food security. – Social Services Provider (Maricopa County)
>
> There is housing insecurity everywhere but in our community is becoming a critical issue. We don't have enough resources to provide for all that need assistance with rental, utility assistance. Food insecurity is also an issue and living in an area considered to be a food desert. Education attainment is still a problem with underfunded and understaffed schools. In addition, it's no accident that the poorest areas in the valley are also the hottest during the summer. – Social Services Provider (Maricopa County)
>
> The cost of living continues to go and many residents are reporting that almost 50% of their income is going to housing. This does not leave enough money for a family to survive. Poverty rates are increasing and homelessness is increasing. – Community Leader (Maricopa County)
>
> There aren't enough resources to help people who are unhoused become housed. Housing is healthcare and healthcare is housing. – Social Services Provider (Maricopa County)
>
> Housing has always been an issue in the Valley but has gotten much worse over the past few years due to rising rents, home prices and interest rates. Families are left trying to decide between putting food on the table or paying rent. While there are more high-paying jobs coming to the valley, they tend to be highly skilled positions and we do not have the training programs for those skills. – Community Leader (Phoenix)
>
> Thinking of a person holistically is important; if their housing/food/community is unsafe/unstable, the individual is bound to have more health issues. My community is polluted, impoverished, and lacks affordable housing. – Social Services Provider (Phoenix)
>
> Access to affordable housing is imperative. It isn't about putting people in a "home," it is truly about connecting people to the right services for their needs, with housing being the successful outcome. Offering people access to a variety of housing models is also important: safe outdoor space, tiny home, shelter, converted motel, mobile homes, apartments with wrap-around services are all needed to make the transition to housing successful. – Social Services Provider (Phoenix)
>
> Lack of affordable/attainable housing; income not keeping pace with rising costs; education not available to all; discrimination in housing and other services. – Public Health Representative (Maricopa County)
>
> Housing is a huge problem as housing costs have increased to force people out of their homes. Wages are not keeping up with inflation. – Public Health Representative (Maricopa County)

Homelessness

> Homelessness and uninsured population growth - strain on resources. – Other Health Provider (Maricopa County)
>
> Homelessness. Homelessness increases aging and worsens health outcomes including co-morbidities and early mortality. The fact that we continue to have high rates of homelessness, including increasing rates of homelessness among older adults, suggests that there is a pressing need for affordable and accessible housing solutions that include wraparound services to prevent homelessness and sustain housing for people who have experienced homelessness. Persistent homelessness increases hospital and ED utilization with increased societal costs and unconscionable outcomes that are incongruent with modern society. – Physician (Maricopa County)
>
> Homelessness is bad in Phoenix and they don't get the medical attention that they need because they either don't want it or don't know they need it. Income plays a big part in health and wellness. If people don't have insurance they won't get checked out. And if they do have insurance, sometimes the deductible is so high they can't afford to get checked out. Unfortunately discrimination does play a role in the health care that people receive. Knowingly or maybe unknowingly people automatically have a mindset when someone comes in for help. That mindset determines how they will serve the individual. – Social Services Provider (Phoenix)
>
> Maricopa County lacks truly healthy neighborhoods. In working with people experiencing homelessness and understanding the rate of people losing their housing and the lack of emergency shelter, the lack of affordable housing, and the extreme heat of summer, at times it feels like people in positions of power and influence really aren't interested in supporting health communities. For every 18 households that fall in to homelessness, our community is only able to find housing for 10. – Social Services Provider (Maricopa County)

Access to Care/Services

> Lack of access can lead to homelessness. – Community Leader (Maricopa County)
>
> Without basic needs met, families and community members cannot access healthcare services (thinking about their health is the last priority). – Other Health Provider (Maricopa County)
>
> Many under-resourced communities don't have access to what they need to live a healthy and fulfilling life. – Social Services Provider (Maricopa County)

Income/Poverty

> Poverty rate, immigration status, and education. – Physician (Maricopa County)
>
> High quality health care is mostly available to high income people. Insurance isn’t affordable especially if housing takes over a third of your income. Food insecurity prevents children from learning at an early age and the lingering effects hinder access to later educational opportunities. Affordable childcare is often substandard. – Community Leader (Phoenix)
>
> Large gap between wealthy and poor in our community. Resources are available for those who have. The have-nots are under-resourced. Northern Maricopa county has few low income resources because the perception is it is a wealthy community. Noone wants to acknowledge the hidden poverty. – Social Services Provider (Maricopa County)

Awareness/Education

> Arizona has a failing education system with classroom sizes for most children practically guaranteed to produce individuals with minimal skills and capacity to engage in a fruitful career. Housing is unaffordable for virtually every income level in our community and for those in poverty, housing options are limited to dangerous parts of town where crime and drugs run the streets. Minorities and women continue to face discrimination in the workplace and in laws that dictate what someone can do with their own body. – Social Services Provider (Maricopa County)
>
> We have very limited college going rates. This affects income and health. – Community Leader (Maricopa County)

Cost of Living

> Higher cost of living, no rental stabilization, wages not keeping up with inflation, less tolerance in communities in general. – Other Health Provider (Maricopa County)
>
> Maricopa County is extremely unaffordable for the majority of people who live here. This is exacerbating the SDOH (losing housing, substance use increase). The environment, specifically the heat and the abundance of concrete that increases heat in the Valley, is concerning. – Community Leader (Maricopa County)

Funding

> We have underfunded social programs for decades in AZ. Systemic racism impacts how funds are distributed disproportionately to communities based on tax base and who lives there. This will continue until we elect a more diverse and equitable state government. – Community Leader (Maricopa County)

> SDOH contribute to the downstream health effects. AZ has not invested resources in these social determinants and therefore, people's overall health is impacted. – Public Health Representative (Maricopa County)

Incidence/Prevalence

> A huge body of research and literature points to this as a major problem. – Social Services Provider (Maricopa County)
>
> Working in this field we know we serve about 1/7 residents. The SDOH are factor that often effect their health and ability to improve their current situations. – Social Services Provider (Maricopa County)

Cultural/Personal Beliefs

> Holistic communities define how a community member thrives in a community reaching their full potential. – Community Leader (Phoenix)

Disease Management

> If SDOH are not addressed, health (adhering to diabetes) becomes secondary. Our community is struggling with affordable housing and lack of housing results in patients not having a stable place to live, which results in not having ability to place insulin in refrigerator, etc. and becomes a ripple effect thereafter. – Other Health Provider (Maricopa County)

Follow Up/Support

> Lots of seniors without support, and living alone limits access to care. – Other Health Provider (Maricopa County)

Health Disparities

> Disparities between different segments of the community. – Social Services Provider (Maricopa County)

Nutrition

> Many chronic health and mental health conditions are exacerbated by people not being able to meet their basic needs for food and housing, or adequate transportation to make their health appointments. – Social Services Provider (Phoenix)

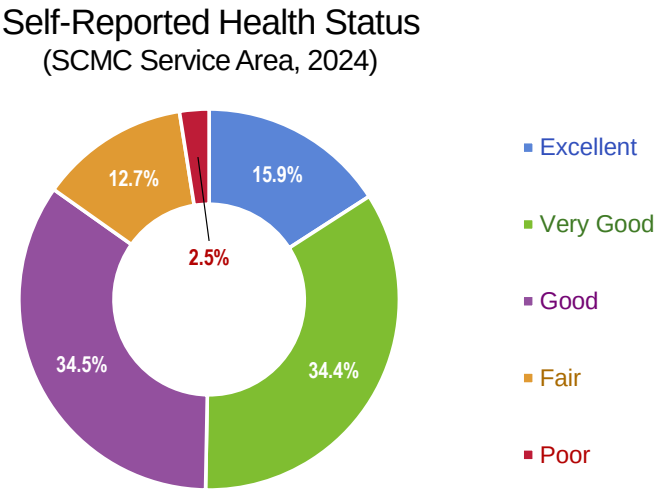
Transportation

> Lack of transportation, patients have hard time going to ED, or going to doctors appointments. – Physician (Maricopa County)
>
> Transportation to medical appointments is a huge problem for older adults who don’t drive. Medicare and many health plans do not cover the cost of medical transportation. – Social Services Provider (Phoenix)

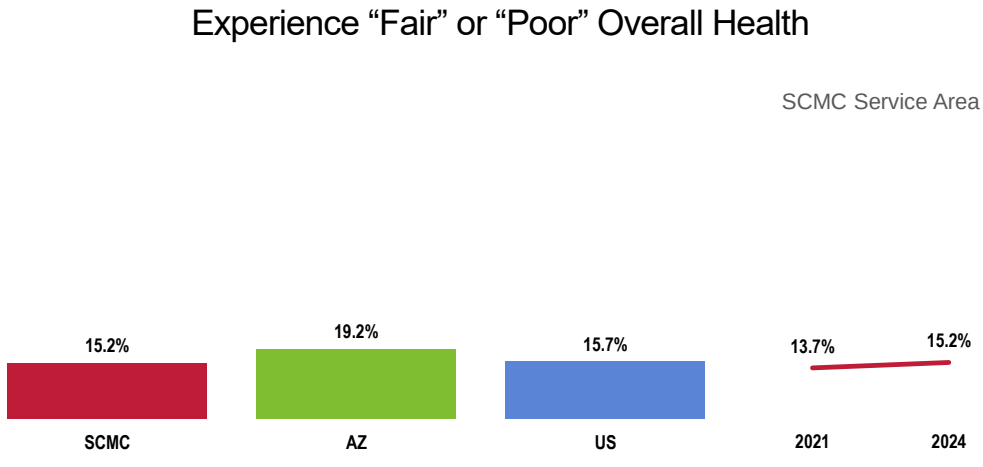
HEALTH STATUS

Overall Health

PRC SURVEY ► "Would you say that in general your health is: excellent, very good, good, fair, or poor?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(SCMC Service Area, 2024)

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

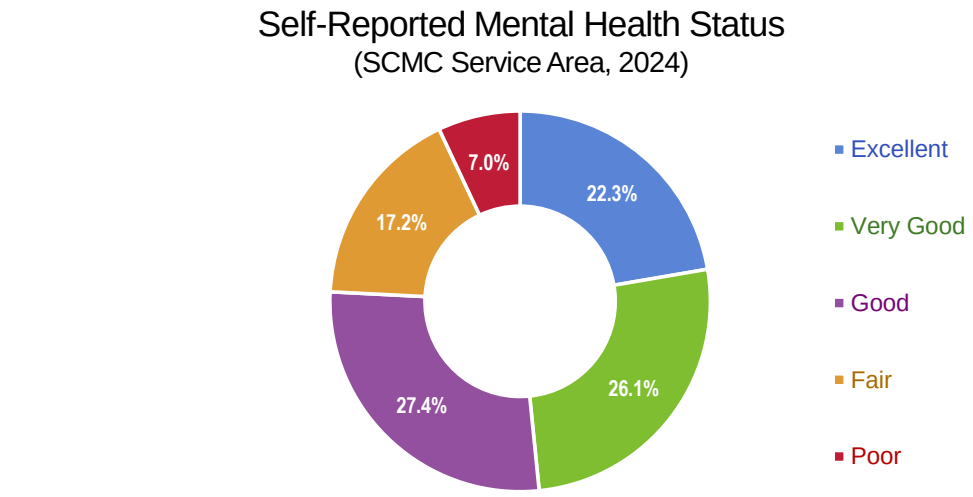
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

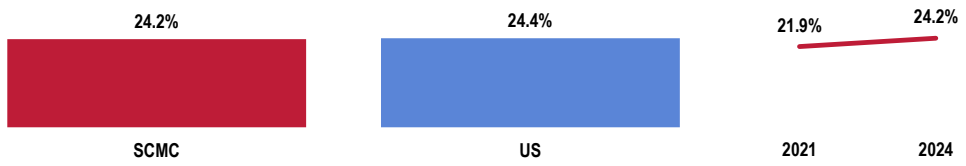
PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

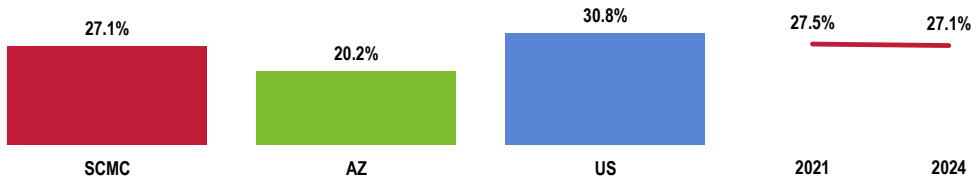
Depression

Diagnosed Depression

PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder

SCMC Service Area



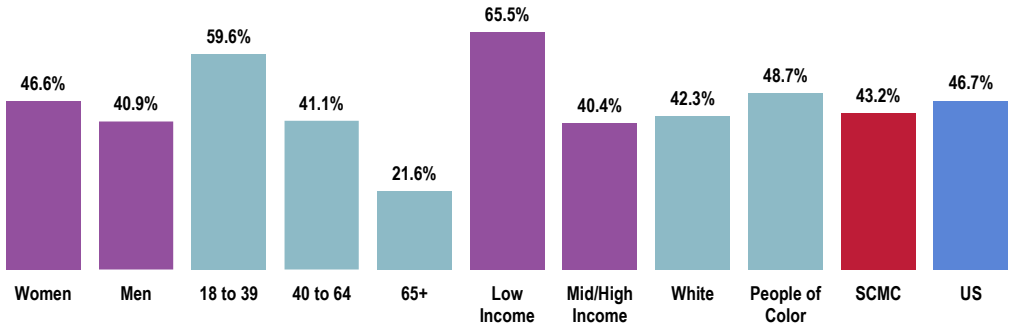
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC SURVEY ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(SCMC Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

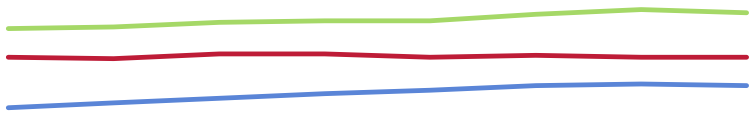
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



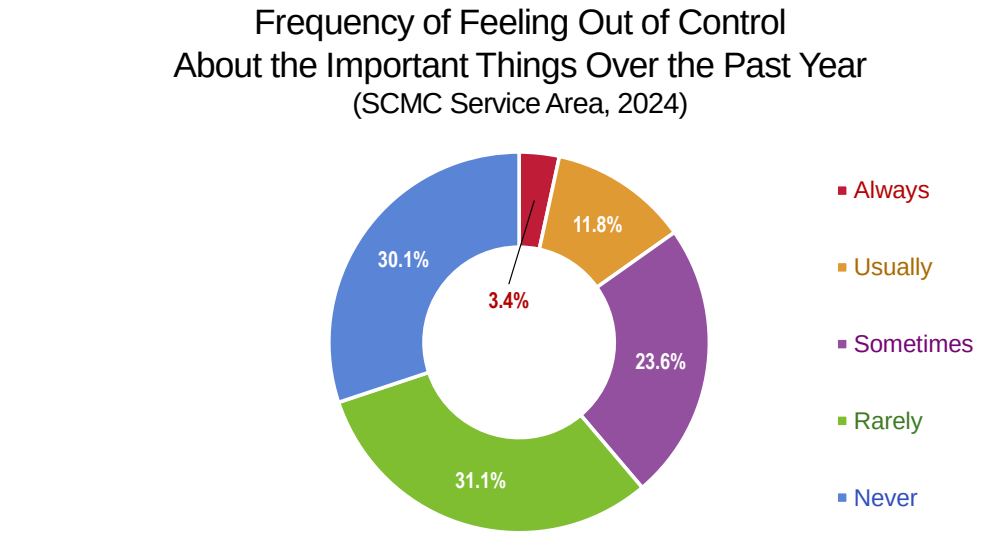
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	15.7	15.6	15.9	15.9	15.7	15.8	15.7	15.7
AZ	17.5	17.6	17.9	18.0	18.0	18.4	18.7	18.5
US	12.5	12.8	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

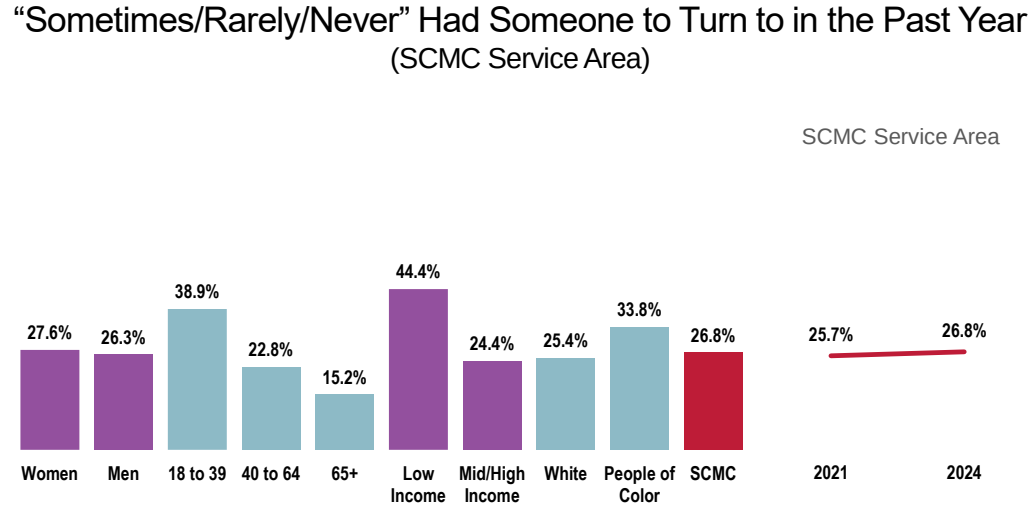
Coping & Support

PRC SURVEY ► "In the past 12 months, how often have you felt that you were NOT able to control the important things in your life? Would you say: always, usually, sometimes, rarely, or never?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.

PRC SURVEY ► "In the past 12 months, how often have you had someone you could turn to if you needed or wanted help? Would you say: always, usually, sometimes, rarely, or never?"



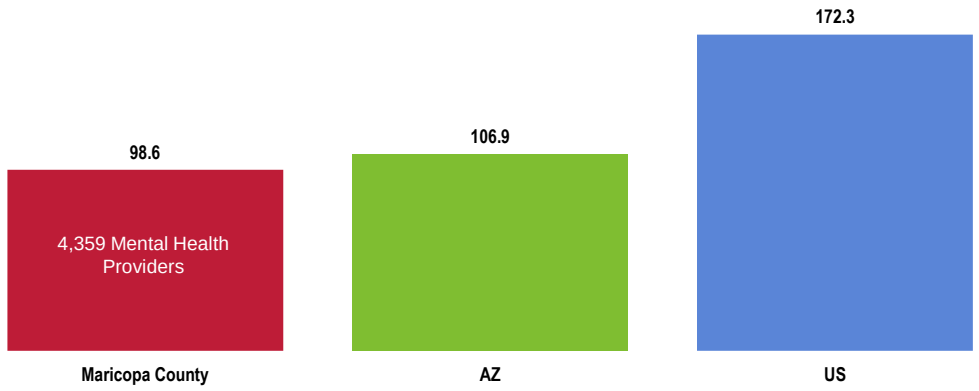
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.

Mental Health Treatment

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]

Number of Mental Health Providers per 100,000 Population
(2024)



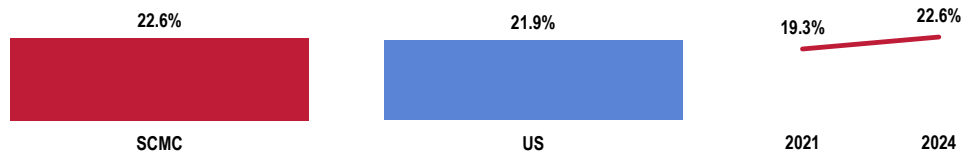
Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

SCMC Service Area



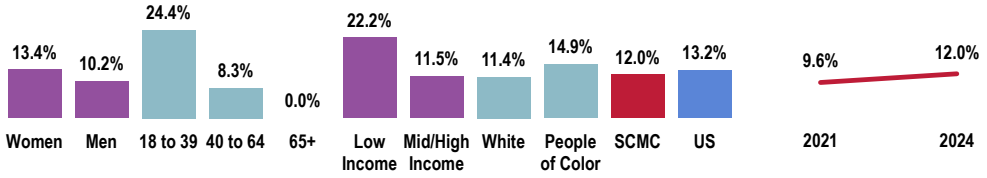
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services
When Needed in the Past Year
(SCMC Service Area, 2024)

SCMC Service Area

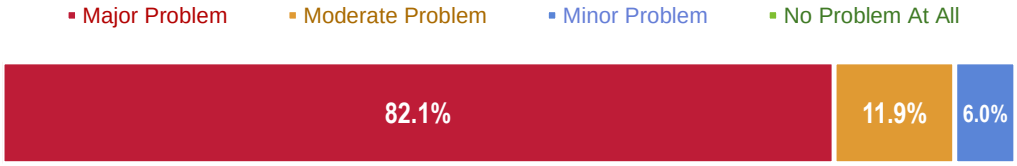


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of
Mental & Emotional Health as a Problem in the Community
(Key Informants; SCMC Service Area, 2024)



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of resources. Not knowing where to turn to, and stigma. – Social Services Provider (Maricopa County)
>
> Access to the appropriate care. – Social Services Provider (Maricopa County)
>
> Access to the provider, as in appointments. – Physician (Maricopa County)
>
> Lack of access to care. Lack of early intervention in schools. – Public Health Representative (Maricopa County)
>
> Access to mental health services, access to integrated care models, such as medical and behavioral health services under one roof, transportation and childcare. – Other Health Provider (Maricopa County)
>
> Access to care. – Physician (Maricopa County)

People with serious mental illness do not have enough access to urgent psychiatric care, mental health/behavioral health inpatient beds, and tremendous disconnect to services through behavioral health clinics. There seems to be a lack of accountability on the behavioral health providers in following treatment plans. On top of that the stigma of mental health issues is a barrier for people to seek help. – Social Services Provider (Maricopa County)

Many agencies closing due to issues with AHCCCS. – Other Health Provider (Maricopa County)

Access to high quality care. – Other Health Provider (Maricopa County)

Access to services, making mental health on the same playing field as physical health. – Community Leader (Phoenix)

Mental health care is incredibly hard to access and the level of care provided - nearly always in group therapy sessions - offers no path to a full recovery but rather some small band-aids that might help someone hobble forward. There is no integrated plan or system of care and those who struggle with mental health have to jump from place to place with 2 weeks of meds offered at a time rather than a comprehensive assessment from a trained psychiatrist and real-time solutions to the crisis. – Social Services Provider (Maricopa County)

Access to good mental health resources in our community is lacking. Wait times to get in can be months long to get established with a longer term provider. Many providers also do not accept insurance, which makes it more challenging and inequitable. – Physician (Maricopa County)

Both getting a professional appointment initially and then receiving treatment. – Community Leader (Phoenix)

I know little about access to programs, but it appears access is limited. – Community Leader (Phoenix)

Access to services, stigma, and willingness to seek help. – Community Leader (Maricopa County)

Access to care immediately. Many people have to reapply for AHCCCS before they can seek help. Access to consistent care. Transportation for care. Storage of medications when they are homeless. – Social Services Provider (Phoenix)

There are not enough resources or programs in the state. – Social Services Provider (Maricopa County)

Lack of care, very fragmented care, and no help with housing. – Community Leader (Maricopa County)

Homelessness

Unhoused individuals with mental health issues, access to services. – Social Services Provider (Maricopa County)

Homelessness. Veteran limited access to treatment and long wait times. – Other Health Provider (Maricopa County)

I see that a lot of transients have mental health issues and there are not enough places to house them and provide them with treatment. It is not only our community's issue, this is a statewide problem. – Social Services Provider (Maricopa County)

This is definitely a huge issue within our community and you can go so many different ways with this. Homelessness is the first thing that comes to mind when you talk about mental health. There are so many unhoused individuals in our community and they all suffer from some sort of mental health issues. Society doesn't want to deal with this segment of the population so they push them out so they don't have to deal with them. And the organizations that do deal with them are under staffed and under funded. This is hard work but important work that needs to be done. Prison reform is another area that needs attention. We put people in prison and say we are going to reform them but they end up coming out of prison worse than when they went in. The psychological toll that prison has on people is so horrible. And then there are the every day people that deal with mental health that try to fix it on their own. Their is a stigma of getting help for mental health. – Social Services Provider (Phoenix)

Homeless, poor social living conditions. Drug ETOH and underemployment. – Physician (Maricopa County)

Lack of Providers

Lack of providers, social stigma and lack of insurance. – Public Health Representative (Maricopa County)

Lack of services from insufficient providers, to limited providers who address specialty issues or populations such as adolescents, seniors, and LGBTQIA. – Public Health Representative (Maricopa County)

There are not enough providers and insurance, whether commercial or private insurance, so it limits the frequency the community is able to access counseling services. – Other Health Provider (Maricopa County)

Lack of mental health providers. Having to wait to be seen by someone. My perception is that many people who are homeless have mental health issue and have addictions to various substances. My perception is that there are too many people dealing with trauma and not enough agencies/providers. – Community Leader (Phoenix)

Our mental health system is not functioning well. There is a shortage of therapists for those who need it. For people with serious mental illness, many are unable to consent to treatment and are significantly suffering, but our system for court ordering people into mental health treatment is complex and attempts to mandate treatment are often unsuccessful. – Social Services Provider (Phoenix)

Incidence/Prevalence

> Anxiety and depression, mood disorders, isolation and loneliness. – Community Leader (Maricopa County)
>
> Depression and anxiety. – Social Services Provider (Phoenix)

Loneliness and Isolation

> Loneliness and isolation. – Community Leader (Maricopa County)
>
> Social isolation. Since the pandemic, individuals have become more socially isolated. Social isolation is connected to higher rates of dementia, poorer health monitoring and overall poor outcomes. – Other Health Provider (Maricopa County)
>
> Loneliness and lack of access to community gathering places. – Community Leader (Maricopa County)

Alcohol/Drug Use

> This is not my area of expertise, but the opioid epidemic is destroying an increasing number of families. The consequences for their children are devastating. The homelessness crisis in our community is reaching epidemic proportions, draining funding away from many critical human services provided by community-based organizations. Prevention is always the most effective, affordable and compassionate solution, yet funding is rarely invested in prevention solutions. – Social Services Provider (Maricopa County)
>
> High population of substance abuse, leading to treatment aversion. – Other Health Provider (Maricopa County)

Denial/Stigma

> Stigma and lack of access to chronic services for mental health. – Physician (Maricopa County)

Due to COVID

> Mental health issues have increased since the COVID pandemic and resources are limited. – Community Leader (Maricopa County)
>
> With the exponential increase in people seeking assistance with mental health issues (as a result of, or brought to light by COVID), the mental health field in Maricopa County is not able to reach everyone. We have a shortage of providers in general and a shortage of providers that take insurance. – Community Leader (Maricopa County)

Access to Care for Uninsured/Underinsured

> It is difficult for those with SMI to access the resources that the state is suppose to provide. In particular, there are limited counseling services available with respect to trauma-informed care and even more limited ability for those with SMI to have appropriate housing (including group) unless they happen to have a wealthy family who can pay the high prices. And, if the family steps in, the state won't do anything to support them. – Community Leader (Phoenix)

Awareness/Education

> Lack of understanding and resources, especially with the current homeless population. – Social Services Provider (Maricopa County)

Co-Occurrences

> I believe mental health is a catalyst for other challenges people face within the community (i.e., homelessness, substance use disorder). Little understanding and stigma surround mental health and not many people understand where to find or seek out resources. – Community Leader (Maricopa County)

Family Support

> A caring and loving support system, people who are supporting people, at a low right now. – Social Services Provider (Maricopa County)

Government/Policy

> State-funded mental health services are awful. – Physician (Phoenix)

Income/Poverty

> Income disparity leading to hardships in life. Drug lords preying on the vulnerable population. – Community Leader (Phoenix)

Insurance Issues

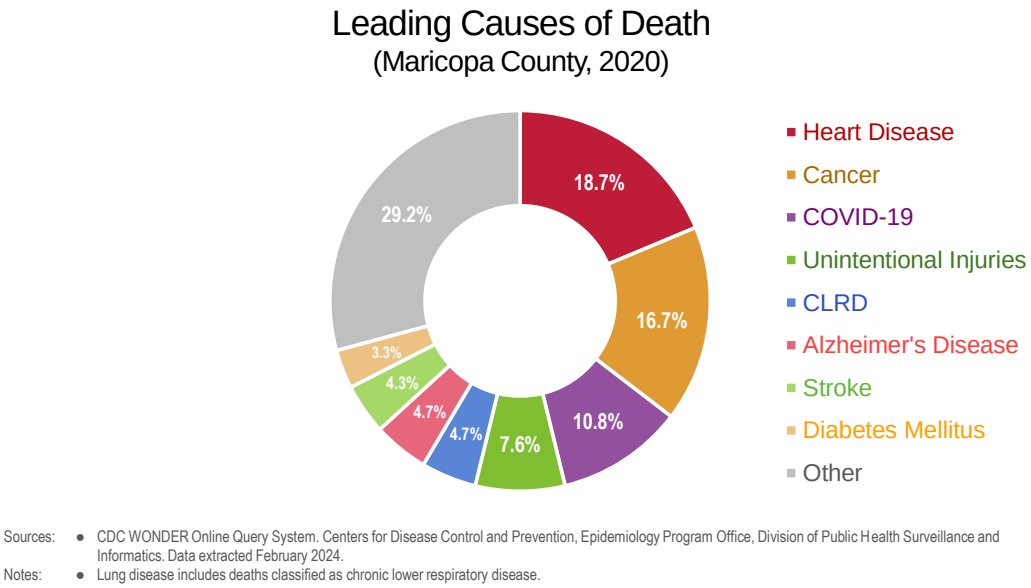
> Lack of insurance coverage for long term or any mental health care. Lack of diverse and culturally responsive options for mental care options. – Community Leader (Maricopa County)

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes: ● Lung disease includes deaths classified as chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Arizona and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death. [COUNTY-LEVEL DATA]

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Maricopa County	AZ	US	Healthy People 2030
Heart Disease	135.3	138.4	164.4	127.4*
Cancers (Malignant Neoplasms)	127.0	130.2	146.5	122.7
Falls [Age 65+]	88.0	81.6	67.1	63.4
COVID-19 (Coronavirus Disease) [2020]	81.8	87.6	85.0	—
Unintentional Injuries	58.7	61.1	51.6	43.2
Alzheimer's Disease	36.3	32.7	30.9	—
Lung Disease (Chronic Lower Respiratory Disease)	36.2	38.6	38.1	—
Stroke (Cerebrovascular Disease)	31.3	31.3	37.6	33.4
Unintentional Drug-Induced Deaths	26.8	25.8	21.0	—
Diabetes Mellitus	23.1	24.1	22.6	—
Suicide	15.7	18.5	13.9	12.8
Alcohol-Induced Deaths	12.9	15.1	11.9	—
Cirrhosis/Liver Disease	12.0	15.7	12.5	10.9
Pneumonia/Influenza	10.9	11.4	13.4	—
Motor Vehicle Deaths	10.9	13.1	11.4	10.1
Kidney Disease	6.6	7.8	12.8	—
Homicide	6.3	6.5	6.1	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

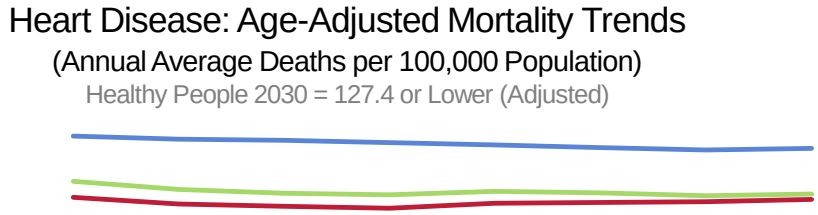
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	136.5	132.8	131.5	130.3	133.2	133.6	134.0	135.3
AZ	145.6	141.0	138.8	138.0	139.9	139.1	137.4	138.4
US	171.3	169.6	168.9	167.5	166.3	164.7	163.4	164.4

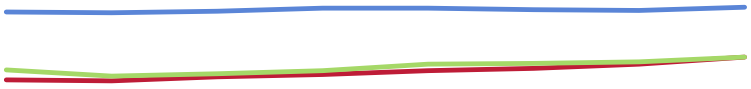
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	28.4	28.3	28.8	29.1	29.6	29.9	30.4	31.3
AZ	29.7	28.9	29.2	29.6	30.4	30.5	30.7	31.3
US	37.0	36.9	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

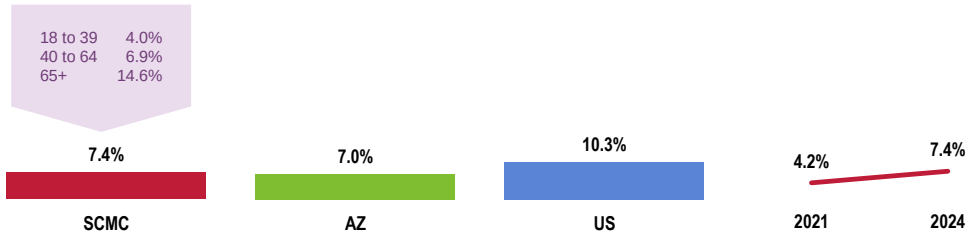
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke

SCMC Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

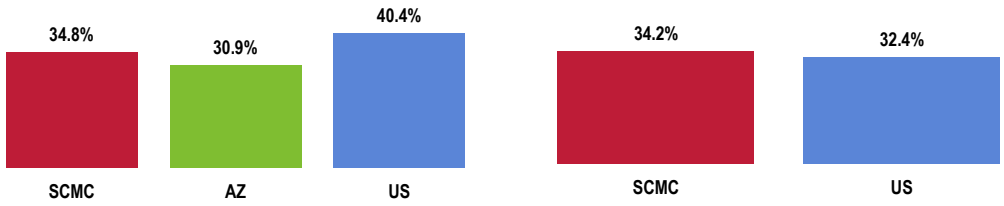
PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower

Prevalence of High Blood Cholesterol

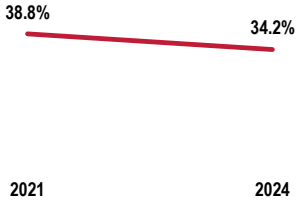


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(SCMC Service Area)
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol
(SCMC Service Area)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

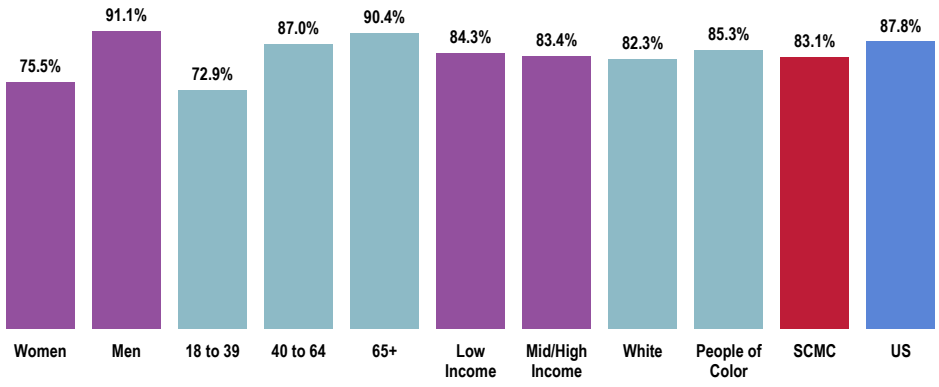
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

The next chart reflects the percentage of adults in the area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

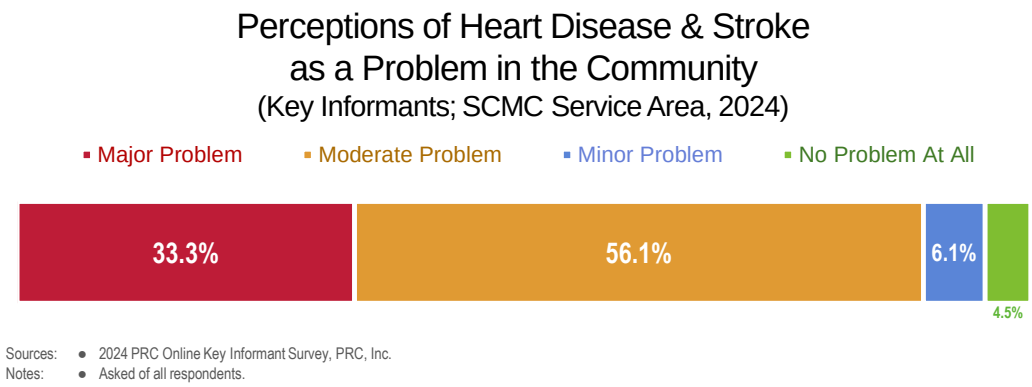
Exhibit One or More Cardiovascular Risks or Behaviors
(SCMC Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Reflects all respondents.
● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Heart disease is the leading cause of death for women in the United States. – Public Health Representative (Maricopa County)
>
> Heart disease is a leading cause of death. – Public Health Representative (Maricopa County)
>
> Heart disease and stroke are the No. 1 and No. 4 killers in Arizona, with most cases being largely preventable. They are also very expensive disease states; if you survive the costs for surgeries, medication, therapy, and on-going monitoring are extremely high. This is a burden on families. – Community Leader (Maricopa County)
>
> Rates of heart disease and stroke continue to be quite high despite increased high cost health services. – Physician (Maricopa County)
>
> I have read these conditions are impacting the health of citizens. – Community Leader (Phoenix)
>
> This is the leading cause of death in Arizona. – Community Leader (Maricopa County)
>
> High rates of death in relation to these issues. – Social Services Provider (Maricopa County)

Access to Affordable Healthy Food

> Lack of access to affordable healthy food. Smoking is prevalent among this population. Unsafe housing that exposes people to unhealthy conditions. It is undetected in many cases, which is also due to limited access to appropriate primary care. – Social Services Provider (Phoenix)
>
> Lack of access to quality, organic food. Lack of education on the topic. – Community Leader (Phoenix)

Nutrition

> Heart disease and stroke I believe is the number-one killer of people. This has a lot to do with diet, exercise and genetics. It's something that I think about a lot and I'm sure it's on the minds of a lot of people in Phoenix. This is something that can be controlled by diet and exercise to some extent. I think this is an important issue that needs to be taught at an early age why diet and exercise are so important to your health. My dad died at an early age from heart disease so I know firsthand how serious this is. Doctors should be talking about this with all of their patients and they should have a baseline for all of their patients. I wish there was more that we could do to detect heart disease and I know things are changing all of the time, but unfortunately this continues to be the number-one killer of people around the world. – Social Services Provider (Phoenix)
>
> Similar to DM, poor diets and activity levels amongst multiple areas. – Other Health Provider (Maricopa County)

Aging Population

> Age of our community, diabetes, tobacco use, and obesity. – Physician (Maricopa County)

Comorbidities

> We see a number of folks who present with these comorbidities. – Social Services Provider (Maricopa County)

Environmental Contributors

> Air quality, pollution, lack of preventative care, and lack of healthy nutrition choices. – Community Leader (Maricopa County)

Income/Poverty

> Low income individuals, in general, and particularly those of African decent have a disproportionately high occurrence of heart disease and stroke. – Social Services Provider (Maricopa County)

Prevention/Screenings

> They are prevalent in the communities or surrounding areas where I live and the community is not taking action to prevent or seek care early on. – Other Health Provider (Maricopa County)

Cancer

ABOUT CANCER

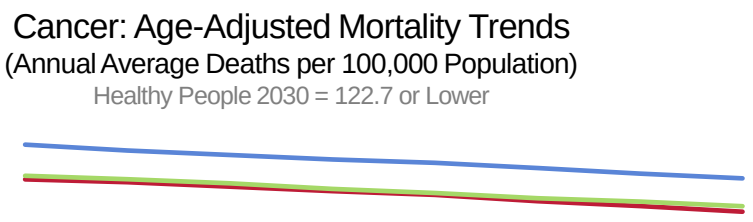
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types). [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	145.9	144.2	141.7	139.0	136.9	133.1	130.3	127.0
AZ	148.0	146.1	143.7	140.3	138.0	134.8	132.9	130.2
US	166.2	162.7	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Lung cancer is by far the leading cause of cancer deaths. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

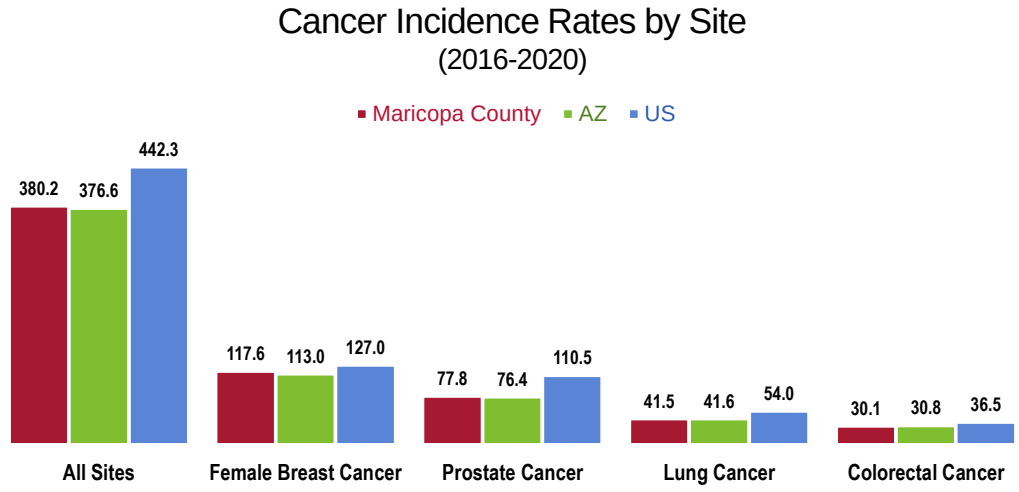
	Maricopa County	AZ	US	Healthy People 2030
ALL CANCERS	127.0	130.2	146.5	122.7
Lung Cancer	25.3	26.2	33.4	25.1
Female Breast Cancer	17.9	17.7	19.4	15.3
Prostate Cancer	16.7	17.0	18.5	16.9
Colorectal Cancer	12.1	12.2	13.1	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population.

Prevalence of Cancer

PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"

PRC SURVEY ► "Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)

Prevalence of Cancer

SCMC Service Area

The most common types of cancers cited locally include:

1) Skin/melanoma 28.0%
2) Breast 12.7%
3) Prostate 10.3%

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer Screening

PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

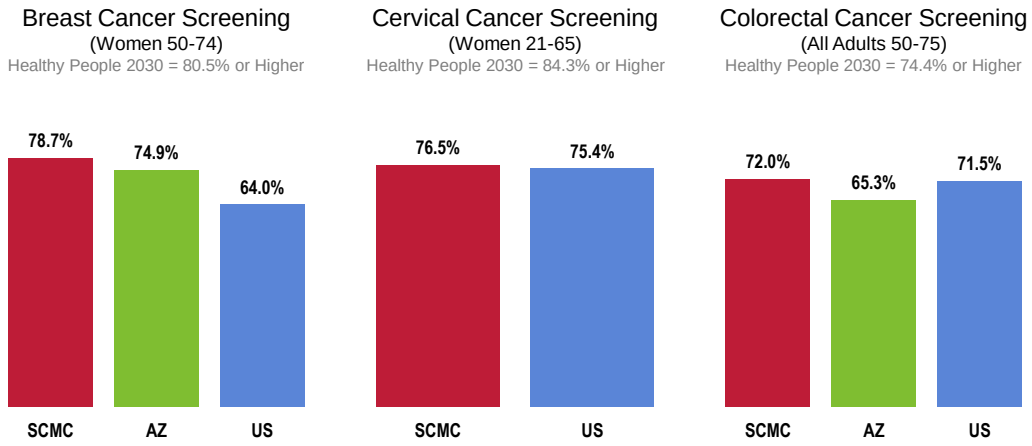
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

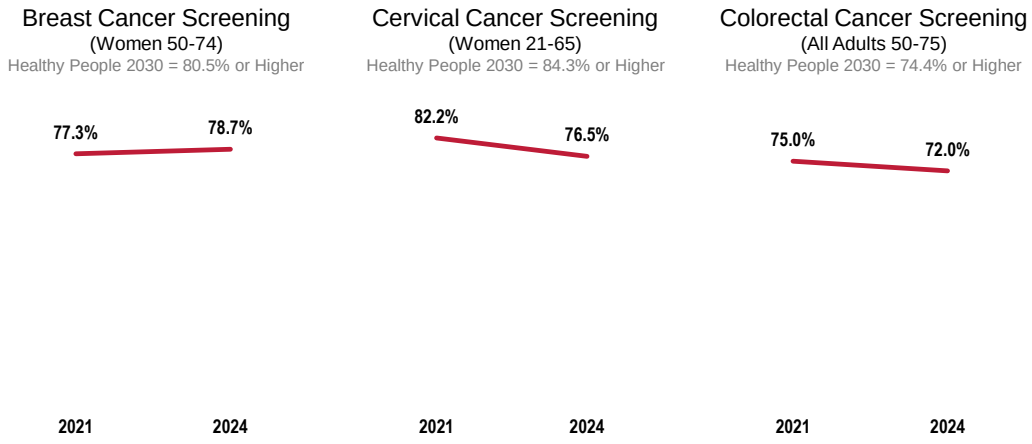
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

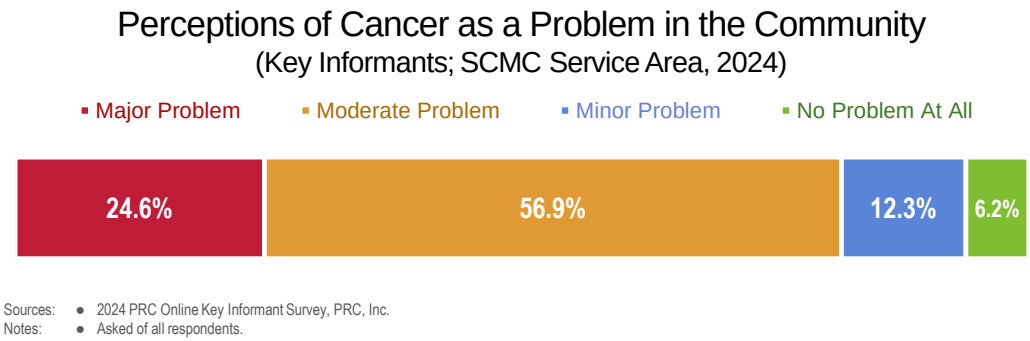


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Cancer seems to be more common now than ever before. There have been a lot of advancements in detecting cancer sooner but I'm not sure people know about these tests and are taking advantage of these tests because of insurance. I also believe that insurance stands in the way of a lot of people getting the treatment that they need because of the cost. I had an employee that only did every other week treatments vs weekly treatments because they couldn't afford doing it every week which just didn't make sense to me. We are learning about new causes for cancer every day and I'm sure it's hard to keep up with all of this in the health industry let alone in the general public. – Social Services Provider (Phoenix)
>
> Cancer is a significant health issue, not only in Maricopa County, but nationwide. We need to have better protocols to screen for and treat cancer early. – Community Leader (Maricopa County)
>
> Because we see a fair number of folks who have been diagnosed, especially with stomach and pancreatic cancer. – Social Services Provider (Maricopa County)
>
> Cancer diagnosis in younger patients is growing and we don't know all the reasons why. Cancer continues to be a costly and high burden on patients. Access to care exacerbated by the pandemic causes delay in diagnosis leading to increased morbidity and mortality. Additionally, many cancers are directly linked to lifestyle behaviors including tobacco but more now related to diet and obesity. Further resources are needed to impact and reduce those know links to increased risk for cancer. we also need to address the environmental causes of cancer in our communities. – Physician (Maricopa County)
>
> On the rise overall, not just my community, especially colorectal and pancreatic. – Physician (Maricopa County)
>
> In my age group, including myself at 59, so many have been stricken with many different forms of cancer. – Social Services Provider (Maricopa County)
>
> Cancer is one of the top causes of death and impacts so many people throughout the community. – Public Health Representative (Maricopa County)

Access to Affordable Healthy Food

> Lack of quality food and wellness opportunities for disadvantaged members of our society. – Community Leader (Phoenix)

Access to Care/Services

> Accessing screening for cancer is not equitable across the County. There are areas, such as Maryvale, where a prevalence of cancer has affected low income households. Affordable care for people with cancer doesn't really exist, making the cost of treatment prohibitive to maintaining housing. – Social Services Provider (Maricopa County)

Affordable Care/Services

> High cost treatment and it is only palliative care, no cure, high mortality rates. – Physician (Maricopa County)

Awareness/Education

> The prevalence of cancer as well as the types of cancer that would be preventable or curable with earlier access to information and/or elimination of risk factors present in the community that are known cancer-causing elements. – Social Services Provider (Maricopa County)

Family Support

> Everyone knows someone who has cancer. Missing layer of support for the whole family going through it. – Social Services Provider (Maricopa County)

Government/Policy

> With all of the money our government has thrown into vaccines for COVID, imagine if they had treated cancer like the moon shot, where would we be today. More needs to be done. – Other Health Provider (Maricopa County)

Homelessness

> With limited access to care for many people experiencing homelessness, regular primary care is not the normal way people access care. Too many use the emergency room or urgent care when ongoing care primary care is how people get true care. – Social Services Provider (Phoenix)

Prevention/Screenings

> Lack of community engagement with screening, early detection, and uninsured access to treatment options. – Other Health Provider (Maricopa County)

Respiratory Disease

ABOUT RESPIRATORY DISEASE

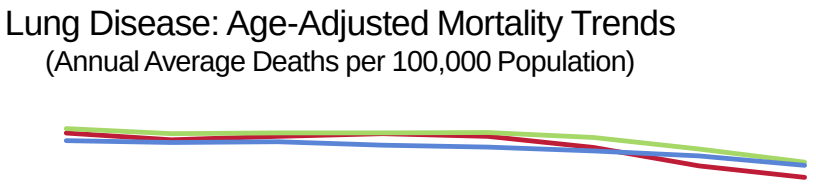
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Lung Disease

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow. [COUNTY-LEVEL DATA]



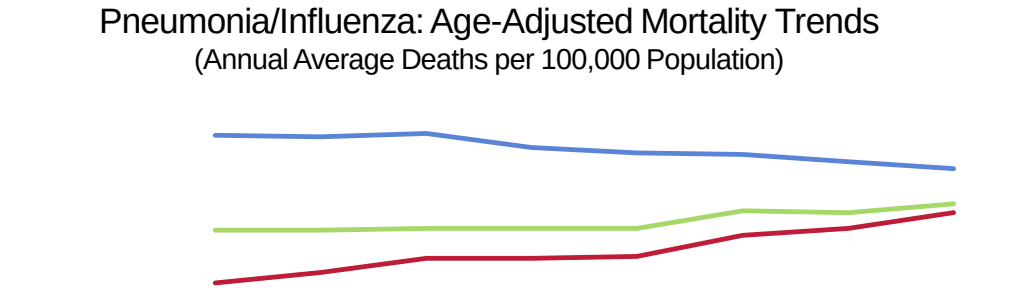
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	43.2	42.1	42.7	43.1	42.7	40.9	38.0	36.2
AZ	43.9	43.1	43.2	43.2	43.3	42.5	40.7	38.6
US	42.0	41.7	41.8	41.3	41.0	40.4	39.6	38.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza

Pneumonia and influenza mortality is illustrated here. [COUNTY-LEVEL DATA]



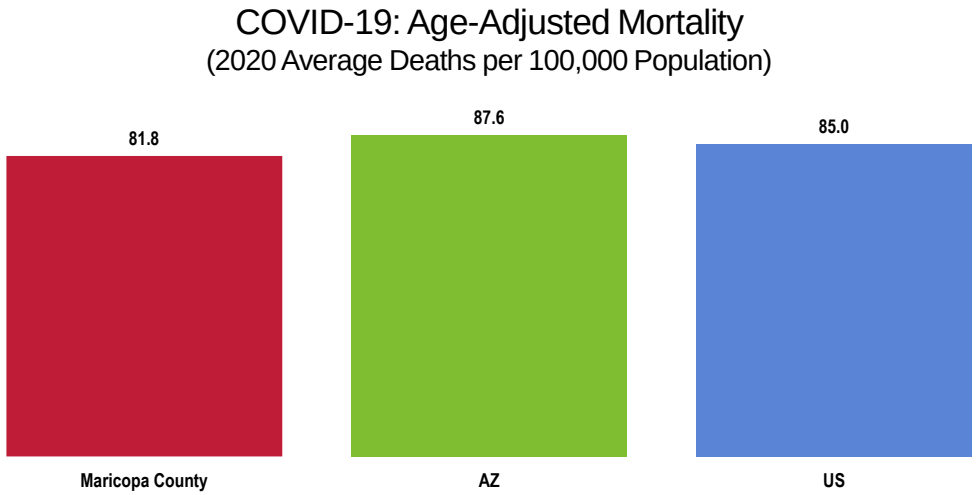
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	6.9	7.5	8.3	8.3	8.4	9.6	10.0	10.9
AZ	9.9	9.9	10.0	10.0	10.0	11.0	10.9	11.4
US	15.3	15.2	15.4	14.6	14.3	14.2	13.8	13.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted COVID-19 (Coronavirus Disease) Deaths

Age-adjusted mortality for COVID-19 is illustrated in the following chart. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"

Prevalence of Asthma

SCMC Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► "Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

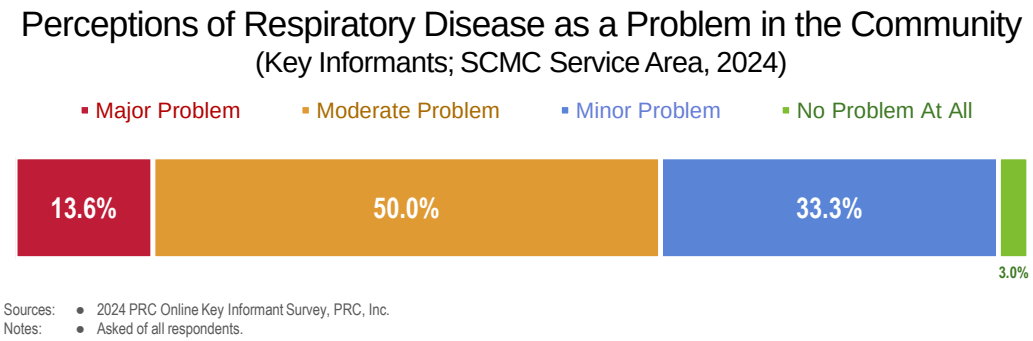
SCMC Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Environmental Contributors

> With a growing population, pollution from factories, automobiles and factories will continue to make it harder for people with respiratory problems. – Social Services Provider (Maricopa County)
>
> COPD is in the top five killers for Arizona. With increased pollution, it continues to increase. – Community Leader (Maricopa County)

Incidence/Prevalence

> Much reporting has occurred related to RSV, COVID and other respiratory diseases. – Community Leader (Phoenix)
>
> RSV and Influenza A spike and poor air quality. – Other Health Provider (Maricopa County)

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

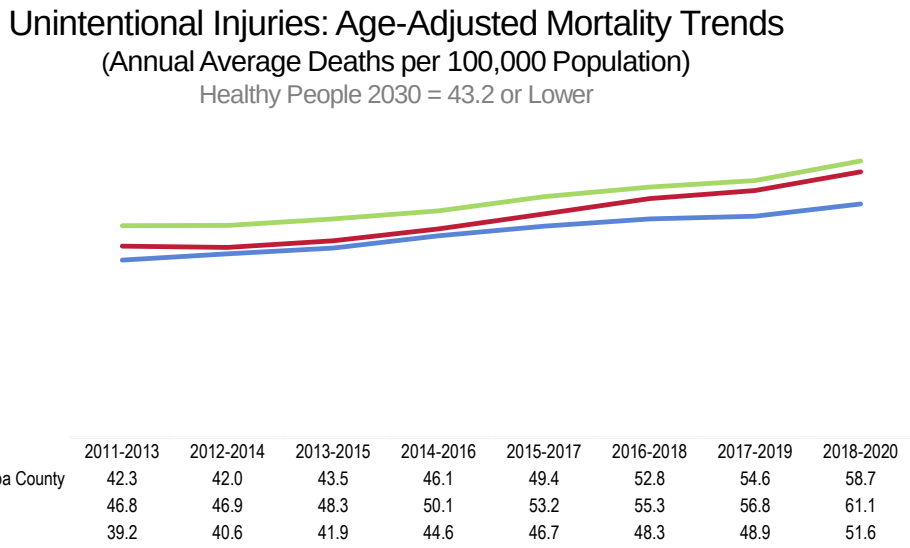
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	42.3	42.0	43.5	46.1	49.4	52.8	54.6	58.7
AZ	46.8	46.9	48.3	50.1	53.2	55.3	56.8	61.1
US	39.2	40.6	41.9	44.6	46.7	48.3	48.9	51.6

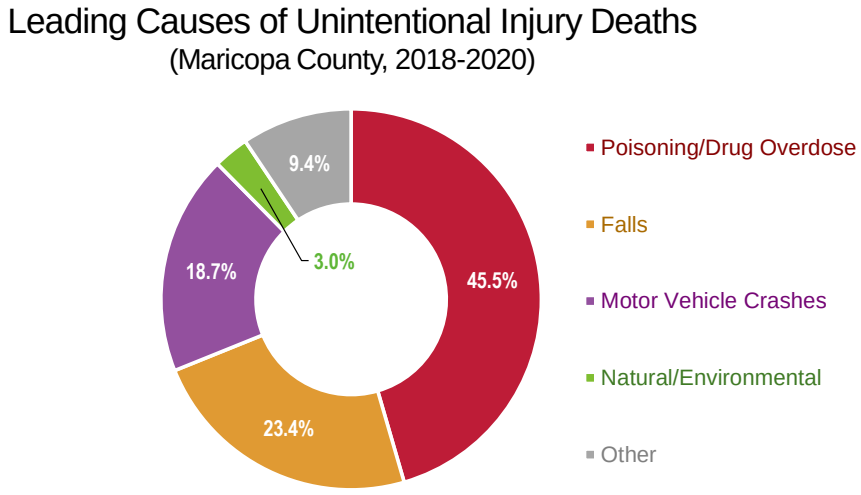
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

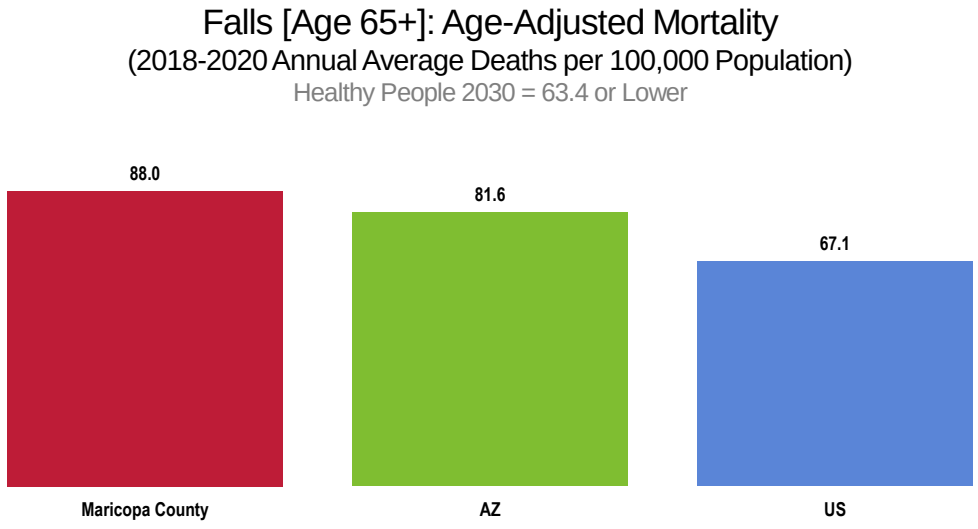
The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Fall-Related Deaths

Age-adjusted mortality attributed to falls (among adults age 65+) is shown in the following chart. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]

Homicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	5.6	5.4	5.4	5.7	6.1	6.1	6.0	6.3
AZ	6.2	5.7	5.5	5.6	6.1	6.3	6.2	6.5
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

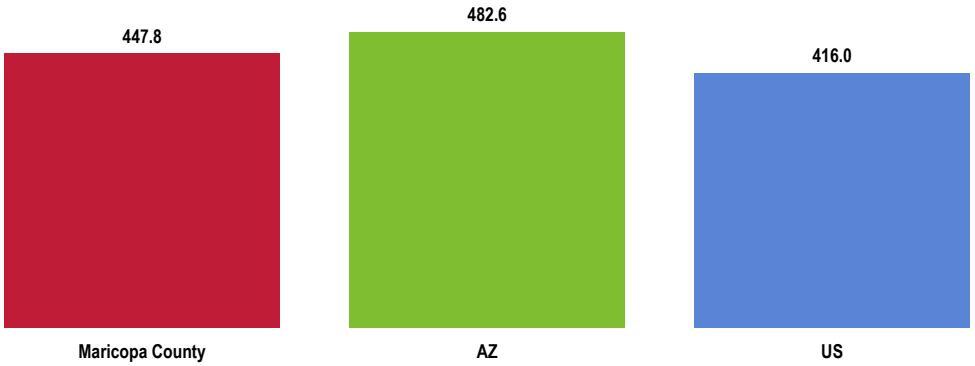
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]

Violent Crime Rate
(Reported Offenses per 100,000 Population, 2015-2017)



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Violent Crime Experience

PRC SURVEY ► "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

PRC SURVEY ► "During the past 12 months, has anyone threatened you or another member of your household with physical violence? This includes threatening to hit, slap, push, kick, or physically harm them in any way."

Victim of a Violent Crime in the Past Five Years
(SCMC Service Area, 2024)

Separately, a total of 7.6% of respondents report that a member of their household has been threatened with physical violence in the past year.

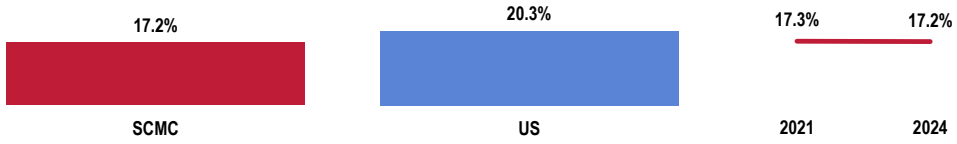
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 32, 302]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ► "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

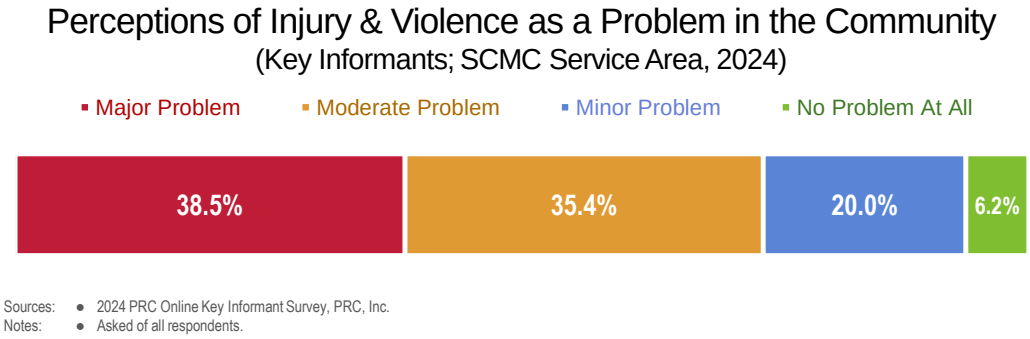
SCMC Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> At places where I work, I see a lot of assault-type visits. – Physician (Maricopa County)
>
> Arizona, Maricopa County, has an extremely high rate of vehicle and pedestrian accidents. – Community Leader (Maricopa County)
>
> Major city, significant violent incidents and traffic injuries and deaths. – Social Services Provider (Maricopa County)
>
> We have a victim advocate program within Friendly House and it's evident through our experience that this is an existing and growing problem in our community. – Social Services Provider (Maricopa County)
>
> Phoenix has high rates of pedestrian accidents, traffic accidents and wrong way drivers. Some of the worst intersections in the country. Red light running, gun violence, and a shortage of public safety, Phoenix police officers. – Social Services Provider (Maricopa County)
>
> We track major crime statistics and these are a major part of our community. – Community Leader (Phoenix)
>
> Our catchment areas for our clinics in Maryvale post high crime and violence prevalence. – Social Services Provider (Maricopa County)
>
> Injury and violence have become a national issue that clearly is impacting our community. Every day, there are news stories about murders and violent acts. – Public Health Representative (Maricopa County)
>
> Increase of aggressive behavior and gun-related incidents and injuries. – Social Services Provider (Maricopa County)
>
> Due to the increase in crime, these are the results of that issue. As crime increases, so do these issues. They go hand in hand. – Community Leader (Phoenix)
>
> Increase in crimes over last 24 months. – Other Health Provider (Maricopa County)

Homelessness

> With the increase in the number of people experiencing homelessness, violence, drug use and untreated mental health issues continue to rise. These issues expose people both those on the street and community members reaching out to offer services are in jeopardy of becoming a victim. More community education and awareness of people needs is necessary. – Social Services Provider (Phoenix)
>
> Increased homelessness. – Other Health Provider (Maricopa County)
>
> Transient nature of Maricopa County, so many new residents each day. Under funded and understaffed resources for prevention, including police, fire, and mental health system prevention expertise. – Community Leader (Maricopa County)

Gun Violence

> Our county has a high rate of suicide by gun, as well as a lot of guns in general per capita. – Community Leader (Maricopa County)
>
> Gun violence with automatic weapons. There is no need for these weapons to be in the public's hands. They are military weapons only. – Social Services Provider (Maricopa County)

> Shootings in Phoenix are high and youth that are in our program talk about gun shots in their neighborhood all of the time. This not only affects them physically but mentally. Homelessness also plays a part in this too as we try to figure out solutions to keep unhoused people safe. You hear a lot about shootings in the news every day and until there are laws to help reduce gun violence this will continue to rise. I believe mental health has a lot to do with the gun violence and ensuring guns are not in the wrong hands is a start. – Social Services Provider (Phoenix)

Alcohol/Drug Use

> Rates of drug overdose are high, particularly fentanyl, and injuries and deaths due to motor vehicle crashes have been increasing. Self-harm and suicide have also increased. – Public Health Representative (Maricopa County)

Social Media/Technology

> I've noticed an increase of fights the youth in my community are engaging in. The use social media to capture, promote, and encourage fights seem to be on the rise. – Social Services Provider (Phoenix)

Diabetes

ABOUT DIABETES

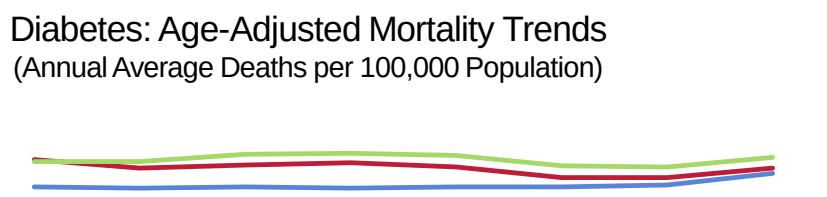
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	23.9	23.1	23.4	23.6	23.2	22.2	22.2	23.1
AZ	23.7	23.7	24.4	24.5	24.3	23.3	23.2	24.1
US	21.3	21.2	21.3	21.2	21.3	21.3	21.5	22.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Diabetes

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

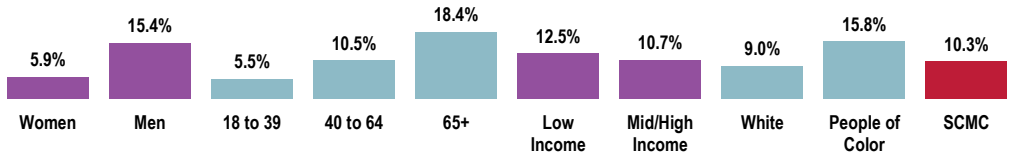
Another 17.4% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

SCMC Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(SCMC Service Area, 2024)

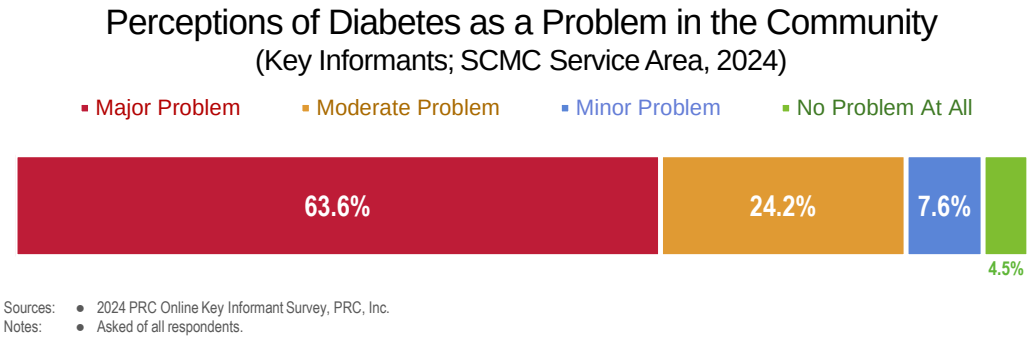


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Education for self-management, access to healthy foods, and access to necessary medications. Access includes both geographic and economic access. – Physician (Maricopa County)
>
> Education and support in managing their disease, cost of healthy food, education on benefits and types of physical activity. – Community Leader (Maricopa County)
>
> Provide community members with education and access to healthy and nutritional foods. – Social Services Provider (Maricopa County)
>
> Access to nutrition advice and ability to get support in managing caloric intake and food choices. – Physician (Maricopa County)
>
> There are a lack of resources for optimal treatment including needed diabetes education programs, lifestyle medicine programs to address non pharmacological treatment options that are cost saving, lack of trained endocrinologists, and lack of payment for needed medications know to improve morbidity and mortality,1 in 3 patients are at risk for diabetes nationally and more 1 in 10 have diabetes. It is epidemic and the consequences of diabetes lead to multiple know poor health outcomes (cardiovascular, stroke, vision loss, amputation and chronic neuropathy/pain to name just a few) with associated significantly increased costs. – Physician (Maricopa County)
>
> Lack of health literacy in a language and level that the community understands. Lack of financial income to pay for health insurance and seek care. Lack of preventable care and education. – Other Health Provider (Maricopa County)
>
> Access to education, challenges with behavioral health and habits. – Other Health Provider (Maricopa County)
>
> Knowledge about diabetes and access to proper care, including transportation. – Social Services Provider (Maricopa County)
>
> Education and understanding of prevention and healthy choices. Access to healthy food is another challenge for people with diabetes in my community. – Social Services Provider (Phoenix)
>
> Knowledge about nutrition and how to prepare healthy food, or access to prepared foods that are healthy. – Community Leader (Maricopa County)

Nutrition

> Nutritious food is still an issue for families and individuals across Maricopa County. There are food deserts where individuals cannot purchase fresh fruits and vegetables. Also, the cost of these fresh items and healthier choices is often more expensive than the fast food options available more widely. Each of these factors impact individuals with diabetes, or pre-diabetes. – Community Leader (Maricopa County)
>
> Food deserts, which lead to unhealthy food options and obesity. – Community Leader (Maricopa County)
>
> Controlling diet and losing weight. – Social Services Provider (Phoenix)
>
> Multiple poorly controlled dietary intake concerns, and lack of physical activity. In addition, often adherence issues with treatment are seen. – Other Health Provider (Maricopa County)
>
> About 50% of our patients admitted to our facility are diabetic, mostly due to their dietary habits. – Other Health Provider (Maricopa County)

> With the number of food deserts and food swamps in Maricopa County, it is challenging for people to eat healthy, especially low income households. Finding access to assessment, diagnosis, and treatment is additionally challenging for low income households. – Social Services Provider (Maricopa County)

Access to Affordable Healthy Food

> Lack of access to healthy food choices. Absence of diabetes prevention and information efforts for low income communities. – Social Services Provider (Maricopa County)
>
> Access to quality food and education on the topic. – Community Leader (Phoenix)
>
> Lack of access to healthy foods. Lack of places for people to exercise and for kids to play. – Public Health Representative (Maricopa County)
>
> Food desserts and cost of high quality fresh food. – Community Leader (Maricopa County)
>
> Access to healthy food that is affordable. A place to store their medication and regular education on how to manage their disease. – Social Services Provider (Phoenix)

Access to Care/Services

> Access to health care, healthy food, and education. – Community Leader (Maricopa County)
>
> Access to comprehensive care. Not enough resources for education on nutrition and lifestyle changes to minimize risk and impact, and not enough access to nutritious foods or environments that encourage regular exercise. – Social Services Provider (Phoenix)
>
> Lack of access to primary care, therefore community members do not know they are diabetic. Cost of medications and insulin. – Other Health Provider (Maricopa County)
>
> No central coach coordinating care. – Physician (Phoenix)

Affordable Medications/Supplies

> Affording newer injectable diabetes medications. – Physician (Maricopa County)
>
> When you have diabetes, the costs of medications and testing supplies can be prohibitive, as can the cost of a healthy diet plan that will improve your condition. – Community Leader (Maricopa County)
>
> Affording insulin, people with diabetes who have not yet been diagnosed, foot and eye care that targets underserved diabetics to decrease diabetic morbidity and mortality. – Other Health Provider (Maricopa County)

Obesity

> Weight management and poor diet choices. – Physician (Maricopa County)
>
> Weight management and enough personal discipline to stay permanently on a healthy lifetime way of life. – Social Services Provider (Maricopa County)
>
> Obesity and related issues. Lack of healthy food, lack of knowledge about a healthy diet, and side effects of diabetes, such as amputations, etc. – Public Health Representative (Maricopa County)
>
> Obesity and access to healthy food. – Social Services Provider (Maricopa County)

Diagnosis/Treatment

> I find that patients are not being treated aggressively for diabetes. The providers at larger corporatized practices are treating diabetes with minimal treatment, such as metformin. Providers are not always choosing to treat type 2 diabetes based on individualized risk of complications. – Physician (Maricopa County)

Lifestyle

> Changing lifestyle to better adopt healthy behaviors. – Public Health Representative (Maricopa County)

Prevention/Screenings

> Healthy habits, ways to avoid getting diabetes. – Community Leader (Phoenix)

Transportation

> Many of our adults suffer from type 2 diabetes. They are challenged with getting transportation to treatment, access to endocrinologists, affordable medicine and healthy affordable food. – Social Services Provider (Maricopa County)

Kidney Disease

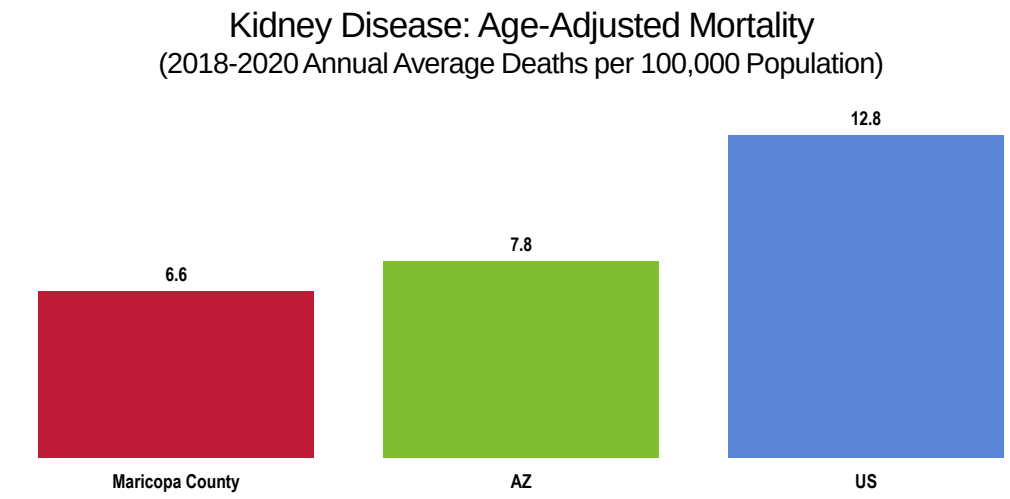
ABOUT KIDNEY DISEASE & DIABETES

Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Age-Adjusted Kidney Disease Deaths

Maricopa County mortality from kidney disease is shown in the following chart. [COUNTY-LEVEL DATA]

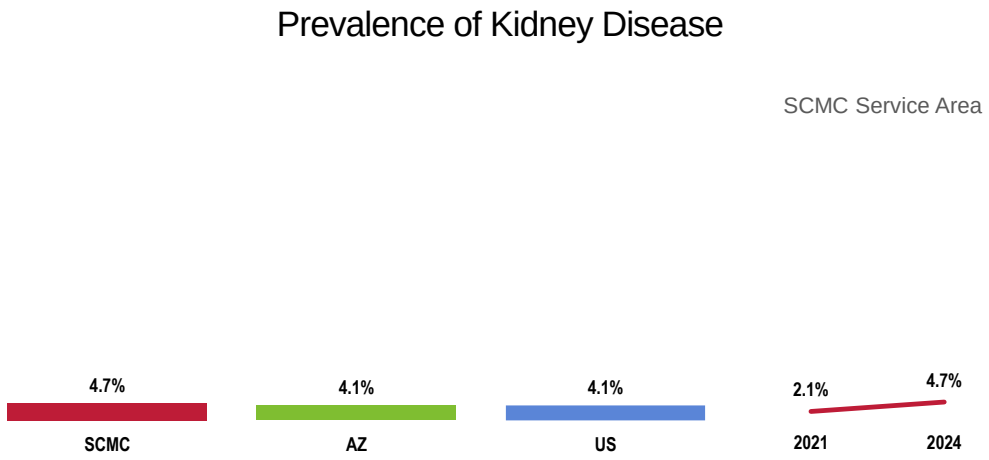


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

PRC SURVEY ► "Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 301]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

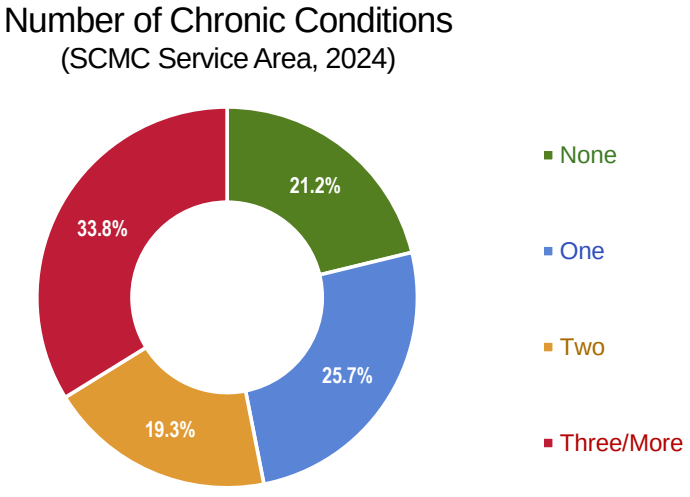
Disabling Conditions

Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

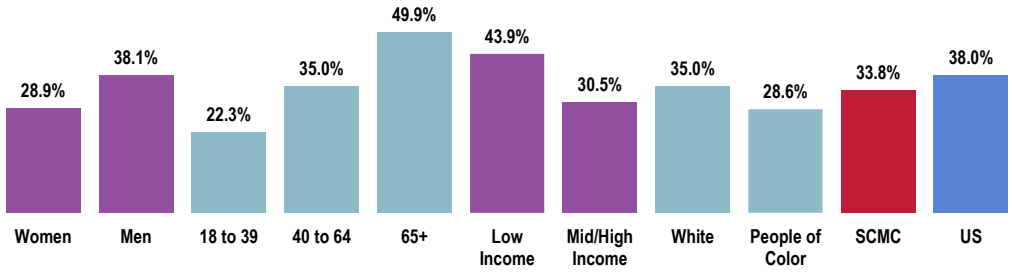
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 107]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, kidney disease, lung disease, obesity, and stroke.

Have Three or More Chronic Conditions
(SCMC Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, kidney disease, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

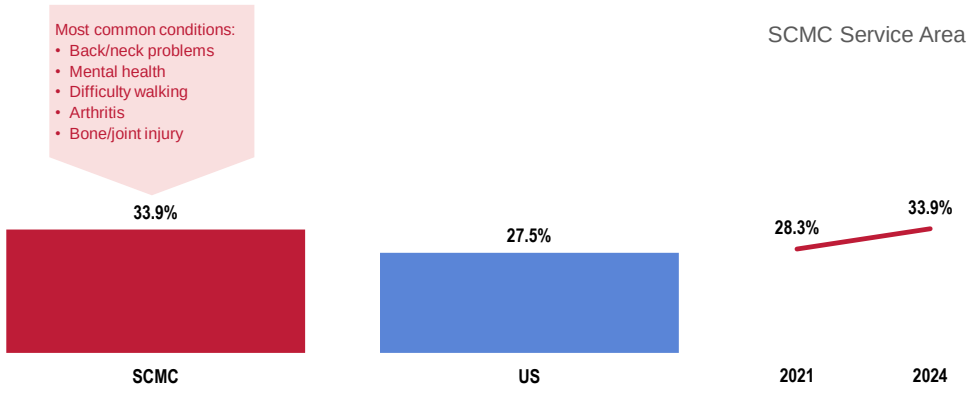
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

PRC SURVEY ► [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

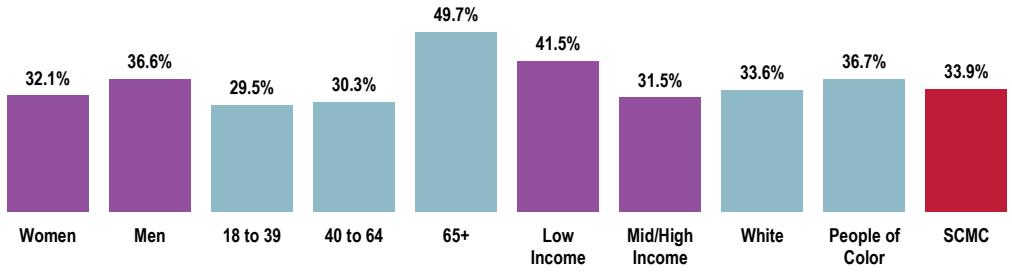
Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem

(SCMC Service Area, 2024)

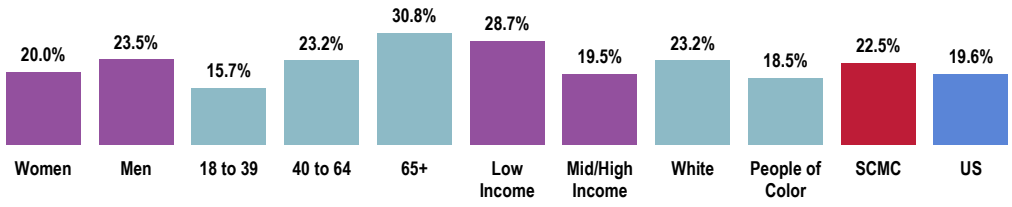


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ► "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(SCMC Service Area, 2024)
Healthy People 2030 = 6.4% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

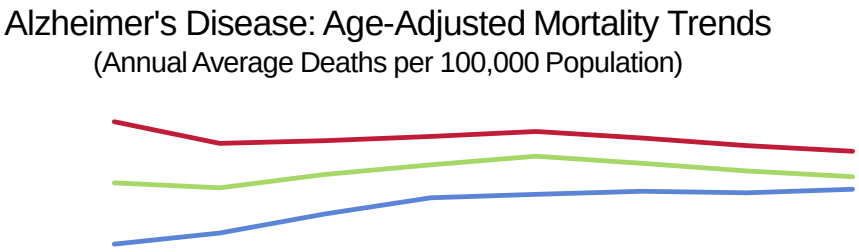
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	40.5	37.4	37.8	38.4	39.1	38.2	37.1	36.3
AZ	31.8	31.1	33.0	34.4	35.6	34.6	33.5	32.7
US	23.1	24.7	27.4	29.7	30.2	30.6	30.4	30.9

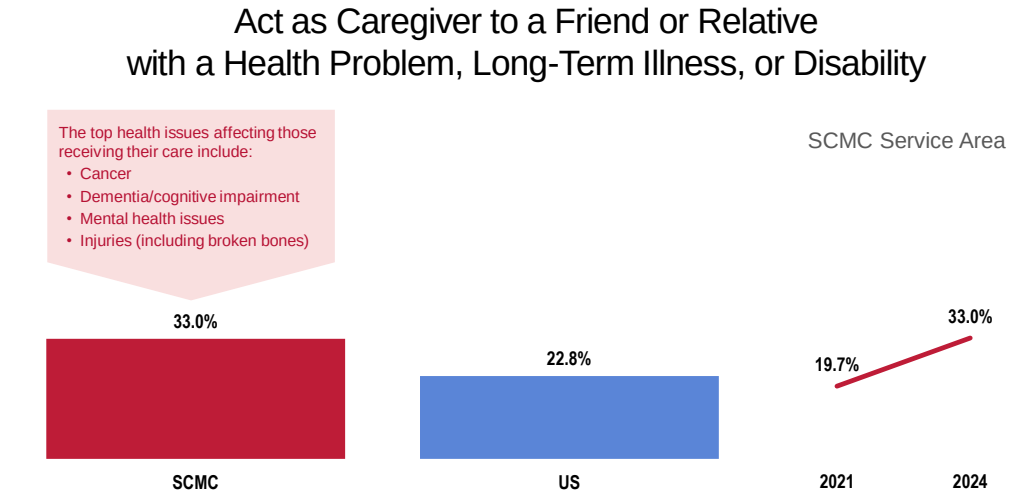
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Caregiving

PRC SURVEY ► "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

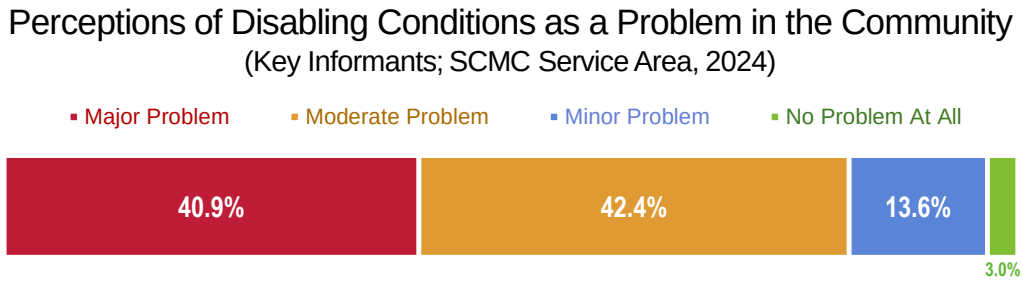
PRC SURVEY ► [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> Dementia care is the big concern here. With our aging population, there are not enough people to provide dementia care in the healthcare system. Additionally, families are burdened by the care needed for their family members. Cost of care in nursing home or assisted living especially including memory care are cost prohibitive for most leaving people at risk for adverse outcomes. – Physician (Maricopa County)

> We have an aging population, and particularly among low income individuals, not enough resources to care for people who have disabling conditions. There is a gap between when someone is able to live independently and when they qualify for long term care. Those who are unable to continue working are often without resources to sustain them while they wait for disability benefits, and disability benefits often do not cover the cost of living. There are not enough case management resources or programs for those experiencing disabling conditions. – Social Services Provider (Phoenix)
>
> Aging population. – Community Leader (Maricopa County)
>
> For older adults, it restricts their mobility. Medicare and many health plans do not pay for eyeglasses or hearing aids. – Social Services Provider (Phoenix)
>
> We have a rapidly growing senior population, which brings a significant increase in chronic health conditions, including those listed above. – Social Services Provider (Maricopa County)
>
> Vast elderly population in Maricopa County, and large volumes of chronic pain and AMS individuals. – Other Health Provider (Maricopa County)
>
> The population in the public sector is aging. They suffer from dementia, chronic pain and vision and hearing loss. Access to affordable care is limited and often not affordable for them. – Social Services Provider (Maricopa County)

Access to Care/Services

> I believe there are a lot of services for our elderly residents that are missing in our community. Always hear about folks not having access. – Social Services Provider (Maricopa County)
>
> Several older individuals do not have access to services or do not understand how to obtain services available to them. – Community Leader (Maricopa County)

Diagnosis/Treatment

> The amount of untreated mental illness right now is just astonishing and this may be the number one medical issue in our country today. – Social Services Provider (Maricopa County)
>
> Under recognition of disabling conditions compounds vulnerabilities in vicious cycles that results in poverty, worse health outcomes, homelessness, and increased mortality. – Physician (Maricopa County)

Incidence/Prevalence

> Alzheimer's is one of our five leading causes of death. Chronic pain can lead to substance use. If we continue to focus on root causes instead of the issues, we can reduce many of these conditions. – Public Health Representative (Maricopa County)
>
> We see a lot of chronic pain in our clinics. – Other Health Provider (Maricopa County)

Affordable Care/Services

> Resources are expensive. Not located in all areas, and many families struggle with the burden of caregiving, in addition to other responsibilities due to poor community resources. – Other Health Provider (Maricopa County)

Built Environment

> Phoenix and other cities in Maricopa County are not built for people with disabilities. City streets and public transportation are not designed for those with assistive devices. Mental illness can also be a disabling condition and Maricopa County is woefully under capacity for serving everyone who needs assistance. – Social Services Provider (Maricopa County)

Employment

> When we talk to families, they reference these conditions as to why they cannot work, take their kids to school, etc. – Community Leader (Phoenix)

Homelessness

> People that are homeless or experiencing extreme poverty, they simply do not have the resources seek the level of care they need. Example: a child from another country not eligible for AHCCCS but has cerebral palsy can't get a wheelchair replacement due to families limited income or available funds. – Social Services Provider (Phoenix)

Impact on Quality of Life

> Individuals with disabling conditions, which limit their activities, have decreased quality of life. – Social Services Provider (Maricopa County)

Transportation

> Due to the expense of owning a vehicle and the unreliable and unaffordable public transportation system, individuals with any disabling condition are unable to access basic services. Often they live in food deserts or grocery deserts where any mobility challenges will further relegate them to eating from corner liquor stores shelves and struggling to get to care providers. – Social Services Provider (Maricopa County)

Income/Poverty

> Income disparities, which lead to folks being overburdened with hard, low paying jobs, affecting their long term wellness. – Community Leader (Phoenix)

Insurance Issues

> They just cycle in and out of Emergency Rooms with no long term care insurance and no funding for home care. – Physician (Phoenix)

Obesity

> Obesity. – Physician (Maricopa County)

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

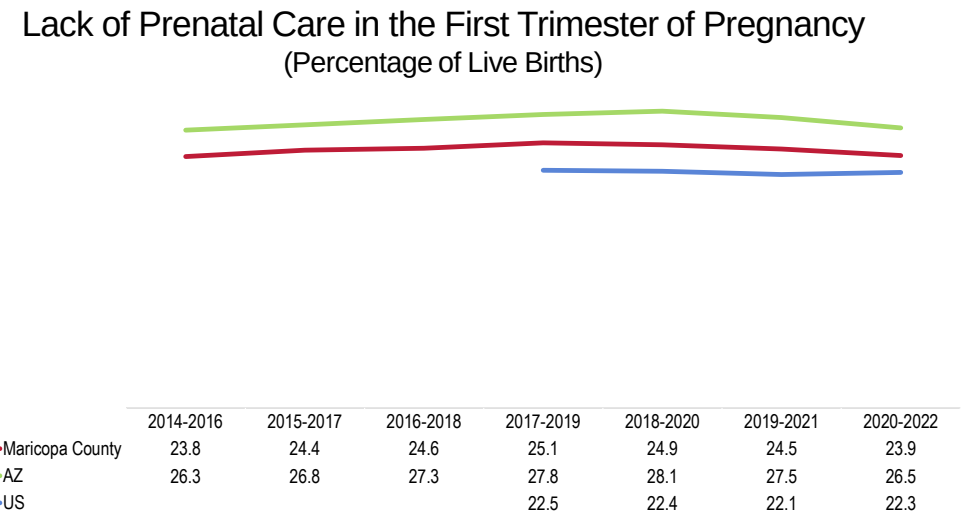
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of women who did not receive prenatal care during their first trimester of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022
Maricopa County	23.8	24.4	24.6	25.1	24.9	24.5	23.9
AZ	26.3	26.8	27.3	27.8	28.1	27.5	26.5
US				22.5	22.4	22.1	22.3

Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.

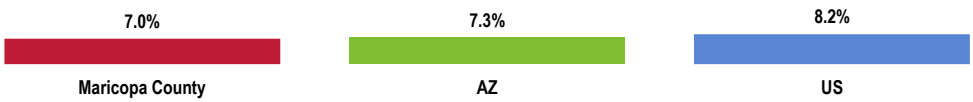
Note: • This indicator reports the percentage of women who do not obtain prenatal during their first month of pregnancy (if at all).

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2014-2020)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	5.7	5.9	5.6	5.6	5.4	5.3	5.1	4.8
AZ	5.7	5.8	5.7	5.6	5.4	5.4	5.4	5.2
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2024.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

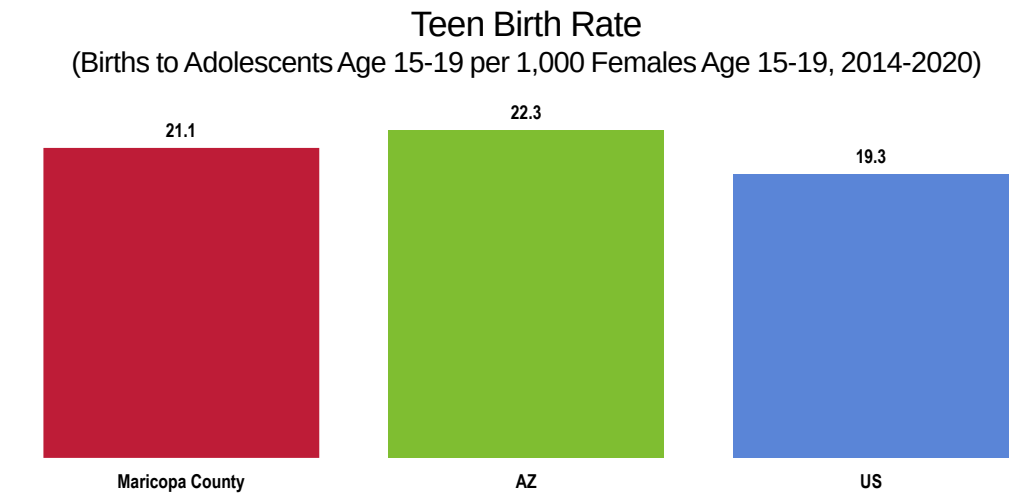
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]

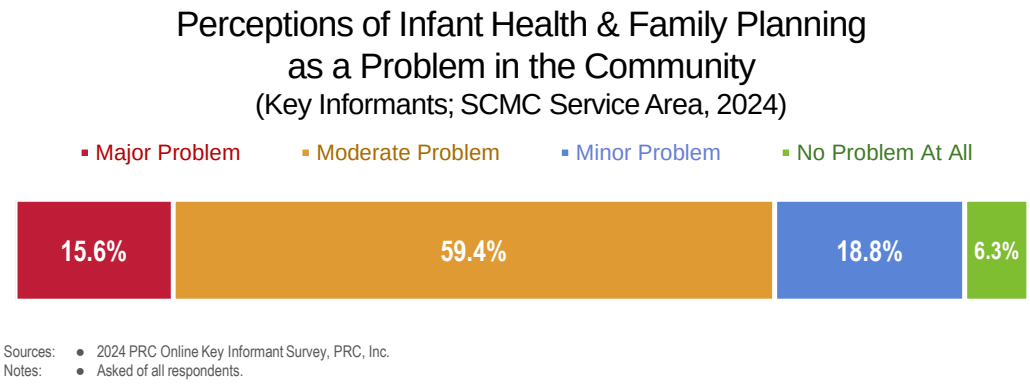


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Government/Policy

> Changing abortion laws have created uncertainty, what is the current law, how do I get help if needed, etc. – Social Services Provider (Maricopa County)
>
> The current legal landscape and denial of services, as well inability to get covered services outside of just discounts and self-pay for those over income for health insurance marketplace and or AHCCCS or Medicaid. – Other Health Provider (Maricopa County)
>
> Bans on abortion prevent adequate health care choices in Arizona. – Community Leader (Maricopa County)

Cost of Living

> I believe that not many people understand infant safety, such as safe sleep, proper use of car seats. Additionally, it is difficult for people to plan to have a family when the cost of living, groceries and transportation is so expensive. – Community Leader (Maricopa County)

Incidence/Prevalence

> The US has one of the highest rates of infant mortality in the world! We know that the first five years of a child's life can define a person's future, yet we do not adequately take care of our moms during pregnancy and after birth. This problem may only get worse with limiting access to family planning services. – Public Health Representative (Maricopa County)

Reproductive Health is Being Legislatively Restricted

> Reproductive health. Access to birth control and other reproductive health services is being legislatively diminished and barriers are being erected, especially for women. – Community Leader (Phoenix)

Parental Influence

> Lack of parenting skills leads parents to not seek appropriate care. Teaching people to use their AHCCCS or Insurance benefits to connect with appropriate care, pediatric services, nutritional support services are important along with family planning to build strong safe families. – Social Services Provider (Phoenix)

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

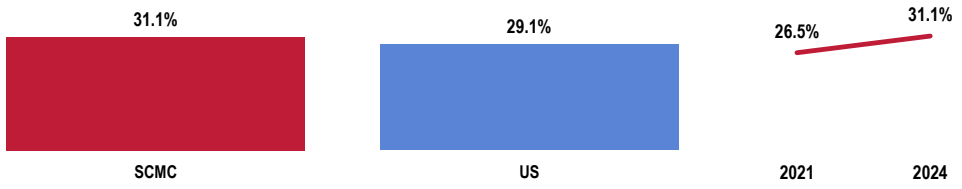
PRC SURVEY ► "Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

PRC SURVEY ► "How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

Consume Five or More Servings of Fruits/Vegetables Per Day

SCMC Service Area



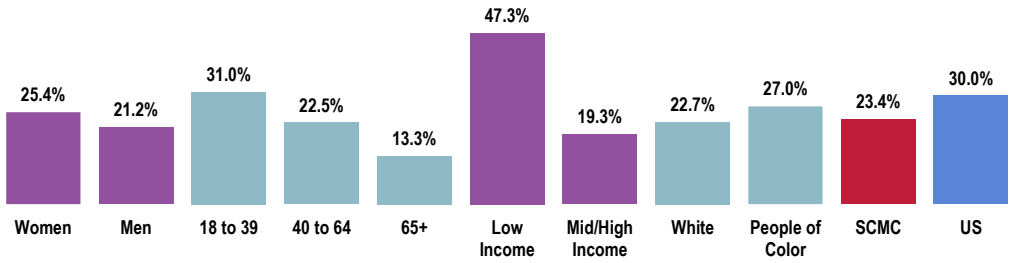
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

PRC SURVEY ► "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(SCMC Service Area, 2024)



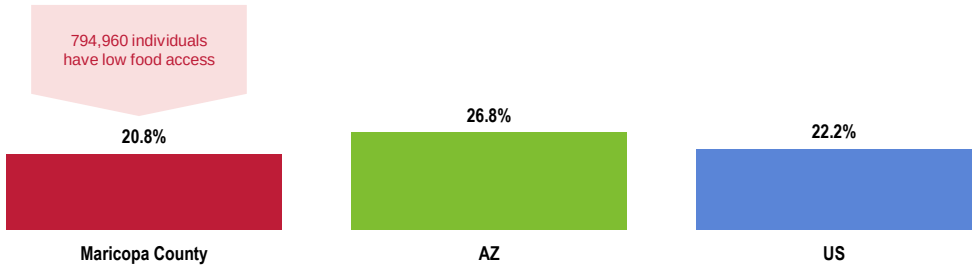
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]

Population With Low Food Access
(2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

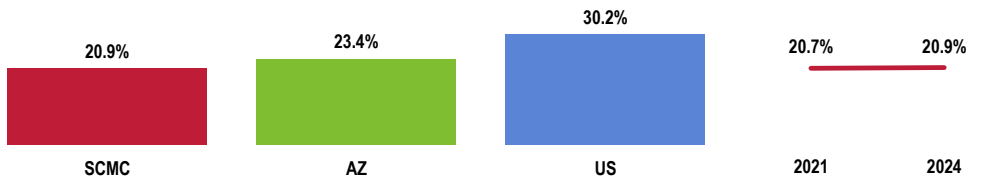
Leisure-Time Physical Activity

PRC SURVEY ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower

SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"

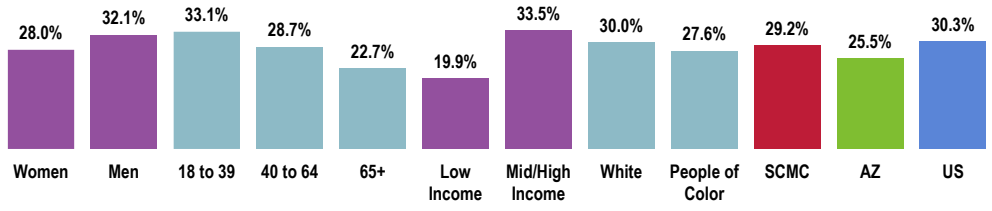
PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

Meets Physical Activity Recommendations
(SCMC Service Area, 2024)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

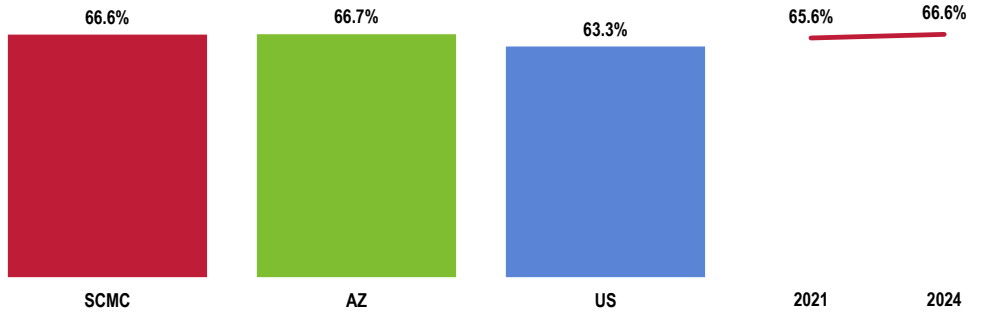
PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

SCMC Service Area



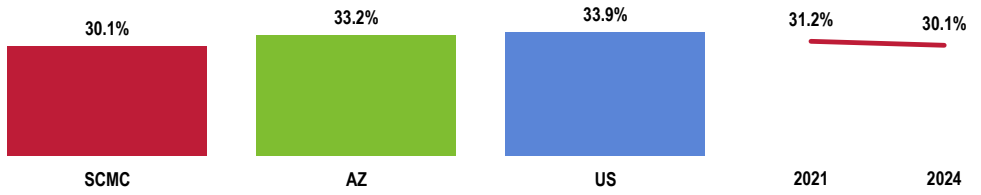
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

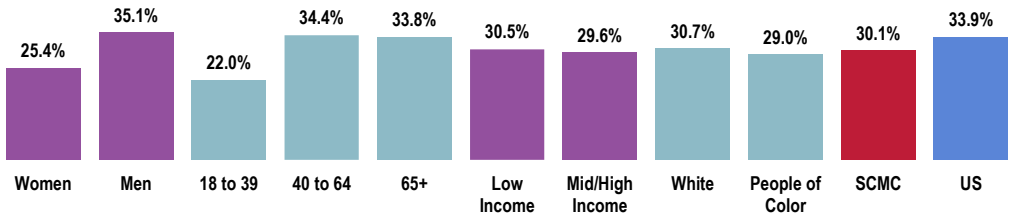
SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Prevalence of Obesity
(SCMC Service Area, 2024)
Healthy People 2030 = 36.0% or Lower



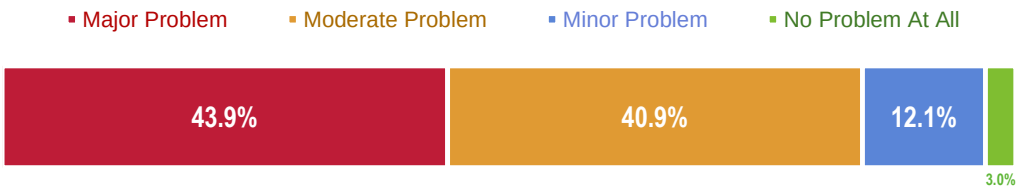
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Key Informants; SCMC Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> Access to healthy foods, sedentary lifestyles, such as sitting in offices and playing video games. Limited access to walkable, safe streets. School playgrounds are locked up. Indoor places to recreate during the summer. – Public Health Representative (Maricopa County)
>
> Access to affordable, healthy, local food is difficult. Many individuals resort to fast food. – Community Leader (Maricopa County)
>
> With most of our current population being mid to lower class in income and with inflation at the grocery stores, families are eating fast food because it is more affordable and kids, along with adults, are at a record obesity rate. – Social Services Provider (Maricopa County)
>
> Access to healthy affordable food. Proliferation of fast food and junk foods. – Community Leader (Maricopa County)
>
> Access to affordable food. – Social Services Provider (Maricopa County)

> The costs for grab-and-go foods are cheaper than the healthy foods which take time to prepare. Families are ashamed to ask for help with food. Families are no longer doing physical activities together due to work demands. – Community Leader (Phoenix)
>
> Older adults often cannot afford to buy nutritious foods, and because of mobility issues, they do not get enough exercise. – Social Services Provider (Phoenix)
>
> Access to healthy food is challenging for those with limited incomes. Unhealthy food leads to unhealthy weight and that's exacerbated by the lack of physical activity, especially during the heat of summer. Food banks try to fill the need to healthy food but they cannot do it on their own. Food deserts need to be addressed. – Community Leader (Phoenix)
>
> Limited access to healthy food, limited grocery store access, lack of transportation to purchase food, lack of appropriate food storage or prep areas. Community Parks in many situations are closed which limits access to places to rest, participate in sport activities or to get out of the sun or rain. Limited access to healthy food, also means dietary needs related to illness is unmet. – Social Services Provider (Phoenix)

Awareness/Education

> Lack of knowledge, how to cook healthy food. Lack of access to fruits and vegetables. Lack of motivation to eat healthy. – Social Services Provider (Maricopa County)
>
> Community education, primary care provider knowledge. – Other Health Provider (Maricopa County)
>
> The community doesn't fully understand nutrition and doesn't have access to many healthy nutritious food options. – Social Services Provider (Phoenix)
>
> Lack of knowledge, cost of food, and lack of access to quality food. – Community Leader (Maricopa County)

Nutrition

> Food deserts and limited healthy food choices in many communities. – Community Leader (Maricopa County)
>
> Fast food restaurants on every corner. A pervasive lack of engaging in healthy activity among a high proportion of our community. Children following the examples set by their parents, among many others. – Social Services Provider (Maricopa County)
>
> The existence of food deserts in some neighborhoods. The cost of produce, the relatively cheap prices of fast food versus healthful options. – Community Leader (Phoenix)
>
> People do not eat enough nutritious food and eat processed and unhealthy foods, do not get exercise, and are not able to maintain a healthy weight. These lifestyle factors contribute significantly to multiple chronic diseases including cardiovascular disease, diabetes, and cancer. – Physician (Maricopa County)

Obesity

> Increase in obesity, which then contributes to lower age for obesity related conditions, such as cholecystitis, high cholesterol, diabetes, etc. – Other Health Provider (Maricopa County)

Substance Use

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

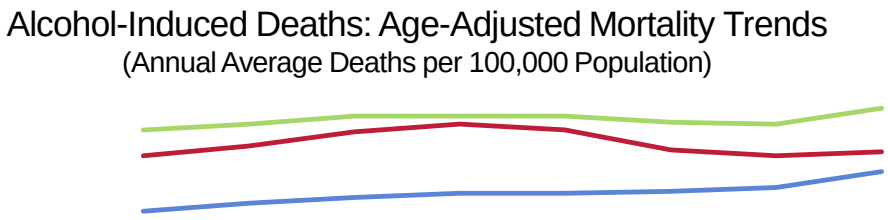
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol Use

Age-Adjusted Alcohol-Induced Deaths

The following chart outlines age-adjusted, alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	12.7	13.2	13.9	14.3	14.0	13.0	12.7	12.9
AZ	14.0	14.3	14.7	14.7	14.7	14.4	14.3	15.1
US	9.9	10.3	10.6	10.8	10.8	10.9	11.1	11.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

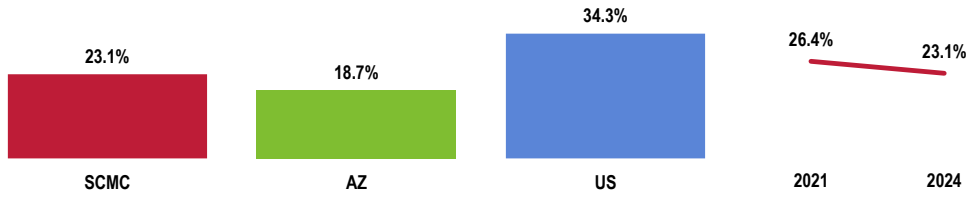
PRC SURVEY ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Engage in Excessive Drinking

SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

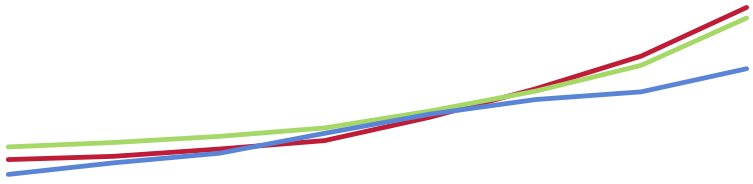
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drug Use

Age-Adjusted Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Maricopa County	12.4	12.7	13.4	14.2	16.4	19.1	22.2	26.8
AZ	13.6	14.0	14.6	15.4	17.0	18.9	21.3	25.8
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

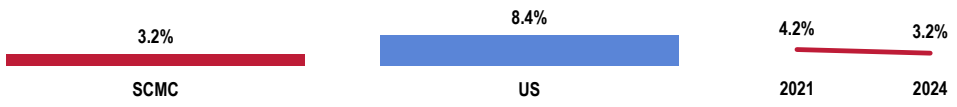
Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

PRC SURVEY ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month

SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

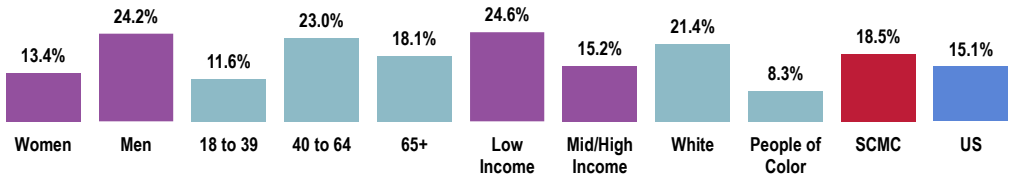
Notes:
- Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ► "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(SCMC Service Area, 2024)



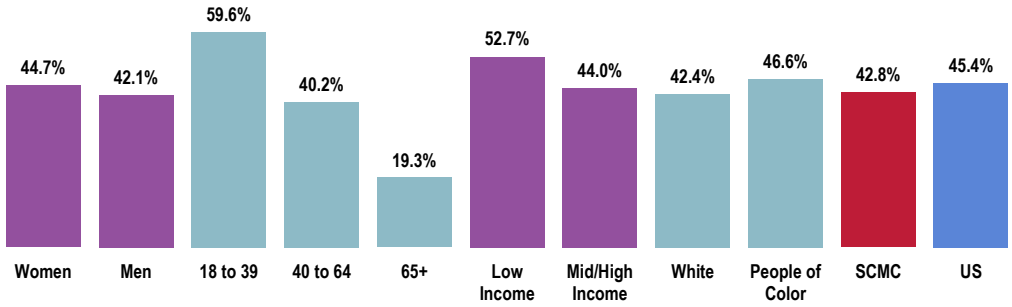
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ► "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(SCMC Service Area, 2024)

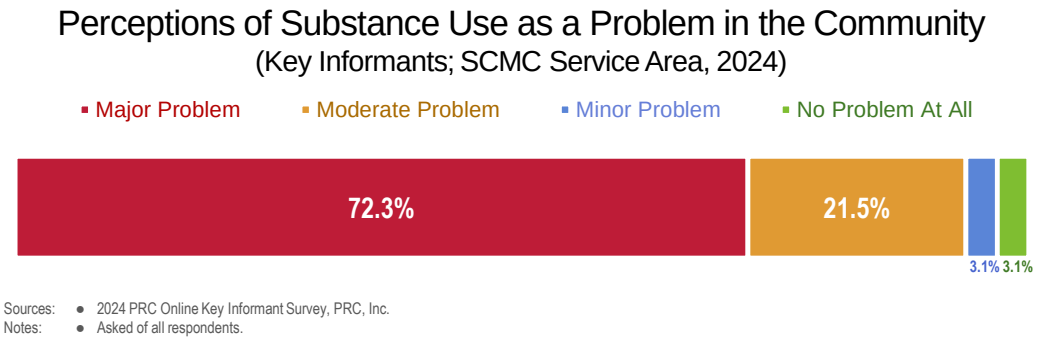


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to care and support. – Physician (Maricopa County)
>
> Not enough treatment facilities, easy availability of drugs, stigma, and it is difficult to overcome. – Public Health Representative (Maricopa County)
>
> Not enough substance use resources. For example, outpatient treatment programs and medicated assisted treatment programs. Stigma is always a challenge. – Social Services Provider (Maricopa County)
>
> Scheduling as a new patient is extremely difficult. Clients needing to apply for AHCCCS first can be delayed in seeking services for up to two months while their case is pending. – Social Services Provider (Phoenix)
>
> Lack of mental health services. Lack of financial resources and facilities to address the problem. Disinterest among many addicts to participate in available programs, and on and on. – Social Services Provider (Maricopa County)
>
> Immediate assistance, salutogenic approach, access to medicated treatment, and assistance to minors. – Social Services Provider (Phoenix)
>
> Restrictions on programming and availability. – Social Services Provider (Maricopa County)

Denial/Stigma

> Stigma and lack of locations for treatment and naloxone. – Community Leader (Maricopa County)
>
> Stigma and available resources. – Social Services Provider (Maricopa County)
>
> Stigma and lack of options for residential facilities. – Public Health Representative (Maricopa County)
>
> Stigma, awareness of the depth and breadth of this problem. – Other Health Provider (Maricopa County)
>
> Shame, NIMBY, and political will. – Community Leader (Phoenix)
>
> Stigma and cost. – Physician (Maricopa County)
>
> Stigma and lack of resources. – Public Health Representative (Maricopa County)

Awareness/Education

> Drug addiction has become such a problem across the country. Teaching about the effects of drugs in the community helps but isn't stopping people from trying them. Knowing where to go if you need help with addiction is something that isn't readily available and it's costly. Substance abuse is bad in the homeless community but they don't have the resources to do to a detox center. And if they go somewhere to detox when they get out they go back to the same living conditions and start using all over again. This is something along with Mental Health that the country needs to figure out how to fund it so that it makes a difference. – Social Services Provider (Phoenix)
>
> Lack of education in the community. We don't have enough BH literacy education outside of provider offices and federally qualified health centers. We need to get in front of the community and educate that its okay to ask for help and services especially in schools and recreational centers. – Other Health Provider (Maricopa County)
>
> Education. – Community Leader (Phoenix)
>
> Identifying available resources that are right for the community members. – Social Services Provider (Maricopa County)

Homelessness

> It would seem there are many people with addictions to various substances. Many people, who are homeless with addictions, aren't getting consistent care. – Community Leader (Phoenix)
>
> Getting unhoused to accept and stay in services. – Social Services Provider (Maricopa County)
>
> Vast level of homelessness unwilling to seek treatment. – Other Health Provider (Maricopa County)

Affordable Care/Services

> Cost. – Social Services Provider (Maricopa County)
>
> Not enough free detox. – Other Health Provider (Maricopa County)

Easy Access

> Drugs like fentanyl are extremely cheap in Maricopa County. I don't know enough about the illegal drug trade, but Arizona does not seem to have a handle on removing the criminal activity that continues and grows. People with substance use disorder are not able to access affordable, licensed programs, as there are not enough of them. And people who need treatment and lose their income are at risk of losing their housing. – Social Services Provider (Maricopa County)
>
> Cheap drugs. I have heard that the cost to get high is low. I believe with the high cost drugs, eventually people run out of money or steal and get in trouble and that takes care of part of the drug problem. There probably aren't enough drug centers. – Physician (Maricopa County)

Incidence/Prevalence

> There continues be an epidemic of substance abuse, to include opiates and heroin. – Community Leader (Maricopa County)
>
> Fentanyl is a growing concern and issue. Many people are using on the streets and this is visible at any part of the city and at any time you drive around. – Community Leader (Maricopa County)

Diagnosis/Treatment

> Lack of treatment, cost of treatment, and no housing. – Community Leader (Maricopa County)

Disease Management

> Client cooperation and desire for help. – Community Leader (Maricopa County)

Environmental Contributors

> We should do waste water testing like they do in Tempe, to know where the problems are first. – Community Leader (Maricopa County)

Insurance Issues

> Substance use treatment is often dictated by insurance. Often those with the most severe addictions have contact with the criminal justice system, but there is not sufficient means to mandate inpatient substance use treatment, which is often what people need in order to address their addictions. Substance use treatment should be the first choice in sentencing through the criminal justice system, rather than fines or misdemeanor charges. Medication Assisted Treatment should be more readily available to all. – Social Services Provider (Phoenix)

Law Enforcement

> Resources from local communities, primarily law enforcement and mental health care professionals, are lacking or strained and simply cannot respond to the multitude of individuals and incidents occurring throughout the community. Substance users, including those who use and sell substances, have become a proliferation in a plethora of locations throughout local cities. – Community Leader (Maricopa County)

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

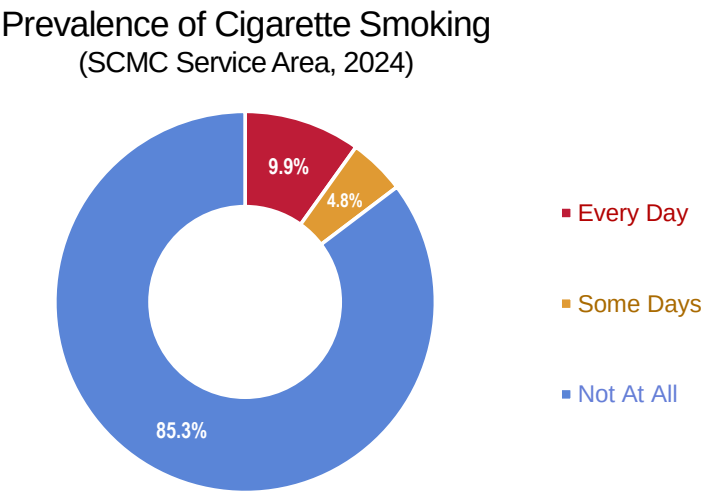
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

SCMC Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

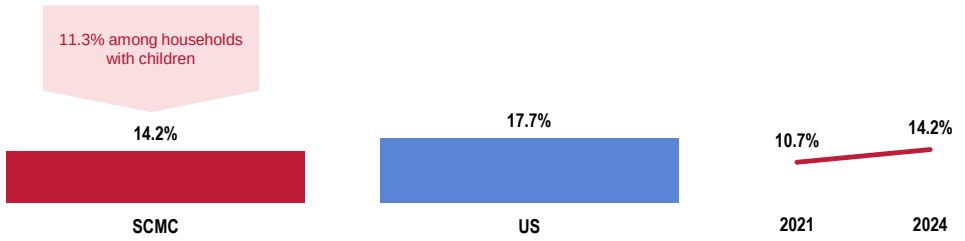
Environmental Tobacco Smoke

PRC SURVEY ► "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home

SCMC Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

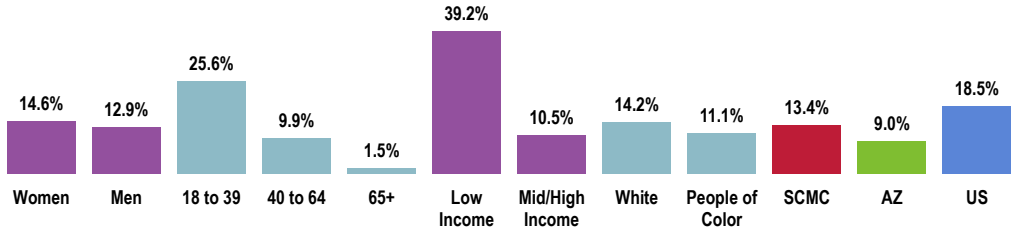
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(SCMC Service Area, 2024)



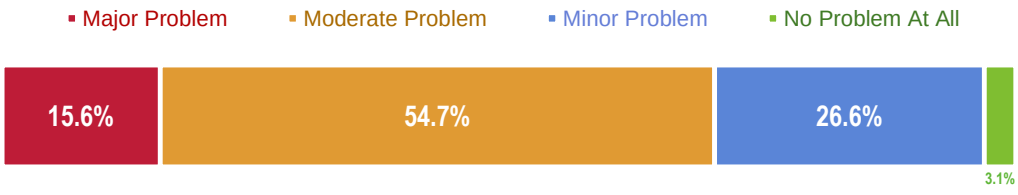
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants; SCMC Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

E-Cigarettes

> We are seeing vaping take the place of cigarettes in our system. – Community Leader (Phoenix)
>
> Vaping continues to be a gateway to other drugs. – Public Health Representative (Maricopa County)
>
> Vaping is an epidemic, with more than 50% of youth now self-reporting that they have used tobacco products in the last 30 days. The community does not universally acknowledge the dangers of vaping like they do smoking combustible cigarettes. There needs to be more awareness about the science showing how harmful vape products are. – Community Leader (Maricopa County)

Cardiovascular Health

> Tobacco is a significant driver of heart disease. The fact that youth are still easily able to access tobacco including nicotine-based vaping products guarantees that we will continue to have high economic and social costs associated with heart disease long into the future. – Physician (Maricopa County)

Incidence/Prevalence

> Still 16% of Arizona residents utilize tobacco. – Other Health Provider (Maricopa County)

Social Norms/Community Attitude

> Tobacco use within this community is more accepted. There are convenience stores within blocks of each other all advertising tobacco products and its use. Tobacco use among people experiencing homelessness is a complicated situation, people smoke because of the availability of tobacco, the addiction to tobacco and tobacco stops people from feeling hunger. – Social Services Provider (Phoenix)

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

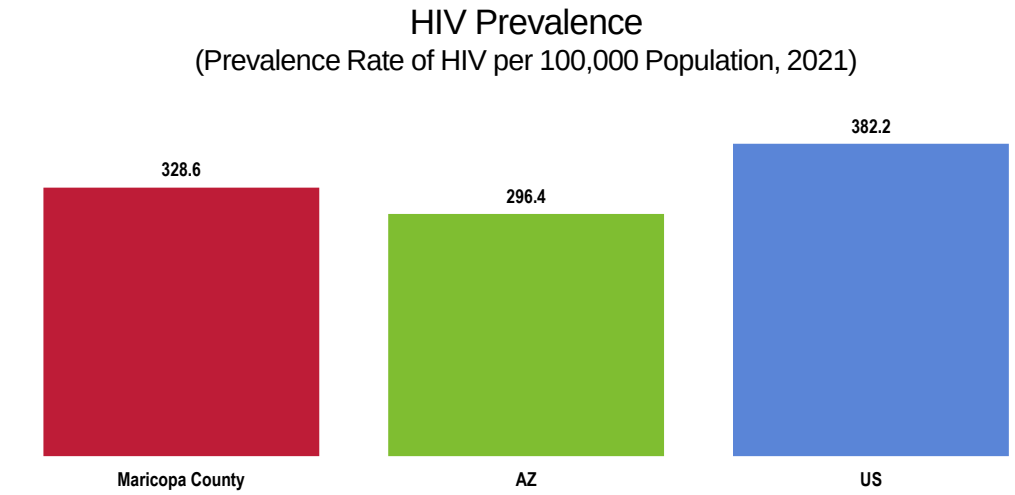
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people’s risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn’t prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

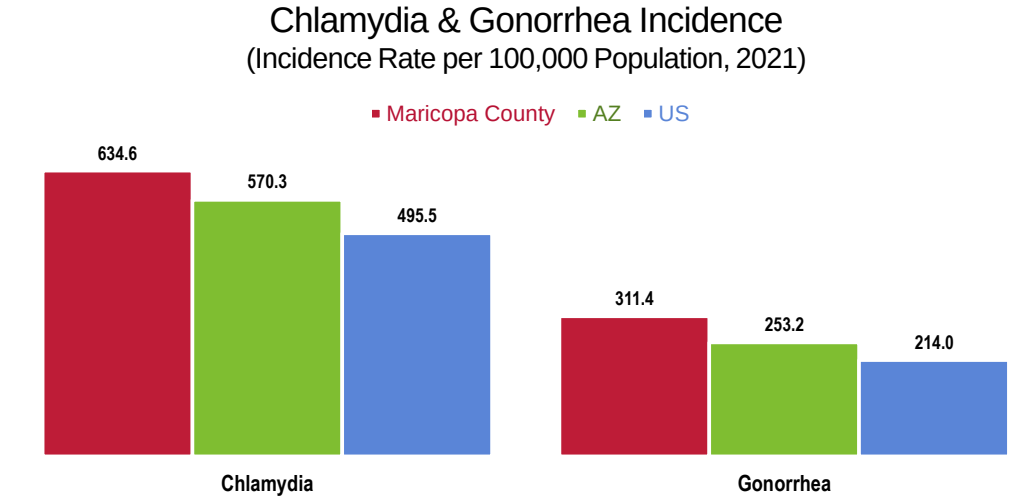
Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

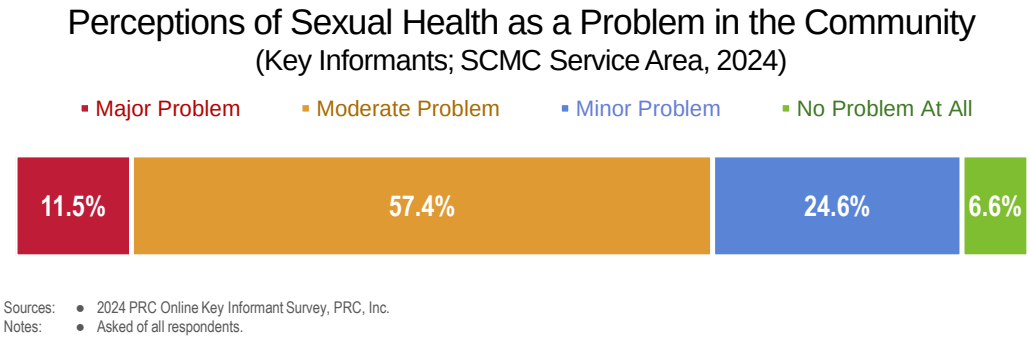
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Youth and young adults don't know or understand the importance of safe sex. They aren't aware of women's health clinics and/or not sure what their rights are. – Social Services Provider (Phoenix)
>
> Not educated. – Other Health Provider (Maricopa County)

Incidence/Prevalence

> I have heard reports about the increase in incidents of STDs in Arizona among certain populations. Sexual health is not openly discussed and there is a lack of educational support. – Community Leader (Phoenix)
>
> See a lot of patients with STI. – Physician (Maricopa County)

Denial/Stigma

> Maricopa County has one of the highest rates of congenital syphilis in the country. Chlamydia rates have skyrocketed. Stigma associated with getting tested. Getting tested is not on the radar of many people. – Public Health Representative (Maricopa County)

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid (or another state-sponsored program)**, or VA/military benefits?"**

PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

Lack of Health Care Insurance Coverage

(Adults 18-64)

Healthy People 2030 = 7.6% or Lower

SCMC Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; SCMC Service Area, 2024)
Healthy People 2030 = 7.6% or Lower

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC SURVEY ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

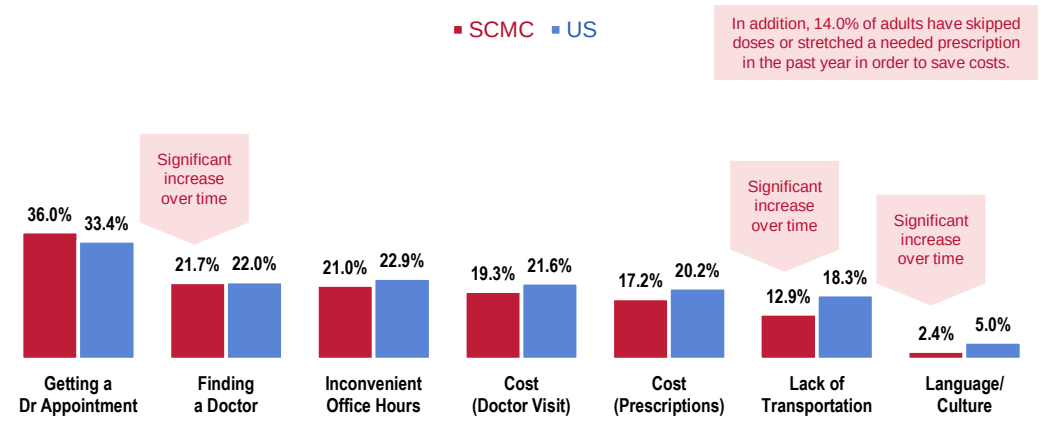
PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

Also:

PRC SURVEY ► "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

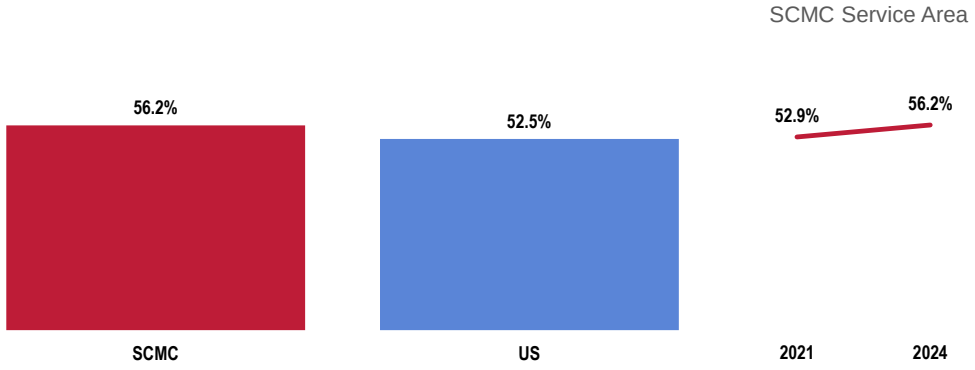


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

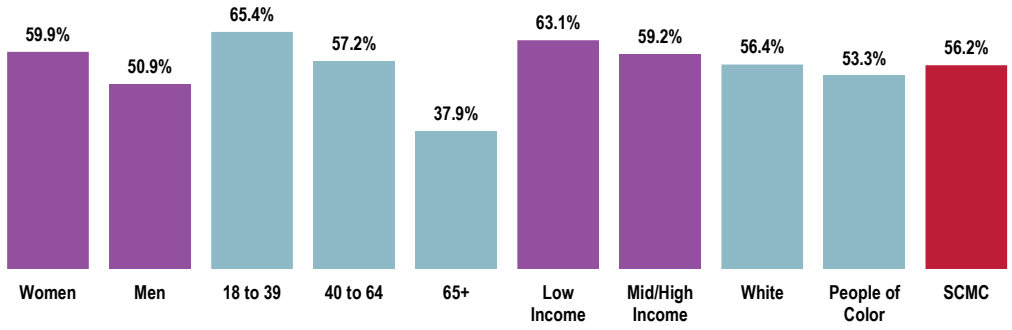
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 19, 119]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(SCMC Service Area, 2024)

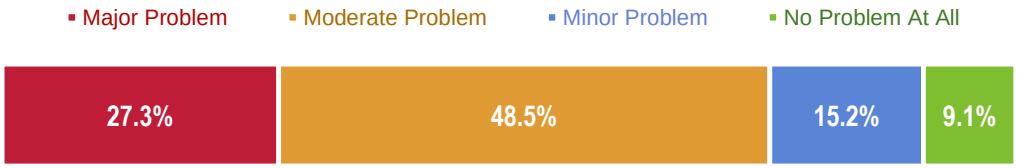


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: ● Asked of all respondents.
● Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants; SCMC Service Area, 2024)



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to care as evidenced by long waits to see physicians, primary care physicians unavailable, decline in quality of comprehensive care, limited access to specialists with ridiculous wait times. Specialists and physicians not contracted with any insurance. One of the biggest issues is a lack of on-call specialists in emergency rooms. This is worsening every year. – Physician (Phoenix)
>
> Getting the services to the families where they are at, as compared to families going to centers, doctor's offices, etc. – Community Leader (Phoenix)
>
> Access to mental and behavioral health services, especially for children and those with private insurance or self-pay. Also, anytime I have to make an appointment with a specialist, it's 3–6 months away. That's way too long to wait for a problem I'm having now. Access to developmental pediatricians is a 1-year or longer wait for my kids. – Community Leader (Maricopa County)

> Availability of services, child health coverage, and not enough general practitioners. – Community Leader (Maricopa County)

Affordable Care/Services

> Cost of services, process to get in to see a medical professional, and availability of appointments to see primary care physicians and mental health providers. – Social Services Provider (Phoenix)
>
> Inability to afford care when other options are not available. For example, Medicaid or opting for insurance at work. Financial assistance is limited to low federal poverty levels. – Other Health Provider (Maricopa County)
>
> The cost of health care. – Public Health Representative (Maricopa County)
>
> Affordability is a major issue for healthcare. Preventative care and screenings are critical for catching disease stages early, but this kind of care is easily postponed due to expense. – Community Leader (Maricopa County)

Lack of Providers

> Lack of available providers or facilities in the immediate area. Transportation is an issue especially since people have to preschedule rides. Hard if there is urgent need. Transportation is also an issue regarding prescription pickup and drop offs, other testing - it requires multiple transportation requests. If providers did more onsite services like X-rays, blood draws, it would be easier. Appointments for dental services should be a covered and transportation for dental appointments. – Social Services Provider (Phoenix)
>
> Not enough providers, the expense, and long waits for appointments. – Public Health Representative (Maricopa County)

Transportation

> Transportation to appointments. Limited number of healthcare workers and an even more limiting number of culturally competent health care workers. – Public Health Representative (Maricopa County)
>
> Many of the people we serve lack transportation, internet access, or the support needed to access healthcare services. Seniors and informal kinship families, those who are low income or not proficient in English, are more vulnerable than most. – Social Services Provider (Maricopa County)

Access to Care for Uninsured/Underinsured

> Services for the underinsured and uninsured is an ongoing issue. – Social Services Provider (Maricopa County)

Aging Population

> Our population including those older and sicker is growing rapidly in Maricopa County and we do not have enough providers particularly primary care providers with access available to patients. This drives increased cost with poorer outcomes, increased use of more expensive venues for care like urgent care and emergency rooms, and can result in delay in diagnosis for critical diseases. Specialty care too is impacted particularly for dementia expertise. Significant burnout in healthcare is making the situation worse with more individuals at risk to leave their professions or cut back on their hours of patient care. Plans to expand education including medical schools is a good start but we will need more advanced practitioners and dedicated teaching resources to ensure quality care as well as robust recruiting to our area to meet the current and growing needs. We must also address the underlying health system burden on our providers that is exacerbating burnout and attrition. – Physician (Maricopa County)

Homelessness

> Our organization provides healthcare to people experiencing homelessness. By the nature of being unhoused, it is very difficult for this population to access care. Transportation, stigma and stereotypes are some challenges. – Social Services Provider (Maricopa County)

Income/Poverty

> Poor financial situation and poor availability of primary care in the area. – Physician (Maricopa County)

Language Barriers

> Accessing the application in the person's native language, and transportation. – Social Services Provider (Maricopa County)

Lifestyle

> Individual ability to set health goals and achieve them. Many people feeling they are stuck in their health situation and “it is what it is.” – Social Services Provider (Maricopa County)

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

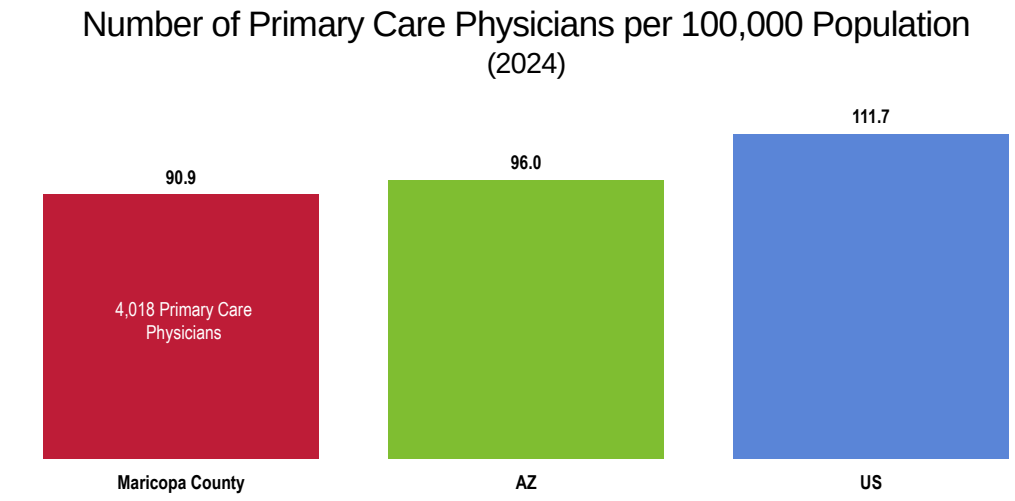
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. [COUNTY-LEVEL DATA]

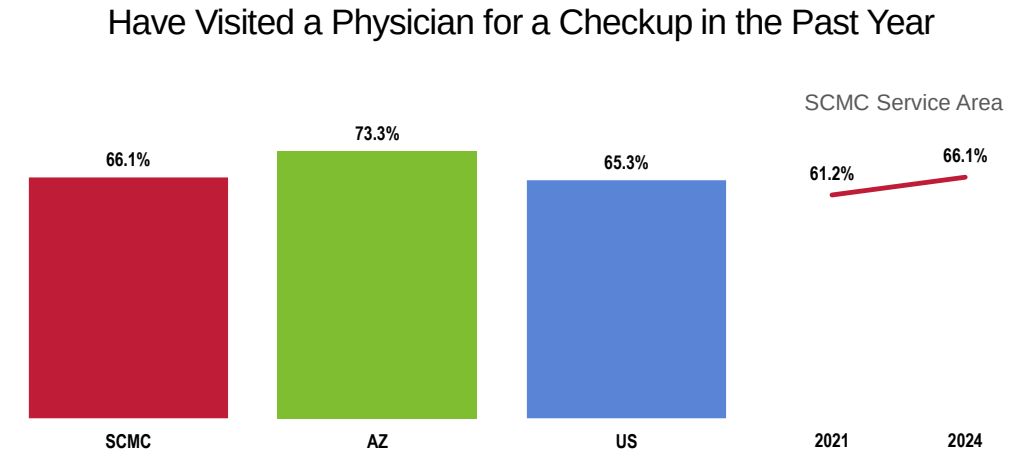


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2024 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

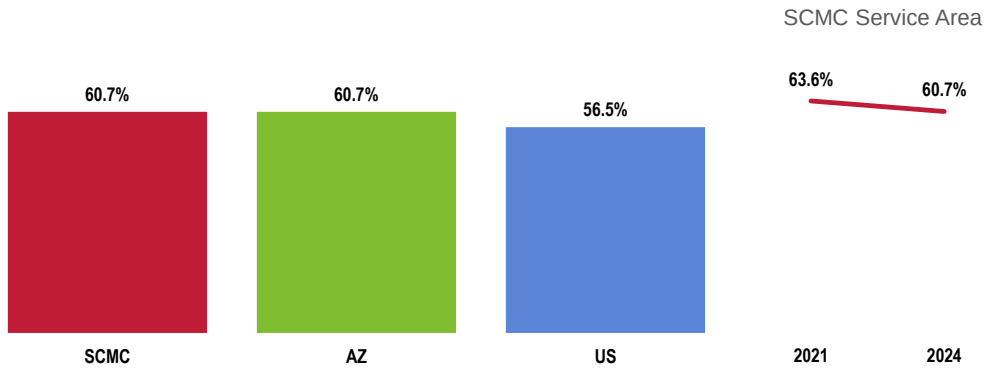
– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 17-18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

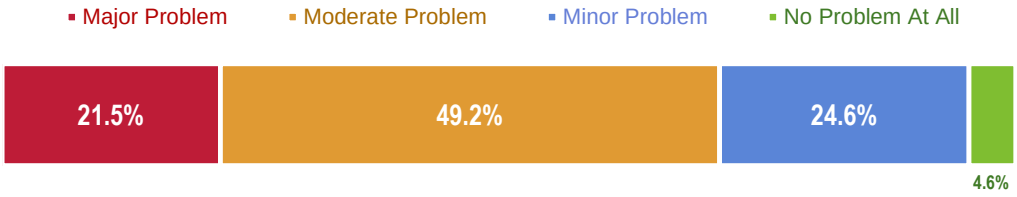
Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health as a Problem in the Community

(Key Informants; SCMC Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Insurance Issues

> Medicare and most health plans do not pay for oral care, and older adults often cannot afford cleaning and oral care. Often when a tooth goes bad, they can only afford an extraction. The lack of healthy teeth and gums impacts their nutritional intake because they only eat soft foods. Dentures can also be too expensive for low-income older adults. – Social Services Provider (Phoenix)
>
> Medicare does not cover dental care, which means as our population ages, fewer have access to routine oral health checkups and dental care. – Other Health Provider (Maricopa County)

Access to Care/Services

> Adults lack access to care. Children are not seeing dentists. Lack of dentists accepting Medicaid. – Public Health Representative (Maricopa County)
>
> Limited access to dentists, lack of knowledge of importance of oral health and relationship to overall health. – Other Health Provider (Maricopa County)

Affordable Care/Services

> Dental services are costly so people delay or skip getting regular dental care. Lack of treatment can lead to lingering complications that can affect overall health. – Community Leader (Phoenix)
>
> Expensive and not a priority for people without insurance. – Community Leader (Maricopa County)

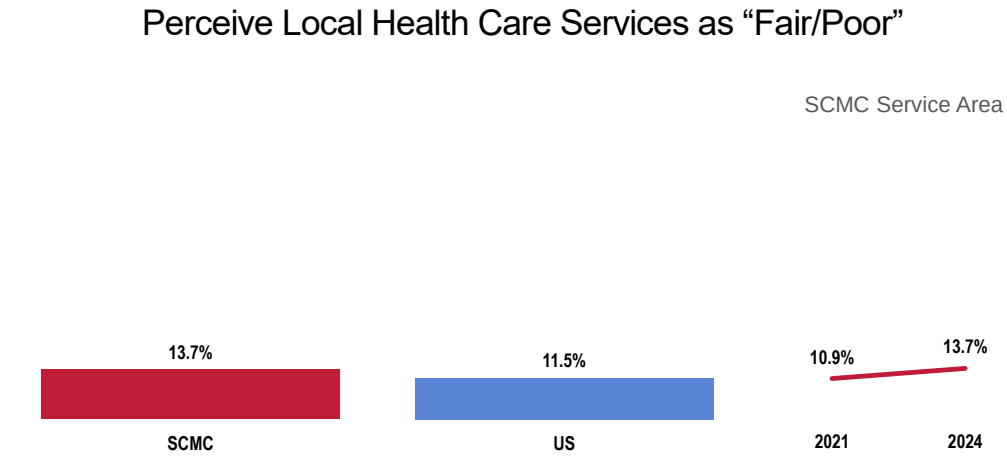
Co-Occurrences

> Oral health and heart health are tied together closely. If people had regular access to dental care, cleanings, fillings, and dentures, it would improve the health outcomes people. Limited access to dental care means people live with pain and infection unnecessarily. – Social Services Provider (Phoenix)

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Adelante
- AHCCCS
- Area Agency on Aging
- Aster Aging
- ASU Street Medicine
- Central Arizona Shelter Services
- Chicanos Por La Causa
- Churches
- Circle the City
- City of Phoenix Housing/Hope VI Project
- County Programs
- Dentist's Offices
- DES
- Duet
- Federally Qualified Health Centers
- First Things First
- Foothills Caring Corps
- Friendly House
- Healthcare Recruiting Organizations
- Homeless ID Project
- Homeless Support Clinics
- HonorHealth
- Hospitals
- Jewish Family Services
- Keys to Change
- Local Philanthropy
- Mission of Mercy
- Mountain Park Community Health Services
- Neighborhood Ministries
- NOAH
- Public Mental Health System
- Residency Programs
- St. Mary's Food Bank
- St. Vincent de Paul
- State Funding for Universities
- Terros Health
- Touchstone
- Universities
- Valle Del Sol
- Valleywise
- Wesley Community Center
- YMCA

Cancer

- American Cancer Society
- AZCCC
- Banner Health
- Banner Health – MD Anderson
- Cancer Coalition
- Cancer Support Network
- Cancer Treatment Centers
- Circle the City
- City of Hope
- Doctor's Offices
- Employer Screenings
- Federally Qualified Health Centers
- Hospitals
- Leukemia and Lymphoma Society
- Mayo Clinic
- Mobile Mammography
- Mountain View Park
- Neighborhood Ministries
- Public Health Department
- St. Vincent de Paul
- Sunnyslope Community Center
- Support Groups
- T Gen
- Well-Woman Program

Diabetes

- ADA
- Blue Zones
- Christian Community Clinic
- Circle the City
- Community Gardens
- Community Health Centers
- Community Health Workers
- Desert Mission Food Bank
- Diabetes Association
- Diabetes Coalition
- Diabetes Prevention Program
- Doctor's Offices
- Double Up Food Bucks
- Esperanza – Advance Community

Federally Qualified Health Centers
Food Banks
HonorHealth
HonorHealth North Mountain Hospital
Hospitals
Insurance
Jewish Family Services
LocalFirst Arizona
Mayo Clinic
Mountain View Park
Neighborhood Ministries
NOAH
Nutrition Services
Public Information Campaigns
School System
St. Mary's Food Bank
St. Vincent de Paul
TCAA
Terros Health
Unlimited Potential
Valle Del Sol
Valleywise
Weight Loss Clinics
Wesley Community Center
WIC
YMCA

Disabling Conditions

Ability 360
ACCHSS
Alzheimer's Association
Area Agency on Aging
Arizona Agency on Aging
Arizona Caregiver Coalition
Arizona State Departments
Aster Aging
Caring Corps
Chronic Disease Self-Management Programs
Dementia-Friendly Cities – Tempe
Duet
Eyes on Learning
Family Resource Centers
Federally Qualified Health Centers
Foothills Caring Corps
Foothills Food Bank and Resource Center
HonorHealth
Hospice of the Valley
Mountain View Park
Neighbors in Need
Recovia
Senior Centers
Southwest Lending Closet
St. Vincent de Paul
Valle Del Sol
YMCA

Heart Disease & Stroke

Abrazo Heart Hospital
American Heart Association
Banner University Heart Institute
Boys and Girls Clubs
Doctor's Offices
Family Resource Centers
Federally Qualified Health Centers
Food Banks
HonorHealth
Hospitals
Mayo Clinic
Mountain View Park
Public Information Campaigns
Screenings
Valleywise
YMCA

Infant Health & Family Planning

Desert Star
Federally Qualified Health Centers
First Things First
Healthy Start
Hushabye Nursery
Mom Doc
Nurse Family Partnership
Planned Parenthood

Injury & Violence

Behavioral Health Providers
Circle the City
City of Phoenix
Courts
CPLC/De Colores Shelter
Friendly House
Glendale Behavioral Health Clinic
HonorHealth
Jewish Family Services
Law Enforcement
Mental Health First Aid Training
Naloxone
New Pathways for Youth
Nonprofit Organizations
One-n-Ten
Opioid Assistance and Referral Line

- Sojourner Center
- UMom
- United Way
- Valleywise
- West Valley Health Clinic

Mental Health

- 988
- Ability 360
- AHCCCS
- Ascend
- Behavioral Health Providers
- Caring Corps
- CBI
- Central Arizona Shelter Services
- Churches
- Circle the City
- Community 43
- Community Bridges
- Community Centers
- COPA Health
- Coppersprings
- CPR
- Crisis Hotlines
- Doctor's Offices
- Equality Health
- evolveMD
- Federally Qualified Health Centers
- HonorHealth
- Hospitals
- Jewish Family Services
- La Frontera Empact
- Law Enforcement
- Maricopa Crisis Response
- McDowell Mountain Preserve
- Mental Health Professionals
- Mercy Care
- Mind 24/7
- NAMI
- NOAH
- Nonprofit Organizations
- Not My Kid
- Phoenix Rescue Mission
- Quail Run
- Recovia
- School System
- Scottsdale Center for the Arts
- Social Work Group
- Solari
- Southwest Behavioral
- St. Luke's
- Tension and Trauma Releasing Exercises
- Terros Health
- Touchstone
- United Way
- Valle Del Sol
- Valleywise
- Veterans Services
- Via Linda Behavioral Hospital
- YMCA

Nutrition, Physical Activity & Weight

- Andre House
- Area Agency on Aging
- Arizona Food Bank Network
- Blue Zones
- Boys and Girls Clubs
- Churches
- Community Gardens
- Desert Mission Food Bank
- Doctor's Offices
- Federally Qualified Health Centers
- HonorHealth
- Jon's Lutheran Church Food Pantry
- Parks and Recreation
- Phoenix Rescue Mission
- School System
- Senior Food Programs
- SNAP
- Social Clubs
- Social Work Group
- St. Mary's Food Bank
- St. Vincent de Paul
- WIC
- YMCA

Oral Health

- Annual Dental Mission
- BrighterWay
- Dental Foundation
- Dental Sealant Program
- Dentist's Offices
- Federally Qualified Health Centers
- Mobile Dental Programs
- NOAH
- St. Vincent de Paul
- Valleywise

Respiratory Diseases

- Doctor's Offices
- HonorHealth

- Vaccinations

Sexual Health

- Aunt Rita's
- Doctor's Offices
- Federally Qualified Health Centers
- Maricopa County
- Maricopa County Public Health Department
- Planned Parenthood
- School System
- Southwest Center

Social Determinants of Health

- A New Leaf
- AARP
- Ability 360
- Adult Protective
- AHCCCS
- Area Agency on Aging
- Arizona Agency on Aging
- Arizona Apprenticeship Program
- Arizona at Work
- Arizona Hugs
- Building Intentional Communities
- CBI
- Central Arizona Shelter Services
- Chicanos Por La Causa
- Chispa
- Circle the City
- City of Tempe
- Cover Arizona
- DES
- Desert Mission
- Desert Mission Food Bank
- Doctor's Offices
- Dress for Success Phoenix
- Equality Health
- Family Housing Hub
- Federally Qualified Health Centers
- Food Banks
- Foothills Caring Corps
- Foothills Food Bank and Resource Center
- Foundations
- Fresh Start
- Friendly House
- FSL
- Goodwill Industries
- Government
- Headstart
- HonorHealth
- Human Service Campus
- John F. Long Family Service Center
- Keys to Change
- Libraries
- Lincoln Learning Center
- Maricopa County Public Health Department
- Nonprofit Organizations
- One-n-Ten
- Parks and Recreation
- School System
- Section 8 Housing
- Sojourner Center
- Solari
- St. Joseph the Worker
- St. Mary's Food Bank
- TCAA
- UMom
- Unite Us
- Veterans Services
- Vitalyst

Substance Use

- 211
- AA/NA
- AHCCCS
- Arizona Hugs
- Ascend
- Banner Poison Control/OAR Line
- CBI
- Celebrate Recovery
- Circle the City
- CMS
- CODA
- Community Bridges
- Crossroads
- Doctor's Offices
- Federally Qualified Health Centers
- Friendly House
- Health Care Facilities
- HonorHealth
- HonorHealth North Mountain Hospital
- Hospitals
- Independent Treatment Facilities
- Law Enforcement
- Libraries
- Maricopa County Narcan Program
- Mental Health Professionals
- Naloxone
- NOAH
- Open Hearts
- Opioid Assistance and Referral Line
- Parks and Recreation

Phoenix Police Department
Phoenix Rescue Mission
Quail Run
Recovia
School System
Shot in the Dark
Sonoran Prevention Works
Southwest Behavioral
St. Vincent de Paul
Substance Abuse Programs
Substance Abuse Therapists
Terros Health
Vogue Rehab

Tobacco Use

Arizona Quit Line
Ashline
HonorHealth
Phoenix Police Department

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, HonorHealth has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $405 million in community benefit in 2022, excluding over $122million in uncompensated Medicare in 2022.
- During 2022, more than $155 million in charity care and other financial assistance programs were provided to patients.

HonorHealth also serves our community through these programs:

Desert Mission

For more than 90 years, HonorHealth Desert Mission has been improving the health and well-being of individuals from all socioeconomic walks of life. Desert Mission supports HonorHealth's commitment to healthy communities by offering:

- Early childhood education and enrichment
- Employment and economic success
- Food Bank access and nutrition support
- Senior day care and enrichment

Military Partnership

Launched in 2004, the HonorHealth Military Partnership Program provides trauma and deployment training to all branches of the military, active duty, National Guard and Reserves. The 7,500-square-foot training center is located on the HonorHealth Scottsdale Osborn Medical Center campus. The program offers:

- U.S. Air Force Magnet and Surgical Leadership Fellowship
- Readiness skill sustainment training
- Medical simulation training
- Nurse Transition Program
- Critical Care/Emergency Trauma Nursing Fellowship

Blue Zones

Residents of the original blue zones areas make healthy choices because those choices are easy—even unavoidable—in their surroundings. That's why Blue Zones Project Scottsdale focuses on influencing the life radius, the area close to home in which people spend 90 percent of their lives. In Blue Zones community transformations, collaborators optimize the built environment, municipal policies and ordinances, restaurants, schools, grocery stores, faith-based organizations, and workplaces, social networks, habitat, and inner selves. Achieving well-being improvement will allow our community to move the needle forward so that positive environmental changes become engrained in the community and the health choice becomes the healthy choice for all residents. HonorHealth is the leading sponsor of Blue Zones Project Scottsdale.

Addressing Significant Health Needs

HONORHEALTH SONORAN CROSSING MEDICAL CENTER conducted its last Community Health Needs Assessment in 2021 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that HONORHEALTH SONORAN

CROSSING MEDICAL CENTER would focus on developing and/or supporting strategies and initiatives to improve:

- Behavioral Health
- Access to Food
- Access to Health Care Services
-

HONORHEALTH SONORAN CROSSING MEDICAL CENTER focused on behavioral health, access to food and access to health care services as a collective strategy to address chronic disease.

Strategies for addressing these needs were outlined in HONORHEALTH SONORAN CROSSING MEDICAL CENTER's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by HONORHEALTH SONORAN CROSSING MEDICAL CENTER to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Behavioral Health	
Community Health Need	**Behavioral Health**
Goals	• Partner with community behavioral health services provider to increase access to services. • Integrate depression and anxiety screenings and behavioral health providers in points of care. • Expand support groups and trauma informed care training. • Support programs for outpatient substance use disorder prevention and treatment.

Strategy 1: Continue Behavioral Health Hospital Launch	
Strategy Was Implemented?	Yes.
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: HonorHealth Case Management and Behavioral Health Steering Committee External: Universal Health Services
Results/Impact	Via Linda Behavioral Health Hospital opened in April 2023. Via Linda Behavioral Health Hospital has 120 beds and provides specialized mental health treatment for patients who need acute inpatient psychiatric hospitalization or intensive outpatient programming.

Strategy 2: Add Points of Care such as Multidisciplinary Medical Centers	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Medical Group Management, Risk Management and Leadership External: None
Results/Impact	Two new Free-Standing Emergency Rooms were co-located with Fast Med Urgent Care locations: Prasada and Paradise Valley beginning in 2023. These multidiscipline medical center names HonorHealth "Complete" Care now offers Emergency Room level physicians and staff, always open, no appointment necessary. Prasada and Paradise Valley locations were previously underserved neighborhoods.

Strategy 3: Support Community Health Centers Behavioral Health Intake Depression Screenings and Care Coordination	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Case Management and Behavioral Health Steering Committee External: NOAH (Neighborhood Outreach Access to Health)
Results/Impact	In 2023 NOAH performed 18,588 depression screenings.
Strategy 4: Partner with External Providers to Offer Outpatient and Residential Mental Health and Substance Abuse services	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: HonorHealth Case Management and Behavioral Health Steering Committee External: Universal Health Services
Results/Impact	Via Linda Behavioral Health Hospital opened in April 2023. Via Linda Behavioral Health Hospital offers an Intensive Outpatient Program in-person and virtually. The Intensive Outpatient Program utilizes evidence-based therapy models and psychoeducation for three hour each day up to five days per week. This program addresses a myriad of mental health concerns including suicidal ideation, depression trauma, anxiety, relationship conflict, anger & emotional regulation and co-occurring issues such as substance use and assisting patient to improve their overall well-being through independent living skills, personal and career development.
Strategy 5: Continue HonorHealth Medical Group Depression and Anxiety Screenings:	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: HonorHealth Medical Group Primary Care Clinics External: None
Results/Impact	HonorHealth Medical Group 30 Primary Care clinics screened patients for depression and anxiety beginning in 2022.
Strategy 6: Integrated behavioral health clinician into HonorHealth Medical Group Primary Care practices	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: HonorHealth Medical Group Primary Care Clinics, Behavioral health Steering Committee External: evolvedMD
Results/Impact	HonorHealth Medical Group 30 Primary Care clinics screen patients for depression and anxiety. In the event of a positive screening result, the primary care clinical may refer the patient to on-site behavioral health specialist provided by evolvedMD.

Strategy 7: Add Support Groups for Well-Being, Health Conditions and Chronic Disease Management	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Women's Health Services, Bariatric Program, Cardiac Rehabilitation Services External: Cancer Support Community Arizona
Results/Impact	HonorHealth supports Cancer Support Community Arizona to conduct cancer patient support groups, outreach, and education. HonorHealth Women's Health Services provides the following support groups: New Moms, Perinatal Loss and Pregnancy and Postpartum Depression and Anxiety Support Groups. There were over 800 participants in these support groups in 2023. The HonorHealth Bariatric Program offers a Bariatric support group. HonorHealth Cardiac Rehabilitation Services offers Heart Healthy Classes and Cooking classes for community members.
Strategy 8: Continued Employee Training regarding Trauma Informed Care	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Chief of Caregiver Wellness and Patient Experience, Director of the Wellbeing Center of Excellence, Academic Affairs External: None
Results/Impact	Since 2021, HonorHealth has created new internal infrastructure with two new positions focused on support and training related to mental well-being for self and in caring for others. The Director of the Wellbeing Center of Excellence offers trainings, workshops and interventions on topics such as how to mitigate stressors when working with critically ill patients over a protracted period of time. Academic Affairs' clinical educators implemented a New Graduate Nurses Residency Circle of Support which meets weekly since 2022.
Strategy 9: Continue Care-giver Well-Being Programs	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center
Partnering Organization(s)	Internal: Vice-President Chief of Caregiver Wellness and Patient Experience and the Well-being Center of Excellence External: Blue Zones
Results/Impact	The Well-being Center of Excellence was founded in 2022. It is a resource for all employees. This resource includes Support program for caregivers (see next bullet point), wellness webinars, physical health discount memberships, financial support resources and legal support resources. Current opportunities for caregivers to participate in Well-being support programs include: 'Care for the caregiver Support Line, 1:1 Peer Support, Peer Group Support, HonorNurse Soul Nurse, Nursing Residency Circle of Support and Mentor Support Circle. HonorHealth begun a Wellness Squad in 2023. The Wellness Squad is a tribe of employees at HonorHealth that supports each other in all pursuits of well-being. HonorHealth pledged to become a certified Blue Zones worksite through various benchmarks of employee well-being. All of these programs are intended to assist HonorHealth employees take care of themselves, retain workforce and to be able to care for our patients.

Strategy 10: Continue Opioid Stewardship Steering Committee Workplan	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Opioid Stewardship Committee, Behavioral Health Steering Committee External: Arizona Department of Health Services
Results/Impact	Opioid Stewardship Committee strategic plan includes three aims; improving safety and adverse drug events, reducing or preventing opioid overdose deaths by expanding access to naloxone and medications for opioid use disorder, improving patient experience and compassionate care through patient and clinician education on pain management and opioid use disorder.
Strategy 11: Support Intensive Outpatient Programs for the treatment of Substance Use Disorder	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Via Linda Behavioral Health Hospital, Behavioral Health Steering Committee and Case Management External: NOAH (Neighborhood Outreach Access to Health)
Results/Impact	Via Linda Behavioral Health Hospital opened in April 2023. Via Linda Behavioral Health Hospital offers an Intensive Outpatient Program in-person and virtually. The Intensive Outpatient Program utilizes evidence-based therapy models and psychoeducation for three hour each day up to five days per week. This program addresses a myriad of mental health concerns including suicidal ideation, depression trauma, anxiety, relationship conflict, anger & emotional regulation, and co-occurring issues such as substance use and assisting patient to improve their overall well-being through independent living skills, personal and career development. Additionally, NOAH accepts referrals from HonorHealth for substance use disorder and provides medication assisted treatment.

Priority Area: Access to Care	
Community Health Need	**Access to Care**
Goals	• Strengthen affiliation with community health centers to improve access points. • Provide more points of access to services in the network; physical and virtual. • Expand post-discharge navigation and support services. • Address economic barriers to accessing care through eligibility support and enrollment. • Expand workforce capacity residency training programs, student internships, clinical rotations, and military training programs. • Improve access to new treatments and advanced standards of care through clinical research.
Strategy 1: Continue "Hospital to NOAH" Referral and Navigation Program	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Case Management External: NOAH
Results/Impact	HonorHealth and NOAH have a referral program. If the patient does not have a primary care provider and/or is uninsured the HonorHealth case manager will generate an electronic referred within the Electronic Health Record that prompts a case manager at NOAH to proactively contact the individual. There are an average of over 300 referrals per month from HonorHealth to NOAH within the "Hospital to NOAH" program. In 2023 there were 3,595 referrals from HonorHealth Medical Center Emergency Departments to NOAH.
Strategy 2: Provide more Points of Access to services; Physical Options	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Strategic Planning External: None
Results/Impact	During 2022 and 2023 HonorHealth opened two new "Complete Care" facilities which include a free-standing Emergency Department and Urgent Care Clinic. This facility is open 24 hours a day and is designed to provide access to various levels of care in one location.

Strategy 3: Provide more Points of Access to services; Virtual Options	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Information Technology Department, Transformation Office, Patient Experience, Marketing, Strategic Planning, Clinical Leadership from the HonorHealth Medical Group and the Customer Technology Council External:
Results/Impact	HonorHealth Medical Centers added chat bot scheduling in 2023. HonorHealth Medical Group expanded virtual access through improved scheduling options. The self-serve digital scheduling resulted in 125,231 digitally scheduled visits during 2023. According to Press Ganey, HonorHealth reported consumers felt there was “ease of Scheduling” 79% of the time in 2023.
Strategy 4: Provide “Bridge Hospital to Home” Program	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Care Management, Home Health External: Hospice of the Valley
Results/Impact	HonorHealth implemented a program to assist patients who had unmet needs important to recovery and wellbeing beyond the inpatient setting called “Bridge Hospital to Home”. Some of the services provided in the Bridge to Home program include, providing durable medical equipment, transportation services through a Community Based Organization, or in some cases; hospice care.
Strategy 5: Implement Closed-Loop-Referral Program	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: External:
Results/Impact	HonorHealth Medical Group created 119 cases in April 2024, 460 year-to-date through April 2024. HonorHealth Medical Center created 139 cases in April 2024, 670 year-to-date through April 2024. Desert Mission accepted 150 patients referred for Food Insecurity and closed the loop for 121 in 2023. Desert Mission accepted 161 patients referred for Food Insecurity and closed the loop for all 161 year-to-date April 2024.
Strategy 6: Continue Eligibility Support and Enrollment	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Desert Mission refers to NOAH External: NOAH (Neighborhood Outreach Access to Health)
Results/Impact	NOAH performs over 18,000 eligibility evaluations for public benefits and healthcare annually.

Strategy 7: Expand Workforce Capacity	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Center for Nursing Excellence, Military Partnerships, Allied Professional and Clinical Rotations External: Public and private colleges and universities, school districts and branches of the United States military
Results/Impact	HonorHealth provides supervised clinical rotation opportunities for nursing programs and allied health professional programs. HonorHealth hosts twelve graduate medical education residency programs. HonorHealth Military Partnership provides trauma and deployment training to all branches of military, active duty and National Guard and Reserves.
Strategy 8: Improve Access to New Treatments and Advanced Standards of Care through Clinical Research	
Strategy Was Implemented?	Yes
Target Population	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Clinical programs supported by research trails External: Partnership with private sector, Foundations, Health Systems, Research Institutes, Universities.
Results/Impact	HonorHealth physicians and researchers are moving science forward with over 200-plus active research studies in: Bariatrics (weight loss), Cancer, Heart and vascular health, Neurologic and spine conditions, Trauma. The HonorHealth Research Institute is a collaborative enterprise with 100-plus employees and 300 investigators working toward tomorrow's cures. The institute runs a sustainable, self-supporting operation that benefits patients, the health system and the greater community. The HonorHealth Research Institute is a research incubator. The incubator is a platform for the science that makes a doctor's idea a reality, bringing it to market quickly and improving patient care.

Priority Area: Access to Food	
Community Health Need	**Access to Food**
Goals	• Offer a variety of program to address food insecurity and nutrition at Desert Mission Food Bank. • Provide additional points of access to health foods. • Increase food insecurity screenings and referral. • Implement Closed-Loop-Referral system in partnership with Community Based Organizations. • Develop external partnerships to broaden connection between food, nutrition and chronic disease.
Strategy 1: Continue Desert Mission Food Bank Operations for Vulnerable Populations	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Desert Mission Food Bank External: St. Mary's Food Bank
Results/Impact	Desert Mission Food Bank provided emergency food to 8,326 unduplicated families in 2022 and to 10,096 unduplicated families in 2023. Desert Mission provided 3,296 low-income senior food boxes (CSFP) in 2022 and 4,880 boxes in 2023.
Strategy 2: Provide Additional Points of Access to Healthy Foods	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Desert Mission Food Bank, HonorHealth Culinary Services External: Phoenix area School Districts
Results/Impact	HonorHealth Culinary Services prepares 900 ready-to-eat meals for delivery to homebound individuals per week. Desert Mission Food Bank provided the Granite Reef Senior Center produce bags and bread totaling 10,448 in 2022 and 17,457 bags in 2023. Desert Mission Food Bank delivered 10,448 "snack pacs" for children in 2022 and 8,016 in 2023 to 14 title 1 schools in the community served. Farm Stand (a Desert Mission Food Bank program) is an event to sell local organic produce from a HonorHealth Medical Center location. In 2022, there were 37 events and in 2023 there were 20 events.

Strategy 3: Expand Medical Center Food Insecurity Screening and Referrals	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: Case Management, Nursing Staff External: Community Based Organizations on UniteUs/Contexture Referral Platform
Results/Impact	HonorHealth Medical Centers began screening for food insecurity utilizing the Center for Disease Control's Hunger Vital Sign two question food insecurity screening tool in 2022. HonorHealth Sonoran Crossing Medical Center screened 31.92% inpatients which resulted in a 4.45% positivity rate between March 2022 and September 2023.
Strategy 4: Expand Food Insecurity Screening and Referrals at Additional Points of Care	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: HonorHealth Medical Group External: Community Based Organizations on UniteUs/Contexture Referral Platform
Results/Impact	HonorHealth Medical Group began screening for food insecurity utilizing the Center for Disease Control's Hunger Vital Sign two question food insecurity screening tool in 2022. HonorHealth Medical Group primary health locations screened 35% of patients (913 individuals) that resulted in an 8% positivity rate in March 2022. HonorHealth Medical Group primary care locations screened 52% of patients (3,496 individuals) that resulted in an 4% positivity rate in March 2023.
Strategy 5: Implement Closed-Loop-Referral System at Points of Care	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: HonorHealth Medical Group and Desert Mission External: UniteUs/Contexture
Results/Impact	HonorHealth Medical Group created 119 cases in April 2024, 460 year-to-date through April 2024. HonorHealth Medical Centers created 139 cases in April 2024, 670 year-to-date through April 2024. Desert Mission accepted 150 patients referred for Food Insecurity and closed the loop for 121 in 2023. Desert Mission accepted 161 patients referred for Food Insecurity and closed the loop for all 161 year-to-date April 2024.

Strategy 6: Develop External Partnerships to Broaden Connection between Food, Nutrition and Chronic Disease	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of HonorHealth Sonoran Crossing Medical Center service area
Partnering Organization(s)	Internal: VP Chief of Caregiver Wellness and Patient Experience, Well-being Center of Excellence External: Blue Zones Project Scottsdale
Results/Impact	Residents of the original blue zones areas make healthy choices because those choices are easy—even unavoidable—in their surroundings. That's why Blue Zones Project focuses on influencing the life radius, the area close to home in which people spend 90 percent of their lives. In Blue Zones community transformations, collaborators optimize the built environment, municipal policies and ordinances, restaurants, schools, grocery stores, faith-based organizations, and workplaces, social networks, habitat, and inner selves. Blue Zones work is rooted in lessons learned from the world's longest-lived cultures. We translated these lessons into environmental changes that strengthen social ties, reshape places, and sharpen policies to support healthy choices. Plans to increase access, quality and quantity of nutritious food in places where residents live, learn, work and play; include changing the systems and policies involved in food environments. Objectives include building food skills by prioritizing education on how to grow and cook healthy food, making healthy food accessible and affordable for everyone and growing the local food supply. Eating wisely includes the following principles eating a plant-slant diet, using smaller plates to eat less at meals and maintain a healthy relationship with alcohol. The Blue Zones Project Scottsdale is a five year "blueprint" of actions launched in 2024. Success will be defined by well-being measures.