



PIMA COUNTY

Community Health
Needs Assessment

2018



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Welcome to the 2018 Pima County Community Health Needs Assessment!

Executive Summary & Core Findings

Welcome to the 2018 Pima County Community Health Needs Assessment, also known as the CHNA. Since the enactment in 2010 of the Patient Protection and Affordable Care Act (PPACA), which requires non-profit hospitals to assess and address the health needs of the communities they serve, Pima County's nonprofit hospitals have taken a unified, collaborative approach to meeting these requirements by conducting a joint CHNA. Together with public health professionals, community health centers, social services agencies, health advocates, emergency responders, residents, and community leaders, the CHNA enables stakeholders to harness their collective networks, resources, and expertise to identify and prioritize major health issues and needs confronting residents of Pima County.

During initial discussions for the 2018 CHNA, stakeholders elected to view community health needs through the lens of **social determinants of health** – or “conditions in the environments in which 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” (Healthy People 2020). While several social determinants of health are addressed in this report in addition to health indicators and outcomes such as leading causes of death and disease, this report highlights three in particular: poverty, education, and health insurance. These three factors largely determine a person's access to the resources that support health outcomes and are closely related to the other indicators in this report.

This collaborative process emphasized finding the strengths and assets within the community as well as salient health concerns through review of published data. Community input was critical and collected via:

- 18 Key informant interviews
- 5 Focus groups (n=48)
- 1 electronic survey (n=174)
- 2 community forums (n=134)

The core findings in this report are a synthesis of all data collection and stakeholder processes.

The Good: Strengths

The 2018 CHNA found that community members have a very holistic perception of health to include physical, mental, social, economic, and spiritual interconnectedness. They emphasized quality of life to include a state of feeling well, happy, competent, with the ability to handle stress. Furthermore, stakeholders describe the “big picture” of a healthy community including green spaces, parks, a clean environment, and the availability of fresh, local foods. Community members described social determinants of health such as living wages, affordable childcare, shelter for everyone, specifically affordable and safe housing.

Community members also pointed to the cultural diversity and unique identity of Pima County: that people are resilient and resourceful. Service providers described the spirit of collaboration and the compassion and dedication of their community partners and organizations. They also acknowledged that Pima County has one of the highest nonprofit per capita rates in the country. Stakeholders identified at least five innovative efforts to reach vulnerable community members with complex needs and described an additional 47 programs or organizations as assets, listed further in this report.

What does the data say?

Pima County ranks 4th overall of 15 counties in Arizona according to County Health Rankings and Roadmaps, and **ranks 1st for clinical care, and 2nd for health behaviors.**

Access to a primary care provider is important for health status. Arizona's ratio of population to provider is 424 for every 1 provider; Pima County's ratio is 373:1.

Food insecurity is an area of concern as well as an important social determinant of health. While there is always room for improvement, Pima County has a lower percentage of food insecure children and adults than Arizona as a whole.

Pima County has met and exceeded the Healthy People target for **infant mortality**, with a 2016 rate of 4.7 infant deaths per 1,000 live births.

County-level data from the BRFSS are available through 2014, and show Pima County's **percentage of obese adults** at 25 percent, lower than both Maricopa County and Arizona and meeting the Healthy People 2020 target of 30 percent or less. *Despite meeting national benchmarks, addressing obesity remains a major health need and is discussed further in this report.

Pima County has very successful **school immunization rates**, with more than 94 percent of all children in child care receiving the recommended immunizations- meeting and exceeding the Healthy People 2020 objective for immunizations for 19-35 month olds.

Vaccine preventable diseases are any infectious diseases where an effective preventive vaccine exists, such as influenza, mumps, pertussis, tetanus, measles, and varicella, among others. Pima County has a lower rate of vaccine-preventable disease than Arizona as a whole.

Social Determinants of Health

Education is a key driver of health status. More Pima County residents have high school and college degrees than Arizonans overall.

The Not So Good: Health Needs

The 2018 CHNA process identified the following health needs for Pima County:

- **BEHAVIORAL HEALTH:** including mental illness and substance use/misuse;
- **OBESITY & RELATED CHRONIC DISEASES:** especially diabetes and childhood obesity; and
- **ACCESS TO SERVICES:** including how services are provided, location, and overall availability.

What does the data say?

BEHAVIORAL HEALTH

Pima County residents report an average of 3.9 poor **mental health** days per month, and 12 percent of community members report frequent mental distress. Among the Medicare population, 13.5 percent are treated for depression.

Suicide is the 10th leading cause of death in Pima County. The areas of *Green Valley, Drexel Heights, Oro Valley, Picture Rocks, Tanque Verde, Tucson Estates, Tucson South East, and Valencia West* have statistically significant higher rates of suicide compared to the rest of Arizona. A leading Healthy People 2020 indicator is to reduce the rate of suicides to 10.2 per 100,000. Pima County's rate of suicides is 17.1 per 100,000.

Alcohol is the 2nd cause of morbidity in Pima County, and 14 percent of adults in Pima County report binge or heavy drinking. Between 2012-2016, 32 percent of driving deaths were due to alcohol impairment, a total of 496 deaths.

Opium use and unspecified **drug use** are the 4th and 8th leading causes of morbidity in Pima County, respectively. Drug induced death rates in Pima County are statistically higher, compared to Arizona, including opioid, heroin, and pharmaceutical use.

The ratio of population to **mental health providers** is 600:1 in Pima County; U.S. top performing communities have a 330:1 ratio. Pima County stakeholders are concerned with the lack of pediatric and adolescent mental health specialists. In particular, the school system lacks mental health resources and counselors are typically academic advisors, usually without training in mental health.

OBESITY & RELATED CHRONIC DISEASES

Cancer and heart disease continue to be the two leading causes of death among Pima County residents, as they are throughout Arizona and the U.S. These causes of death are connected to many of the health indicators in this report, including physical activity, smoking, obesity, nutrition, and social determinants of health.

Heart disease has surpassed cancer as the leading cause of death in Pima County, with 170.6 deaths per 100,000 people, much higher than the Healthy People 2020 target of 103 deaths per 100,000 people.

In Pima County, there were an estimated 155 deaths from cancer per 100,000 population in 2016. **The death rate for cancer is higher than the state of Arizona at 142.2 per 100,000.** Some areas have higher rates of cancer mortality per 100,000 than the county overall, including Valencia West (155.6 per 100,000), Marana (156.3 per 100,000), Tucson East (157.3 per 100,000), Tucson Central (165.3 per 100,000), and Pascua Yaqui Tribe (283.8 per 100,000).

In 2014, 25 percent of Pima County's residents were **obese**- an increase from 22 percent in 2012. Although rates are lower than both Maricopa County and Arizona and meet the Healthy People 2020 target of 30 percent or less, this community-identified need is confirmed by the data.

Based on the latest data, an estimated 13.11 percent of adults had ever been told they were diagnosed with **diabetes**, higher than both Maricopa County at 11.42 percent and Arizona at 10.66.

Healthy People 2020 lists **commercial tobacco** use as a leading health indicator related to chronic disease, with a target to reduce adult smoking to 12 percent of the population. Approximately 14 percent of Pima County adults are smokers.

The most recent data show that only 26.3 percent of Pima County residents reported eating the **recommended amounts of fruits and vegetables**.

Although Pima County performs better than state and national trends, 18 percent of community members report no leisure time **physical activity**, and 13 percent of residents have no access to exercise activities.

ACCESS TO SERVICES

Pima County stakeholders identified access to services as a major health need, and it is noted that access to services is a cross-cutting concern affecting all health issues related to poor health outcomes, illness, or disease. Access to services extends beyond easily quantifiable measures of access to healthcare, such as health insurance coverage. Stakeholders expressed frustrations around health insurance including affordability, insufficient coverage, eligibility requirements/limitations, wait time for authorizations, and barriers around insurance literacy among the insured. However, concerns that arose were primarily focused on:

- **Provision of services:** integration, coordination, continuity of care, cultural competency;
- **Location and distance** of services: transportation; and
- **Availability** of services: especially lack of behavioral health providers and facilities.

Quantifying these complex systems through secondary data can prove challenging based on interrelatedness of contributing factors, including many of the social determinants of health that are included in this CHNA. This challenge underscores the importance of collecting primary data through community input to better understand the most pressing health needs facing the community.

Secondary data that supports the community's identification of access to services as a major health need include primary care scores, population to primary care provider score, and transportation score. Overall, while Pima County has more primary care providers per population and has a slightly better transportation score than the state, there are disparities among Primary Care Areas (PCAs) facing greater challenges in access to services.

Primary Care Scores represent the level of medical underservice in an area. The higher the score, the greater the medical underservice. The median Primary Care Score among Pima County PCAs is 34. The communities of **Drexel Heights, Green Valley, Tucson Foothills, Tucson Central, Tucson South, Pascua Yaqui Tribe, Ajo, Flowing Wells, San Xavier** and **Tohono O'odham Nation** have PCA scores higher than the median.

Population to Primary Care Provider Ratio is the number of primary care providers per total population. Arizona's ratio of population to provider is 424 for every 1 provider; Pima County's ratio is 373:1. Sixteen of the 23 PCAS have a higher population to provider ratio than the county.

Transportation Scores determine the adequacy of transportation in a Primary Care Area. The higher the score, the less adequate or greater the need for transportation. The Arizona statewide transportation

score is 110; the overall Pima County score is 109. The communities of **Tucson West, Tucson East, Tucson South, Tucson Foothills, Tucson Central, Flowing Wells, Green Valley, San Xavier, Pascua Yaqui Tribe** and **Tohono O’odham Nation** all have transportation scores higher than the County overall.

Social Determinants of Health

Poverty. In 2017, 24 percent of Pima County residents earned less than 125 percent of the federal poverty level, with 37 percent of African Americans and 47 percent of American Indians experiencing these levels. Geographic disparities exist with the 30-50 percent of the population in the western portion of the County and some urban pockets below federal poverty levels.

Physical environment. Pima County ranks 10th of 15 Arizona counties for physical environment. These factors include air pollution/particulate matter, drinking water violations, severe housing problems, driving alone to work, and having a long commute, according to County Health Rankings and Roadmaps.

Geographic disparities. As demonstrated above, there are large disparities among Primary Care Areas in Pima County for several indicators. These are described more thoroughly in the report. However, these areas tend to represent lower-income and/or more rural populations that struggle with access to health care, healthy foods, and other key social determinants of health.

Housing. In Pima County 9.4 percent of homeowners and 25.8 percent of renters were severely burdened by cost, meaning they spent 50 percent or more of their income on housing. These rates are slightly higher than both Maricopa County and Arizona as a whole.

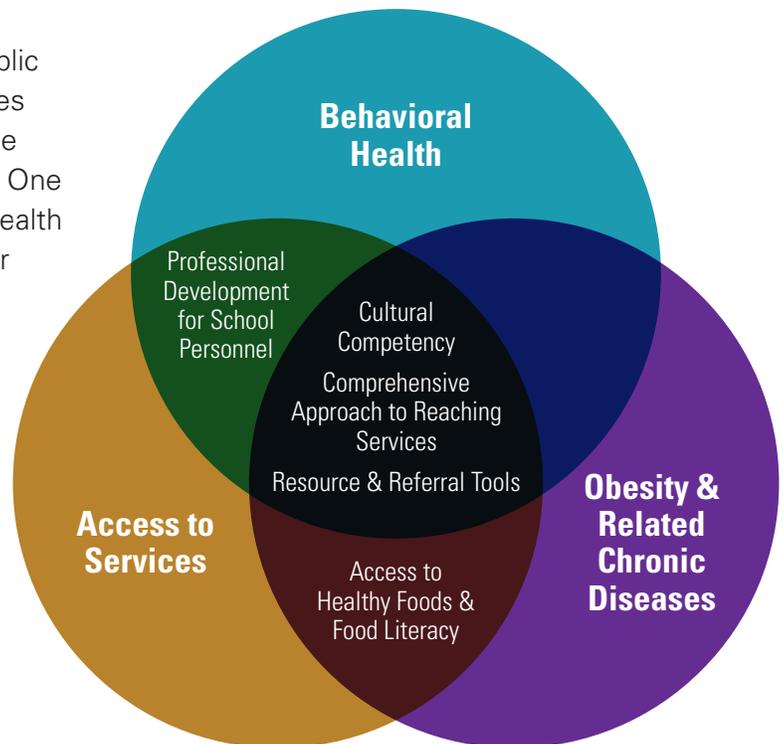
Community-Proposed Solutions

The conclusion of the Pima County CHNA process included a community forum attended by 93 community members, health care workers, public health professionals, academics, representatives from community organizations and other people with an interest in the outcomes of the CHNA. One of the purposes was to confirm and prioritize health needs and to propose and prioritize solutions or needed actions.

Community members identified several potential solutions, or needed actions, related to Behavioral Health, Obesity and Related Chronic Diseases, and Access to Services.

These leading proposed solutions cut across the three community health needs as illustrated to the right.

Health Needs and Cross Cutting Proposed Solutions



Comprehensive Approach to Reaching Services. Bringing services to people where they live, work, and play is needed to reduce barriers of time and cost to clients and create efficiency. While health transportation services exist, the system is fragmented and driven by a variety of eligibility requirements, and in some cases availability of volunteers. In rural communities and on tribal reservations, services such as telemedicine could provide specialty care and save community members hours of travel and wait time.

Cultural Competency. Health behaviors are more likely to change when education and outreach efforts consider and account for the day-to-day lives and background of community members. Patients are more likely to access services if the healthcare environment and providers understand their needs. Culturally competent services account for age, language, ethnicity and special needs of vulnerable populations such as at-risk teens, LGBTQ, refugees or persons experiencing chronic homelessness.

Access to Healthy Foods & Food Literacy. The relationship between access to foods and affordability, or the barriers to healthy eating due to poverty, was described by participants. Food literacy includes understanding the relationship between what people eat and their health, and how to make the best food choices. Preparing healthy food in a palatable way will increase the likelihood of sustainable behavior change and eating habits.

Professional Development & Training for School Personnel. Many school counselors serve as academic counselors and do not necessarily have a background or training in psychology or social work and are not typically licensed mental health providers. Furthermore, there is a lack of pediatric and adolescent psychiatry services community wide. Given a rise in youth substance use and misuse and suicide, school personnel need to have specialized training.

Resource & Referral Tools. Service providers from all domains, including behavioral health, primary care, and social services, need tools readily available to be able to link their clients to needed services. These tools would be an outcome of service integration and collaboration between a variety of agencies, emphasizing a holistic approach to caring for clients with multiple needs.

Next Steps & Community Health Improvement Plans

Many stakeholders and organizations will find ways to use the Community Health Needs Assessment (CHNA) and determine where they can best address community concerns and needs. These stakeholders include hospitals, health departments, community health centers, and social service organizations, among others.

Individual nonprofit hospitals will use the CHNA to develop implementation plans in support of their respective community benefit programs. In addition, the CHNA will influence the work of **Healthy Pima**, a community-based initiative committed to improving the health of Pima County residents through collective action by raising awareness, mobilizing existing resources and taking action. Based off the findings from this CHNA, Healthy Pima will develop and implement short and long-term strategies to focus the efforts and work of nonprofits, for-profits, government entities, business leaders, and diverse community groups over the next three years.

For more information on the Healthy Pima Initiative including how to get involved, visit: www.healthypima.com

Comments and questions regarding the 2018 Pima County Community Health Needs Assessment can be sent to healthypima@pima.gov.

Introduction

CHNA Background & Purpose

The purpose of a Community Health Needs Assessment (CHNA) is to understand the overall health status of a community. CHNAs enable communities to define and analyze health priorities and identify opportunities for optimizing improvements for health and wellbeing. Community members work collaboratively to address these priorities through partnerships.

The Public Health Accreditation Board requires a CHNA every five years; and through the Patient Protection and Affordable Care Act (PPACA), nonprofit hospitals are required to conduct a CHNA every three years. 2018 represents the third collaborative effort to conduct a CHNA in Pima County, with leadership from hospitals, county and tribal health departments, federally qualified community health centers, and participation and community input from a diverse group of advocates, service providers, as well as concerned citizens.

Community Defined by CHNA

Communities transcend geographic boundaries established by streets, neighborhood names, and zip codes. Part of the CHNA process is to capture the unique identity of Pima County in order to harness community assets to promote health and wellbeing, and to impact the factors that are detrimental to community health.

For the purposes of this CHNA, the community assessed is Pima County, Arizona. All collaborating organizations conducting the CHNA serve Pima County. Throughout the CHNA process, community members were asked to consider the whole of Pima County, to include urban, rural, incorporated, non-incorporated areas; and to consider health services broadly, including direct healthcare and also support and education related to health issues.

Written Comments Received & Evaluation of Impacts of Actions Taken Since Prior CHNA

Written Comments Received from Prior CHNA:

The Internal Revenue Service requires nonprofit hospitals to make the CHNA widely available to and solicit feedback from the public. All collaborating nonprofit hospitals and the Pima County Health Department made the 2015 CHNA publicly available on their respective websites and provided the public an opportunity to submit written comments through email. These websites will continue to allow for written community input on the organizations' most recent joint 2018 CHNA report.

At the time of this 2018 CHNA report development, none of the hospitals or Health Department had received any written comments on the 2015 CHNA. The hospitals and Health Department will continue to solicit and track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate staff.

Evaluation of Impact of Actions Taken Since Prior CHNA:

Addressing the Opioid Epidemic

The collaborative approach between hospitals, public health, health centers and community organizations that Pima County stakeholders have undertaken since the enactment of the Affordable Care Act has enabled these organizations to identify collective actions to address the community's most pressing health needs. For example, in 2013, stakeholders agreed to collectively address access to care as measured by the number of individuals enrolled in health insurance.

In 2015, the Pima County Community Health Needs Assessment identified opioid dependency and substance abuse disorder as emerging health needs in the county. Substance abuse disorder had escalated as a community health need and the opioid epidemic had elevated to a top priority. To begin to better understand this community health need, the assessment planning group joined with the Mayor Jonathon Rothschild Healthcare Sector Partnership Taskforce on community collaboration to better understand the problem in the region. To promote that understanding, a community visioning session was held in February 2017 with 75 community participants, including first responders, healthcare providers, public health officials, and general community members impacted by the epidemic. The group prioritized the following areas of focus: decreasing the number of opioid prescriptions, more treatment sites and services to accommodate an increase in those needing treatment, and education for health professionals and the broader community. The group also identified the importance of maintaining access to health coverage provided by the Affordable Care Act and support from elected officials and community leaders.

As a community, what was learned was used to inform work addressing the opioid epidemic. Numerous professional development and community health symposiums have been held on the topic to educate care providers. Providers have worked with local, state and federal officials to develop public policy to decrease prescribing and increase access to services; and individual health systems have developed programs to address this critical community health need.

Like much of the nation, a significant decline in rates of opioid abuse and misuse in Pima County has not been seen and it continues to be identified as a community health need in the 2018 CHNA. By shining the light on the epidemic, the beginnings of community infrastructure have been built to both prevent future addictions and provide a path to recovery for those seeking it. The problem was years in the making and will require a similar long-term focus to significantly reduce the rate of opioid use and misuse across Pima County.

While nonprofit hospitals are required to develop system-specific plans to address the key health needs identified by the CHNA, the value of taking a collective impact approach to address key health needs cannot be overstated. System-specific plans can be found on each nonprofit hospital's respective websites.

Who Was Involved?

The 2018 Pima County CHNA consisted of a core planning committee that met regularly to help guide and support the process. Committee members provided input and direction regarding selection of data sources, development of primary data collection instruments such as key informant and survey questionnaires and helped identify opportunities to involve stakeholders. Committee members also played a key role in ensuring participants in the CHNA process reflected the broad and diverse demographics of the Pima County population.

Community Health Centers

- **El Rio Community Health Center** *Nancy Johnson, CEO*
- **Desert Senita Community Health Center** *Jonathan Leonard, CEO*
- **Marana Community Health Center** *Clinton Kuntz, CEO; Rose Skupeika, Director of Integrated Operations*
- **Mariposa Community Health Center** *Ed Sicurello, CEO*
- **United Community Health Center** *Rodolfo Jimenez, CEO*

Health Departments

- **Pascua Yaqui Tribe** *Apryl Krause, Alternative Medicine Clinic Director*
- **Pima County Health Department** *Marcy Flanagan, Director; Alan Bergen, Senior Program Manager*
- **Tohono O’odham Department of Health & Human Services** *Rosemary Lopez, Director*

Hospitals

- **Banner – University Medical Center** *Jim Elco, Senior Director of Strategy and Planning; Lori Taplin, Director of Strategy and Planning*
- **Carondelet Health Network – St. Mary’s Hospital and St. Joseph’s Hospital** *Kelly Raach, Market Director of Strategy; Melissa Shafer, Physician Relationship Manager*
- **Tucson Medical Center** *Julia Strange, VP Community Benefit; Mary Atkinson, Director of Wellness; Laurie Ledford, Wellness Dietician*

Also

- **Community Food Bank of Southern Arizona** *Michael McDonald, CEO*
- **Healthy Pima (Pima County Health Department)** *Nic Cogdall, Senior Strategist; Mary Kinkade, Senior Advisor*
- **Pima County Administrator’s Office** *Francisco García, Assistant County Administrator and CMO*
- **Tohono O’odham Nation Executive Branch** *Verlon Jose, Vice Chairman*
- **Consulting Team** *Emily Coyle, Rebecca Drummond, and Keely Bo Breedlove (See Appendix for consultant qualifications and credentials)*

CHNA Process & Methods

The Pima County CHNA was led by a planning committee comprised of key stakeholders in healthcare including local federally qualified community health centers, non- and for-profit hospitals, and tribal and county health departments. The Pima County Health Department coordinated and facilitated monthly planning committee meetings.

Secondary Data Collection & Data Sources

Secondary data, or pre-existing data, including publicly available health statistics and demographic data, were updated since the 2015 CHNA. With input from the planning committee, as well as input from participants at the first community forum, additional health indicators of special interest were investigated. Comparisons were made to state rates and Maricopa County, the largest metropolitan area in Arizona. When possible and appropriate, Pima County Primary Care Area (PCA) statistics are presented to provide deeper context and understanding of health disparities within the county.

Several sources of data were consulted to present the most comprehensive picture of Pima County health status and outcomes, including the Arizona Department of Health Services, the Centers for Disease Control and Prevention, and the U.S. Census Bureau. Additionally, certain websites that provide more interpretation and allow for broader comparisons with other communities across the state and country are included. These sites, such as County Health Rankings and Roadmaps, Feeding America, and Arizona Health Matters, tend to aggregate data from a variety of sources and are frequently consulted for community health needs assessments.

Below is a listing of the data sources and websites from which information in this CHNA is compiled:

- **American Lung Association:** www.lung.org
- **Arizona Department of Health Services (ADHS)**
- **Arizona Health Matters**
 - Arizona Health Matters was an electronic one stop source of unbiased data and information about community health and healthy communities in general. Indicators were searchable by county and zip code. The website closed in 2018.
- **Arizona Cancer Registry**
 - http://healthdata.az.gov/query/module_selection/azcr/AzCRSelection.html
- **Community Profiles Dashboard**
 - <https://www.azdhs.gov/gis/community-profiles-dashboard/index.php>
- **Immunization Program**
 - Immunization Coverage Levels <https://azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#reports-immunization-coverage>
- **Population Health and Vital Statistics**
 - Hospital Inpatient Discharges & Emergency Room Statistics <https://pub.azdhs.gov/health-stats/report/ahs/ahs2016/index.php>

- **Primary Care Areas (PCA) Statistical Profiles**
 - <https://www.azdhs.gov/prevention/health-systems-development/data-reports-maps/index.php#statistical-profiles-pca>
- **Behavioral Risk Factor Surveillance System (BRFSS):** www.cdc.gov/brfss
- **Bureau of Labor Statistics:** www.bls.gov
- **Community Data:** Local agency data was provided by the Community Food Bank of Southern Arizona, El Rio Community Health Center, local hospitals, and the Pima Council on Aging. While these data sets may not all be presented here, they were reviewed, and these community contributions were appreciated.
- **Community Commons:** www.communitycommons.org
- **County Health Rankings & Roadmaps:** www.countyhealthrankings.org
- **Environmental Protection Agency (EPA):** www.epa.gov
- **Feeding America:** www.feedingamerica.org
- **Healthy People 2020:** www.healthypeople.gov
- **Pima Council on Aging:** www.pcoa.org
- **Pima County Health Department:** www.pima.gov
- **PolicyMap:** www.policymap.com
- **Robert Wood Johnson Foundation State of Obesity:** www.stateofobesity.org
- **US Census Bureau:** www.census.gov

Primary Data Collection

Primary data, or new data collected directly from the community, were collected to gather more information on health needs and strengths of the community and to engage the community in the process. Community input was a critical component of the assessment process. By listening directly to community health leaders, advocates, service providers, and clients, information was gathered that otherwise would not so readily be understood from published data. In particular, the intersection of health outcomes and social determinants, including specific community context is made clearer.

Qualitative primary data collection consisted of:

- 18 Key Informant interviews (KI)
- 5 focus groups (n=48)
- 2 community forums (n=134)
- 1 electronic survey (n = 174)

Key Informant Interviews

The purpose of conducting KI interviews is to have more in-depth personal discussions to gather input from representative community members. These can be community leaders or community members representing specific sub-population or their proxy. An initial list of interviewees from the 2015 CHNA was reviewed by the planning committee and recommendations were made for potential KIs in 2018. Criteria for identifying KIs was determined by the following questions:

- **What members of the community have a significant level of influence in community matters?**
- **Whose approval from within the community is needed to bring about significant change in the community?**
- **Are there individuals who do not hold formal leadership positions in the community that you feel are particularly knowledgeable about this topic or issue?**

Additional KIs were identified using a “snowball” method, i.e. suggestions made by KIs themselves. A total of 18 KI interviews were conducted, primarily by telephone. In-person interviews were offered and occasionally requested.

Key informants represent a range of Pima County health, nonprofit, rural, and tribal organizations. Below is a list of the organizations and Key Informant’s role:

ORGANIZATION	ROLE
Abacus Health	Care Coordination Manager
Arizona Complete Health	Director of Program Innovation
Carondelet Medical Group	Director of Behavioral Health
Catholic Community Services	Chief Executive Officer
City of Tucson	Staff Assistant, Environmental & General Services
Desert Senita Community Health Center	Chief Executive Officer
El Rio Community Health Center	Community Health Outreach Worker (CHW)
Interfaith Community Services	Chief Executive Officer
International Rescue Committee	Clinical Therapist and Program Supervisor
Marana Community Health Center	Chief Executive Officer
Marana Unified School District	Registered Nurse, Marana High School
Pima County Health Department	Program Manager, Ending Poverty Now
Planned Parenthood of Southern Arizona	Director of Education
Southern Arizona Legal Aid	Executive Director
Sunnyside Unified School District	Director Career and Technical Education / JTED
Tohono O’odham Department Health & Human Services	Director
Tucson Fire Department	Community Services Outreach Coordinator, TC3 Program
UA College of Law	Director for Innovation for Justice Program

Type of organization and community served by the key informant were also documented, including:

- **Population represented:** 1) medically underserved, 2) low-income persons, 3) minority populations, 4) populations with chronic diseases
- **Specialized knowledge, expertise, role or Interviewee.**
- **Type of organization/role:** 1) County Health Department, 2) Tribal Health Department, 3) Nonprofit organization, 4) Academic Expert, 5) Community Based Organization, 6) Healthcare Provider, 7) Private Business, 8) Health Insurances or Managed Care Organization, 9) Faith-based Organization, 10) Schools

Focus Groups

The purpose of conducting focus groups is to identify a “norm” that participants center toward with regards to attitudes, beliefs, practices or behaviors. They can also be used to validate and / or challenge what has been published in prior assessments and / or stated by Key Informants. Focus group participants have similar characteristics such as same type of work, e.g. teachers, nurses, outreach workers; similar “call to action,” e.g. parents of students at a certain district, persons with same illness; or similar demographic, e.g. elderly, LGBTQ, etc.

Focus groups were chosen based on their insight to inform and provide context to the key drivers of health: 1) insurance status, 2) poverty, 3) education. Themes anticipated to surface were 1) health issues/ needs identified by the clinical and secondary data, and 2) health needs of those who are functioning outside of the system. Groups were also selected by ‘proxy’ so as not to burden vulnerable community members.

The following focus groups were conducted:

- 1. Community Health Outreach Workers/ CHWs (n=11)** CHWs participated from El Rio Community Health Center, a federally qualified community health center that has one of the highest enrollment rates into the Arizona Health Care Cost Containment System (Medicaid), largely due to its outreach efforts. Representatives from its various locations, including southeast, south, northwest, and downtown Tucson locations attended. This focus group was conducted in English and in Spanish.
- 2. Community Meal Attendees (n=14)** Community members facing food insecurity participated in a focus group during a community meal. Meals are offered weekly through a partnership between a local church on the east side of Tucson and the Community Food Bank of Southern Arizona in Tucson.
- 3. First Responders & Hospital Emergency Departments (n=7)** Participants representing the following organizations attended:
 - Banner University Medical Center
 - Carondelet Health Network (2)
 - Tucson Fire Department (2)
 - Tucson Medical Center
 - Tucson Police Department, Mental Health Support Team (MHST)

4. Healthcare Providers (n=7) Providers from El Rio Community Health Center participated including from the following roles and departments:

- Chief Clinical Officer
- Certified Nurse Midwife
- Director of Behavioral Health
- Director of Clinical Pharmacy
- DO, Family Medicine (for Pasqua Yaqui Tribe)
- Medical Director, Internal Medicine
- MD, Pediatrics

5. School Nurse Supervisors (n=10) Supervising Nurses in Tucson Schools (SNITS) meets monthly to share resources, network, and support each other on common health issues in schools. The SNITS network reaches beyond Tucson to include schools in Green Valley, Marana, and Sahuarita. Nurses from the following districts attended the CHNA focus group:

- Amphitheater Unified (Tucson)
- Catalina Unified (Tucson)
- Continental Elementary School District No. 39 (K-9, Green Valley)
- Flowing Wells Unified (Tucson)
- Marana Unified (Marana)
- Tucson Unified (Tucson)
- Sahuarita Unified (Sahuarita)

Community Forums

Two community forums were held to include community stakeholders and gather input into the CHNA process. Forums were publicized through the Healthy Pima listserv, through KIs and Focus Group participants, and shared through stakeholder networks.

1st Forum

The purpose of the first forum was to:

- **Share information** and preliminary findings with stakeholders of Pima County;
- **Elicit feedback** pertaining to the emerging themes; and
- Identify and **address any gaps** in data collected.

Approximately **41 community members** attended the first forum. A brief presentation was given to describe the purpose of a Community Health Needs Assessment, including its relevance for Public Health Accreditation and nonprofit hospital requirements. The overall Pima County CHNA process was described, including a discussion of Social Determinants of Health, and data collection methods. Finally, preliminary results from secondary data collection, KI Interviews and focus groups was presented.

Participants then formed five “break out” groups, facilitated by planning committee members. Each group brainstormed their community health issues, then voted on the topics they wanted to discuss the most that day. After these topics were written on a poster board, the group discussed populations most affected, barriers, existing resources, and finally the needed actions to address these issues.

To conclude the forum, one participant was asked to report back to the whole group on their discussion and key highlights. The next steps and upcoming events, such as the electronic survey and second forum were announced, and participants were asked to publicize these through their networks. Extensive notes were taken throughout the process and used to analyze themes along with other data sources.

Community Forums

2nd Community Forum

The conclusion of the CHNA process was marked by a highly publicized community forum attended by 93 community members, health care workers, public health professionals, academics, representatives from community organizations and other people with an interest in the outcomes of the CHNA. The purpose of the second forum was to:

- **Share findings** with stakeholders;
- **Identify and prioritize health needs;** and
- **Identify and prioritize solutions, or needed actions.**

As with the first forum, a brief presentation described the purpose and process of the CHNA. Findings from primary data collection were shared and validated by secondary data. Five salient health concerns that arose during the data collection process were presented along with potential solutions or ways to address the concerns proposed through the community input process. Because there is great flexibility in how communities can identify “health needs,” in this CHNA process participants were asked think about upstream, root causes to health concerns when thinking about needs, with emphasis on social determinants of health.

Prioritization Process: Attendees were then asked to participate in a “**Gallery Walk**” with five stations representing five health needs identified through CHNA data collection. Each station was facilitated by a planning committee member. Participants could choose the topic they wished to begin with, then groups rotated until they had “walked the whole gallery.” At each station participants were asked to identify a resource, action, or other need (or potential solution) related to the respective overarching health need. They could choose a need or proposed solution that had already been identified during the presentation or come up with new solutions/needed actions.

After everyone had a chance to contribute, participants voted using a **nominal ranking technique**. Each person had three stickie dots and placed them on their top solution/need(s). Participants were encouraged to use all three dots for one solution/need or spread them over up to three different solutions/needs. Groups then proceeded to the next station until all five stations had been visited. Station facilitators tallied the total number of dots for each solution/need identified and wrote the top three on a poster. Each facilitator reported out the three solutions/needs with a brief explanation of the discussions that took place.

Participants then walked the gallery again and used five stickie dots to vote on the 15 solutions/needs identified during the first gallery walk under each overarching health need. Through this process, the community prioritized the three top health needs of Behavioral Health, Obesity and Related Chronic Diseases, and Access to Services and along with proposed solutions. Extensive notes were taken and used for final analysis and results for the Pima County CHNA.

Community Survey

A brief open-ended electronic survey was developed in English and Spanish to engage community members who otherwise had no opportunity to participate in the CHNA process and was distributed through networks or “snowball” outreach. The survey link was shared with planning committee members, Healthy Pima members, participants at the 1st Forum, KIs, and focus group participants to send out through their professional and community networks.

The survey consisted of seven open-ended questions, and the respondent’s name and affiliation were optional. Survey questions were a pared down version of the questions asked of KIs, focus group, and 1st forum participants, addressing: health concerns, population affected, needed actions or resources, community assets; and advice or recommendations to the CHNA, including data sources and individuals to be consulted.

It should be noted the survey was not intended or designed to be a representative sample of the community; it was simply a way to reach more people, especially due to the large geographic nature of Pima county, who may wish to provide input but were unable or unaware through other means. A total of **174 community members** responded to the survey.

POPULATION REPRESENTED OR SERVED (N=142)

Low income	90%
Minority populations	82%
Populations with chronic diseases	70%
Medically underserved persons	67%

SECTOR REPRESENTED (N=149)

Nonprofit organization	44%
Healthcare provider	37%
Community based organization	35%
Other	17%
County health department	11%
Academic expert	8%
Government official	6%
Tribal health department	4%
Private business	3%
Health plan, insurer	1%

Limitations with Data Sources

Every effort was made to collect the most relevant and up-to-date county-level data for this CHNA. Due to variations, timing and methodology of data sources (such as the CDC's Behavioral Risk Factor Surveillance System (BRFSS), for example), some health indicators will present more recent and/or comprehensive data than others. Additional limitations with data include:

Accounting for the Entire County. Tucson is a large metropolitan area with many more resources than its rural and unincorporated siblings of Ajo, Green Valley, Marana, Sahuarita, and the tribal communities of Pascua Yaqui and the Tohono O'odham Nation. While much effort was made to receive community feedback from these areas, this aspect could be improved in the future.

Availability of County Level Data. Many health indicators of interest to stakeholders are only available at the state level. Conversely, while some local organizational data was collected, it is not necessarily representative of the whole county.

Complex Systems. The complexity of accessing services is challenging to capture through published data. Throughout the report social determinants of health are emphasized through a variety of social indicators such as poverty, housing, or food insecurity. Needs around coordination of care, continuity of care, and general access to services is less straightforward to document with secondary data, thus the importance of community input and documentation of first-hand experiences of community members.

Data discrepancies. In some cases, multiple data sources or years of data collected were used for a single indicator in order to provide the most complete picture of an indicator's impact. Because of variability in data collection methodology, analysis, or the year(s) examined, there may be variability within an indicator as well.

Primary Care Area (PCA) Data. What may appear to be significant changes in rates from year to year should be interpreted with caution, as they may represent changes in PCA designation methodology that occurred within ADHS to more appropriately reflect community boundaries and align with federal designation areas. PCA data from American Indian communities of San Xavier, Tohono O'odham Nation, and Pascua Yaqui should be interpreted with caution.

Responding to Local Needs. There is much interest to find data describing census tract, zip code, or neighborhood levels; however, the scope of the CHNA is to focus on county-level data. PCA level data is presented as much as possible.

Timing of Surveillance Data. Turnaround time to obtain analyzed and published data is such that most recent surveillance data is typically two years or older at time of CHNA development.

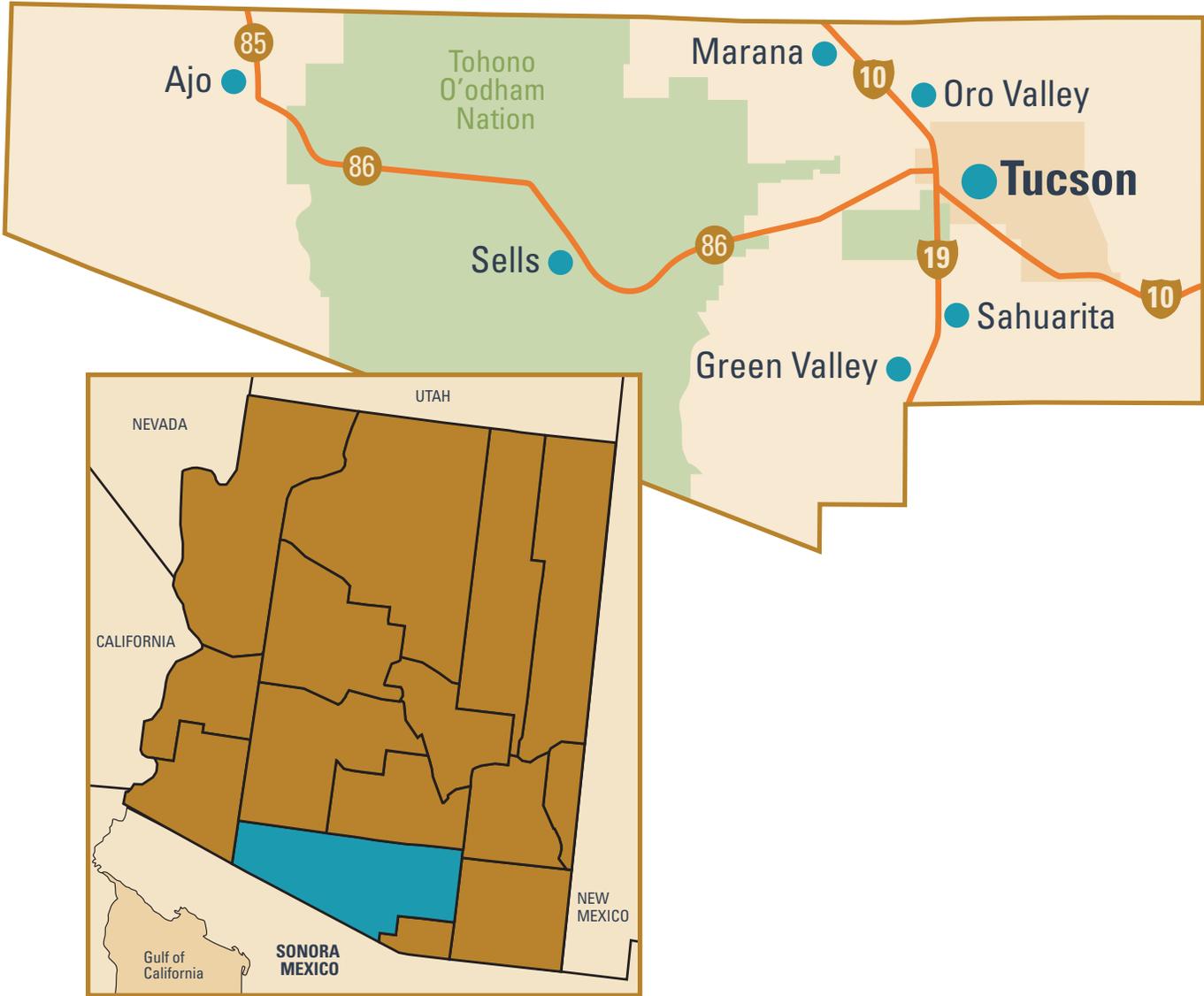
Demographics & Health

Community Profile

Location & Geography

Pima County is located in southern Arizona, just north of the state of Sonora, Mexico. Created in 1864, Pima County is one of the four original counties in Arizona, and initially encompassed the entirety of southern Arizona acquired by the Gadsden Purchase.

Most of the county population lies in and around the urban city of Tucson, the state’s second largest city. Other urban areas near Tucson include the towns of Oro Valley and Marana north of Tucson, and Sahuarita and Green Valley to the south. The rest of the county is sparsely populated to the west including the towns of Sells and Ajo. The county also includes two Native American communities- the Pascua Yaqui Tribe, and the Tohono O’odham Nation.



Population & Age Distribution

The American Community Survey's most recent 5-year aggregated data sets covers 2012-2016 census data. As of the 2012-2016 census period, Pima County was home to an estimated 1,003,338 people.

POPULATION <i>U.S. Census</i>				
Population	2000	2010	2012-2016	% Change 2000 to 2012-2016
Pima	843,746	980,236	1,003,338	18.91
Arizona	5,130,632	6,728,577	6,728,577	31.15

Aggregated 2012-2016 census data shows that 17.8 percent of the population is over the age of 65, and 60.34 percent are of working age.

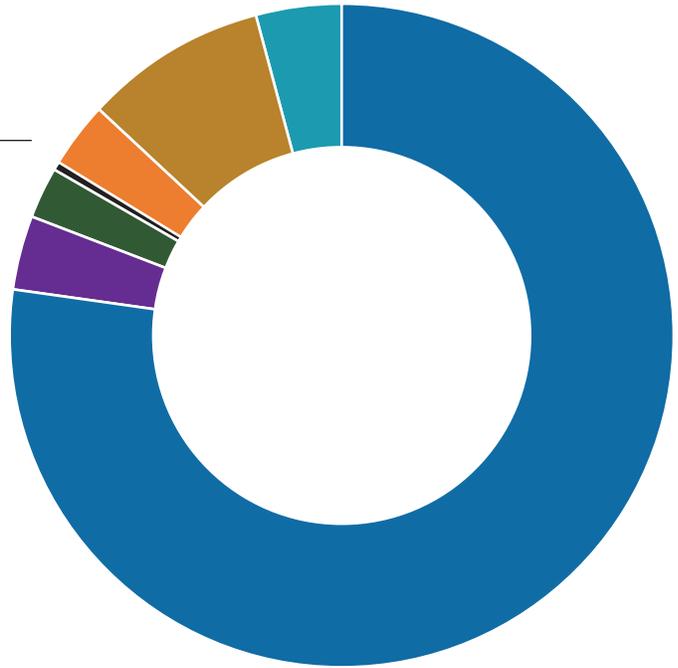
AGE DISTRIBUTION <i>U.S. Census</i>		
Age	Number	Percent
Under 5	59,511	5.93
Under 18	219,290	21.86
Working Age (18-64)	605,436	60.34
Aging (65+)	178,612	17.8

Race & Ethnicity

Of the people living in Pima County between 2012-2016, 77.32 percent are White, 3.52 percent are African American, 36.11 percent are Hispanic, 2.72 percent are Asian, 0.15 percent are either Native Hawaiian or Pacific Islander, 3.24 percent are American Indian or Alaskan Native, 8.91 percent are of “some other race” and 4.14 percent are of two or more races. Approximately 36 percent of the population is Hispanic.

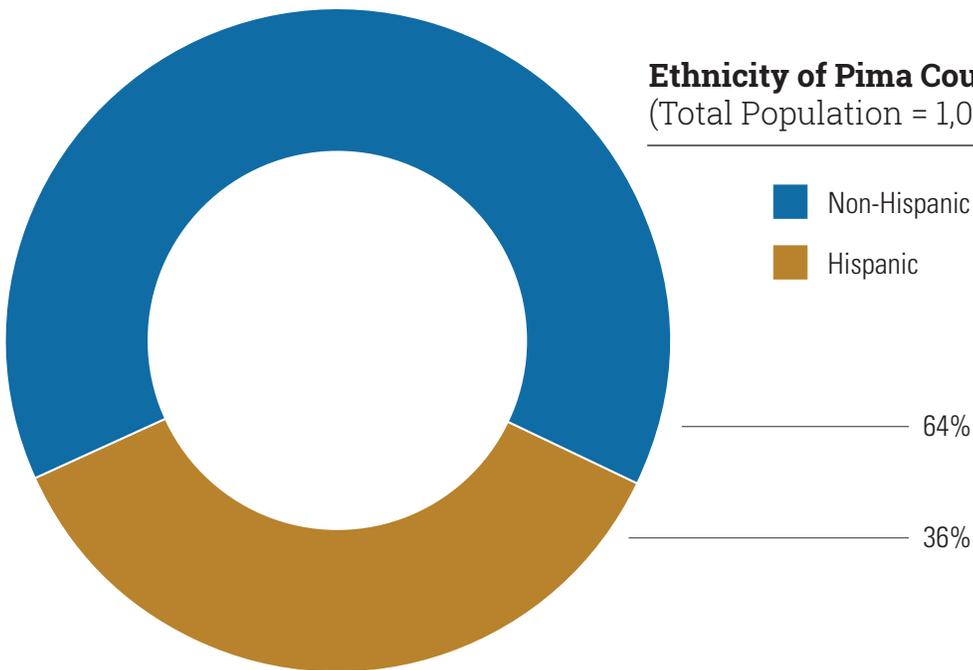
Race of Pima County Residents, 2012-2016

(Total Population = 1,003,338)



Ethnicity of Pima County Residents, 2012-2016

(Total Population = 1,003,338)



Source: www.census.gov

Employment

The following table shows the number of people who were employed, unemployed, in the labor force, as well as the unemployment rate for the market in Pima County as of October 2018, according to the Bureau of Labor Statistics.

Unemployment rates are generally lower in Pima County than the rest of the state.

Employment Rates: October 2018 Bureau of Labor Statistics				
	Employed	Unemployed	In Labor Force	Unemployment Rate
City (Tucson)	249,633	11,297	260,930	4.3
City (Marana)	22,018	716	22,734	3.1
City (Oro Valley)	18,914	794	19,708	4
City (Sahuarita)	12,124	434	12,558	3.5
County (Pima)	468,161	20,174	488,335	4.1
Tucson Metro Area	468,161	20,174	488,335	4.1
State (Arizona)	3,299,100	156,127	3,455,227	4.5



Key Social Determinants of Health

According to the Centers for Disease Control and Prevention, “social determinants of health are conditions in the environment in which 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.” (Healthy People 2020).

Social determinants of health (SDOHs) are typically categorized within five key domains, as defined by the CDC: Neighborhood and Built Environment, Health and Health Care, Social and Community Context, Education, and Economic Stability. A variety of individual indicators are found throughout these domains and often overlap.

Education, health insurance coverage and poverty are highlighted in this CHNA because they are among the most predictive indicators of health status. These factors are often interrelated and can affect a person’s access to health care services and healthy behaviors and have significant influence on health outcomes.

Healthy People 2020 targets for these indicators include:

- **Education:** 87 percent of students who graduate with a regular diploma 4 years after starting 9th grade.
- **Health insurance coverage:** Increase to 100 percent the proportion of persons with medical insurance.
- **Poverty:** *There is not currently a Healthy People 2020 target for poverty, but the nationwide baseline is 15.1 percent of all persons and 22 percent of children ages 0-17 were living in poverty in 2010.

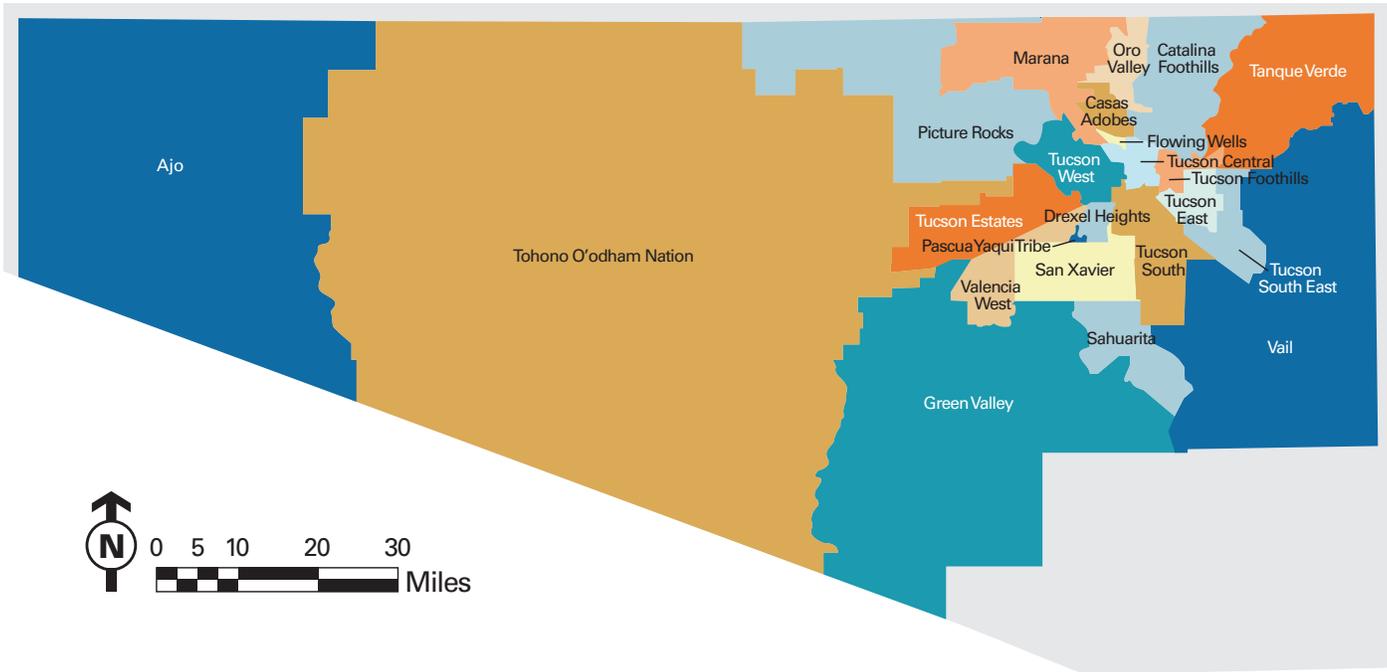


Source: www.healthypeople.gov

For the purposes of this CHNA, key social determinants of health and select other indicators are reviewed more closely through comparison of data available at the sub-county level through **Primary Care Area Statistical Profiles (PCAs)**. A Primary Care Area is a geographic area in which most residents seek primary health services from the same place(s). Examining select indicators at a sub-county level can help demonstrate disparities in health status and outcomes and support community health planning efforts to determine where interventions may have the most impact.

The most recent data available at the Primary Care Area level are from the year 2016 and are presented in this CHNA to provide greater insight and understanding regarding the geographies and populations of greatest need throughout Pima County. *Note: Indicators do not always perfectly align with Healthy People 2020 indicators but may serve as proxies.*

Pima County Primary Care Areas



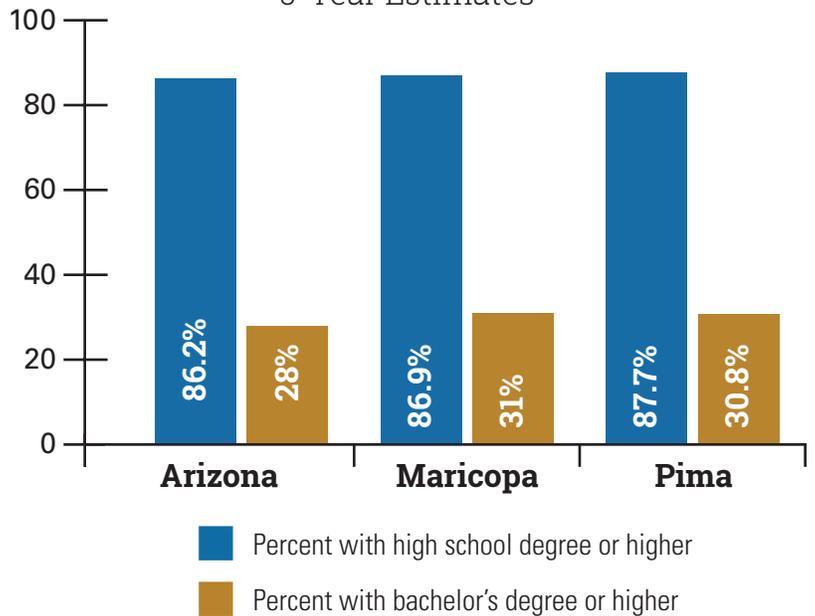
Source: Arizona Department of Health Services Community Profiles Dashboard

Education

Education plays a significant role in a person's health throughout their lives and can contribute to health in a number of ways. Barriers to education can impact a person's ability to find employment, which can in turn affect a person's income, where they live, and their ability to afford and access health care. Education can affect health literacy, impacting a person's ability to understand health information and determine early signs of illness or disease. Research shows high school graduates live longer than people who did not graduate high school. (American Public Health Association.) Pima County has higher percentages of high school and college graduates than Arizona.

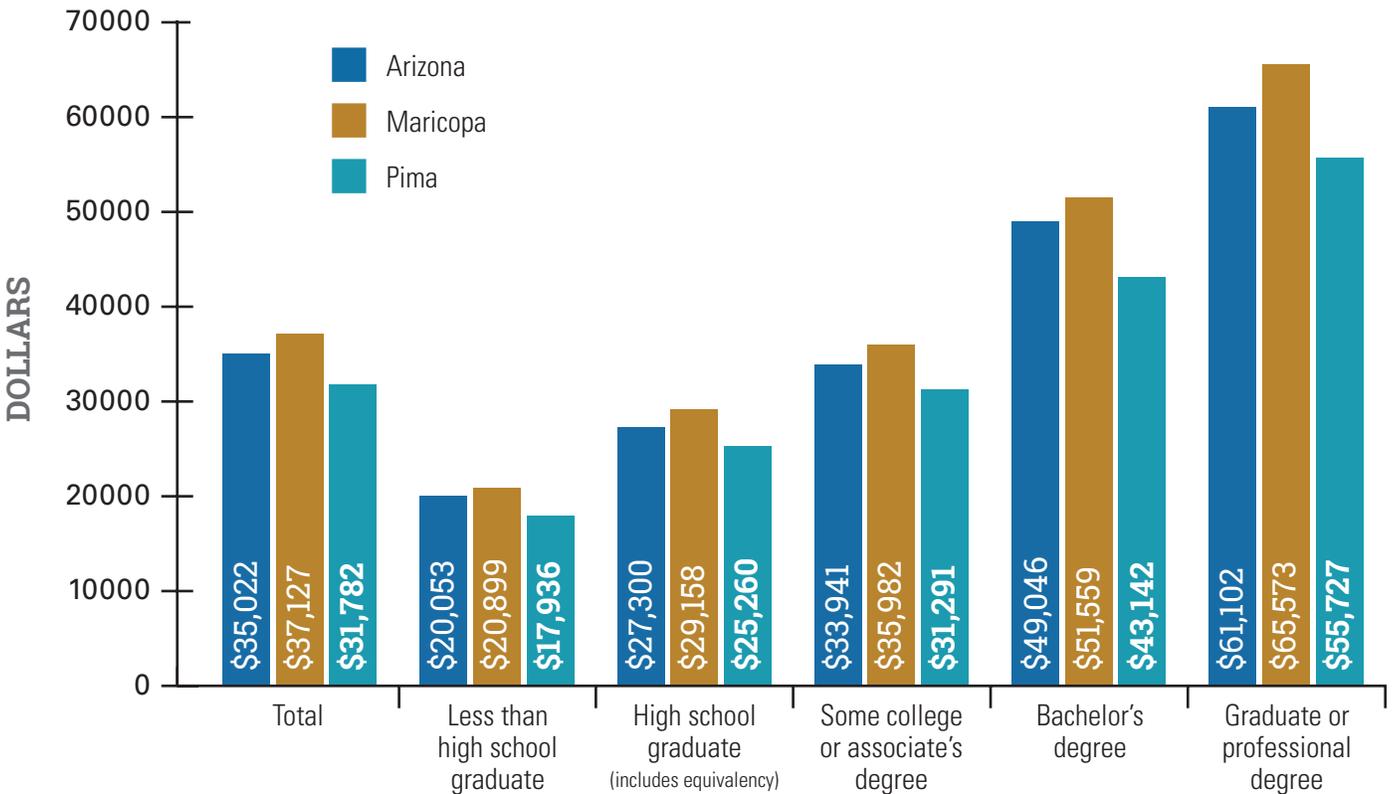
Educational Attainment

U.S. Census, 2012-2016 American Community Survey 5-Year Estimates

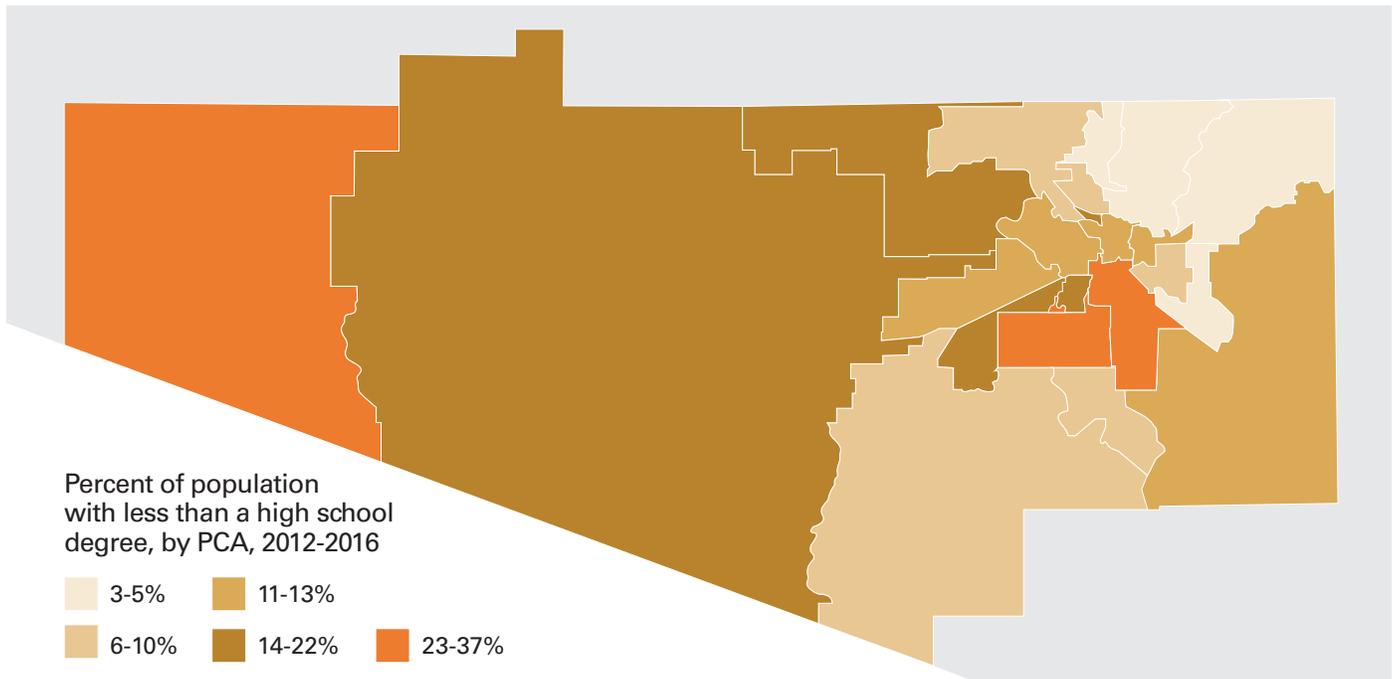


Median Earnings by Educational Attainment

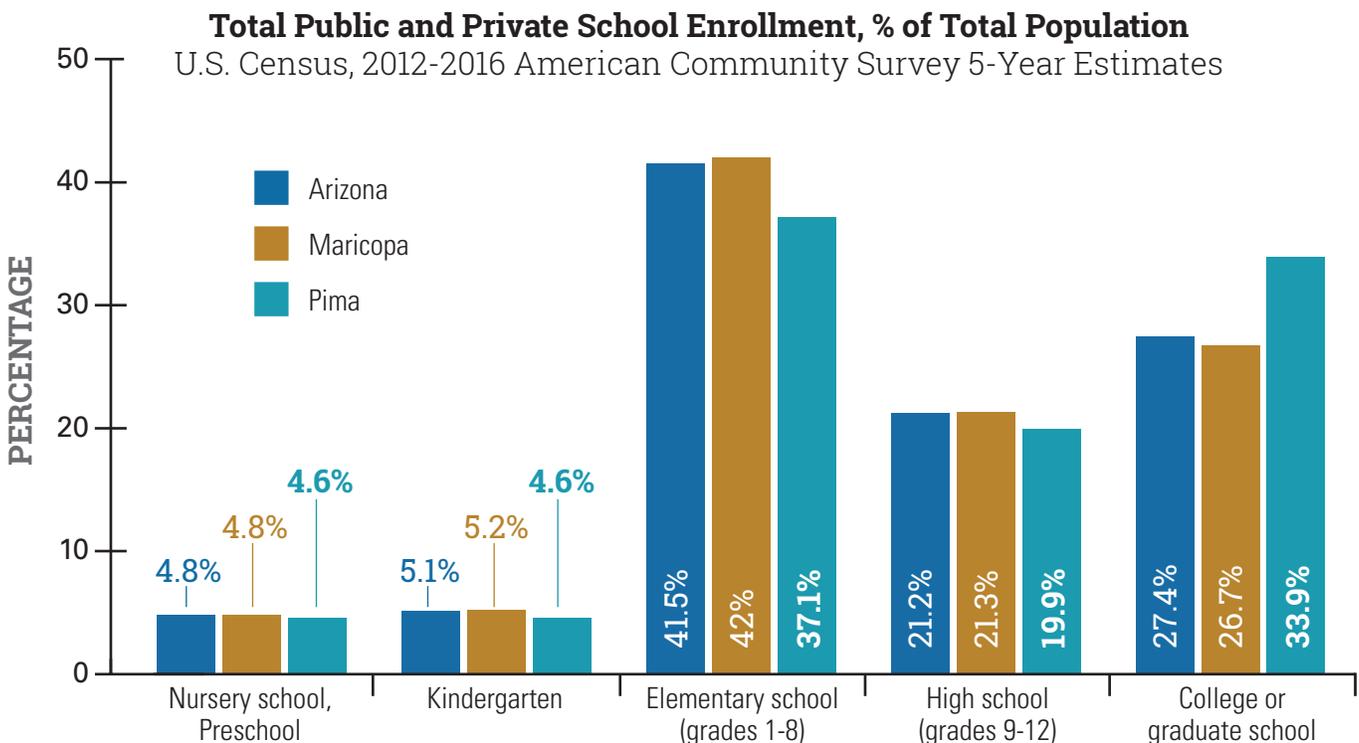
U.S. Census, 2012-2016 American Community Survey 5-Year Estimates



Certain areas within Pima County tend to have higher percentages of people with educational attainment below the level of a high school degree. The map below shows an estimate of the percentage of residents with less than a high school degree by PCA.



Schools can play a powerful role in addressing social determinants of health, and enrollment in school gives children a chance at benefiting from interventions designed to address social determinants. As of 2017, Pima County has 223 district schools in 17 public school districts with approximately 129,000 students enrolled. (Pima County Public Schools, 2017)

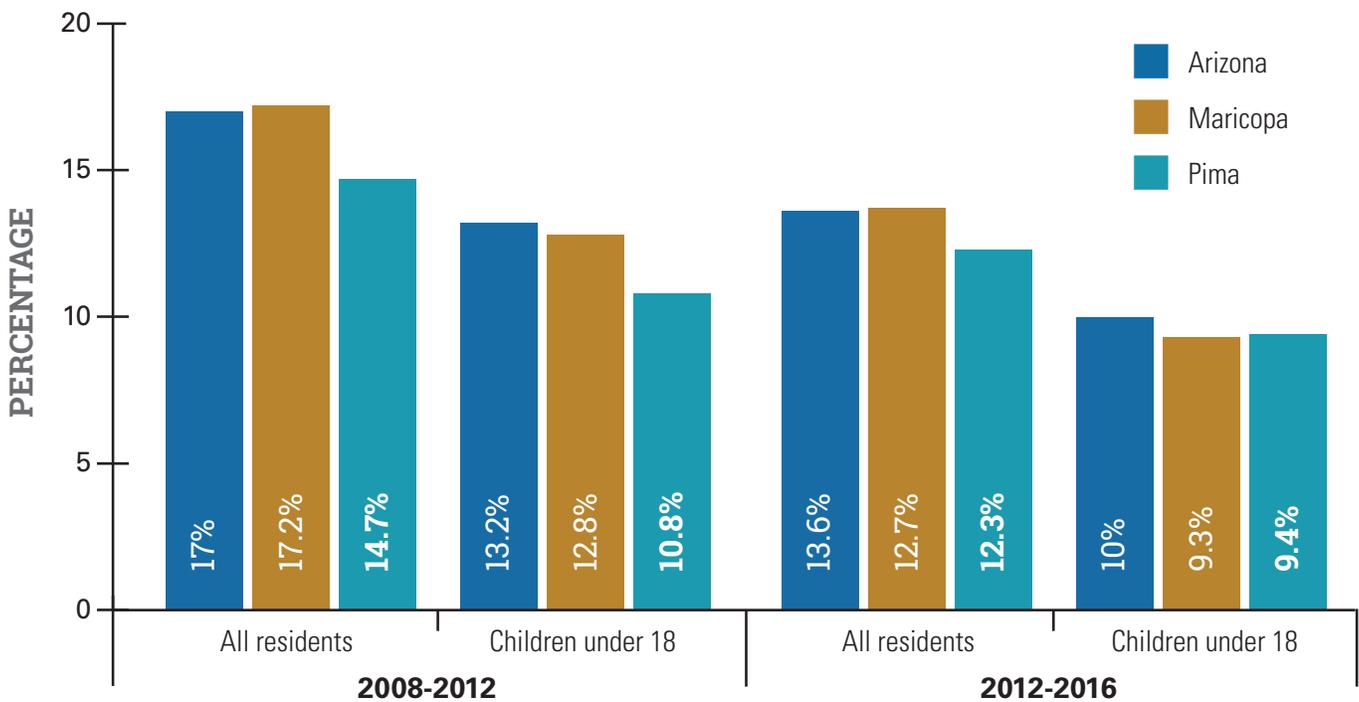


Health Insurance

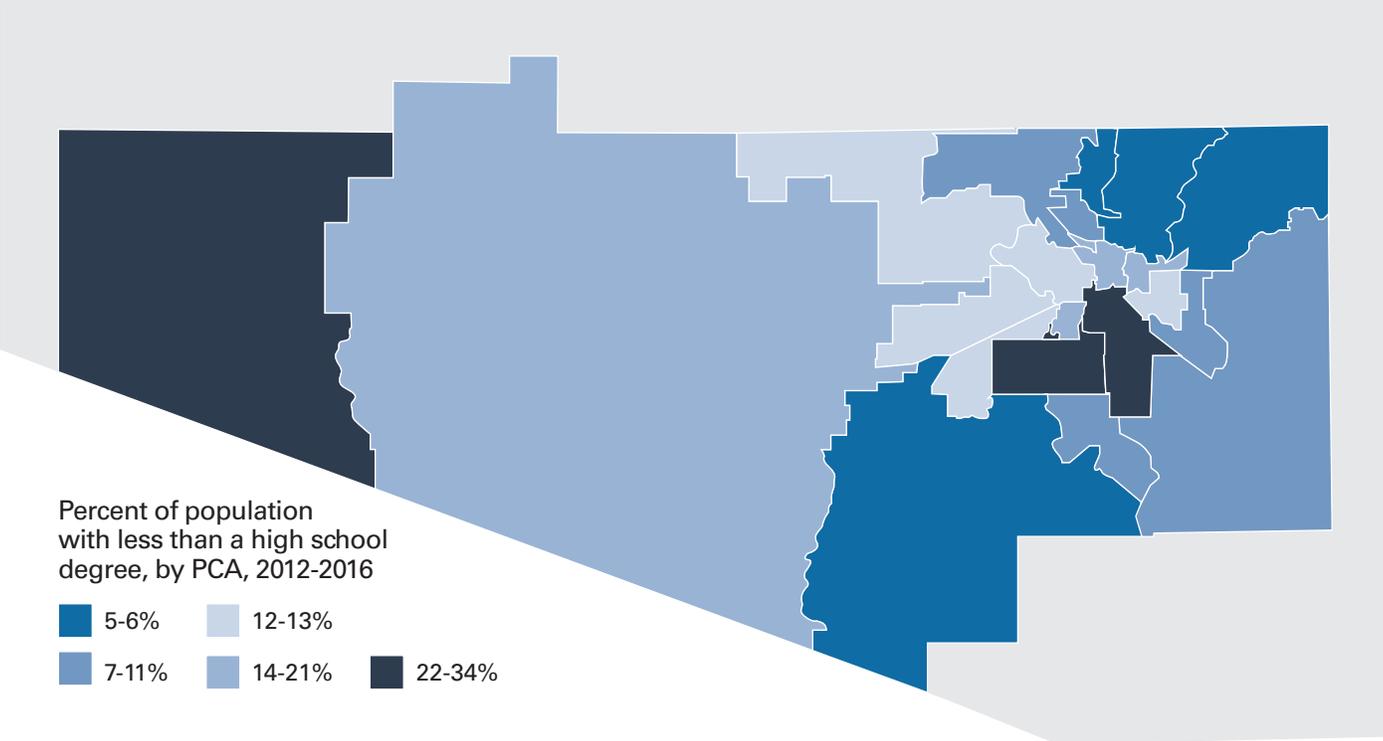
Thousands of adults and children throughout Pima County remain uninsured despite the fact that the percentage of people with health insurance has increased, thanks in large part to the passage of the Patient Protection and Affordable Care Act (ACA) of 2010, which included expanded access to the state's Medicaid program (AHCCCS), as well as coordinated efforts by Healthy Pima partners and stakeholders to enroll residents in health insurance coverage. Without adequate and affordable health insurance, people may opt not to seek medical care, be unable to pay for prescription drugs, or ration prescription drugs, leading to worse health outcomes. People without insurance may avoid seeing primary care providers for screenings and checkups and visit emergency rooms instead, often when conditions have worsened and treatment is more costly and/or less effective.

Percentage of People Without Health Insurance

U.S. Census, 2008-2012 and 2012-2016 American Community Survey
5-Year Estimates



As with educational attainment, disparities exist throughout Pima County by PCA, with certain areas experiencing significantly higher percentages of uninsured than others. These areas tend to also have lower educational attainment and a larger proportion of people living in poverty.



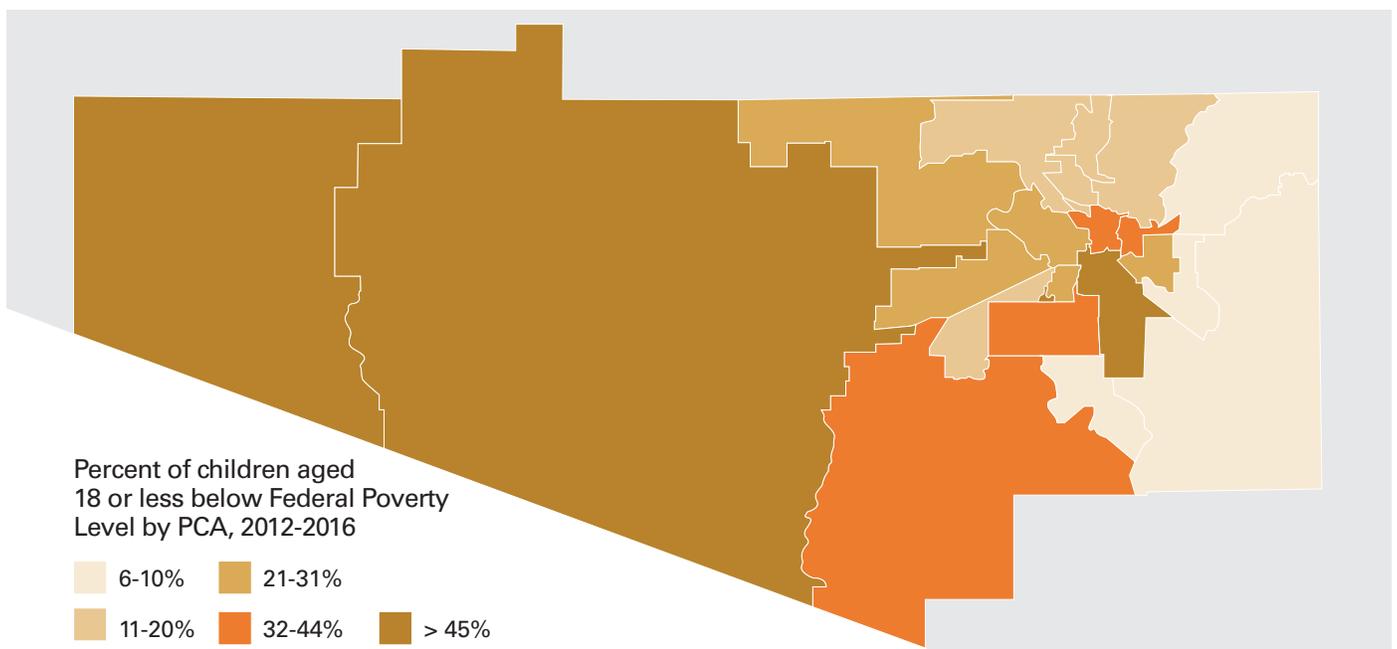
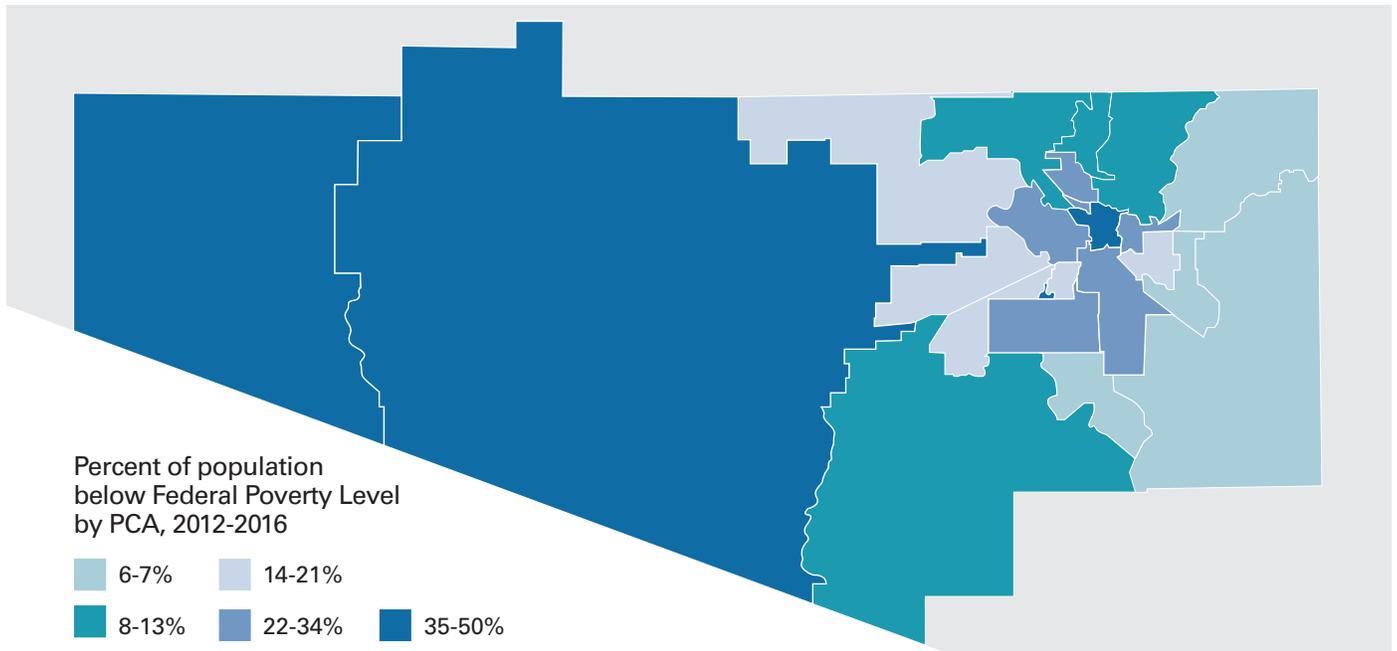
While gains have been made throughout Pima County in ensuring more adults and children have health insurance, shortened enrollment periods may deter people from signing up for health insurance in the short term, while uncertainty about the future of the ACA and its policies may undo these gains in the longer term.



Poverty

Poverty can have a devastating effect on health and is closely related to other key health indicators. A high poverty rate can be a cause and effect of economic conditions, lower quality schools and education, and decreased business survival. Poverty can be a major barrier to accessing health care when needed, obtaining healthy and nutritious food, and can increase an individual's stress levels which can lead to a host of other diseases. As with a lack of insurance and lower educational attainment, the causes of poverty often stem from social, economic and political injustices extending back generations.

The maps below demonstrate the variation in poverty among PCAs throughout Pima County. The U.S. Census Bureau determines the federal poverty threshold annually.



Local SDOH Snapshot:

El Rio Community Health Center

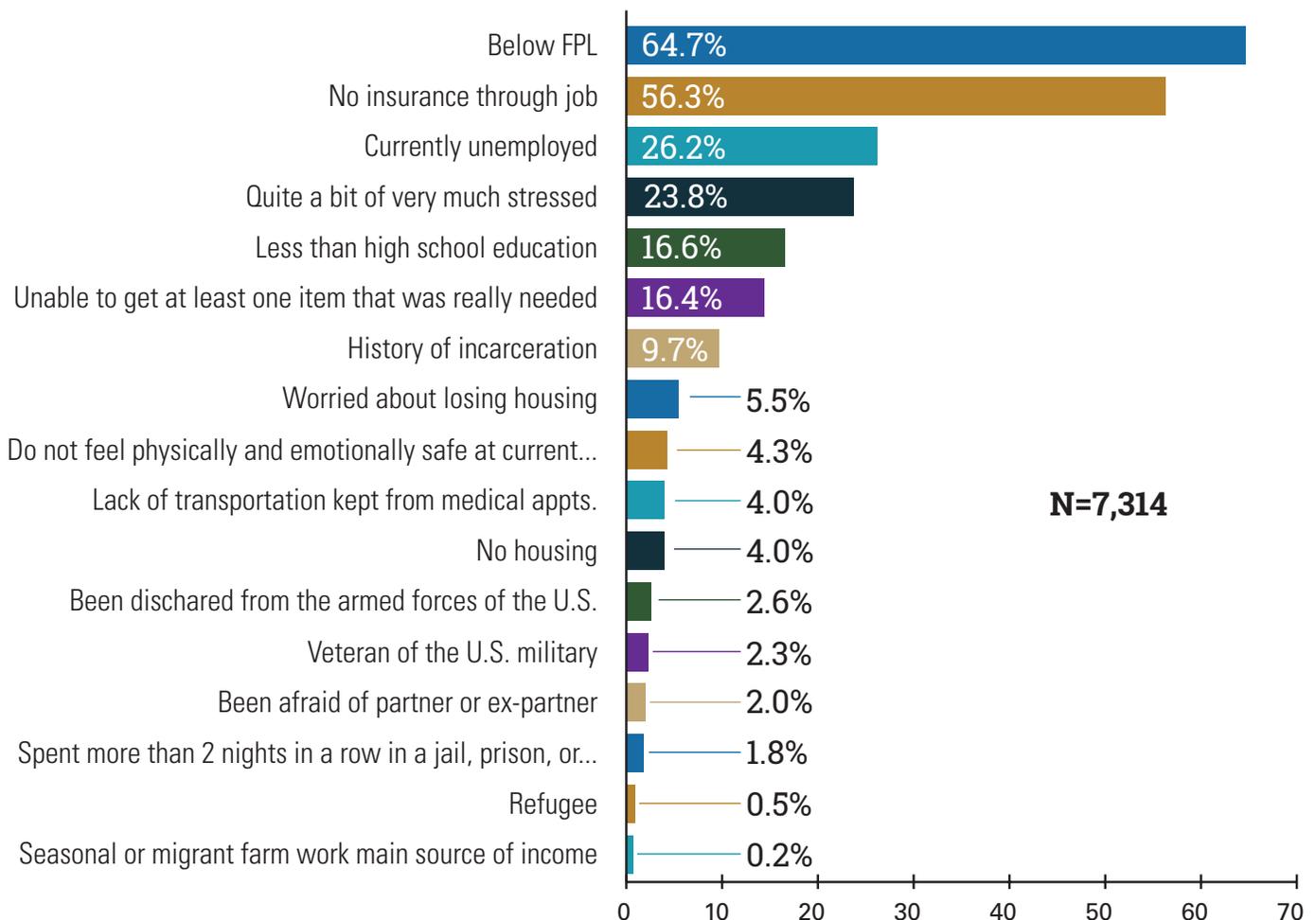
As one of the largest Federally Qualified Health Centers in the United States, El Rio Community Health Center provides primary care health services to more than 100,000 adults and children throughout Pima County. Like many health centers, El Rio is interested in using social determinants data to manage and improve the health of their patient population and community. Recently, El Rio implemented The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health.

The El Rio PRAPARE data was selected for inclusion in this CHNA because it helps to present a more comprehensive picture of the barriers Pima County residents seeking primary health care face during their daily lives.

The following chart provides a snapshot of El Rio patients' responses to specific questions related to social determinants of health:

Overall Social Determinants of Health Barriers - By Question

El Rio Community Health Center, 5/2017-1/2019



Health Indicators

The CDC defines a health indicator as “A measurable characteristic that describes:

- The **health of a population** (e.g., life expectancy, mortality, disease incidence or prevalence, or other health states);
- **Determinants of health** (e.g. health behaviors, health risk factors, physical environments, and socioeconomic environments);
- **Health care access**, cost, quality, and use.”

Health indicators may refer to a specific population, geography, political jurisdiction, or other place. For the purposes of this CHNA, health indicators will be presented at a county-wide level with select indicators presented at the PCA level to demonstrate disparities present throughout the county.

The health indicators are presented in alphabetical order for ease of reference and to avoid assigning any importance based on order. Furthermore, many of the indicators are inextricably linked to each other. For example, physical activity may affect diabetes as well as obesity and mental health, and mental health can affect suicide, substance use disorder and injury and violence. Similarly, substance use disorder can impact a person’s ability to access health care, but lack of access to care can exacerbate substance use and misuse.

Indicators are presented based on the latest data available within weeks of drafting this report. Because data sources may vary depending on indicator (for example, the percentage of people meeting physical activity goals comes from the Behavioral Risk Factor Surveillance System survey conducted by the CDC, whereas rates of diabetes are calculated and published by the Arizona Department of Health Services), years of data may also vary. In most cases, comparisons for Pima County indicators are made against Maricopa County, since it is the only other major urban area in Arizona, and to the state of Arizona as a whole. Healthy People 2020 targets may also serve as a benchmark for some indicators.



Access to Health Services

Access to *health* services is broad expression that encompasses a variety of different indicators, as evidenced by Pima County community members in the Community Input section. For the purposes of this indicator page, data from 2017 Primary Care Area Statistical Profiles that include the **primary care score, ratio of population to primary care providers**, and a **transportation score** are presented. **All definitions** and data for these indicators are derived from ADHS' Bureau of Women's and Children's Health for unless otherwise noted.

- **Primary Care Score:** This is the sum of points that each Primary Care Area (PCA) is given by the Primary Care Index; it represents the level of medical underservice in an area. The higher the score, the greater the medical underservice.
 - **The median Primary Care Score among PCAs is 34; PCAs with a Primary Care Score higher than the median are: Drexel Heights, Green Valley, Tucson Foothills, Tucson Central, Tucson South, Pascua Yaqui Tribe, Ajo, Flowing Wells, San Xavier and Tohono O'odham Nation.**
- **Primary Care Population to Provider Ratio:** This is the number of primary care providers per total population. Arizona's ratio of population to provider is 424 for every 1 provider; Pima County's ratio is 373:1.
 - **Only seven (7) PCAs have a population to provider ratio lower than the county's ratio. These PCAs are San Xavier, Tucson Foothills, Casas Adobes, Tucson Central, Tucson West, Oro Valley, and Catalina Foothills.**
- **Transportation Score:** Transportation is critical in terms of accessibility of health care. Many populations, including low-income, rural, elderly and disabled, face challenges with transportation to health care. Statistical Profiles provide transportation scores for each PCA. Adequacy of transportation is determined by the transportation score. The higher the score, the less adequate or greater the need for transportation. The Arizona statewide transportation score is 110; the overall Pima County score is 109.
 - **The following PCAs have transportation scores higher than the overall Pima County score: Tucson West, Tucson East, Tucson South, Tucson Foothills, Tucson Central, Flowing Wells, Green Valley, San Xavier, Pascua Yaqui Tribe and Tohono O'odham Nation.**

The table on the following page lists all Pima County PCAs and their respective Access to Care indicator scores.

Access to Health Services

ADHS Bureau of Women's and Children's Health Primary Care Area Statistical Profiles (2017)

Primary Care Area	Primary Care Score	Population to Provider Ratio	Transportation Score
Ajo	65	3629:1	*
Casas Adobes	20	210:1	92
Catalina Foothills	14	307:1	84
Drexel Heights	38	2258:1	99
Flowing Wells	66	3584:1	140
Green Valley	38	880:1	142
Marana	16	532:1	76
Oro Valley	12	298:1	91
Pascua Yaqui Tribe	64	718:1	185
Picture Rocks	30	1544:1	105
Sahuarita	20	693:1	84
San Xavier	68	162:1	147
Tanque Verde	18	365:1	76
Tohono O'odham Nation	76	629:1	190
Tucson Central	44	230:1	132
Tucson East	28	581:1	114
Tucson Estates	34	1362:1	98
Tucson Foothills	40	188:1	131
Tucson South	46	879:1	129
Tucson South East	16	424:1	69
Tucson West	34	273:1	112
Vail	12	662	67
Valencia West	32	1907:1	95
Pima County	N/A	373:1	109
Arizona	N/A	424:1	110

Air Quality

Air quality is an important factor in public health. The World Health Organization (WHO) estimates that each year, 800,000 people die from the effects of air pollution. Children exposed to air pollution are more susceptible to respiratory disease.

The Pima County Department of Environmental Quality releases an annual report on air quality throughout eastern Pima County. The latest report published in July 2018 lists several air quality monitoring stations throughout Pima County. The Department monitors for five criteria pollutants: carbon monoxide (CO), ozone (O₃), particulate matter (PM 10 and PM 2.5), nitrogen dioxide (NO₂) and sulfur dioxide (SO₂). These pollutants can lead to harmful health effects, including breathing difficulties, asthma attacks, susceptibility to infections, reduced heart and lung function, fatigue, and chest pain. Detailed information on Pima County air quality monitoring can be found at www.pima.gov.

The American Lung Association (ALA) releases an annual State of the Air report that assigns a letter grade of A-F. The letter grades correspond to a ranking of 1-5 to counties based on the number of ozone pollution and high particle pollution days that range from "Unhealthy for Sensitive Groups" to "Very Unhealthy" as defined by the Air Quality Index (AQI). The ALA report also provides an estimate of the number of people who are at higher risk of health effects from pollution ("at-risk groups"). (American Lung Association, 2018)

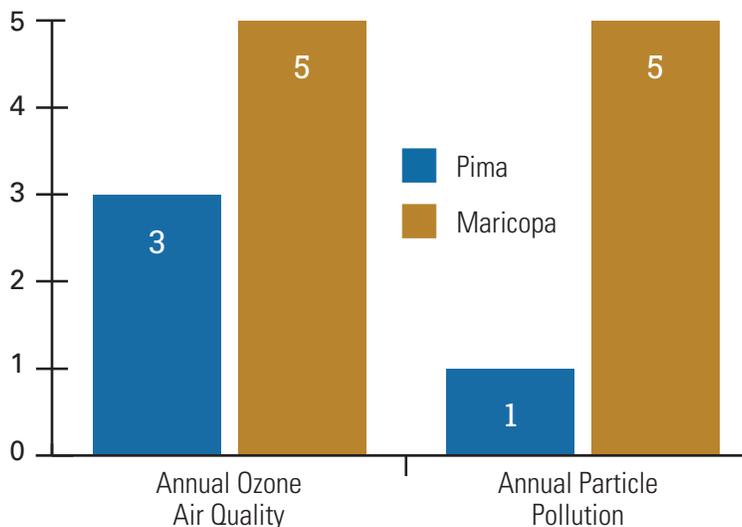
For the measurement period 2014-2016, Pima County received a letter grade of "C" for high ozone days and a letter grade of "A" for high particle pollution days.

Aging

As people age, their risk of disease and injury increases. With more and more Americans living longer, the proportion of older adults requiring health and health care services will increase. According to HealthyPeople.gov, older adults can reduce their risk of injury and disease by engaging in regular physical activity, though less than 60 percent of older adults are physically active. Additionally, while the ACA enacted provisions that make it easier for older Americans to get preventive care, such as requiring Medicare to cover cancer screenings and immunizations, many of these services still are underutilized.

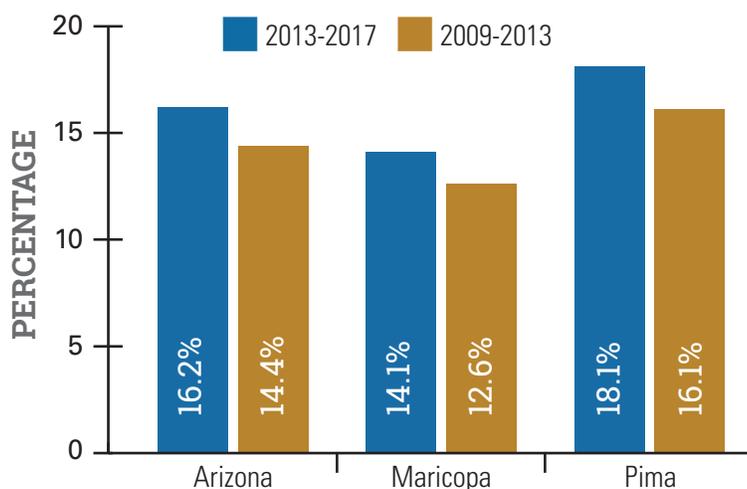
The Pima Council on Aging's (PCOA) Area Plan for 2018-2021 lists older adults' primary concerns as "falling/fear of falling; understanding Medicare; maintaining and repairing their home; yard maintenance; access to transportation; services needed to assist with their ability to live independently in their home; sufficient income to meet their basic needs; utility costs; the cost of assistive devices (hearing aids, glasses); loneliness and isolation; memory loss and affordable housing."

Air Quality, 2014-2016
American Lung Association



According to the U.S. Census Bureau's American Community Survey 5-year Estimates from 2013-2017, the number of Pima County residents ages 65 years and older is estimated at 182,720 – or about 18.1 percent of the total population. This demographic is growing quickly, having increased about 15 percent from 2013-2017 compared to a 2.1 percent increase in the total County population during the same time. As the older population increases, the need for caregiving resources, such as long-term care facilities and/or support from family members as caregivers, will also increase.

Percent of Population Age 65 Years and Older
U.S. Census, American Community Survey
5 Year Estimates

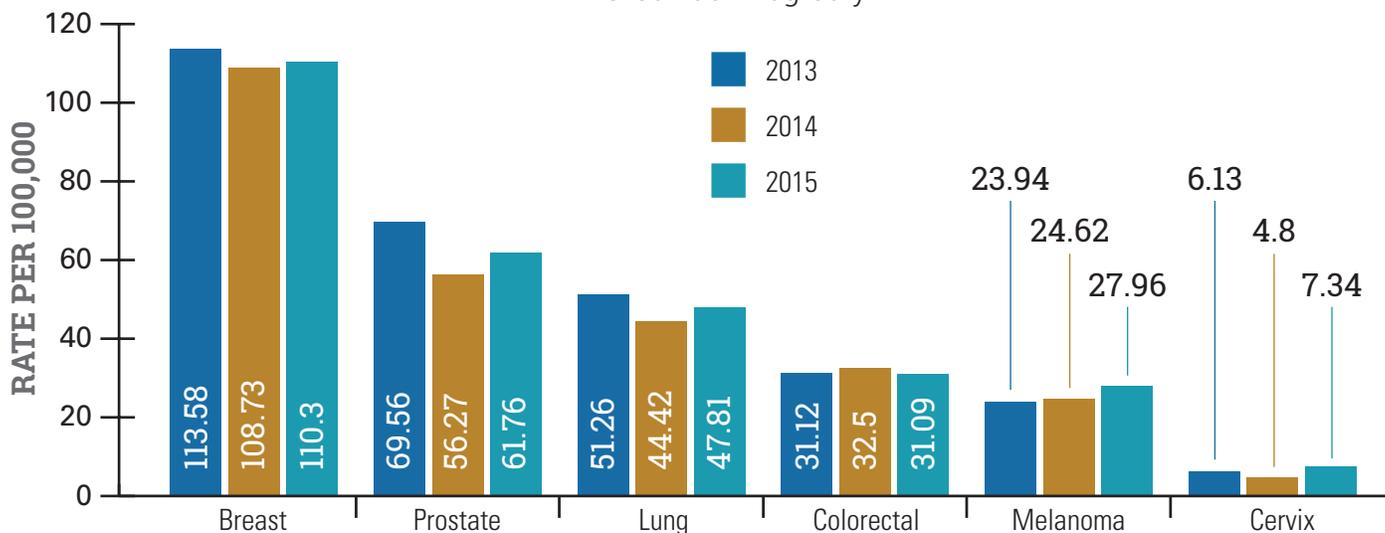


Cancer

Despite progress in cancer research, prevention, treatment, and early detection, cancer remains a leading cause of death among Pima County residents, as well as throughout Arizona and the United States. While millions of people throughout the country who have heard the words “you have cancer” are living full, productive and fulfilling lives, reducing the incidence of cancer through prevention and screening can lead to fewer deaths from the disease. Certain behaviors, such as not smoking, getting regular exercise, eating lots of fruits and vegetables, and avoiding ultraviolet light exposure can reduce a person’s chances of getting cancer.

Cancers selected for inclusion in this assessment below are either among the most common diagnoses (lung, colorectal, female breast and prostate) and/or have effective prevention and/or early detection interventions to reduce the risk of death or catch cancer early (for example, HPV vaccination can prevent most cases of cervical cancer, and avoiding tanning beds and excessive sun exposure can reduce the risk of melanoma and other skin cancers).

Cancer Incidence per 100,000 – Pima County; 2013, 2014, 2015
ADHS Cancer Registry



There are an estimated 378.2 cases of cancer per 100,000 people in Pima County each year, compared to 392.2 cases in Maricopa.

Certain populations within the county are seeing high mortality rates from cancer. **Social determinants** such as transportation, health insurance coverage and access to healthy food and physical activity can all play a role in cancer mortality. In addition, disparities in care, including lack of education about cancer prevention, risk factors and treatment can also lead to an increased burden of cancer death. There is also a large body of research that demonstrates the difference in timeliness of treatment for certain cancers as well as survival rates among different racial and ethnic groups in the United States. The **University of Arizona Cancer Center Cancer Health Disparities Program** offers additional information and resources on cancer health disparities.

In Pima County, there were an estimated 155 deaths from cancer per 100,000 population in 2016 (more information on trends is under the indicator titled Leading Causes of Death). **The death rate for cancer is higher than the state of Arizona’s rate of 142.2 per 100,000.** The PCAs that have higher rates of cancer mortality per 100,000 than the county overall are Valencia West (155.6 per 100,000, Marana (156.3 per 100,000), Tucson East (157.3 per 100,000), Tucson Central (165.3 per 100,000, and Pascua Yaqui Tribe (283.8 per 100,000).

Cancer Mortality by PCA per 100,000 – 2016 <i>ADHS Community Profiles Dashboard</i>	
Tanque Verde	99.3
Oro Valley	101.3
Catalina Foothills	108.1
Tucson South East	146.6
Sahuarita	123.3
Casas Adobes	150.3
Vail	118.7
Ajo	105.4
Marana	156.3
Tohono O’odham Nation	*
Green Valley	110.3
Picture Rocks	108.2
Flowing Wells	115.8
Tucson Foothills	149.1
Tucson West	130.1
Tucson Estates	108.6
Tucson East	157.3
Valencia West	155.6
Drexel Heights	102.9
Tucson Central	165.3
Tucson South	135.3
San Xavier	110.3
Pascua Yaqui Tribe	283.8

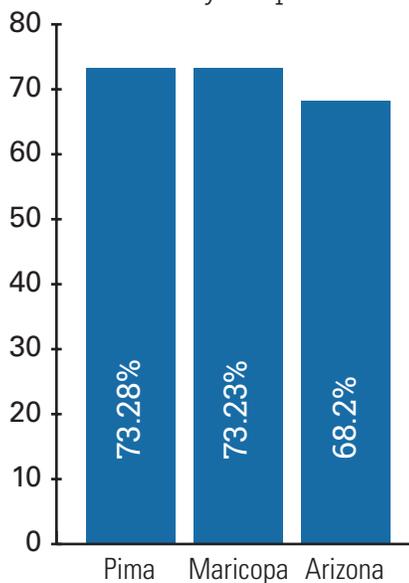
Clinical & Preventive Services

Having regular checkups with a primary care provider – usually a physician, nurse practitioner, physician’s assistant or other medical professional – can lead to better health maintenance and outcomes. According to Healthy People 2020, having a usual primary care provider can improve communication between the patient and provider and enhance trust in the provider, increase the likelihood that patients will get the care they need, and lower the risk of death. The Healthy People target is 83.9 percent of people reporting seeing a usual primary care provider, 81.1 percent for women aged 50-74 who receive breast cancer screenings, and 70.5 percent for people who receive recommended colorectal cancer screenings based on the current guidelines. Note: data for colorectal cancer screening is presented for the two largest cities in Pima County and Maricopa County, Tucson and Phoenix, due to the availability of data.

The relationship between provider and patient can help promote healthy behaviors, such as diet and exercise; protect patients from vaccine-preventable infectious diseases through vaccinations, especially children; and ensure proper screening for diseases that may be developing but for which people may or may not be showing symptoms. (Healthy People 2020).

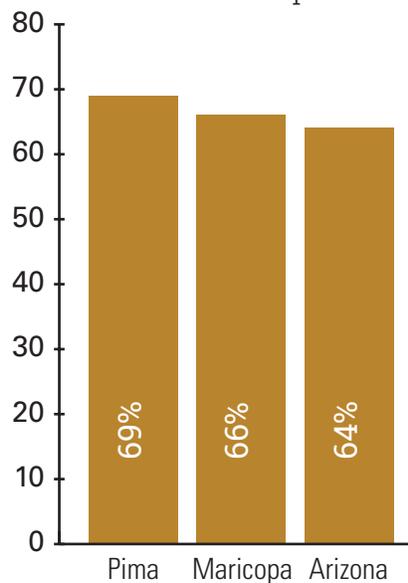
Percent of Persons with a Usual Primary Care Provider, 2013

CDC BRFSS and Policy Map



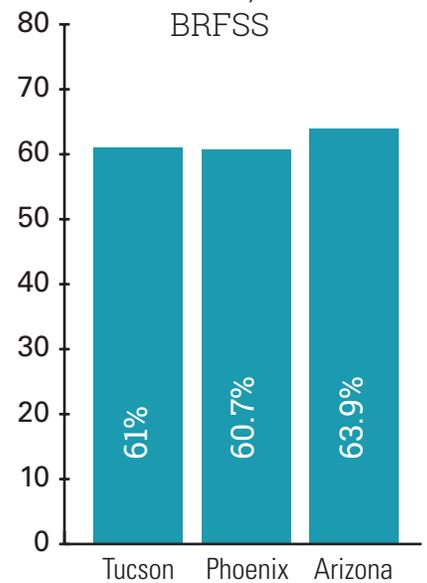
Female Medicare Enrollees 67-69 Yrs. with Mammogram in Past 2 Years, 2014

County Health Rankings and Roadmaps



Percent of Persons aged 50-57 Who Had Colorectal Cancer Screening, 2016

CDC, BRFSS



Diabetes

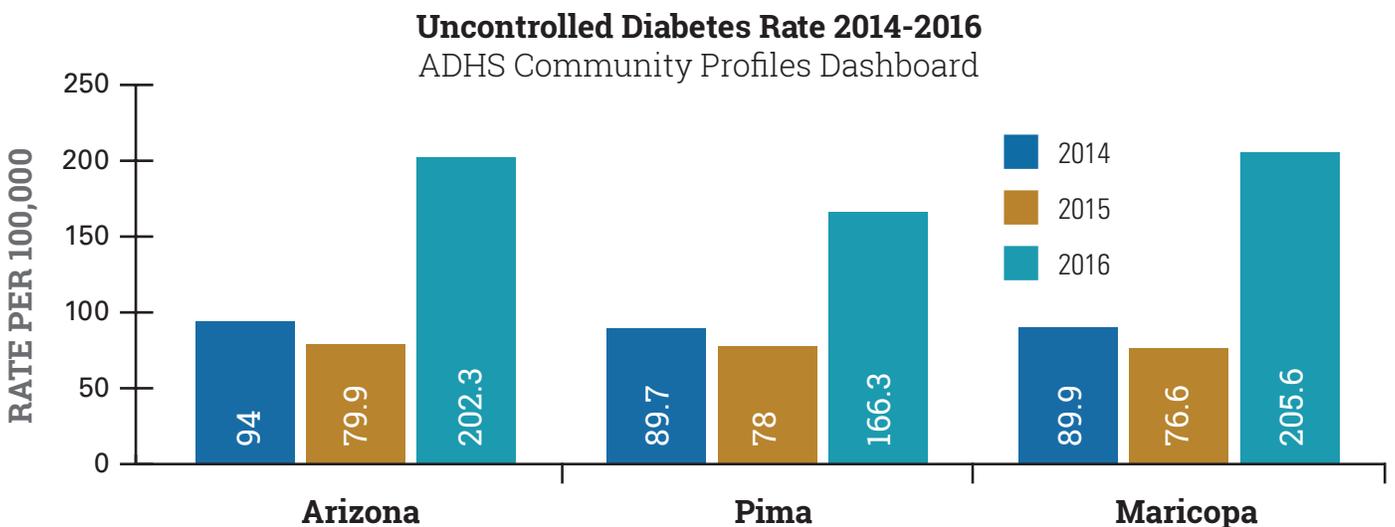
Diabetes, which includes Type I, Type II and Gestational Diabetes, is among the leading causes of death in Pima County as well as across the state and nation. Diabetes occurs when a person cannot produce enough of the hormone insulin (or develops a resistance to insulin), which controls a person's ability to use glucose (sugar) in the bloodstream as fuel. Uncontrolled diabetes can lead to a significantly greater risk of death from other complications, such as heart attack, and can cause serious disabilities including kidney failure, blindness, and limb amputation. Diabetes is closely related to obesity and the two conditions are often co-occurring.

Objectives for Healthy People 2020 include reducing the proportion of people with uncontrolled diabetes, reducing new cases of diabetes and increasing appropriate care for people with diabetes.

In Pima County in 2013 (the latest available data from the BRFSS), **an estimated 13.11 percent of adults** had ever been told they were diagnosed with diabetes, higher than both Maricopa County at 11.42 percent and Arizona at 10.66. In addition, Arizona tracks the rate per 100,000 people of death from diabetes as well as uncontrolled diabetes (A1c measurement of 9 percent or greater) at the county and primary care area level. These data show a lower rate of uncontrolled diabetes across PCAs in Pima County than the state as a whole.

The latest **Diabetes in Arizona: The 2018 Burden Report** prepared by the Arizona Department of Health Services includes information about the financial costs of diabetes to the state.

Diabetes Rates by PCA – 2016	
Rate per 100,000	
Tanque Verde	41.9
Oro Valley	59.7
Catalina Foothills	74.3
Tucson South East	85.1
Sahuarita	86
Casas Adobes	93.8
Vail	99.2
Ajo	109.7
Marana	132.6
Tohono O'odham Nation	133.8
Green Valley	135.7
Picture Rocks	136.6
Flowing Wells	160.1
Tucson Foothills	165.3
Tucson West	170.7
Tucson Estates	176.9
Tucson East	187.6
Valencia West	196.3
Drexel Heights	196.6
Tucson Central	215.7
Tucson South	275.9
San Xavier	844.6
Pascua Yaqui Tribe	932.5



Disabilities

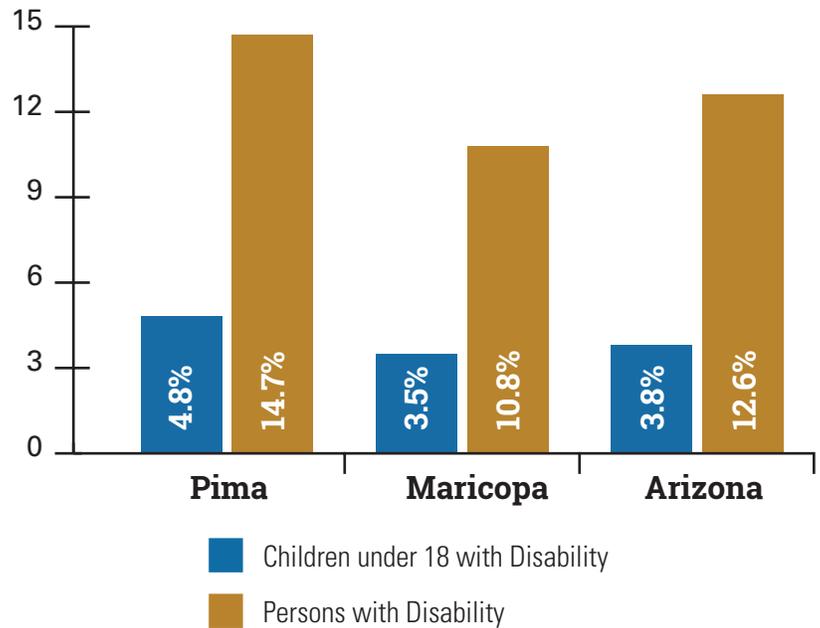
According to Healthy People 2020, there are approximately 56.7 million people, or 18.7 percent of the population, living with a disability. The U.S. Census Bureau includes the following criteria when determining disability status: hearing, vision, or cognitive difficulty, ambulatory difficulty, self-care difficulty (e.g. bathing or dressing), and independent living difficulty (doing errands, visiting a doctor's office, etc.).

Like individuals without disabilities, individuals with disabilities contribute in important and meaningful ways to their communities and society. However, there is evidence to suggest that people with disabilities may face increased barriers to accessing preventive health

care and may be more likely to engage in unhealthy behaviors. A main reason to understand the proportion of a population that is living with one or more disabilities is the importance of ensuring health equity among the entire population. Communities can help improve health equity for persons with disabilities by removing environmental, policy and social barriers to inclusion, improving the availability of and access to assistive technology, and improving public health monitoring and data collection of disability indicators. (Healthy People 2020).

In Pima County, approximately 14.7 percent of the population has one or more disability, compared to 10.8 percent and 12.6 percent in Maricopa County and Arizona as a whole, respectively. Close to five percent of children in Pima County are living with a disability.

Percent of Population with Disability, 2012-2016
U.S. Census, ACS 5-Year Estimates



Food Insecurity

The United States Department of Agriculture (USDA) defines food insecurity as “the disruption of food intake or eating patterns because of lack of money and other resources.” Factors considered when determining whether a certain population is food insecure include poverty, household income, homeownership, race and ethnic demographics, and unemployment rates.

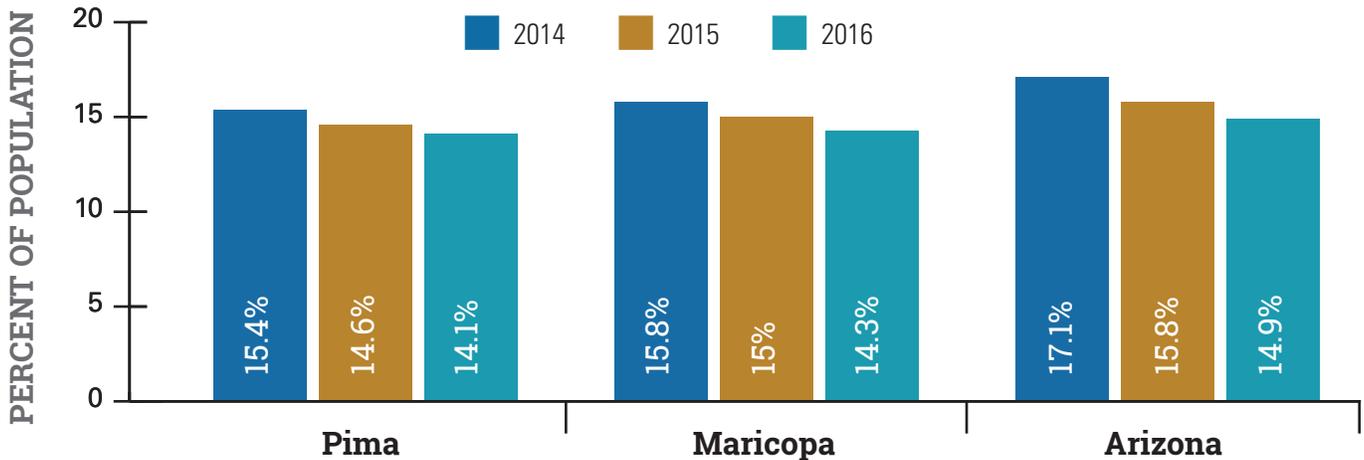
Both adults and children who are food insecure may be at higher risk of obesity, and children who are food insecure and do not have regular access to nutritious and high quality food may be more likely to face developmental problems and poor mental health when compared to food secure children. (Healthy People 2020)

The Community Food Bank of Southern Arizona points out that solving hunger requires a complex approach that can be addressed by “providing job training programs, opportunities for civic engagement, and community education; supporting our local food economy; advocating for food justice, and more.” (Bedwell & Renkert, University of Arizona BARA, 2017).

In 2016, an estimated 141,120 people, or 14.1 percent of the population, were food insecure in Pima County. Of those, an estimated 26 percent are above the eligibility threshold of 185 percent of the Federal Poverty Level for the Supplemental Nutrition Assistance Program (SNAP) and other nutrition assistance programs.

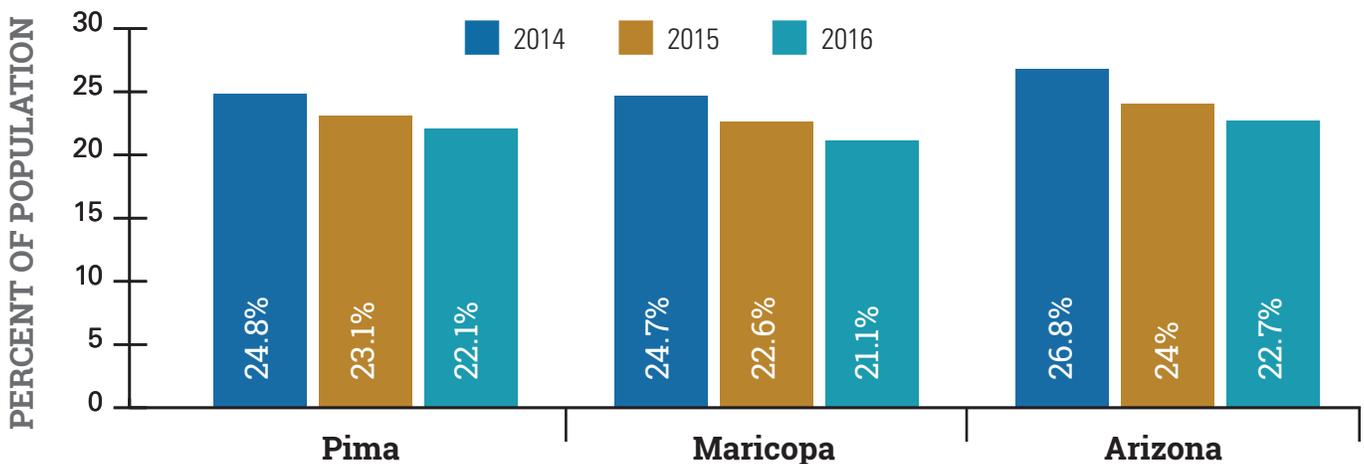
Rate of Food Insecurity, 2014-2016

FeedingAmerica.org



Child Food Insecurity Rate, 2014-2016

FeedingAmerica.org

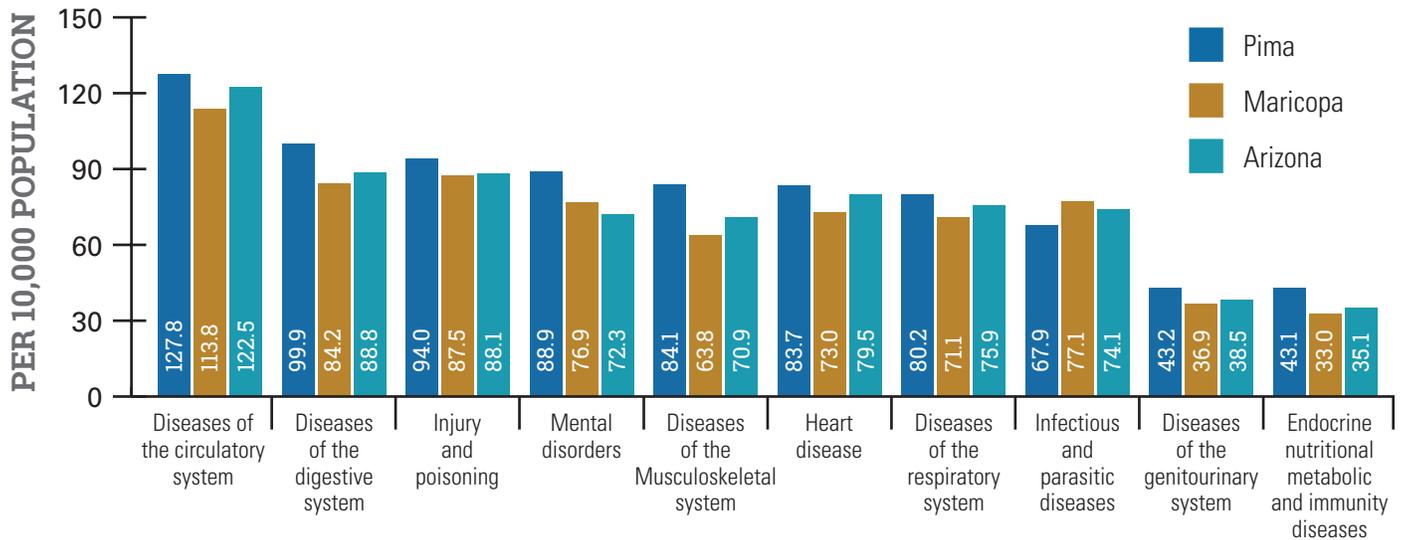


Hospital Discharges

Hospital discharge data can provide valuable, high-quality information about the public's health, as it is reported after patients have been examined in and released from the hospital by medical professionals. Since the last CHNA, the top five leading diagnoses based on hospital discharge data have changed slightly. Mental disorders moved up to the fourth most prevalent diagnosis in 2016 (from sixth in 2013), and rates among all five leading diagnoses (diseases of the circulatory system, diseases of the digestive system, injury and poisoning, mental disorders, and diseases of the musculoskeletal system) are higher than in 2013.

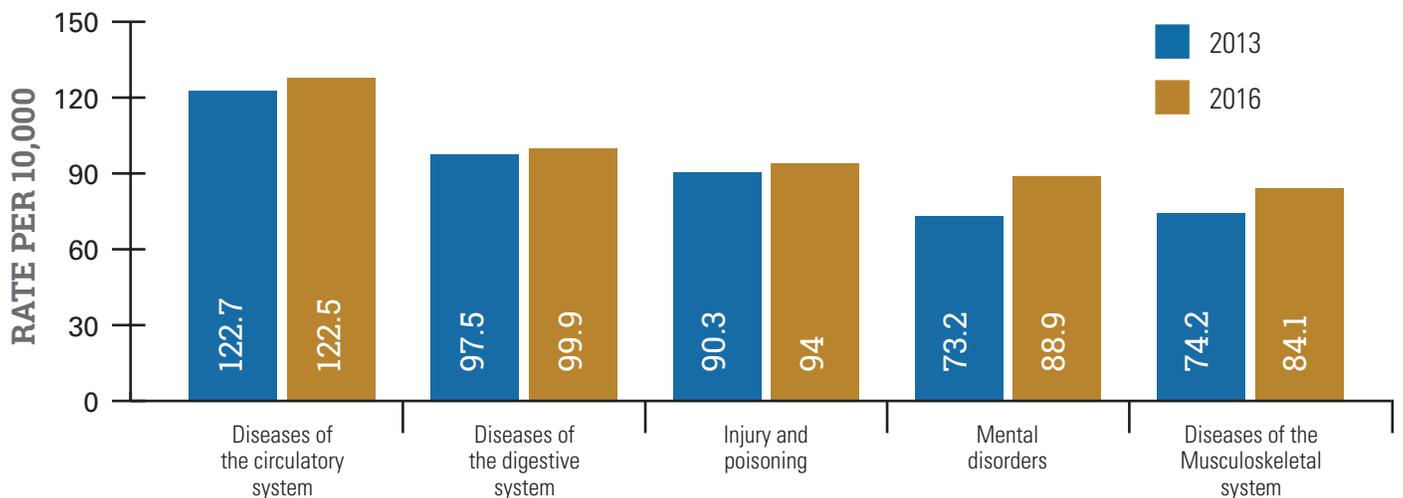
Rate of Inpatient Hospital Discharges by First-Listed Diagnosis, 2016

ADHS Population Health and Vital Statistics



Rate of Inpatient Hospital Discharges by First-Listed Diagnosis, 2013 & 2016

ADHS Population Health and Vital Statistics



Housing Instability

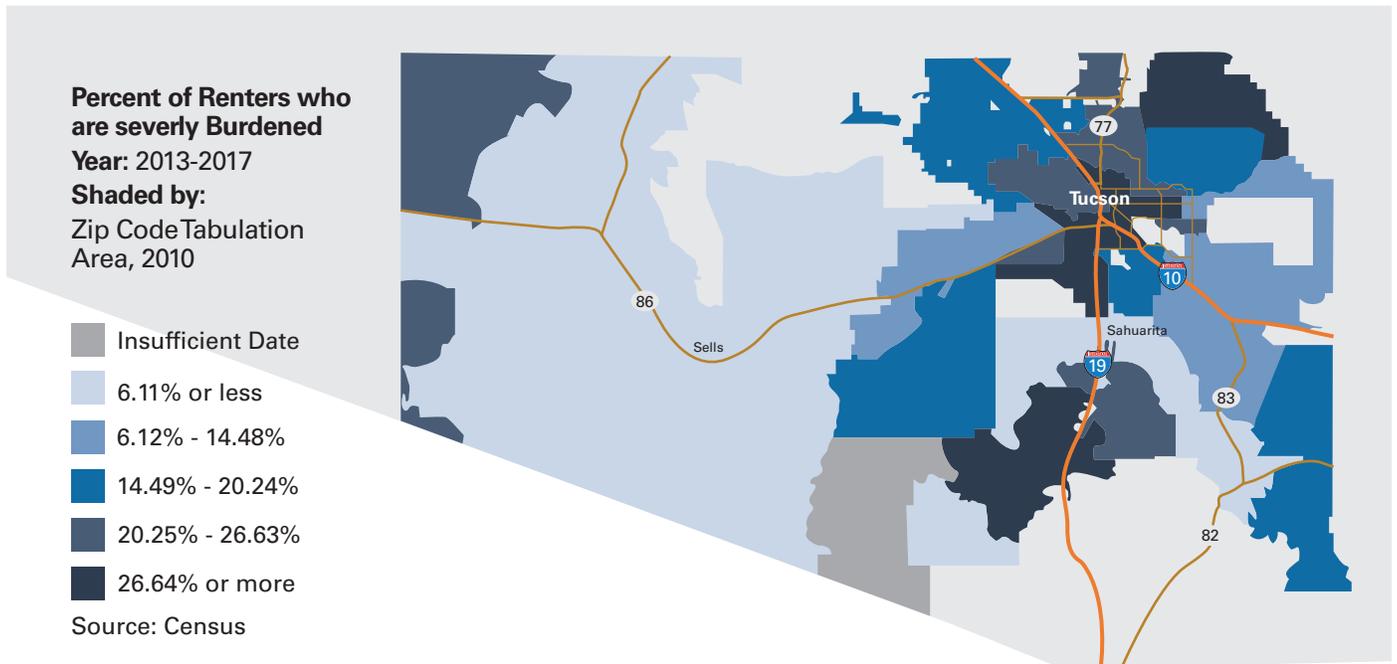
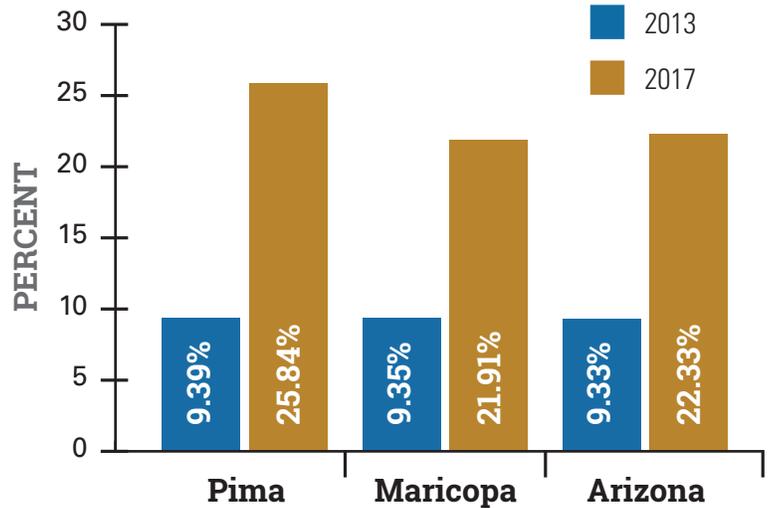
As with other social determinants of health, housing instability – which includes various factors such as trouble paying rent, spending more of a household’s income on housing than other necessities, moving frequently, and overcrowding – is closely linked with poverty. All of these factors can contribute to barriers in accessing health care. Additionally, housing instability can negatively affect mental health through increased stress, physical health through exposure to safety hazards in substandard housing and infectious diseases due to overcrowding, and it can also prevent people from establishing strong community-based social connections.

One accepted measure of housing instability is cost burden. Households are considered to be severely cost burdened if they spend more than 50 percent of their household income on housing. (Healthy People 2020).

From 2013-2017, 9.39 percent of Pima County homeowners and 25.84 percent of renters were severely cost burdened, slightly higher than both Maricopa County and Arizona.

Percent of Renters and Homeowners who are Severely Cost Burdened, 2013-2017

PolicyMap.com



Immunizations

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule (this includes DTaP, Td, Hib, Polio, MMR, Hep B, and varicella vaccines), society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct health care costs by \$9.9 billion.
- Saves \$33.4 billion in indirect costs.

Despite progress, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases. Communities with pockets of unvaccinated and under vaccinated populations are at increased risk for outbreaks of vaccine-preventable

diseases. In 2008, imported measles resulted in 140 reported cases—nearly a threefold increase over the previous year. The emergence of new or replacement strains of vaccine-preventable disease can result in a significant increase in serious illnesses and death (Healthy People 2020). A leading health indicator for Healthy People 2020, the target for the the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) is 80 percent.

School Immunizations. The Immunization Data Report is a self-report survey that each school is required to complete and submit to the Arizona Department of Health Services Immunization Office by November 15th each year per Arizona Administrative Code R9-6-707. Pima County has very successful school immunization rates, with **more than 94 percent of all children in child care having received the recommended immunizations- meeting and exceeding the Healthy People 2020 objective of 80 percent of 19-35 month olds receiving the recommended immunizations.**

Percentage of School Children Immunized in Pima County 2017-2018 Academic Year ADHS, Immunization Program			
	Child Care	Kindergarten	6th Grade
Enrolled #	14,066	10,818	11,028
4+DTAP	94.9	96.2	*
1Tdap	*	*	93.6
3+Polio	96.7	96.5	*
1+MMR	96.7	*	*
2+MMR	*	96.4	98.3
1 MV/MCV	*	*	92.7
3+Hib	96.5	*	*
2 Hep A	77.8	*	*
3+ Hep B	96.1	96.8	98.1
1+Varicella	96.7	97.7	98.5
2+ Varicella	*	*	83
Religious/ Personal Exempt	2.8	2.7	3.5
Medical Exempt	0.4	0.5	0.8
Exempt Every Req'd Vaccine	1.4	1.8	1.4

Vaccine Preventable Disease Rate. Vaccine preventable diseases are any infectious diseases where an effective preventive vaccine exists, such as influenza, mumps, pertussis, tetanus, measles, and varicella, among others. Below are the rates of vaccine preventable disease in Pima County by Primary Care Area (PCA). In some cases * indicates no data. Of note, **Pima County has a lower rate of vaccine-preventable disease than Arizona as a whole.**

Vaccine Preventable Disease Rate Morbidity (per 100,000 persons) <i>ADHS, Community Profiles Dashboard</i>				
	2013	2014	2015	2016
Arizona	23.8	9.5	10.8	6.4
Pima County	12.8	7.6	10.9	4.1
Ajo	*	29.5	*	29.7
Casas Adobes	10.4	6	14.9	7.4
Catalina Foothills	13.3	5	6.7	3.3
Drexel Heights	11.3	7.5	18.8	7.5
Flowing Wells	17.4	11.7	11.8	*
Green Valley	4	*	20.3	8.1
Marana	10.8	1.8	13.9	6.7
Oro Valley	8.9	8.9	13.2	6.5
Pascua Yaqui Tribe	58.2	*	*	*
Picture Rocks	18.6	*	27.8	9.1
Sahuarita	3.3	32	25.1	3.1
San Xavier	*	57.4	*	*
Tanque Verde	12.1	*	18	11.9
Tohono O’odham Nation	13.2	*	*	13.2
Tucson Central	8.8	5.6	10.4	4.8
Tucson East	14	9.8	9.8	2.2
Tucson Estates	*	*	19.7	*
Tucson Foothills	10.5	8.4	4.2	4.2
Tucson South	7.7	4.7	8.8	1.2
Tucson South East	39.8	15	3.7	*
Tucson West	*	2.6	5.2	*
Vail	40.2	29.8	14.5	*
Valencia West	5.6	5.5	*	*

Injury & Violence

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Years of potential life lost
- Disability and disability-adjusted life years lost
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities (Healthy People 2020).

Injury Deaths is the number of deaths from planned (e.g. homicide or suicide) and unplanned (e.g. motor vehicle deaths) injuries per 100,000 population. This measure includes injuries from all causes and intents over a 5-year period. ***It is important to note that deaths are counted in the county of residence of the deceased. So, even in an injury death occurred across the state, the death is counted in the home county of the individual who died.***

- Between 2012-2016 there were **4,113 Injury Deaths for Pima County**, for a rate of 82 (per 100,000 population). The rate for Arizona was 78, with a range of 51-188 (per 100,000 population) *.
- Between 2010-2016 the **homicide rate** for Pima County was 6 (per 100,000 population). The rate for Arizona was 6, with a range of 3-14 (per 100,000) *.

Motor Vehicle Crash Deaths include traffic accidents involving motorcycles; 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bicyclists or pedestrians when colliding with any of the previously listed motor vehicles.

- Between 2012-2016 there were **776 Motor Vehicle Crash Deaths for Pima County**, for a rate of 11 (per 100,000 population). The rate for Arizona is 12, with a range of 10-63 (per 100,000 population) *.

***Source: County Health Rankings and Roadmaps**

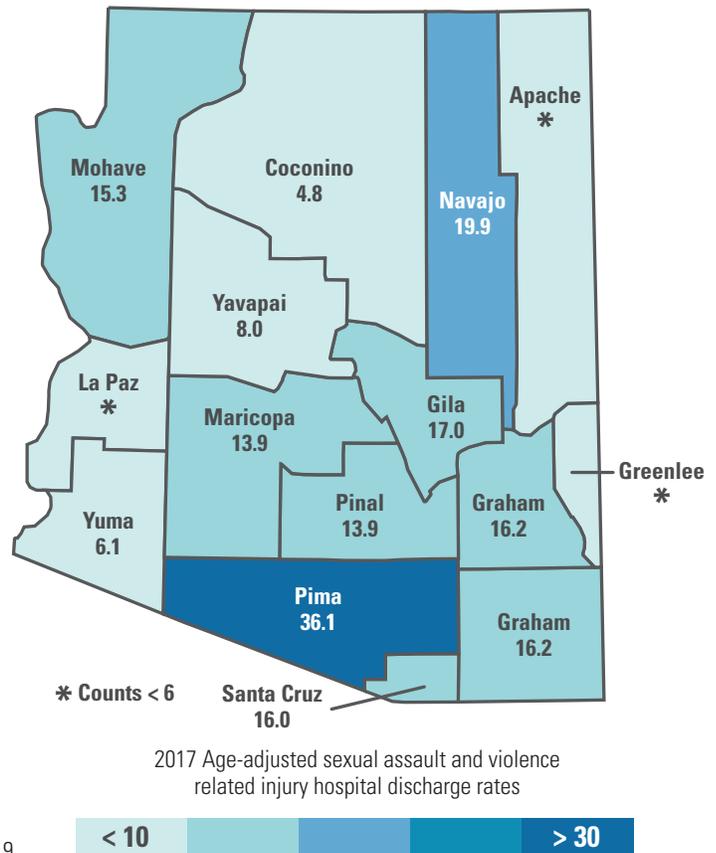
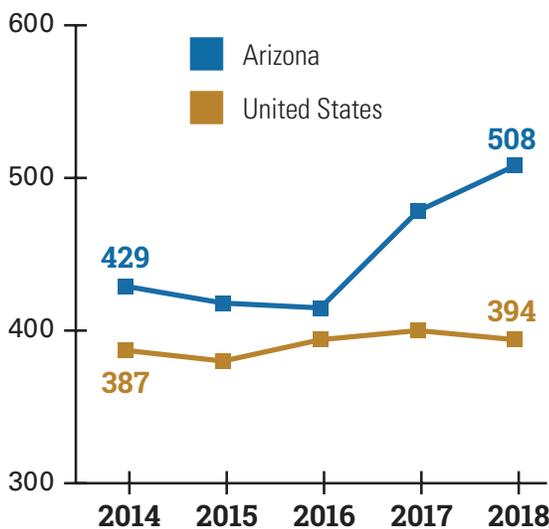
Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, rape, robbery, and aggravated assault. A violent crime rate is the number of violent crimes reported per 100,000 population.

- According to the Federal Bureau of Investigation’s Uniform Crime Reporting Program, between 2012-2014 Pima County residents reported **4,515 violent crime offenses**. Pima County’s violent crime rate was 450, while the overall rate in Arizona was 415, with a statewide range of 111-616 (County Health Rankings and Roadmaps).

Recent data from the Arizona State Health Assessment, published in early 2019, provides insight on crimes related to sexual assault and violence-related injury based on hospital discharges. The data shows a violent crime rate of 36.1 per 100,000 in Pima County, higher than other counties across the state.

Arizona is in the top 10 states with the highest violent crime rates.

Sexual assault and violence-related injury hospital discharge rates can be used to target priorities and services in the state.



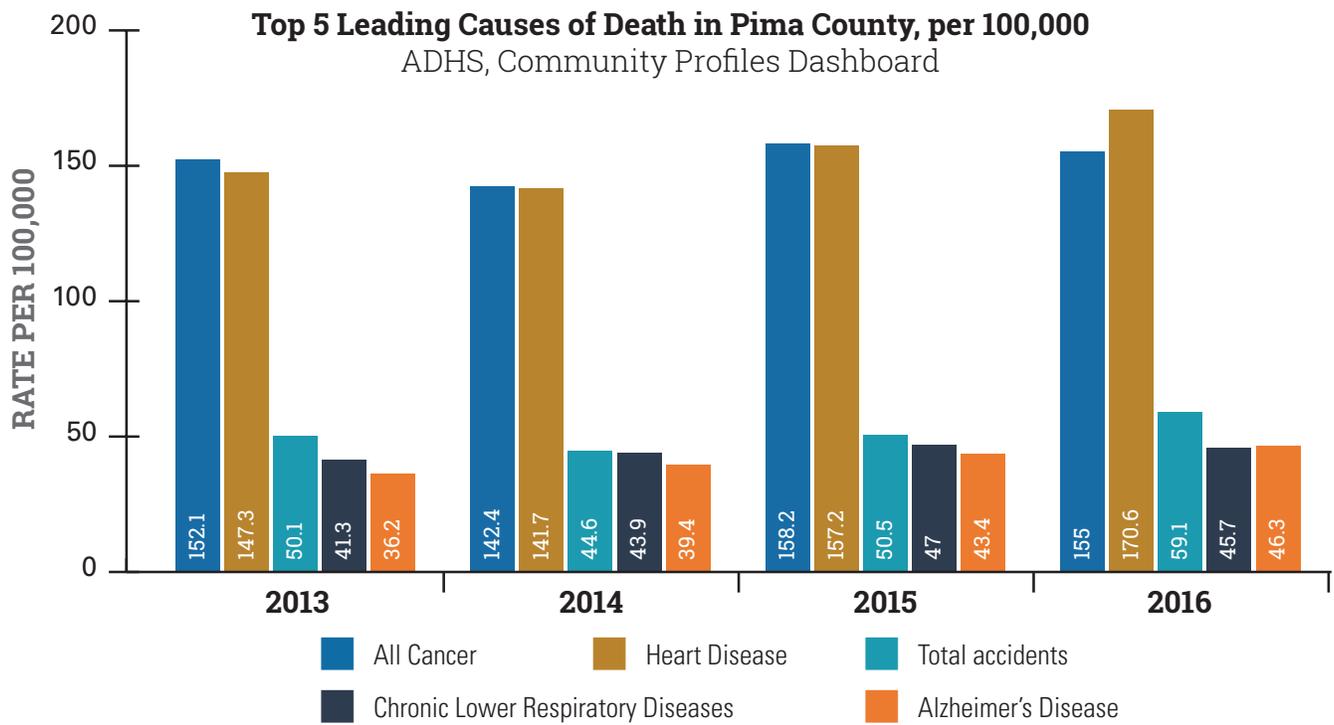
Arizona Department of Health Services, Arizona State Health Assessment 2019

Leading Causes of Death

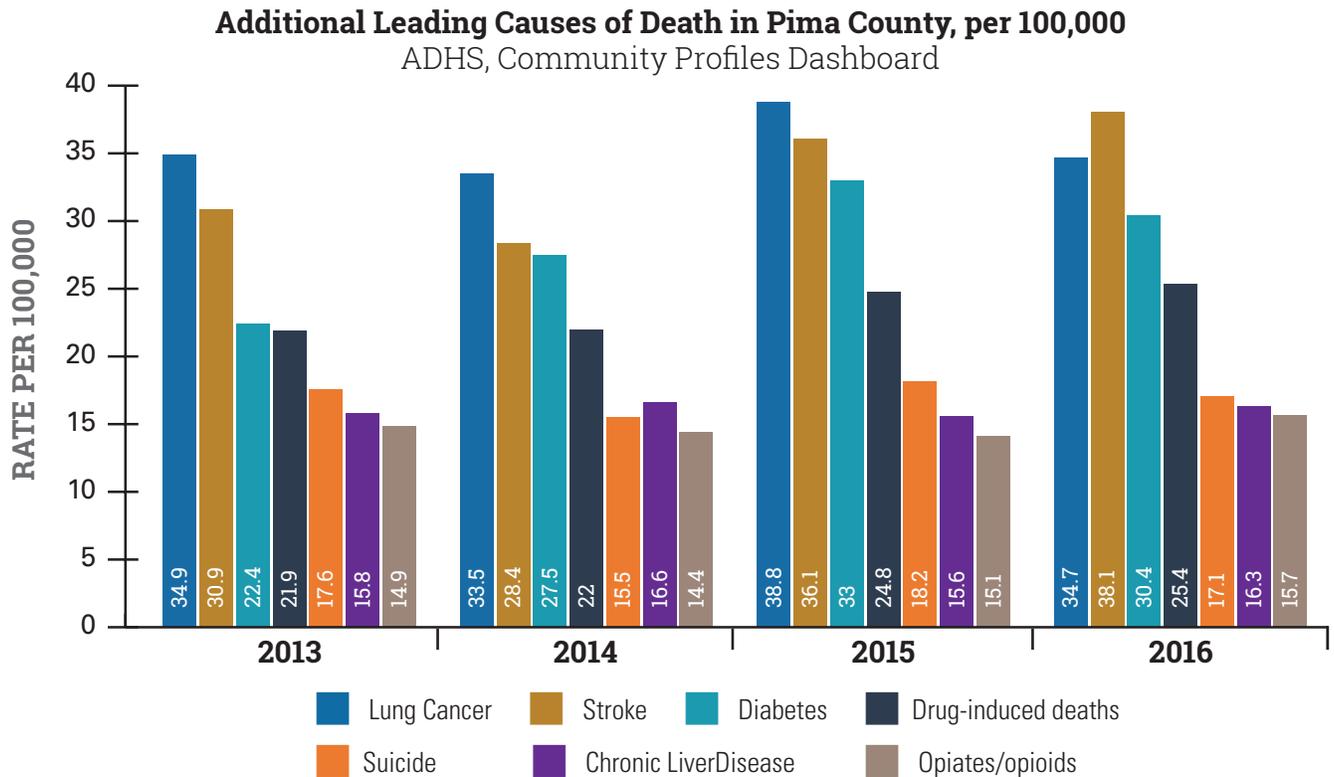
Cancer and heart disease continue to be the two leading causes of death among Pima County residents, as they are throughout Arizona and the U.S. In 2016, more residents died from heart disease, surpassing cancer as the number one cause of death among Pima County residents. Other leading causes of death include accidents, chronic lower respiratory diseases, Alzheimer’s Disease, lung cancer, stroke, diabetes, drug-induced deaths, suicide, chronic liver disease, and opiates/opioids.

These causes of death are connected to many of the health indicators in this report, including physical activity, smoking, obesity, nutrition and social determinants of health. The disparities in rates of death from leading causes are greatest in areas that have higher percentages of the population living in poverty, without health insurance and with lower levels of education.

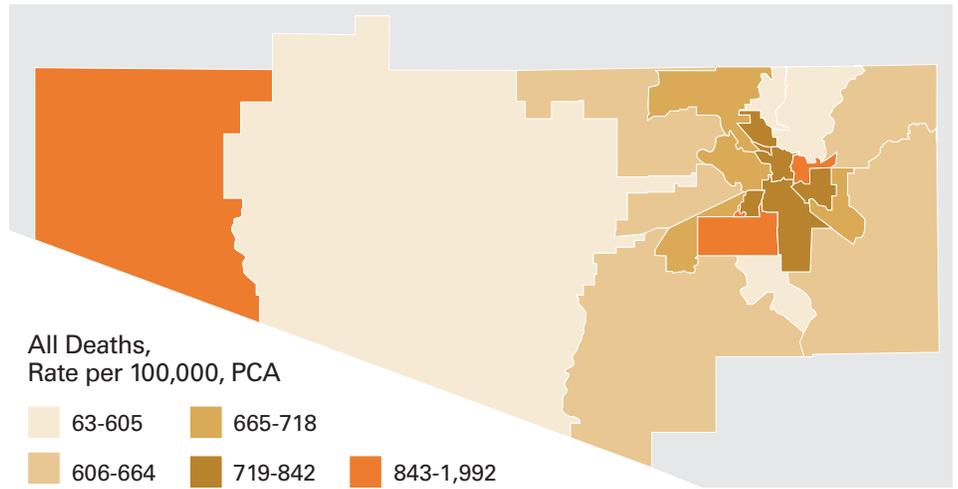
The Healthy People 2020 targets for select leading causes of death are reducing death rates to 161.4/100,000 for cancer; 103.4/100,000 for heart disease; 36.4/100,000 for accidents/unintentional injury deaths; 8.2/100,000 for cirrhosis (often a leading cause of chronic liver disease); 66.6/100,000 for diabetes; and 11.3/100,000 for drug-induced deaths.



Additional leading causes of death among Pima County residents are presented below.

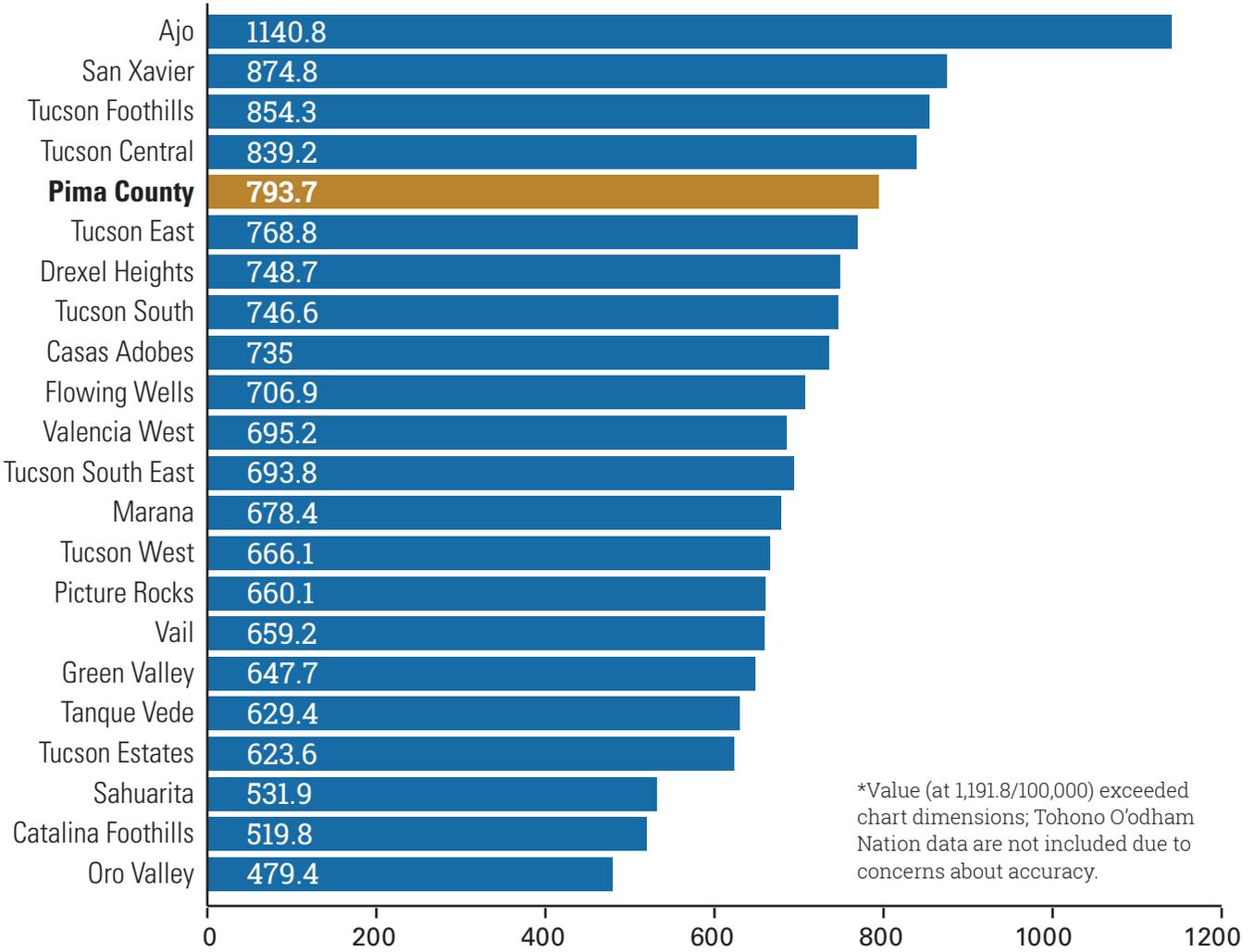


Many areas throughout Pima County are performing better than others. The map at right and chart* below demonstrate the disparity among Primary Care Areas based on the latest available data. Of note, in 2016, the PCAs of Tucson Central, Tucson Foothills, San Xavier, Ajo, and Pascua Yaqui Tribe* had higher rates of death per 100,000 population than the County as a whole (793.7 per 100,000).



*Value (at 1,191.8/100,000) exceeded chart dimensions; Tohono O’odham Nation data are not included due to concerns about accuracy.

All Deaths, Rate per 100,000, Primary Care Areas (2016)
ADHS, Community Profiles Dashboard



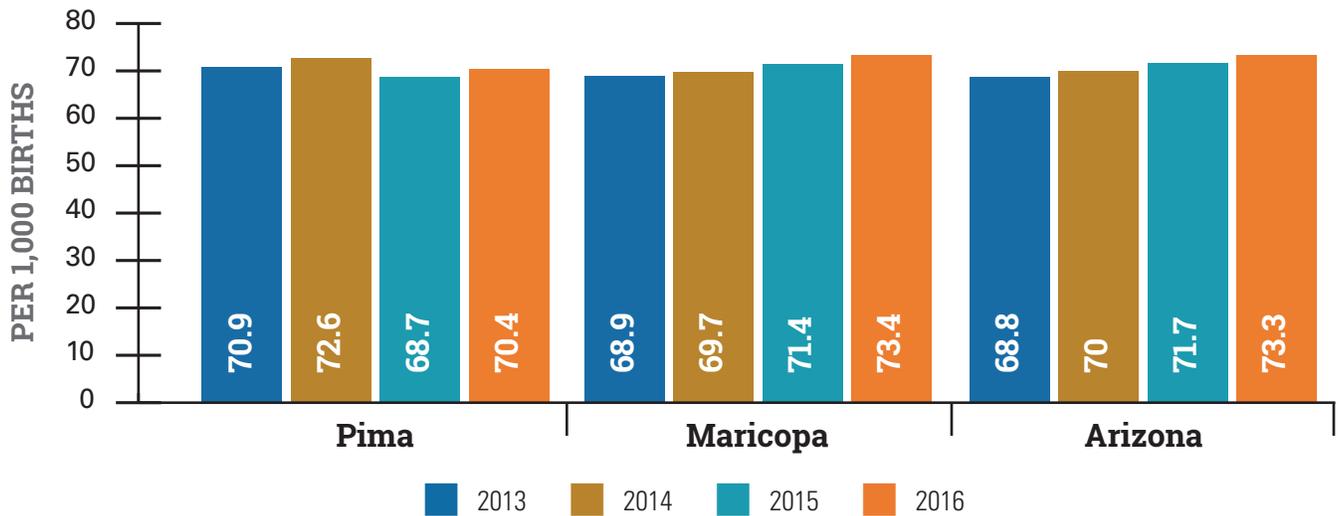
Maternal & Infant Health

The health of a pregnant woman can influence whether her baby may be born early (preterm), sick, or not at a healthy weight (low birth weight). The social determinants of health that impact a woman's health often affect her baby's health as well. The Healthy People 2020 target objectives under Maternal and Infant Health include reducing total preterm births to 9.4 percent of live births; reducing the rate of infant deaths in the first year of life to 6 per 1,000 live births; and reduce the percentage of births that are low birth weight to 7.8 percent. ADHS provides rates for all of these indicators at the county, state and PCA level.

Pima County has met and exceeded the Healthy People target for infant mortality, with a 2016 rate of 4.7 infant deaths per 1,000 live births.

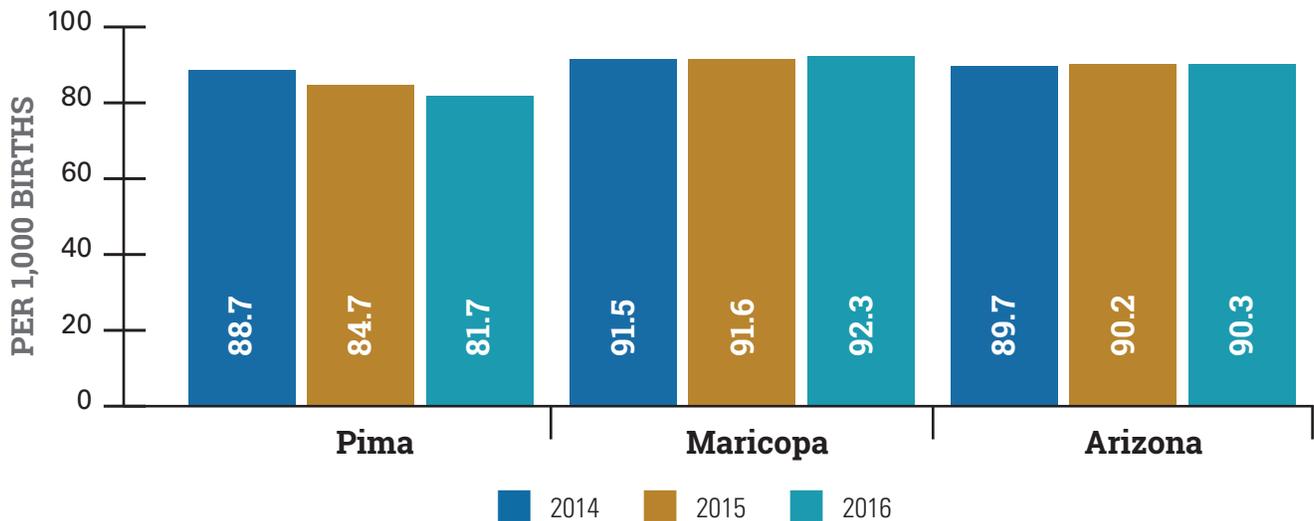
Low Birth Weight Babies (<2,500 gm), 2013-2016

ADHS, Community Profiles Dashboard



Preterm Births, 2014-2016

ADHS, Community Profiles Dashboard

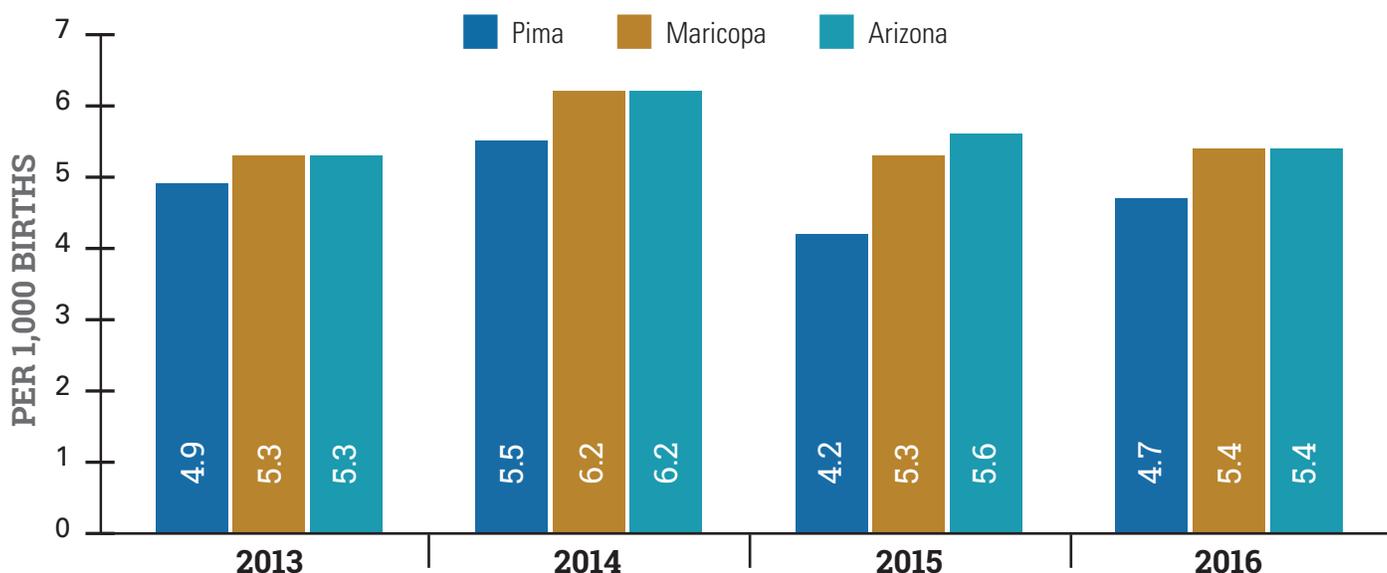


While Pima County is performing better than both Maricopa County and Arizona as a whole in terms of infant mortality, and rates overall have not increased in recent years, it is important to note that as with many health indicators, certain areas have higher rates of infant deaths than others. As with other indicators, these areas are also more impacted by the social determinants of health, including poverty, health insurance, and education. The chart below shows the most recent rates of infant mortality by Primary Care Area. Of note, the following PCAs have infant mortality rates higher than Arizona's rates: **Catalina Foothills, Marana, Drexel Heights, Tucson Central, Tucson Foothills, Tucson Estates, Tanque Verde and Green Valley.**

**Due to small numbers, rates could not be calculated for several PCAs.*

Infant Mortality per 1,000 Births <i>ADHS, Community Profiles Dashboard</i>	
Primary Care Area	Rate
Ajo	*
Casas Adobes	1.3
Catalina Foothills	5.8
Drexel Heights	5.9
Flowing Wells	5.1
Green Valley	21.7
Marana	5.9
Oro Valley	4
Pascua Yaqui Tribe	*
Picture Rocks	*
Sahuarita	*
San Xavier	*
Tanque Verde	10.1
Tohono O'odham Nation	*
Tucson Central	7.5
Tucson East	5.1
Tucson Estates	9.5
Tucson Foothills	8.5
Tucson South	4
Tucson South East	1.7
Tucson West	2.6
Vail	*
Valencia West	*

Infant Mortality, 2013-2016 | ADHS, Community Profiles Dashboard



Mental Health

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In any given year, an estimated 18.1 percent (43.6 million) of U.S. adults ages 18 years or older suffered from any mental illness and 4.2 percent (9.8 million) suffered from a seriously debilitating mental illness. Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7 percent of all years of life lost to disability and premature mortality. (Healthy People 2020) Moreover, suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. (Healthy People 2020)

New mental health issues have emerged among some special populations, such as:

- Veterans who have experienced physical and mental trauma
- People in communities with large-scale psychological trauma caused by natural disasters
- Older adults, as the understanding and treatment of dementia and mood disorders continues to improve

Mental Health Providers

Thirty percent of the U.S. population lives in a county designated as a Mental Health Professional Shortage Area. As the mental health parity aspects of the Affordable Care Act create increased coverage for mental health services, many anticipate increased workforce shortages.

Psychiatrists, psychologists, licensed clinical social workers, counselors, family therapists, and substance disorder specialists are all considered mental health providers.

- In 2017 there were **1,704 mental health providers in Pima County**, with a population to provider ration of 600:1. U.S. top performers have a 330:1 ratio.

Ratio of Population to Mental Health Providers, 2017

County Health Rankings and Roadmaps

Pima County	600:1
Maricopa County	820:1
Arizona	820:1
Range in Arizona	9,610:1 to 530:1
Top U.S. Performers	330:1 (90 th percentile)

Poor Mental Health Days is based on survey responses to the question:

“Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

Average Number of Poor Mental Health Days, 2016 CDC, BRFSS	
Pima County	3.9
Maricopa County	3.7
Arizona	3.9
Range in Arizona	3.7-5.5
Top U.S. Performers	3.1 (10 th percentile)

Frequent Mental Distress is the percentage of adults who reported ≥14 days in response to the question:

“Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

Frequent Mental Distress, 2016 CDC, BRFSS	
Pima County	12%
Maricopa County	11%
Arizona	12%
Range in Arizona	11-19%

Depression in Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. Medicare is the federal health insurance program for persons aged 65 years or older, persons under age 65 years with certain disabilities and persons of any age with end-stage renal disease.

Depression in Medicare Population, 2015 Centers for Medicare and Medicaid Services	
Pima County	13.5%
Maricopa County	13.4%
Arizona	12.9%

Nutrition

There is strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. To change diet and weight, individual behaviors should be addressed, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger. Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

There is strong evidence that residing in a **food desert** is correlated with a high prevalence of overweight, obesity, and premature death. Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores. Additionally, lack of access to fresh fruits and vegetables is a substantial barrier to consumption and is related to premature mortality.

People in Pima County with Low Access to Healthy Foods (2015)

Arizona Health Matters

People 65 years and older with low access to a grocery store	4.4%
Children with low access to a grocery store	4.9%
People with low-income and low access to a grocery store	7.7%

The Food Environment Index ranges from 0 (worst) to 10 (best) equally weights two indicators of the food environment:

1) **Limited access to healthy foods** estimates the percentage of the population that is low income and does not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in nonrural areas, it means less than 1 mile. «Low income» is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.

2) **Food insecurity** estimates the percentage of the population who did not have access to a reliable source of food during the past year. A two-stage fixed effects model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey.

- **The Pima County Food Environment Index score is 7.4.**
- **In 2015, 26.3 percent of Pima County residents reported eating the recommended amounts of fruits and vegetables**

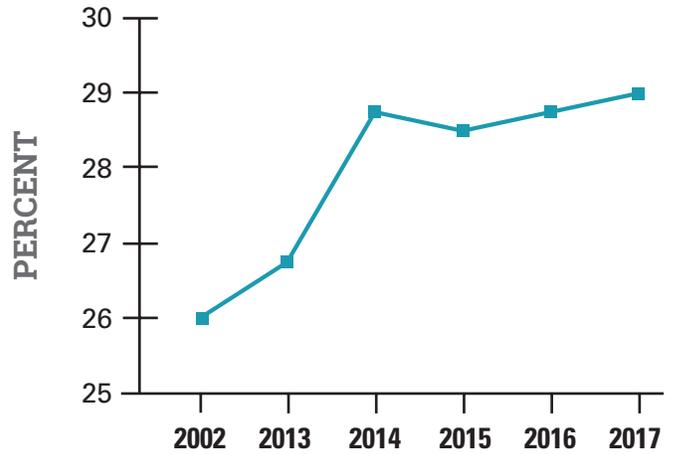
Obesity

Adult Obesity

Obesity has become a nationwide epidemic. A condition that is associated with many other health factors and outcomes referenced in this report, including several leading causes of death, obesity continues to wreak havoc on people’s health and well-being. According to the Trust for America’s Health and Robert Wood Johnson Foundation’s **State of Obesity** report for 2018, Arizona ranks 30th out of 51 U.S. states and the District of Columbia with 29.5 percent of Arizona adults reporting a Body Mass Index (BMI) of 30 or greater. County-level data from the BRFSS are available through 2014, and show Pima County’s percentage of obese adults at 25 percent, lower than both Maricopa County and Arizona and **meeting the Healthy People 2020 target of 30 percent or less.**

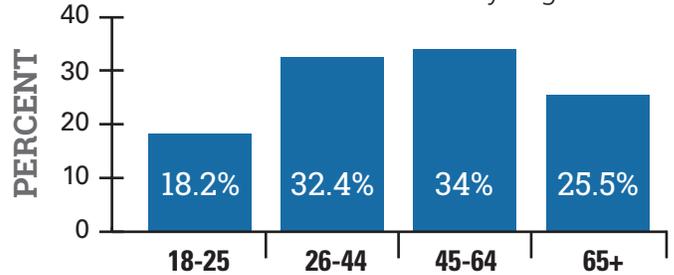
Adults with Obesity, Arizona 2012-2017

RWJF StateofObesity.org



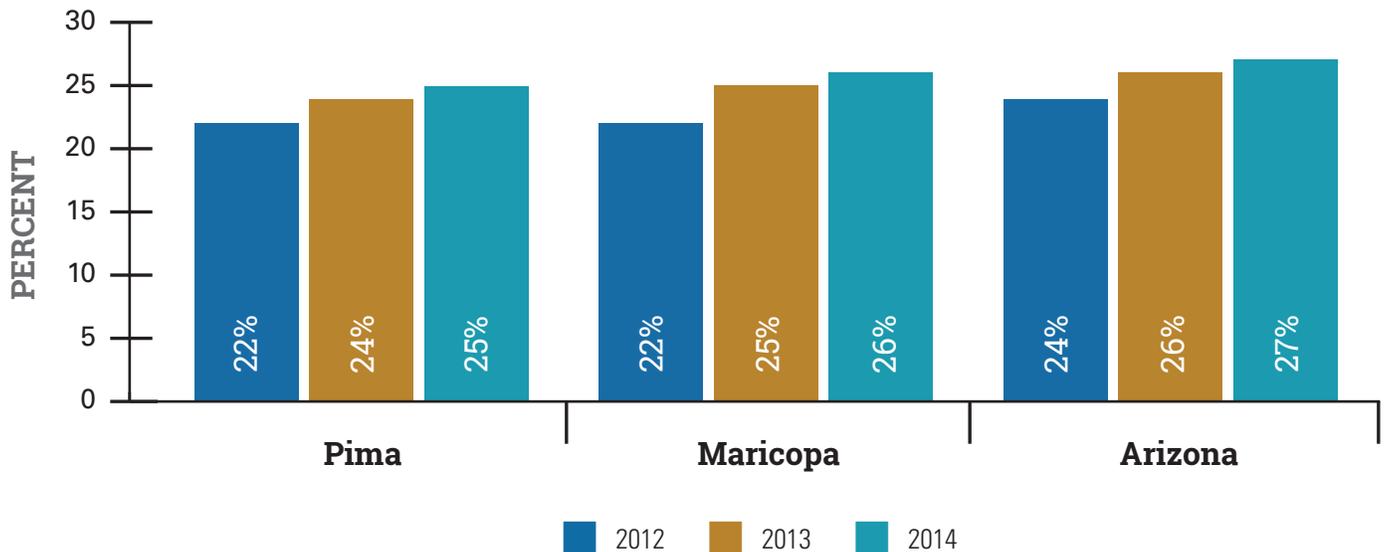
Obesity Rate by Age, Arizona 2017

RWJF StateofObesity.org



Adults with Obesity, 2012-2014

CDC, BRFSS



Childhood Obesity

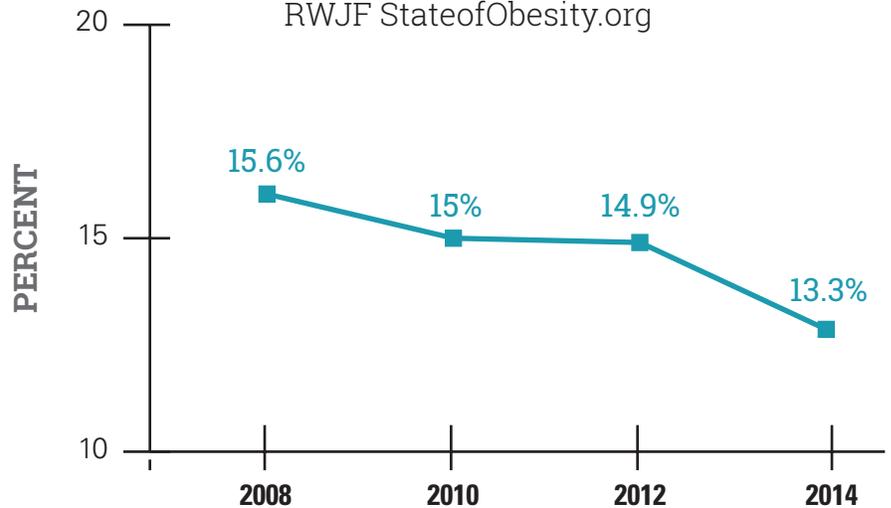
Childhood obesity was identified as an area of concern among Pima County residents through the CHNA primary data collection process, and with good reason. Children who are obese are more likely to become adults who are obese and suffer from obesity-related health conditions.

The Healthy People target for children ages 2-19 years old who are obese is 14.5 percent, and 9.4 percent for children aged 2-5 years. Unfortunately, there are few current or recent sources of data

for monitoring obesity among children at the county or local level. According to StateofObesity.org, which measures obesity among 2-4 year old recipients of the Women, Infants and Children's (WIC) Program, Arizona obesity rates among this population declined from 15 percent to 13.3 percent from 2010-2014. The latest available data for Pima County is from 2011, when 15.3 percent of low-income 2-4 year olds were obese. (PolicyMap.com)

Obesity among 2-4 Year Old WIC Recipients, Arizona 2012-2017

RWJF StateofObesity.org



Physical Activity

Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. Inactivity causes 11 percent of premature mortality in the United States, and caused more than 5.3 million of the 57 million deaths that occurred worldwide in 2008. In addition, physical inactivity at the county level is related to health care expenditures for circulatory system diseases.

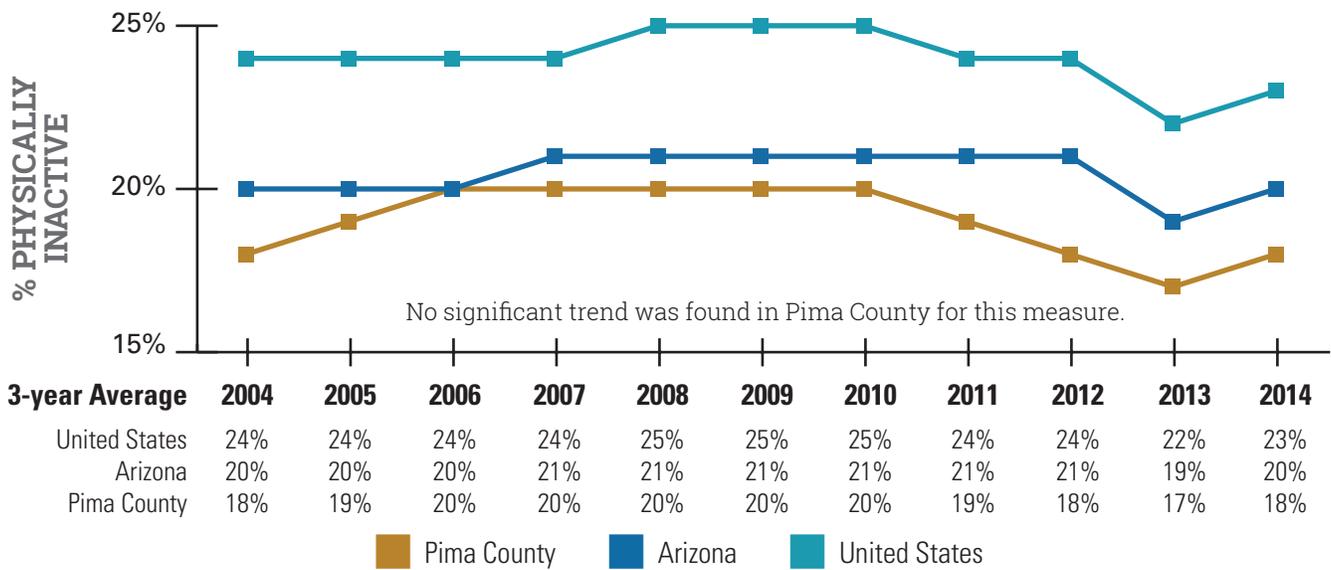
Physical Inactivity is the percentage of adults age 20 and over reporting no leisure-time physical activity. Examples of physical activities provided include running, calisthenics, golf, gardening, or walking for exercise. **Overall Pima County ranks better than state and national trends.**

Physical Inactivity, 2014

County Health Rankings and Roadmaps

Pima County	18%
Maricopa County	19%
Arizona	20%
Range in Arizona	16-30%
Top U.S. Performers	20% (10 th percentile)

Physical Inactivity in Pima County, AZ | County, State and National Trends



Please see Measuring Progress/Rankings Measures for more information on trends. Trends were measured using all years of data.

Source: County Health Rankings and Roadmaps

Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses identified by Standard Industry Classification (SIC) codes and include a wide variety of facilities including gyms, community centers, dance studios and pools.

Individuals below are considered to have adequate access for opportunities for physical activity; they reside in:

- a census block within a half mile of a park or
 - in urban census blocks: reside within one mile of a recreational facility or
 - in rural census blocks: reside within three miles of a recreational facility
- **87% of Pima County residents have access to exercise opportunities.**
 - **Community input from the 2018 CHNA shows that some residents are concerned about excessive heat, and general safety of some recreation areas.**

Access to Exercise Opportunities

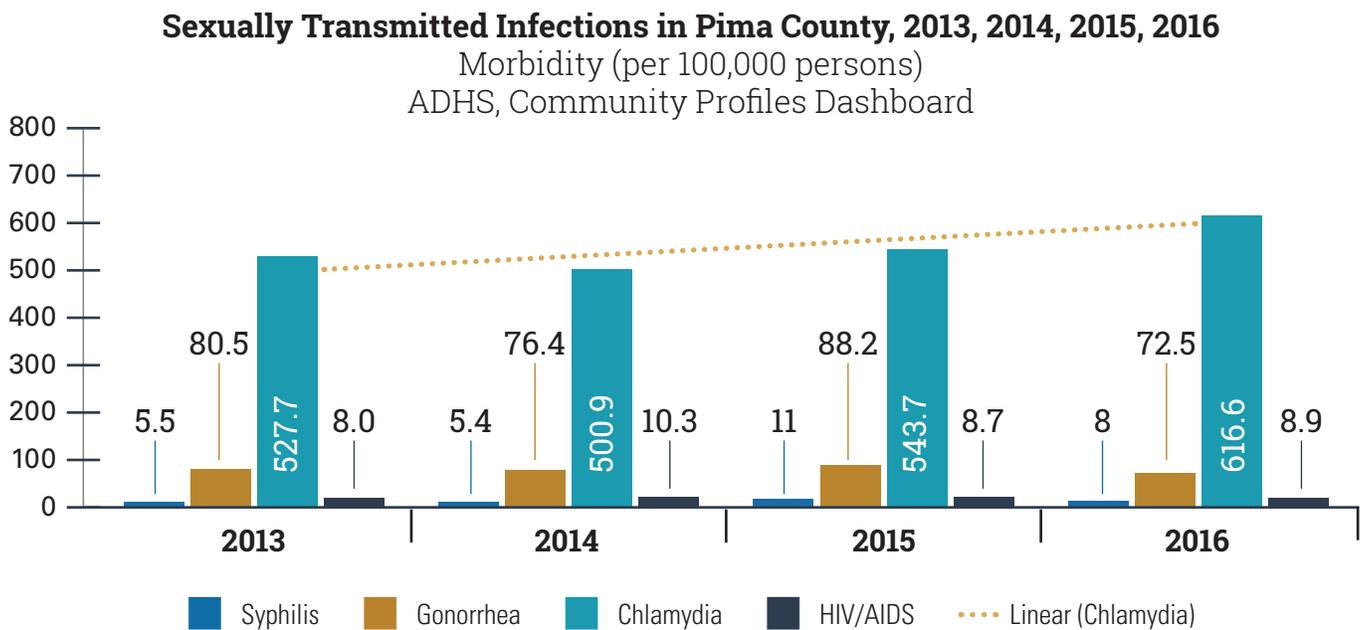
County Health Rankings and Roadmaps, 2010 population, 2016 SIC codes, and 2016 parks data

Pima County	87%
Maricopa County	92%
Arizona	86%
Range in Arizona	23-95%
Top U.S. Performers	91% (90 th percentile)

Sexually Transmitted Infections

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 20 million new STD infections each year—almost half of them among young people ages 15 to 24. The cost of STDs to the U.S. health care system is estimated to be as much as \$16 billion annually. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the United States.

Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile.



- **Chlamydia** is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. **Pima County is experiencing a rise in Chlamydia rates, and fares worse statistically compared to Arizona.**
- **Syphilis** is a sexually transmitted infection. It is easy to become infected and it is easy to detect and cure with testing and treatment.

In 2014, Pima County experienced a spike in syphilis cases compared to 55 cases reported in 2013. Most (72%) cases occurred in men less than 40 years of age who report sex with other men. In this population, 1 of 3 report being infected with HIV. In 2015, 111 cases were reported; these cases continue to occur in men who report sex with other men.

In these previous years, female cases have been less than 6 cases compared to provisional 2016 data. Female cases have significantly increased.

Provisional numbers for Pima County, 2016 (n= 108 cases) Pima County Health Department	
Men (n=93)	Women (n=15)
76% of men identify as MSM (men who have sex with men)	86% have known risk factors that involve drug/alcohol use
47% use internet dating sites or social media to meet partners	33% used internet dating sites or social media to meet partners
30% are co-infected with HIV	14% had sexual contact with MSM (men who have sex with men)

Substance Use/Misuse

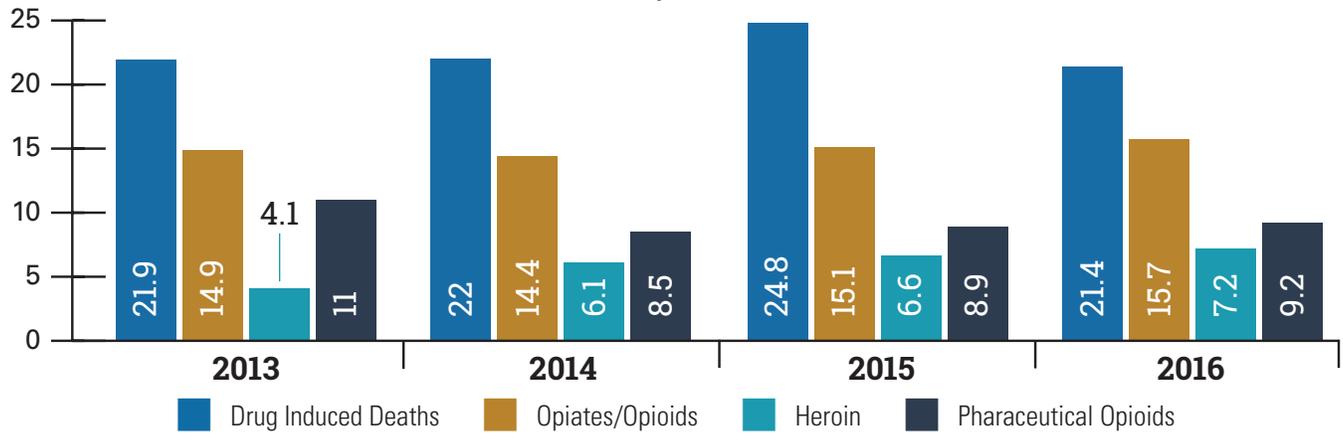
In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95 percent of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring (HealthyPeople.gov).

Substance use or misuse has a major impact on individuals, families, and communities. The effects of substance use or misuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Human immunodeficiency virus/acquired immunodeficiency syndrome
- Other sexually transmitted diseases
- Teenage pregnancy
- Crime
- Motor vehicle crashes
- Suicide
- Physical fights
- Domestic violence
- Child abuse
- Homicide

- **Alcohol** is the **2nd cause of morbidity** in Pima County, and **14 percent of adults** in Pima County reported **binge or heavy drinking** in 2016. Between 2012-2016, **32 percent of driving deaths were due to alcohol impairment**, a total of 496 deaths.
- **Drug induced death rates** in Pima County are statistically higher, compared to Arizona, including opioid, heroin, and pharmaceutical use.

Drug Induced Deaths in Pima County Mortality (per 100,000 persons)
ADHS, Community Profiles Dashboard



Drug Induced Deaths by Primary Care Area, 2016 | Mortality Rates (per 100,000 persons)
ADHS, Community Profiles Dashboard

	Drug Induced Deaths	Opiates/Opioids	Heroin	Pharmaceutical
Arizona	21.4	9.8	4.3	
Maricopa	19.2	9.4	4.1	5.8
Pima	21.4	15.7	7.2	9.2
Ajo	43.0	*	*	*
Casas Adobes	25.2	19.2	10.4	13.6
Catalina Foothills	9.3	*	*	*
Drexel Heights	13.8	8.8	*	8.8
Flowing Wells	24.6	18.7	11.9	10.6
Green Valley	6.7	1.5	*	1.5
Marana	4.3	2.2	*	2.2
Oro Valley	8.0	6.7	3.1	3.5
Pascua Yaqui Tribe	106.7	74.6	33.2	41.4
Picture Rocks	26.1	9.8	4.9	4.9
Sahuarita	9.9	3.8	*	3.8
San Xavier	70.0	*	*	*
Tanque Verde	41.2	21.0	*	21.0
Tohono O’odham Nation	*	*	*	*
Tucson Central	48.5	27.4	16.9	10.4
Tucson East	24.0	15.9	4.5	11.4
Tucson Estates	32.4	18.2	8.9	18.2
Tucson Foothills	31.6	18.4	7.5	11.9
Tucson South	28.9	18.1	8.4	10.4
Tucson South East	14.2	10.6	1.7	8.9
Tucson West	16.6	11.1	9.5	1.7
Vail	12.2	8.5	*	8.5
Valencia West	37.0	23.5	12.0	16.8

*unavailable

Suicide

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide each year globally; many more make an attempt. Suicide remains the second leading cause of death among 15-29 year olds worldwide; a suicide happens once every 20 seconds. It is estimated for every completed suicide, there are 20 others who have attempted. Suicide is the second leading cause of “years of potential life lost” in our state for American Indians. Also of grave concern are suicides among our increasing populations of retirees and veterans.

In 2016:

- There were 1310 deaths by suicide in Arizona.
 - Maricopa County had the highest rate of suicide with 683 deaths.
 - Statewide, there were 292 suicides by women, and 1,018 by men.
 - The youngest suicide was age 9; the oldest suicide was age 96.
 - The majority of suicides were completed with a gun.
- **Suicide was the 10th leading cause of death** in Pima County in 2016.

The Arizona Suicide Prevention Coalition and stakeholders across Arizona have developed ***“An End to Suicide in Arizona 2018 State Plan”***.

For more information visit: <https://www.azahcccs.gov/AHCCCS/ProgramPlanning/EndSuicide/>

Pima County 2018 CHNA stakeholders have an overall concern for behavioral health and mental illness. Participants are concerned about rising rates of youth suicide, and the lack of adolescent and pediatric psychiatrists and behavioral health specialists.

Furthermore, school counselors are typically academic guidance counselors and do not necessarily have training or backgrounds in social work, psychology, or other health professions.

In 2016, the areas of **Green Valley, Drexel Heights, Oro Valley, Picture Rocks, Tanque Verde, Tucson Estates, Tucson South East, and Valencia West** had higher rates of suicide compared to the rest of Arizona. A leading Healthy People 2020 indicator is to reduce the rate of suicides to 10.2 per 100,000. Pima County’s rate of suicides is 17.1 per 100,000.

Intentional Self-Harm (Suicide) | Mortality Rates (per 100,000 persons)
 Arizona Department of Health Services

	2013	2014	2015	2016
Arizona	16.9	16.5	17.9	17.6
Maricopa	15.1	14.9	16.2	16.3
Pima	17.6	15.5	18.2	17.1
Ajo	25.6	21.9	*	11.4
Casas Adobes	27.4	18.7	13.6	11.3
Catalina Foothills	19.2	15.9	11.1	17
Drexel Heights	14.6	14.2	12.2	18.2
Flowing Wells	22.1	13.3	21.5	16
Green Valley	53.7	22.5	61.2	32.1
Marana	11.3	18.0	22.1	14.7
Oro Valley	11.5	6.9	16.7	18.5
Pascua Yaqui Tribe	*	*	*	*
Picture Rocks	36.4	33.9	40.5	24.8
Sahuarita	13.9	3.9	4.5	11.2
San Xavier	*	*	*	*
Tanque Verde	5.8	24.2	14.3	32.0
Tohono O'odham Nation	*	*	*	*
Tucson Central	17.8	18.5	18	15.2
Tucson East	15.1	21.8	27	13.7
Tucson Estates	6.4	7.6	19.4	36
Tucson Foothills	26.2	16.0	27.6	16.7
Tucson South	10.8	16.0	11.8	13.8
Tucson South East	1.3	4.5	20.7	19.1
Tucson West	26.9	10.4	8.4	8.8
Vail	24.9	12.3	11.5	16.5
Valencia West	22.5	11.2	16.2	22.1

*data not reported or is unreliable

Tobacco

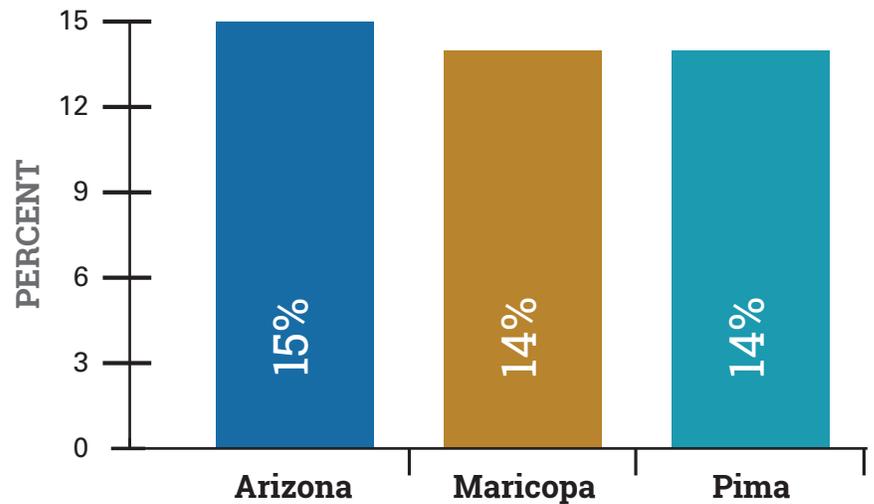
Each year approximately 443,000 premature deaths can be attributed to smoking. Cigarette smoking is identified as a cause of various cancers, cardiovascular disease and respiratory conditions, as well as low birthweight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

Healthy People 2020 lists tobacco as a leading health indicator, with a target to reduce adult smoking to 12 percent of the population. Approximately 14 percent of Pima County adults are smokers.

Adult smoking is the percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. The overall range of smokers in Arizona is 14-22 percent of the population.

Percentage of Adults in Pima County Who Are Current Smokers, 2016

CDC, BRFSS



Community Input

Primary Data Collection and Community Input:

Conducting primary data collection through key informant interviews, focus groups, surveys and community forums as part of the community health assessment process provides a deeper look into the health needs and strengths of the community and more engagement of the community in the process.

Primary data can complement and enrich the understanding and interpretation of data collected from existing published sources, otherwise known as secondary data, such as morbidity and mortality data. The collection and analysis of primary data can help to fill potential gaps in the secondary data sources. For example, the social context of a community is less straightforward to capture through secondary data. Likewise, the complexity of an individual's health needs and extent to which services are easy or difficult to reach is also challenging to demonstrate through published data alone. In addition to filling identified gaps, the primary data may highlight critical themes or issues that the secondary data does not.

Perhaps as important as a thorough data set, gathering primary data provides opportunities for the community to be engaged through the community health needs assessment (CHNA) process and to ensure that the community members' voices are heard. Engagement at this stage can lead to stronger community support and involvement throughout the community health improvement plans and processes

effort. Community health improvement efforts are most effective when community members are active in addressing their own needs and visions for a healthy community. Particular attention to groups with unique health or social issues who are often underrepresented in community planning efforts can be accomplished through direct participation or through their proxies. For example, it may not be appropriate to directly collect information from victims of domestic abuse or people experiencing homelessness or drug addiction for the CHNA but working with proxies or service providers concerned about their welfare would be suitable.

Initial Community Input & Final Forum:

The Pima County CHNA gathered initial community input through a variety of methods. Analysis across all data sources sought to identify common themes and concerns. Results presented here are a synthesis of those themes.

The following approaches were used to collect primary data through community input:

Key Informant Interviews (n=18)

5 Focus Groups (n=48)

1st Community Forum (n=41)

Community Survey (n=176)

The purpose of these processes was to examine:

- Concepts of health and healthy communities
- Community assets and strengths
- Community health concerns and affected populations
- Community proposed solutions

Participants were also asked about existing resources in the community to address identified health needs or concerns as well as their perceptions of strengths of the community. The quality of programs or services—what works, and what needs improvement—was a critical focus area. Finally, the needed resources, actions, and policies were addressed. Participants were invited to make recommendations and bring to attention any unmet needs not being addressed.

After common health concerns (or preliminary “needs”) were identified, a final community forum took place where 93 stakeholders had the opportunity to add to the conversation of populations affected, resources available or needed, and ultimately to prioritize the needs along with proposed solutions.

Concepts of Health & Healthy Communities

Key Informants and Focus Group participants were presented with specific open-ended questions including:

“What is your vision of a healthy community?”

“How do you define health?”

While some community members focused on an individual's ability to function pain free or optimally, and even "be happy," most people commented very broadly to include human interactions and the community environment. The following are highlights of community concepts of health and healthy living:

"The whole person: physical, social, economic, and spiritual"

"Functioning at the highest level possible; quality of life"

"A state of feeling well, happy, competent; ability to handle stress"

"Everybody helping everybody; honesty, caring, love"

"Shelter for everybody; affordable, safe housing"

"Green spaces, parks: walkability; clean environment"

"Fresh, local foods"

"Livable wages; affordable childcare"

Community members promoted a sense of social justice and equity, commenting on human attributes and human needs such as safety and shelter. The ability to have gainful work and take care and afford quality childcare is part of a healthy community.

The emphasis on factors such as housing, food, and economic security, among others, with equal or greater weight than specific disease states or physical health concerns, reflects the broader CHNA process' focus on social determinants of health as key elements in a comprehensive approach to assessing community health needs.

Community Assets & Strengths

When asked broadly "What's healthy about Pima County?" CHNA stakeholders identified a variety of positive community attributes. When asked about community assets, participants were asked to consider:

- Individual people and characteristics, such as within the population served
- Built or natural aspects of the community
- Specific organizations, programs, or services available

Participants recognized the **resilience** and **resourcefulness** of their clients, acknowledging that their clients often know more about available services than they do. Clients often share information and resources through their own community networks and help each other out.

Pima County has a **unique cultural and natural landscape**, and a good climate (except in the summer) for being outdoors. There is a **spirit of compassion** in the community as seen by its high per capita number of nonprofits and "immigrant friendly" environment.

A list of specific initiatives, assets and resources available to address health needs as identified by stakeholders is found at the end of the Community Input section of this report.

Community Health Needs, Affected Populations & Proposed Solutions

Key informants, focus groups, 1st forum attendees, and survey participants were all asked about their perceptions of issues or concerns in the community, which could include specific health issues or other community concerns. Asking about who is most affected by these concerns begins to get to a better understanding of **social determinants of health** and upstream root causes. Additionally, barriers to address these issues were considered.

Three very broad concerns surfaced among Pima County stakeholders. For the purposes of this CHNA, **these concerns serve as the overarching health needs** identified through community input and validated by secondary data analysis:

- **BEHAVIORAL HEALTH**
- **OBESITY & RELATED CHRONIC DISEASES**
- **ACCESS TO SERVICES (cross cutting)**

A discussion of the results from the community input/primary data collection and analysis process follows the description of each prioritized health need, below. A review of the secondary data collected as they relate to each health need provides additional objective validation of the importance of each health need to the status of the community's health. These data are presented under the heading "Supporting Secondary Data."

HEALTH NEED: BEHAVIORAL HEALTH

Behavioral health was addressed very broadly and included concerns about mental illness and substance use or misuse, as well as a lack of providers and facilities. Below are some specific topics and concerns:

- Mental illness such as Severe Mental Illness (SMI), depression
- Undiagnosed or untreated mental illness
- Addiction and substance use or misuse, especially opioids and alcohol
- Complexity of chronic pain management in light of opioid crises
- Lack of detox and treatment centers, need for sobriety centers for people experiencing homelessness
- Lack of providers, case manager turnover, services closing
- Mental health support in school system (Adverse Childhood Experiences, presence of immigration authorities, school shootings, lack of counselors)
- Increasing rates of youth suicide
- Domestic violence and child abuse
- Criminal justice nexus

***Special Concern: Youth and School Climate**

School nurses are concerned about the lack of counselors, and behavioral health was their top health concern overall. In Pima County (and Arizona generally) counselors primarily are academic advisors, and there is a need for skilled training. Nurses identified a need for Trauma Informed Care and recognized the role that Adverse Childhood Experiences (ACES) play in the wellbeing of young people. School nurses also described other aspects of school climate, whether it be school shootings nationwide or immigration lockdowns locally contributing to stress among students.

Confirming this issue, providers and emergency medicine representatives discussed the lack of pediatric and adolescent psychiatric services available and rise of youth suicide.

***Special Concern: Criminal Justice Nexus**

There is an understanding that community behavioral health – related to alcohol or drugs, domestic violence, gun crime, and their respective intersections – is often first dealt with in the criminal justice system, leading to incarceration. These individuals face difficulties upon release finding employment, and housing. Legal advocates for low income and disenfranchised people described how eviction and domestic violence lead to chronic stressors which may become entangled with substance abuse and other health issues.

Confirming this issue, one healthcare provider working in an American Indian community stated,

“I am concerned about the rates of my patients with criminal records who cannot find jobs, which produces higher rates of recidivism and complicates their re-entry to society greatly. It also affects the quality of the lives of their children and families not being able to contribute financially.”

Supporting Secondary Data

- Pima County residents report an average of 3.9 poor **mental health** days per month, and 12 percent of community members report frequent mental distress. Among the Medicare population, 13.5 percent are treated for depression.
- **Suicide** is the 10th leading cause of death in Pima County.
- **Alcohol** is the 2nd cause of morbidity in Pima County, and 14 percent of adults in Pima County report binge or heavy drinking. Between 2012-2016, 32 percent of driving deaths were due to alcohol impairment, for a total of 496 deaths.
- Opium use and unspecified **drug use** are the 4th and 8th leading causes of morbidity in Pima County, respectively. Drug-induced death rates in Pima County are statistically higher compared to Arizona, including opioid, heroin, and pharmaceutical use.
- The ratio of population to **mental health providers** is 600:1 in Pima County; U.S. top performing communities have a 330:1 ratio.

Most Affected and Root Causes

Exploring who is most affected by the identified health needs through community input leads to a better understanding of how social determinants of health contributes to health disparities. Furthermore, community input can mitigate the challenges inherent in capturing the full breadth of community health needs through secondary data, such as disease and death rates, alone, by providing a richer context of the factors and circumstances facing those most affected by the health needs.

There are concerns among social service and healthcare providers about **untreated serious mental illness** (SMI) among people experiencing homelessness, complicated by substance use and misuse, the complexity of emergency room use and the need for transitional housing upon discharge. First responders, in particular, discussed the need for detox centers for people experiencing homelessness.

Vulnerable groups include LGBTQ persons, persons with disabilities, refugees, undocumented immigrants, all of whom who receive very limited services and live with high levels of stress and anxiety. There is also widespread acknowledgement that **poor, uninsured, and underinsured** people face barriers to accessing services.

Community Proposed Solutions

- Detox and treatment centers
- Sobriety centers of people experiencing homelessness
- Harm reduction
- Pediatric and adolescent clinicians
- Trauma Informed Care
- Early diagnosis and intervention
- Integrated care
- Secure funding and contracts with Regional Behavioral Health Authorities (RBHAs)
- Transitional housing
- Mobile psychiatric services
- Transportation for special populations (e.g. children, homebound) and affordability
- Take better care of elderly
- Reduce stigma
- Navigators and outreach to gain trust of homeless population
- Reduce insurance authorization barriers

HEALTH NEED: OBESITY & RELATED CHRONIC DISEASES

Broadly speaking, stakeholders are concerned with obesity and related chronic diseases. There was widespread acknowledgment about how obesity is linked to other health conditions, particularly diabetes and hypertension, and emphasized the need to address lifestyle and environmental factors, in addition to healthcare services, with access to healthy foods and food literacy as proposed solutions. There is a great deal of available secondary published data that support the community's concern regarding obesity and related chronic diseases.

Supporting Secondary Data

- Cancer and heart disease continue to be the two leading causes of death among Pima County residents, as they are throughout Arizona and the U.S. Obesity puts people at greater risk for developing heart disease and many types of cancer.
 - **Heart disease** has surpassed cancer as the leading cause of death in Pima County, with 170.6 deaths per 100,000 people, much higher than the Healthy People 2020 target of 103 deaths per 100,000 people.
 - While Pima County has met and exceeded the Healthy People 2020 target of reducing **cancer death rates** to 161.4 per 100,000 people, Pima County still has a higher death rate from cancer (155 per 100,000) than Arizona (142.2 per 100,000).
- In 2013 Pima County, an estimated 13.11 percent of adults had ever been told they were diagnosed with **diabetes**, higher than both Maricopa County at 11.42 percent and Arizona at 10.66 percent.
- Healthy People 2020 lists commercial tobacco use as a leading health indicator related to chronic disease, with a target to reduce adult smoking to 12 percent of the population. Approximately 14 percent of Pima County adults are smokers.
- While Pima County has met and exceeded the Healthy People 2020 target of 30 percent or fewer adults with obesity, data show that the percentage of Pima County residents with obesity increased from 22 percent in 2012 to 25 percent in 2014.
- In 2015, only 26.3 percent of Pima County residents reported eating the recommended amounts of fruits and vegetables.
- Although Pima County performs better than state and national trends, 18 percent of community members report no leisure time physical activity, and 13 percent of residents have no access to exercise opportunities.

Most Affected and Root Causes

It was generally recognized that obesity and related chronic diseases affect “everyone” and that downstream chronic disease is a leading cause of morbidity and death; but there is a special concern for **young people and childhood obesity**. Community members are concerned about “food deserts” especially in **rural communities**. For this reason, **American Indians** are greatly affected by lack of access to healthy foods. **Older adults** are affected due to co-morbidities common later in life. Additionally, there are many barriers for **poor, undocumented, and uninsured people** to access health care services.

Community Proposed Solutions

- Health literacy
- Physical Education / physical activity in schools
- Healthy school fundraising
- Healthier school meals
- Early childhood education
- Access to safe outdoor recreation

- Access to nutritious foods
- Restaurant portions and nutritional information
- Healthy retail stores
- Patient education
- Increased screenings
- Preventative services
- Breastfeeding initiatives
- Public policies

HEALTH NEED: ACCESS TO SERVICES

Pima County stakeholders identified access to services as a major health need, and it should be noted that access to services is a cross-cutting concern affecting all health issues related to poor health outcomes, illness, or disease. Access to services extends beyond easily quantifiable measures of access to healthcare, such as health insurance coverage. Stakeholders expressed frustrations around health insurance including affordability, insufficient coverage, eligibility requirements/limitations, wait time for authorizations, and barriers around insurance literacy among the insured. However, concerns that arose were primarily focused on:

- **Provision of services:** integration, coordination, continuity of care, cultural competency
- **Location and distance** of services: transportation
- **Availability** of services: especially lack of behavioral health providers and facilities

Community members described:

- No or insufficient insurance, affordability
- Limited health insurance literacy
- Insurance authorization barriers
- Lack of transportation services
- Lack of behavioral health providers and services
- Non-AHCCCS (Medicaid) uninsured persons, with limited coverage
- Lack of specialty care (and affordability)
- Eligibility requirements
- Social services being maxed out

***Special Concern: Coordination, Continuity, and Integration of Care**

The barriers and abilities to access services is greatly influenced by the availability and provision of those services. Both health care and social service providers express frustration with siloed services and challenges to coordinate services. While stakeholders acknowledge a significant number of non-profit and healthcare agencies, the 'system' is challenging to navigate for both professionals and clients alike.

Special populations such as older adults, chronically homeless, and people facing substance abuse and addiction end up in the Emergency room because they lack coordinated support. Concern for elders upon hospital discharge, especially those who cannot drive and live alone was expressed. Advocates are needed to assist these community members.

***Special Concern: Transportation**

Reaching services is clearly a barrier in rural communities. Additionally, in all areas of Pima County special populations have difficulties reaching services, including homebound adults, people with disabilities, and people who cannot afford the limited existing public transportation that does exist. Stakeholders describe the doubtful future of improved transportation systems in the short run and identify the need to bring services closer to school, work, and home.

Supporting Secondary Data

Access to services can be impacted by social, economic, and environmental or physical/structural factors. For example, a person with a mental or cognitive disability may have health insurance but may have difficulty navigating the complexities of the healthcare system. A single working parent may have access to high quality healthcare but may not have the ability to take time off work to visit a doctor for regular preventive screenings. Quantifying access to services through secondary data can prove challenging based on the complexity and interrelatedness of contributing factors, including many of the social determinants of health that are included in this CHNA. This challenge underscores the importance of collecting primary data through community input to better understand the most pressing health needs facing the community.

Secondary data that supports the community's identify of access to services as a major health need and that are included in this assessment include the transportation score, population to provider ratio, and primary care score (available at the PCA level). Overall, while Pima County has more primary providers per population and has a slightly better transportation score than the state, there are disparities among PCAs with several facing greater challenges in access to services based on these barriers.

Most Affected and Root Causes

Community input is crucial to understanding the complexities of accessing services, as both healthcare and social services providers describe health needs and issues affecting a variety of people. As previously described, complexity is not easily captured through the existing published data.

Stakeholders describe those most affected as people experiencing **co-morbidities** and facing barriers with **social determinants of health**, such as **persons experiencing homelessness** who also suffer from mental illness or addiction, or **older adults** with chronic disease or disability who have complex health needs. Generally, people with **limited social networks** are susceptible to "falling through the

cracks.” These people need support for getting to appointments and navigating the system. There are **vulnerable populations** that need culturally competent care such as LGBTQ, refugees, at-risk teens, and undocumented immigrants who are hesitant to seek help. People living in **rural communities** face limited availability and location of services.

Community Proposed Solutions

- Health literacy
- Non-emergency medical transportation
- Coordination of services, integrated care
- Continuity of care
- Cultural competency
- Services for undocumented residents
- Resources directories
- Bus pass access
- Mailboxes for people experiencing homelessness
- Walk-in appointments
- Telemedicine / telehealth
- Mobile clinics

Emerging Themes

The following **cross cutting** concerns arose during the assessment process as social determinants of health and needs to be addressed to promote physical and mental health.

Built and Natural Environment has presented as an emerging health topic. Broadly speaking, this pertains to environmental health and quality- from clean air, clean water, and spaces free from environmental hazards- to climate change. Additionally, a link has been identified between physical and mental health and access to safe recreational spaces, as well as safety for active forms or transportation such as walking and biking. Below are some specific topics and concerns:

- Pedestrian safety and walkability of community
- Bike safety
- Access to safe recreational areas
- Heat stress
- Shade and protection from heat
- Community Input cont’d
- Tap water
- Air quality
- Climate change
- Lack of community awareness of hazardous places/spaces

Most affected populations include low income, marginalized people, people facing homelessness or housing insecurity, people with disabilities and illness, the elderly, and children.

Community proposed solutions include:

- Safe recreational spaces
- Safe walking and biking areas
- Protection from heat exposure
- Affordable, safe housing
- Funding for environmental clean ups
- Community outreach with regards to available services and environmental hazards/risks
- Build community trust

Housing was a topic raised across many health concerns, including affordable housing for low income community members, and housing that is safe and free from environmental hazards. Additionally, the stress, legal programs, and disruption overall to family life caused by eviction is a concern. A need for housing and safe spaces for the chronically homeless, mentally ill, and other vulnerable populations was also identified. Confirming this concern, a healthcare provider stated:

"I am concerned about some of my patients who have a home but are in poverty and unable to do important safety upkeep. I have patients who are disabled or elderly or just making it financially and this is very difficult. They are living in unsafe conditions due to this."

As an emerging theme, the root causes and proposed solutions were not fully addressed for this current CHNA process. However, it should be noted and considered as a key social determinant of health affecting the Pima County community.

Final Forum: Community Prioritized Solutions

The conclusion of the Pima County CHNA process was marked by a highly publicized community forum attended by 93 community members, health care workers, public health professionals, academics, representatives from community organizations and other people with an interest in the outcomes of the CHNA. The purpose of the second forum was to:

- **Share findings** with stakeholders;
- **Identify and prioritize health needs**; and
- **Identify potential solutions** to prioritized health needs.

As with the first forum, a brief presentation described the purpose and process of the CHNA. Findings from primary data collection were shared and validated by secondary data. Five salient health needs that emerged during the data collection process were presented along with potential solutions or ways to address the needs proposed through the community input process.

The group had a chance through the initial “Gallery Walk” to add to health needs, affected populations, and proposed solutions or potential/needed actions to address the needs, and finally to then rank the proposed solutions. Facilitators tallied the top three proposed solutions/needed actions corresponding to each health need station. The group was then asked to rank the top five proposed solutions across all health needs.

The top five proposed solutions, or needed actions, fell under the three health identified health needs identified earlier: Behavioral Health, Obesity and Related Chronic Diseases, and Access to Services. This ranking further validated the top three health needs identified through the community input and primary data collection process. (All 15 ranked proposed solutions, which includes the top three proposed solutions per each of the five health needs, can be found in the appendix.)

The top five proposed solutions to address the identified health needs are:

- **COMPREHENSIVE APPROACH TO REACHING SERVICES**
- **CULTURAL COMPETENCY**
- **ACCESS TO HEALTHY FOODS & FOOD LITERACY**
- **PROFESSIONAL DEVELOPMENT & TRAINING FOR SCHOOL PERSONNEL**
- **RESOURCE & REFERRAL TOOLS**

Cross Cutting Characteristics

These leading proposed solutions mostly cut across the top three community health needs. Specifically:

- Comprehensive Approaches to Reaching Services, Cultural Competency, and Resource & Referral Tools relate to Behavioral Health, Obesity & Related Chronic Diseases, and Access to Services.
- Access to Healthy Foods & Food Literacy relates to Obesity & Related Chronic Diseases and Access to Services.
- Professional Development & Training for School Personnel relates to Behavioral Health and Access to Services

Health Needs and Cross Cutting Proposed Solutions



Comprehensive Approach to Reaching Services

This proposed solution or needed action surfaced under the health need of Access to Services; however as noted above it cuts across the health needs of Behavioral Health and Obesity and Related Chronic Disease.

Several pathways to “reach” services are needed, such as:

- Mobile clinics
- Telehealth / Telemedicine / Telepsychiatry
- Non-emergency transportation

Participants described several pathways to reach services in addition to services such as mobile clinics, such as telemedicine, and more transportation options such as non-emergency transportation and bus passes.

Bringing services to people where they live, work, and play is needed to reduce barriers of time and cost to clients and create efficiency. While health transportation services exist, the system is fragmented and driven by a variety of eligibility requirements, and in some cases availability of volunteers. In rural communities and on tribal reservations, telemedicine could provide specialty care and save community members hours of travel and wait time.

There are a variety of transportation services, however they all have their associated eligibility criteria. For example, AHCCCS does cover some transportation costs, and community health centers such as El Rio provide taxi vouchers. Some specialty services, such as imaging centers can also provide courtesy transportation; and the American Cancer Society provides transportation assistance for cancer patients. The Elder Alliance and Interfaith Community Services utilize volunteer drivers to assist community members, although these programs struggle to keep up with demand. The complexity of these various services illustrates the challenge and need for comprehensive approaches as identified by stakeholders.

Cultural Competency

This proposed solution or needed action surfaced under the health need of Obesity & Related Chronic Diseases and was originally stated as “Culturally competent (tailored) education”.

However, when considering all community input and data collection, the proposed solution has been generally broadened to “Cultural Competency” as this theme arose with regards to the provision of health services and education, especially with regards to special and most affected populations. Also, as noted above cultural competency cuts across the identified health needs of Behavioral Health and Access to Services.

To be effective in the provision of services, including patient and community education, cultural competency is needed. Services need to be tailored considering age, ethnicity, language, as well as for vulnerable populations:

- LGBTQ
- Homeless persons
- At-risk teens
- Refugees
- Elderly
- Children

Health behaviors are more likely to change when education and outreach efforts consider and account for the day to day lives and background of community members. Patients are more likely to access services if the healthcare environment and providers understand their needs.

Access to Healthy Foods & Food Literacy

This proposed solution or needed action surfaced under the health need of Obesity & Related Chronic Diseases; however as noted above it also relates to Access to Services.

To create healthy eating habits among community members, healthy foods need to be readily available considering:

- Affordability of healthy foods
- Location of healthy foods

The relationship between access to foods and affordability, or the barriers to healthy eating due to poverty, was described by participants.

Food literacy includes understanding the relationship between what people eat and their health, and how to make the best food choices. Preparing healthy food in a palatable way will increase the likeliness of sustainable behavior change and eating habits. Community education for all age groups should account for these elements of food literacy.

Professional Development & Training for School Personnel

This proposed solution or needed action surfaced under the health need of Behavioral Health; however as noted above it also relates to Access to Services. It was originally described as “Counselors at schools with specialized training in behavioral health and substance misuse”; however, it has been broadened to encompass critical school personnel that may include administrators, nurses, instructors in addition to counselors.

Many school counselors serve as academic counselors and do not necessarily have a background or training in psychology or social work and are not typically licensed mental health providers. Furthermore, there is a lack of pediatric and adolescent psychiatry services community wide. Given a rise in youth substance use and misuse and suicide, school personnel need to have specialized training.

The school environment has many stressors for youth including:

- School lockdowns when there is a local immigration event
- National coverage of school shootings
- Bullying
- Gangs

Additionally, school nurses reported unstable home lives as a stressor to students. Adverse childhood experiences (ACE) are shown to result in poor social and health outcomes, and a trauma-informed approach is needed in schools so that students are not punished and excluded from the system when they “act out.” Personnel and counselors need training and support on evidence-based practices to promote a safe school climate and help students with behavioral health needs.

Resource & Referral Tools

This proposed solution or needed action surfaced under the health need of Access to Services and was originally stated as “Resources Matrix (integration and coordination of care)”. However, when considering all community input and data collection, the strategy has been generally broadened to “Resource & Referral Tools” as this theme continues to arise, sometimes discussed as needed resource directories, clearinghouses, or hubs of information to assist service providers and community members in finding needed resources. Also, as noted above, Resource & Referral tools cuts across the identified health needs of Behavioral Health and Obesity and Related Chronic Diseases.

Service providers from all domains, including behavioral health, primary care, and social services, need tools readily available to be able to link their clients to needed services. These tools would be an outcome of service integration and collaboration between a variety of agencies, emphasizing a holistic approach to caring for with multiple needs such as:

- Cash assistance
- Behavioral health
- Child care
- Food insecurity
- Housing
- Health care
- Insurance
- Transportation

Developing, maintaining, and effectively utilizing community resources is an ongoing need and challenge involving complex data management and updates to ever-changing services provided in the community.

The **Arizona 211** is an online system designed to connect people to resources. Pima County has a webpage <https://211arizona.org/pima/> with information on:

- Food, clothing and help paying bills
- Housing and shelter
- Domestic violence and human trafficking
- Health and dental
- Disability related services
- Veteran and military services
- Employment services
- Mental health and support groups
- Substance use disorder
- Government and tribal services
- Individual and family services

There is also a **Directory of Community Resources for Pima County 2017-2018** described as a “guide containing updated information on nonprofit, government, faith-based, and grassroots organizations serving people in Pima County, Arizona. A trusted resource for counselors, social workers, educators, health care providers, clergy, and other helping professionals, the Directory has information about services for children, youth, adults, elders, and families.” This guide is published by Our Family Services Inc. Information & Referral Program.

Emerging Needs

Two needs emerged at the second Community Forum as “parking lot” items – topics not presented or formally developed into the “Gallery Walk” process through the analysis of primary and secondary data leading up to the Forum. However, during the ranking and voting process, these needs received a great deal of attention based on the large number of sticky dot votes. These needs relate to many identified community concerns, such as behavioral health, access to services, housing, and the built and natural environment.

While these needs were not directly revealed throughout the CHNA data collection process, they may indicate areas of increasing concern or closer examination in the future.

The emerging needs identified in the second Community Forum are:

- Safe spaces for marginalized populations, e.g. people using drugs, LGBTQ, persons experiencing homelessness, and connecting them to resources (if desired).
- Community-wide, neighborhood-based disaster preparedness education for “sheltering in place” with a focus on power outages, extreme heat.

Community Identified Assets & Resources

Through the community input process many unique and positive characteristics of Pima County were described. Of special note are the many wonderful organizations and programs that serve the community. Below is a compilation of select initiatives identified by community members.

Spotlight on Innovation

Recent years have seen the introduction of unique initiatives and programs. These initiatives work creatively to reach underserved and vulnerable community members. They're locating people in need, strengthening bonds, safeguarding and improving care, and serving as people's advocates. Below are brief profiles of selected programs.

- **El Rio Community Health Center: Integrated Services and Referral System**

www.elrio.org/about-elrio/community-collaborations

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. Client information is tracked in electronic health records so providers and outreach workers can link them to needed services in the community, such as legal services, housing assistance, or food boxes.

- **Southern Arizona Hospital Alliance**

(520) 327-5461 (TMC's Contact Information)

www.tmcaz.com/southern-arizona-hospital-alliance

The Southern Arizona Hospital Alliance was formed in 2015 with the participation of TMC and 4 other independent hospitals in Bisbee, Benson, Safford, and Wilcox. This alliance leverages existing relationships and allows all the hospitals involved to better serve patients, as well as be more efficient in purchasing, insurance, and electronic records. Further, all hospitals can remain independent entities in the face of an increasingly private, big-business climate.

- **Tucson Collaborative Community Care (TC3)**

520) 791-4512

TC3 works to better the health of individuals chronically engaged with the EMS system. Continual callers are referred by EMS to TC3, who then send a four-person crew of two firefighters, a social worker, and a paramedic to visit the person. They examine their home, talk about the person's issues, and connect them with the correct social services. They have even accompanied patients to their doctor's office to discuss care.

See: <https://www.kgun9.com/news/local-news/how-tucson-fire-is-reducing-ambulance-rides-and-saving-money>

- **Tucson Family Advocacy Program (TFAP): Medical-Legal Partnership for Health**
(520) 694-1624 / <https://www.fcm.arizona.edu/tfap/about-us>
TFAP’s mission is to improve the health of low-income families by providing coordinated legal, medical, social work, and educational services in a health care setting. One of their main goals has been to increase provider awareness of non-medical problems impacting patient health; knowledge of legal and social resources to address those problems; and ability to identify and assist patients in need of those services. In addition, they are working to increase collaborations between Arizona’s medical, legal, and social services communities to enhance the wellbeing of those they serve.
- **Tucson Police Department’s Mental Health Support Team (MHST)**
(520) 791-4444 or emergency 1-866-495-6735 (TDD/TTY): 1-877-613-2076
<https://www.tucsonaz.gov/police/mental-health-support-team-mhst>
MHST was established in 2014 and represents Tucson Police’s philosophical shift in their response to behavioral health incidents. They work to decrease the number of incarcerated mentally ill individuals by serving as an entry portal into mental health treatment, as well as provide early intervention and speedy and thorough case follow-up.

Specific Organizations, Programs, or Services Identified by Stakeholders

AHCCCS Non-Emergency Transportation Service

1-(855) 432-7587

AHCCCS covers and provides non-emergency transportation to and from medically necessary services under 100 miles (round-trip) without prior authorization needed. Longer trips are also covered but will require authorization from AHCCCS.

American Cancer Society Road to Recovery Transportation Program

(520) 321-7981 / www.cancer.org

Arizona’s chapter of the ACS provides cancer patients with rides to and from cancer-related appointments, although rides are dependent on volunteer driver availability within the area.

Answers for Life Pregnancy Center

(520) 308-8990 / www.aftucson.com

Answers for Life Pregnancy Center provides free services for women including pregnancy testing, ultrasounds, options counseling, post-abortion counseling, a prenatal clinic. They also provide free resources for new moms, such as baby clothes, diapers, formula, and baby furniture.

Arizona School for Deaf and Blind (ASDB) Tucson Campus

(520) 770-3458 / www.asdb.az.gov

ASDF is committed to excellence and innovation in education for all children who are hard of hearing, deaf, or have vision loss; leadership and services; collaboration with families, school districts and communities; and partnership with other agencies who are also committed to children who are hard of hearing, deaf, or have vision loss.

Arizona Telemedicine Program (ATP)

(520) 626-2493 / www.telemedicine.arizona.edu

ATP provides telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona. Using telemedicine, ATP provides clinical services to medically underserved populations related to specialty concerns (cardiology, pulmonology, etc.), diabetes, trauma, and home health.

Casa de los Niños Nurse-Family Partnership

(520) 881-0001 / www.casadelosninos.org

Casa de los Niños works in conjunction with the Nurse-Family Partnership to provide pregnant women with a registered nurse who will visit them in their home during pregnancy and continue to support them until the child turns two years old

Clínica Amistad

(520) 305-5107 / www.clinicaamistad.org

Clinica Amistad provides medical services free of charge, including evaluations, acupuncture, consultations for specialty concerns (diabetes, pulmonology, dermatology, etc.), massage therapy and energy therapy. In addition, they also provide health education regarding healthy lifestyle and social services support.

CODAC Health, Recovery & Wellness

(520) 327-4505 / www.codac.org

CODAC offers behavioral health and primary care services for anyone over the age of 6. Their behavioral health services include substance abuse disorders, trauma, depression, anxiety, relationship troubles, schizophrenia, bipolar disorder, major depression and other serious mental health/mood disorders. Their primary care services include wellness check-ups, common illnesses, chronic conditions, injuries, and pharmacy/lab services.

Community Action Agency (CAA)

(520) 724-2667 / www.azcaa.org

CAA provides assistance to low-income families and single adults. Their services include emergency assistance, utility assistance, support services, special needs, food and nutrition, medical prescription and supplies, and rental/mortgage assistance.

Community Bridges, Inc. – Tucson Outpatient Services Center

(520) 323-1312 / www.communitybridgesaz.org

CBI's integrated health practice takes into account people's physical, mental, and behavioral needs and provides care, while also determining if ongoing community resources are needed.
communitybridgesaz.org

Community Food Bank of Southern Arizona

(520) 622-0525 / www.communityfoodbank.org

The Community Food Bank of Southern Arizona's mission is to respond to the root causes of hunger and restore dignity, health, opportunity, and hope to people living in poverty.

Community Health Services (CHC)

(520) 624-5000 / www.chccommunityhealthservices.com

CHC is a community corrections outpatient facility that educates, treats, and assists criminal justice clientele. They have designed curriculum to meet the needs of offenders committing particular offenses, including domestic violence, shoplifting, alcohol abuse, sex offenses, etc. They aim to create positive offender outcomes through education.

Educational Enrichment Foundation (EEF)

(520) 325-8688 / www.eeftucson.org

EEF provides enhanced and enriched learning resources for TUSD students, teachers, and schools through grants, scholarships, professional development programs, and community activities. They serve 49,000 students annually and work to ensure access to educational enrichment within TUSD for low-income students.

El Rio Community Health Center

(520) 670-3909 / SOURCE: www.elrio.org/about-elrio

El Rio aims to improve the health of the community at large through providing comprehensive, affordable, compassionate, and accessible care. They provide medical care, dental care, and behavioral health, as well as offer wellness classes and education around diabetes, asthma, and hospital to home transitions. They have 14 locations around Pima County. In addition, they offer transportation free of charge to individuals within their health system that have no other resources for transportation.

Emerge! Center Against Domestic Abuse

(520) 795-8001 / www.emergecenter.org

Emerge! serves victims of domestic abuse by providing housing, crisis intervention and counseling, support, and advocacy services.

Interfaith Community Services

(520) 297-6049 / www.icstucson.org

Interfaith Community Services works to help people in financial crises stabilize their housing, healthcare, and employment, as well as assist seniors and disabled people stay safe and healthy at home. They have three Job Resource Center in Pima County that provide free services to give clients the tools to be competitive and successful in the job market. ICS also offers transportation services to program members to medical appointments, grocery shopping, and various other errands.

International Rescue Committee (IRC) Tucson

(520) 319-2128 / www.rescue.org

The IRC provides opportunities for refugees, asylees, victims of human trafficking, survivors of torture, and other immigrants to thrive in America. They work with government bodies, civil society actors, and local volunteers to help them translate their past experience into assets that are valuable to their new communities.

JobPath Inc.

(520) 324-0402 / www.jobpath.net

JobPath Inc. sponsors unemployed, underemployed community members as well as ones with criminal records in long-term, college level education and job training programs. They assist participants in achieving long-term self-sufficiency and have a significant economic impact to Pima County.

Living Streets Alliance

(520) 261-8777 / www.livingstreetsalliance.org

Living Streets Alliance's mission and vision is to transform streets into living public spaces that connect community members. They offer many programs/services related to alternative transportation, including Safe Routes to School, bike valet parking service, mobile bike repair, bike rack installation service, neighborhood walkability assessments, and family-friendly bike events.

MHC Healthcare

(520) 682-4111 / www.mhchealthcare.org

MHC Healthcare's mission is to provide compassionate, quality, and accessible whole person health care to their community. They offer medical, dental, and behavioral health services at 15 locations across Tucson, Catalina, Picture Rocks, and Marana.

Market on the Move

(623) 374-2559 / www.streamschurch.org

Market on the Move partners with food banks in Arizona with the intent of reducing food waste, and more importantly, providing life-saving produce to impoverished families.

Mrs. Green's World

(520) 230-3977 / www.mrsgreensworld.com

Mrs. Green's World is a global education platform based in Tucson that produces tangible solutions to inspire action. They strive to raise awareness about climate reality, sustainability, innovation and mindful living through their training, podcasts, media, public speaking, and events. They engage the community by discussing real issues and leveraging experts and science to get trustworthy information

NAMI Southern Arizona

520) 622-5582 / www.namisa.org

NAMI provides mental health advocacy, education, and support to community members with mental illness and their respective loved ones. They have education programs, support groups, training programs, and a "Heart to Heart" program that matches volunteers to participants to build meaningful relationships.

Old Pueblo Community Services

(520) 546-0122 / www.helptucson.org

Old Pueblo Community Services offers people facing homelessness housing, counseling, employment, and support services to help them transform their lives.

Palo Verde Behavioral Health

(520) 322-2888 / www.paloverdebh.com

Palo Verde Behavioral Health is a private psychiatric facility that offers inpatient and outpatient services for people dealing with depression, suicidal thoughts, substance abuse, and other mental health issues. They provide specialized services for adolescents, adults, LGBTQI, as well as Active Duty Military members.

Pima Council on Aging (PCOA)

(520) 790-7262 / www.pcoa.org

PCOA aims to promote dignity and respect for aging, and to advocate for independence in the lives of Pima County's older adults and their families. Over the last 50+ years they have developed an unparalleled network of programs and service partners for older adults.

Pima County Bike Buddy Program

(520) 724-2453 / <http://webcms.pima.gov/cms/One.aspx?portalId=169&pageId=54575>

The Bike Buddy program helps community members get into bicycling and make more trips by bike. They offer one-on-one support and education services by experienced bicycle instructors, as well as free gear including helmets, U-locks, and bike lights.

Pima County Health Department Health Clinics

(520) 724-7770 / <http://webcms.pima.gov/cms/One.aspx?portalId=169&pageId=31112>

The County Health Department provides a range of services at their seven clinic locations, including immunizations, family planning, STI testing/treatment, tuberculosis care, and nutritional programs. <http://webcms.pima.gov/cms/One.aspx?portalId=169&pageId=31112>

Pima County Health Department Life Point

(520) 724-3958 / <https://saaf.org/hiv-prevention-and-testing/prevention-programs>

Life Point offers syringe access at two locations: 175 W. Irvington (Monday 12:30-4:00pm) and 3550 N 1st Ave (Friday 9:00am-3:00pm)

Pima County Library Nurse Program

(520) 724-7770 / <http://webcms.pima.gov/cms/one.aspx?portalId=169&pageId=39186>

The Pima County Health Department and the Pima County Public Libraries maintain a partnership that offers patrons basic health services, education, and support. They serve parents of young children, homeless adults, those with behavioral health needs, and everyone in between. The Pima County Public Library's website has an up-to-date schedule of the nurse visits.

Pima Meals on Wheels

(520) 514-7642 / www.lss-sw.org/pima-meals-on-wheels

Pima Meals on Wheels delivers nutritious meals to homebound seniors in Pima County, as well as conducting daily health and safety checks on each recipient.

Primavera Foundation

(520) 822-5383 / www.primavera.org/what-we-do

Primavera provides pathways out of poverty through a continuum of services. These services include but are not limited to: shelters, drop-in centers, residence centers, rent and utility assistance, temporary and permanent employment, affordable housing, financial coaching, and homebuyer education classes.

Ryan White HIV/AIDS Program

(520) 626-8598 / <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/about-ryan-white-hiv-aids-program>

The Ryan White Program offers a comprehensive system of primary care and essential support services to people living with HIV that are uninsured or underinsured. Services are offered at local community health centers.

SilverSneakers Program

(866) 584-7389 / www.silversneakers.com

SilverSneakers is a free fitness program for seniors that are on Medicare that helps them to utilize local, participating gyms and also offers fitness classes for all abilities led by SilverSneakers trained instructors. There are 9 participating gyms in the Tucson area.

Sonoran Prevention Works

(520) 442-7688 / www.spwaz.org

Sonoran Prevention Works aims to assist those made vulnerable by drug use and other high-risk behaviors by educating not only them, but the community at large via community workshops, trainings, referrals, consultations and risk reduction materials. They also facilitate the largest free naloxone distribution network in Arizona.

Southern Arizona AIDS Foundation Syringe Access Program (SAP)

(520) 628-7223 / <https://saaf.org/hiv-prevention-and-testing/prevention-programs>

SAP provides information, education, and referrals on HIV/AIDS, viral Hepatitis, and other sexually transmitted infections to adults that are current or former drug users. They also run a 1 for 1 needle exchange on Monday and Wednesday evenings.

Stock Inhalers for School Program

(520) 626-9543 / <https://lungresearch.arizona.edu/stockinhaler>

The Stock Inhalers for School Program is a collaboration between the University of Arizona Asthma & Airway Disease Research Center, the Pima County Health Department, Thayer Medical Corp., and Banner University Medical Center. The program provides schools in Pima County with kits containing a medical order, albuterol medication, spacers, documentation forms, and additional resources.

St. Elizabeth's Health Center

(520) 628-7871 / www.saintehec.com

St. Elizabeth's is a faith-based health center committed to providing services to uninsured and underinsured community members. Services include medical, dental, behavioral health, nutrition counseling, child care, and a food pantry for registered patients.

Supplemental Nutrition Assistance Program (SNAP)

(855) 432-7587 / www.benefits.gov/benefit/1050

SNAP provides food benefits, access to nutritional foods, and education on food preparation and nutrition to low-income households.

University of Arizona Mobile Health Program

(520) 621-0088 or (520) 349-6594 (Cell) www.fcm.arizona.edu/outreach/mobile-health-program

The Mobile Health Program provides basic wellness and preventative care to people with acute and chronic conditions, as well as prenatal care. They serve specific areas in southern Arizona, from rural to low-income urban areas.

Ventanilla de Salud

(520) 882-5595 / <http://ventanillas.org>

Ventanilla de Salud is a program created by the Government of Mexico and implemented through 50 Mexican Consulates in the U.S., along with local health organizations. The program aims to improve the health of Mexicans living in the U.S. by increasing access to primary and preventative health insurance coverage and ensure culturally sensitive services to reduce the use of emergency services.

Victory Mobile Medical Unit

(520) 495-7888 / www.vwcaz.org

Victory Worship Center's Mobile Medical Unit aims to make a positive difference in patient's lives by providing high quality, easily accessible and free healthcare to individuals. They run the clinic on the corner of Ruthrauff and Parkway on Tuesdays and Thursdays.

Women, Infants, and Children (WIC)

(520) 724-7777 / https://webcms.pima.gov/health/preventive_health/women_infants_and_child_program

WIC provides nutrition education, screening for nutritional risks, growth monitoring, referrals to local services, and an electronic benefit card to purchase nutritional foods. They serve pregnant women, new mother up to 1-year postpartum, and children up to the age of 5.

WORKshop at Z Mansion

(520) 907-9057 / www.workshop.org

WORKshop aims to be a haven for homeless community members. They serve meals to the homeless every Sunday morning, provide a health clinic every Tuesday, Thursday, and Sunday, maintain and clothes depository, and build meaningful relationships among givers and receivers of services.

Woofs without Roofs

(520) 888-7297 / www.pawstucson.com

Woofs without Roofs is a division of the PAWS Foundation that provides veterinary services to the dogs of Tucson's homeless. They provide medical and preventative care and pet-related supplies, as well as act as a referral source for other nonprofit animal welfare organizations in Southern Arizona.

YMCA of Southern Arizona

(520) 623-5511 / www.tucsonymca.org/about

The YMCA of southern Arizona is a cause-driven organization that focuses on youth development, healthy living, and social responsibility. Their goal is to make Tucson a healthier community while building strong partnerships with local and city organizations to provide programs and services that empower, nurture, and excite.

YWCA of Southern Arizona

(520) 884-7810 / www.ywcatucson.org

The YWCA of southern Arizona's mission is to eliminate racism, empower women and promote peace, justice, freedom, and dignity for all. They promote women's wellness, support small businesses in the community, equip leaders, and advocate for change.

Appendices

Healthcare Facilities

The Internal Revenue Service requires nonprofit hospitals to include a list of community assets and resources available to address the health needs identified through the assessment process. Pima County is host to more than 2,000 licensed providers, including Federally Qualified Community Health Centers, hospitals, hospice care, urgent care facilities, assisted living facilities, ambulatory surgical centers, adult foster care, child care, and many more.

For the purposes of this assessment, we are presenting a listing of hospitals and Federally Qualified Community Health Centers, as well as public health clinics run by the Pima County Public Health Department.

Pima County Public Health Department Clinics and Services			
Abrams Public Health Center	3950 S. Country Club Road, Suite 100, Tucson, AZ 85714	Tuberculosis Screening and Testing, WIC/Food Plus, Birth and Death Records	(520) 724-7770
Ajo Office	120 Estrella, Ajo, AZ 85321	Immunizations	(520) 387-7206
Catalina Community Clinic	3535 E. Hawser Street Catalina, AZ 85739	Immunizations	(520) 825-9299
East Office	6920 E. Broadway Tucson, AZ 85710	WIC/Food Plus, Public Health Nursing, Immunizations, Family Planning	(520) 724-9660
Flowing Wells Office	4500 N. Old Romero Rd., Tucson, AZ 85705	WIC/Food Plus	(520) 293-0352
Green Valley	601 N. La Canada Green Valley, AZ 85739	Family Planning, Immunizations	(520) 825-9299
North Office	3550 N. 1st Ave. Tucson, AZ 85719	Public Health Nursing, Immunizations, Family Planning	(520) 724-2850
Teresa Lee Clinic	1493 W. Commerce Ct. Tucson, AZ 85746	HIV/STD Testing, Well Woman HealthCheck, Family Planning, Public Health Nursing, Immunizations	(520) 724-7900
Tuberculosis Clinic	2980 E. Ajo Way Tucson, AZ 85713	Tuberculosis Screening and Testing	(520) 724-8491

Federally Qualified Community Health Centers

ORTIZ COMMUNITY HEALTH CENTER	12635 W Rudasill Rd	Tucson	85743-9724	520-682-3777
ST. ELIZABETH'S HEALTH CENTER, INC.	140 W Speedway Blvd Ste 100	Tucson	85705-7687	520-628-7871
EL RIO OB/GYN ASSOCIATES	225 W Irvington Rd	Tucson	85714-3054	520-670-3909
EL RIO SANTA CRUZ NEIGHBORHOOD HEALTH CENTER, INC	839 W Congress St	Tucson	85745-2819	520-670-3909
UNITED COMMUNITY HEALTH CENTER AT SAHUARITA HEIGHTS	2875 E Sahuarita Rd	Sahuarita	85629-9434	520-407-5600
UNITED COMMUNITY HEALTH CENTER AT GREEN VALLEY HOS	4475 S I 19 Frontage Rd Ste 139	Green Valley	85614-5884	520-407-5600
KEELING HEALTH CENTER	435 E Glenn St	Tucson	85705-4664	520-616-1560
MARANA HEALTH CENTER MAIN	13395 N Marana Main St Bldg A	Marana	85653-7008	520-682-4111
DESERT SENITA COMMUNITY HEALTH CENTER	410 N Malacate St	Ajo	85321-2254	520-387-5651
EL RIO PASCUA CLINIC	7490 S Camino De Oeste	Tucson	85746-9308	520-670-3909
CLINICA DEL ALMA HEALTH CENTER	3690 S Park Ave Ste 805	Tucson	85713-5042	520-616-6760
DOVE MOUNTAIN HEALTH CENTER	5224 W Dove Centre Rd	Marana	85658-5063	520-616-1445
EL PUEBLO HEALTH CENTER	101 W Irvington Rd Ste 10	Tucson	85714-3050	520-309-3941
BIRTH & WOMEN'S HEALTH CENTER	5979 E Grant Rd Ste 107	Tucson	85712-2368	520-309-2012
FLOWING WELLS FAMILY HEALTH CENTER	1323 W Prince Rd	Tucson	85705-3114	520-887-0800
MARANA HEALTH CENTER BEHAVIORAL HEALTH SERVICES	13395 N Marana Main St	Marana	85653	520-682-1091
EL RIO SOUTHWEST HEALTH CENTER	1500 W Commerce Ct	Tucson	85746-6031	520-670-3909

Federally Qualified Community Health Centers				
EL RIO CHERRYBELL HEALTH CENTER	1230 W. Cherrybell Stravenue	Tucson	85713	520-670-3909
UNITED COMMUNITY HEALTH CENTER AT CONTINENTAL FAMILY	1260 S Campbell Ave Bldg 1	Green Valley	85614-0504	520-407-5604
UNITED COMMUNITY HEALTH CENTER AT FREEPORT MCMORAN	1260 S Campbell Ave Bldg 2	Green Valley	85614-0502	520-407-5604
UNITED COMMUNITY HEALTH CENTER AT THREE POINTS	15921 W Ajo Hwy	Tucson	85735-2032	520-407-5604
MHC PRIMARY CARE	2355 N Wyatt Dr Ste 101	Tucson	85712-2120	520-682-4560
WILMOT FAMILY HEALTH CENTER	899 N Wilmot Rd Ste B	Tucson	85711-1712	520-290-1100
SANTA CATALINA HEALTH CENTER	16701 N Oracle Rd Ste 135	Tucson	85739-9102	520-825-6763
UNITED COMMUNITY HEALTH CENTER AT ARIVACA	17388 W 3rd St	Arivaca	85601	520-407-5600
UNITED COMMUNITY HEALTH CENTER AT CONTINENTAL PEDIATRIC	1150 E Whitehouse Canyon Rd	Green Valley	85614-0560	520-399-9430
UNITED COMMUNITY HEALTH CENTER AT OLD VAIL MIDDLE	13299 E Colossal Cave Rd	Vail	85641-9001	520-407-5600
UNITED COMMUNITY HEALTH CENTER AT AMADO	28720 S Nogales Hwy	Amado	85645-9997	520-670-3909
EL RIO COMMUNITY HEALTH CENTER - SOUTHEAST	6950 E Golf Links Rd	Tucson	85730-1017	520-670-3909
FREEDOM PARK HEALTH CENTER	5000 E 29th St	Tucson	85711-6401	520-790-8500
HEALTH ON BROADWAY	1 W Broadway Blvd	Tucson	85701-3029	520-670-3909
MARANA HEALTH CENTER OB/GYN	2055 W Hospital Dr Ste 115	Tucson	85704-7823	520-797-0011
ELLIE TOWNE HEALTH CENTER	1670 W Ruthrauff Rd	Tucson	85705-1253	520-797-0011

Hospitals				
CURAHEALTH TUCSON	355 N Wilmot Rd	Tucson	85711-2601	520-584-4500
SONORA BEHAVIORAL HEALTH HOSPITAL	6050 N Corona Rd	Tucson	85704-1096	520-469-8700
ARIZONA STATE ELKS ASSN HOSP	1901 E Speedway Blvd	Tucson	85719-4630	
US AIR FORCE HOSP	S Craycroft Rd	Tucson	85707	520-111-1111
VA HOSP SOUTHERN ARIZONA HEALTHCARE SYSTEM	3601 S 6th Ave	Tucson	85723-0001	520-792-1450
BANNER-UNIVERSITY MEDICAL CENTER SOUTH CAMPUS	2800 E Ajo Way	Tucson	85713-6204	520-874-2000
BANNER-UNIVERSITY MEDICAL CENTER TUCSON CAMPUS	1501 N Campbell Ave	Tucson	85724-0001	520-874-4189
GREEN VALLEY HOSPITAL	4455 S I 19 Frontage Rd	Green Valley	85614-5884	520-393-4710
ORO VALLEY HOSPITAL	1551 E Tangerine Rd	Oro Valley	85755-6213	520-901-3549
ST. MARY'S HOSPITAL	1601 W Saint Marys Rd	Tucson	85745-2623	520-872-3000
TUCSON MEDICAL CENTER	5301 E Grant Rd	Tucson	85712-2805	520-327-5461
SELLS HOSPITAL	AZ-86	Sells	85634	520-362-7003
NORTHWEST MEDICAL CENTER	6200 N La Cholla Blvd	Tucson	85741-3529	520-469-8100
ST JOSEPH'S HOSPITAL	350 N Wilmot Rd	Tucson	85711-2602	520-873-3000
CHG HOSPITAL TUCSON, LLC	7220 E Rosewood St	Tucson	85710-1350	469-621-6700
UNIVERSITY STUDENT HLTH UNIT	3rd Cherry Sts	Tucson	85721-0001	
CORNERSTONE BEHAVIORAL HEALTH EL DORADO	1400 N Wilmot Rd	Tucson	85712-4498	520-222-8268
PALO VERDE BEHAVIORAL HEALTH	2695 N Craycroft Rd	Tucson	85712-2243	520-322-2888
ENCOMPASS HEALTH REHABILITATION INSTITUTE OF TUCSON	2650 N Wyatt Dr	Tucson	85712-6106	520-325-1300
ENCOMPASS HEALTH REHAB HOSP OF NORTHWEST TUCSON	1921 W Hospital Dr	Tucson	85704-7806	520-742-2800

Key Informant Interview Guide

Key informant (KI) interviews will take place face-to-face, by phone, or (less preferred) through a written, open-ended questionnaire. If conducted verbally, the interviewer will introduce herself and explain the purpose of the assessment, allowing time to address any questions or concerns.

All KIs will be asked eleven (11) questions. Seven (7) questions are universal, for all KI participants (Q1-Q5 and Q9-Q10). Questions six (6) through eight (8) have been tailored for specific respondents and will vary depending on the KI. For example, if the KI is a community outreach worker, she or he will be asked questions 1-5 (all), followed by questions 6-8 (outreach workers), and finally questions 9-10 (all) for a total of ten questions.

FRAMING STATEMENT “when we say **Pima County we are talking about the whole community urban and rural, incorporated and non-incorporated, and health services are care, support and education related to health issues.**”

To meet federal guidelines the following information will be collected from each Key Informant:

- Name
- Title
- Affiliation
- Population(s) represented: [1] Medically underserved persons; [2] Low-income persons; [3] minority populations; [4] populations with chronic diseases
- Brief Description of Interviewee’s Specialized Knowledge, Expertise, and Representative Role
- Classification(s): [1] Health Expert; [2] Community Leader; [3] Other
- Other characteristics of Interviewees: [1] Federal Health Department representative; [2] Tribal Health Department representative; [3] State Health Department representative; [4] County Health Department representative; [5] Healthcare consumer advocate; [6] Nonprofit organization; [7] Academic expert; [8] Local government official; [9] Community-based organization; [10] Healthcare provider; [11] Private business; [12] Health insurance or managed care organization.



TARGET	QUESTION(S) and PROMPT(S)	ORIGIN
General / all	1. How do you define health?	CHNA Advisory Team; 2015 CHNA
	2. What are the most important issues (health or otherwise) in Pima County? – 2a: Who is most affected by these? – 2b: What services are in place to address these issues? – 2c: Do people utilize these services? Why or why not?	Kaiser Permanente; 2015 CHNA; modified for 2018
	3. What are the three most serious health and well-being issues in Pima County? – 3a: Who is most affected by these? – 3b: What resources are in place to address these issues? – 3c: Do people take advantage of these services? Why or why not?	2012 and 2015 Pima County Health Assessment
	4. What types of programs exist in Pima County to promote... ...physical health or exercise? ...mental health or psychosocial wellbeing? ...health for specific populations (infants, youth, seniors, minority populations, etc.) <i>Prompts: Can you name some programs or initiatives? Do you believe people adequately utilize these programs? Why or why not?</i>	2015 CHNA; new
	5. What services are needed in the community? Who most needs them?	Kaiser Permanente; 2015 CHNA
Health care professionals	6. What is the primary population you serve? <i>Prompts: What are some of the main health challenges? What are people doing to promote their health?</i>	2015 CHNA
	7. Are able to meet the needs of your clients? – 7a: What resources do you rely on to be able to meet these needs? What are some challenges?	Based on 2012 Pima County Health Assessment; 2015 CHNA
	8. What needs of county residents that are not being addressed? What are the biggest barriers to meeting those needs?	New

TARGET	QUESTION(S) and PROMPT(S)	ORIGIN
Health Department (e.g. IHS, TON)	6. What are the assets of the community you serve? Challenges?	Kaiser Permanente
	7. Where do people go when they need health services? – 7a: How has the PP-ACA affected health related decision making in this community?	Community Tool Box; 2015 CHNA
	8. Are primary health services for the clients you serve adequate and accessible? – 8a: (If inadequate / inaccessible) How could these be improved?	2012 and 2015 Pima County Health Assessment
Environmental / Occupational Health Workers	6. How does your work improve people’s health / wellbeing? <i>Prompts: Who is your target population? What are their health concerns? How many people access / benefit from programs?</i>	2015 CHNA
	7. What are some of the challenges you face in your work?	2015 CHNA
	8. What are the resources that you rely on for programs?	2015 CHNA
Outreach Workers (e.g. Promotores)	6. What are some of your community’s assets/strengths? Challenges?	Kaiser Permanente; 2015 CHNA
	7. Where do people in your community go when they need health INFORMATION? – 7a: How has the PP-ACA affected health related decision making in this community?	Community Tool Box; 2015 CHNA
	8. What are challenges in your agency’s day-to-day work? What resources do you rely on?	2015 CHNA
Nonprofit/ Social Service (specific populations)	6. What are some of the assets or strengths of the population you serve? Challenges?	Kaiser Permanente; 2015 CHNA
	7. Where do people in your community go when they need health SERVICES? – 7a: How has the PP-ACA affected health related decision making in this community?	Community Tool Box; 2015 CHNA
	8. What are challenges in your AGENCIES day-to-day work? What resources do you rely on?	2015 CHNA
General / all	9. Are there any new and promising programs/initiatives within this community to support <i>low income and/or minority populations and others with limited access</i> that the CHNA team should be aware of?	New
	10. What advice do you have for a group developing a community health improvement plan to address these needs?	

Focus Group Guide

The purpose of focus group discussions (FGDs) is identify a “norm” or average that respondents center toward with regards to attitudes, beliefs, practices / behavior. They can also be used to validate and/or challenge what has been published in prior assessments and/or stated by key informants. To get the best results during these discussions, the following should apply:

- FGDs should be advertised through a trusted community leader, representative, or body;
- **Focus groups should be between 6 and 10 people, with no more than 12 participants;**
- Participants should have similar characteristics, for example:
 - Same type of work (e.g. Promotores, community health workers)
 - Similar “call to action” (e.g. parents of children in a particular school district or diocese; patients / people affected by the same illness)
 - Similar demographic characteristics (e.g. a discussion focused on elderly or members of the LGBT community or caregivers, etc. should have only participants representing said group)
- Discussions should be held at a convenient time in a neutral, easily accessible place.
 - Is the group being scheduled at a time and place that members of x community will be able to attend?
 - Are there supports in place to offset potential barriers (e.g. a child caregiver to watch children, reimbursement for transportation and/or easy parking)
 - Is the group taking place somewhere where participants will be comfortable speaking? (E.g. If you are asking parents of high school students their perceptions of efforts of the school administration, holding a focus group at a school building may make some participants uncomfortable and unwilling to speak freely.);
- The FGD should be run by an experienced facilitator. One to two recorders (people) should be present to observe not only what is stated, but how statements are made, paying specific attention to tone of voice, body language, etc. of participants. All of this should be recorded with the notes. (There are several pros and cons to using audio recording during FGDs: pros- able to capture what people state verbatim, less stress on recorders / note-takers; cons – participants may feel uneasy and less likely to speak freely, burdensome and difficult transcriptions with more than one voice. If audio recorders are not used, every effort should be made by note-takers / recorders to capture quotes);
- Participants should not have access to questions ahead of time. The list of questions should be brief and open-ended;
- Notes should be made available to participants in real-time to facilitate discussions / ideas (use a whiteboard, flipchart, etc.).

1) Sign-In and Introduction (~10 minutes)

- Participants should sign-in prior to sitting down to start the focus groups. Names and phone numbers and/or emails should be collected in case follow-up is needed. (See appendix I: FGD Sign-In Sheet)
- The **facilitator** will briefly introduce herself / himself, the purpose of the FGD, and why participants have been chosen.

Sample Introduction

Hello. My name is _____, and I am helping with a county-wide collaboration to assess the health and wellbeing of Pima County residents. You have been asked to participate in this discussion because your knowledge of _____ (e.g. community health outreach work) will help us better understand what works for your community as well as what challenges you face as a community. We are very grateful for your taking the time to speak with us so we can learn from you.

Thank you.

- Spend some time reviewing what you can and cannot do as a result of these groups so that you do not raise expectations. Review how their confidentiality will be kept. (E.g. No names associated with notes, unique ID number, etc.)
- After stating the purpose of the FGDs, the facilitator will introduce any assistants (recorders), and ask the participants to introduce themselves. A brief ice-breaker – especially if incorporated into introductions – may help people feel at ease.

2) Rapport-Building (~5-10 minutes)

This is to start to get participants used to the idea of answering and discussing questions in a group setting. Questions should be lighthearted and easy to answer. These can be about phone service providers, what people did over the weekend, current events, etc. (Essentially, whatever is most salient to specific participant group.)

3) In-Depth Discussion (~45-60 minutes)

What is your vision of a healthy community? [National Center for Rural Health Works]

This can be initially vague to get at a broader concept of “health” and wellbeing, but should eventually be specific and focused on the following two questions:

- What is healthy about / in your community? [If health providers, change this to “What is healthy about / in the community you serve?”]
- What is unhealthy about / in your community? [If health providers, change this to “What is unhealthy about / in the community you serve?”]

What are the most important health issues in your community? [New]

- What are some struggles people have staying healthy?
- What are challenges to eating well? Exercising? [Include whatever important health topics were mentioned]
- To ascertain community assets / strengths: What recommendations would you give to people to eat well / exercise / stay healthy [or insert other behavior] in this community?

Where do people in your community go when they need routine health care? [From KI Interview Guide]

- What if they had an emergency? [New – based on key informant interviews with police and fire department]
 - Are services easy to get to?
 - How do you / people in your community pay for services?
 - What effect has the PP-ACA had on people in terms of their health issues?
- **What is the quality of programs to improve health and wellbeing in your community?** [Adapted from Anne Arundel County, Maryland, Community Health Needs Assessment, 2012]
- What programs are available? Can you give us examples?
- Why or why not are programs successful?
 - What are they doing well?
 - What can they do to improve services?

4) Closure (~10 minutes)

Ask participants if there is anything they would like to add or any questions they have. Restate the value of their contribution and thank them. Tell participants how they can get in touch with someone if they have any questions about the Pima County CHNA.



Community Survey (English)

Pima County Community Health Needs Assessment 2018

Introduction

The 2018 Pima County Community Health Needs Assessment (CHNA) is a county-wide collaboration to assess the health and well-being of Pima County residents.

As a community stakeholder, we invite you to participate in this survey to help us better understand what works for your community as well as what challenges the community faces.

This survey consists of 10 questions and should take no longer than 5 minutes. We are very grateful for your time and thoughtful responses.

Health Issues in Pima County

For the purposes of the CHNA, the “community” includes the whole of Pima County: urban, rural, incorporated, non-incorporated. However, you may respond on behalf of a particular population or area that you serve.

Health services include direct healthcare, but also support or education related to health issues.

- 1. Please briefly describe the most important health issues in Pima County.**
- 2. What is the single most important issue you are concerned with?**
- 3. Who is most affected by this health issue? Why?**
- 4. What resources, services, or policy changes are needed to address this issue?**

Strengths and Assets of the Community

Community assets may include:

- Individual people and their characteristics, such as within the population you serve
- Specific organizations, programs, or services available
- Built or natural aspects of the community

- 5. What is healthy about the community? What are its strengths?**
- 6. Please name any new, innovative, or promising initiatives you would like the CHNA to know about.**

Final Thoughts

Please share any recommendations to the 2018 Pima County CHNA, which may include:

- Data sources that should be assessed
- Individuals that should be consulted
- Social Determinants that should be addressed
- Critical health issues that are not currently being addressed in the community

7. Please share your advice or recommendations for the 2018 Pima County CHNA.

Supplemental Information

8. Please describe the population that you represent or serve. Check all that apply.

- Medically underserved persons
- Low income persons
- Minority populations
- Populations with chronic diseases

9. Which sector do you represent? Check all that apply.

- County Health Department
- Tribal Health Department
- Nonprofit Organization
- Academic Expert
- Other (please specify):
- Healthcare Provider
- Private Business
- Health Plan / Insurer
- Government Official

10. Name, Title, Affiliation (optional):

This information will be used to assess participation composition and will not be linked to survey responses overall.



Community Survey (Spanish)

Evaluación de Necesidades de Salud Comunitaria del Condado Pima 2018

Introducción

La Evaluación de Necesidades de Salud Comunitaria del Condado Pima 2018 (“CHNA” por sus siglas en inglés) es una colaboración por todo el condado para evaluar la salud y bien estar de los residentes del condado Pima.

Como parte interesada en la comunidad, usted está invitado/a a participar en esta encuesta para ayudarnos a entender mejor tanto las cosas que funcionan en su comunidad como los retos que existen.

Esta encuesta consiste de diez preguntas y no llevará más de cinco minutos en contestar. Agradecemos su tiempo y sus respuestas valiosas.

Problemas de Salud en la Comunidad

Para los fines de esta encuesta, “comunidad” incluye el Condado Pima en su totalidad: urbano, rural, incorporado, no-incorporado. Sin embargo, puede responder en representación de una población o área específica en la cual presta servicios.

Los servicios de salud incluyen tanto el cuidado médico directo como el apoyo y educación relacionado con problemas de salud.

1. Por favor describa brevemente los problemas de salud más importantes en el Condado Pima.
2. ¿Cuál es el problema que más le interesa a usted?
3. ¿Quiénes son los más afectados por este problema? ¿Porque?
4. ¿Cuáles recursos, servicios o cambios de póliza se necesitan para resolver este problema?

Fortalezas y Recursos de la Comunidad

Los recursos comunitarios pueden incluir:

- Individuos y sus características, por ejemplo, dentro de la población en la cual presta servicios
- Organizaciones, programas o servicios disponibles en la comunidad
- Aspectos contruidos o naturales de la comunidad

5. ¿Cuáles aspectos de la comunidad son saludables? ¿Cuáles son las fortalezas?

6. Favor de nombrar alguna iniciativa nueva, innovadora o prometedor que quisiera compartir con la CHNA.

Pensamientos Finales

Favor de compartir con la CHNA del Condado Pima 2018 algunas recomendaciones, las cuales pueden incluir:

- Fuentes de datos que deben ser evaluadas
- Personas que deben ser consultados/as
- Determinantes sociales que deben ser tratados
- Temas importantes de salud que actualmente no se están tratando

7. Please share your advice or recommendations for the 2018 Pima County CHNA.

Información Adicional

8. Favor de describir la población que usted representa o a la cual presta servicios. Marque todas las opciones que apliquen:

- Poblaciones que sufren de escasez de servicios médicos
- Personas de bajos recursos
- Poblaciones minoritarias
- Personas con enfermedades crónicas

9. ¿Cuál sector representa usted? Marque todas las opciones que apliquen.

- Departamento de Salud Municipal
- Proveedor de Cuidado Médico
- Departamento de Salud Tribal
- Empresa Privada
- Organización Sin Fines de Lucro
- Plan Médico, Aseguradora
- Experto Académico
- Oficial Gubernamental
- Otro (favor de especificar):

10. Nombre, Título, Afiliación (opcional)

Esta información será utilizada para asesorar la composición de los participantes, y no será vinculada a las respuestas de la encuesta en general.

Community Forum #2

Ranking of Needs

5 Concerns/ Health Needs from Primary Data

- 1) Behavioral Health (mental illness, substance abuse)
- 2) Chronic Disease (obesity, childhood obesity, diabetes)
- 3) Access to Services
- 4) Built / Natural Environment
- 5) Coordination / Continuity of Care & Services

Top 3 Proposed Solutions / Needed Actions Identified for Each Concern w/ Final Ranking

1) Behavioral Health

#1) School counselors with specialized training (31)

- #2) Lack of licensed providers who accept insurance and who accept uninsured (6)
- #3) Access to affordable behavioral health services (20)
- #4) Integration of care (advancing it to criminal justice and school systems) (10)

2) Chronic Disease

- #1) Integration of Care (inter-intra organization) (21)

#2) Access to healthy foods and food literacy (31)

#3) Culturally competent (tailored) education, e.g. ethnicity, age, language (31)

3) Access to Services

#1) Resource Matrix (integration and coordination of care) (29)

#2) Comprehensive approach to reaching services (mobile clinics, transportation, telemedicine) (33)

- #3) PWLE (persons with lived experience) informed care (person/client led) (18)

4) Built / Natural Environment

- #1) Safe walking/biking spaces with lighting (18)

- #2) Affordable safe housing with clean water and environmental controls (26)

- #3) Protection (18)

5) Coordination / Continuity of Care/Services

- #1) Re-entry into healthcare system and coordination for care for incarcerated (15)
- #2) Transition of care for elderly from hospital to home care to decrease adverse events in home (18)
- #3) Advocates / Navigators for elderly, e.g. health literacy, legal aide, resources (26)

PARKING LOT

- Tobacco use prevention and easy access to tobacco use cessation, including e-products (integrated care/education) (7)
- **Safe spaces for marginalized population, e.g. people using drugs, LGBTQ, homeless; connected to resources (if desired) (28)**
- Community wide neighborhood-based disaster preparedness education for 'sheltering in place', focus on power outages, extreme heat (22)

Consulting Team

Emily Coyle, MPH

Emily is co-founder of Coyle & Gall, LLC, a public health consulting firm. Emily has been working with Southern Arizona health systems since 2011 to fulfill the IRS' requirements for nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA). Emily received her Master of Public Health degree from the University of Arizona in 2013 and is currently pursuing a PhD in Public Health at the University of Montana.

Rebecca Drummond, MA

Rebecca spent 15 years at the University of Arizona College of Public Health, primarily focused on community-based research and program evaluation, as well as state advocacy with the Arizona Public Health Association and the Arizona School Based Healthcare Council. Her interests and expertise are in school health, rural health, U.S.-Mexico border health, and American Indian health. Rebecca is an independent consultant having started Drummond Consulting, LLC in 2015. She currently provides project leadership, evaluation, and technical assistance to community partners in Pima County, Santa Cruz County, and the Tohono O'odham Nation.

Keely Breedlove, BS (2019)

Keely is a current undergraduate student at the University of Arizona. She is interested in the connection between status and health and hopes to partake in quality improvement within the industry in her future career. In the past, Keely has worked for the American Red Cross, the International Rescue Committee, and the City of Tucson in health and wellness related roles. Keely was an intern at the Tucson Medical Center and contributed greatly to the CHNA.

