PIMA COUNTY

Community Health Improvement Plan

2022-2024

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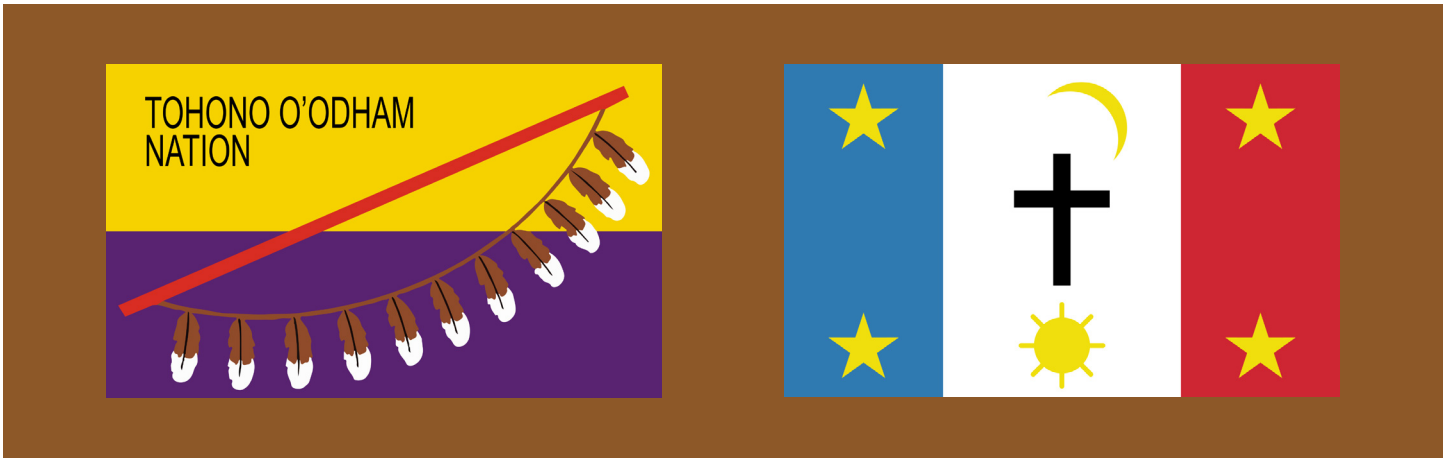

On behalf of Pima County residents, we honor the tribal nations who have served as caretakers of this land from time immemorial and respectfully acknowledge the ancestral homelands of the Tohono O'odham Nation and the multi-millennial presence of the Pascua Yaqui tribe within Pima County. Consistent with Pima County's commitment to diversity and inclusion, we strive toward building equal-partner relationships with Arizona's tribal nations.

healthy Pima

Healthy Now, Wellness for Generations to Come

This plan was published in February 2023 by the Pima County Health Department on behalf of Healthy Pima.

Visit **healthypima.com** or email **healthypima@pima.gov** to learn more.

TABLE OF CONTENTS


A
TO
Z


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SHOT
Protect

COMMITMENT TO IMPROVING COMMUNITY HEALTH

Dr. Theresa Cullen
Pima County Health Director

Dear Members of Healthy Pima and Pima County community residents and partners,

The Pima County Health Department is pleased to share the 2022-2024 Community Health Improvement Plan (CHIP) that will guide our collective efforts to improve health outcomes and advance health equity within the County. The CHIP builds upon community collaboration and ongoing engagement undertaken through the Community Health Needs Assessment process, which resulted in the identification of key health priorities in Pima County. Extensive community engagement and collaboration across agencies and sectors have informed the CHIP and the planned public health actions needed to improve health outcomes in our community.

In December 2020, the Pima County Health Department joined forces with community partners to begin the process of developing Pima County's 2021 Community Health Needs Assessment (CHNA). The process included forming an advisory committee to guide the process across our public health system and sector partnerships and contracting with the University of Arizona, Arizona Prevention Research Center to conduct primary and secondary data collection. Despite the barriers created by the COVID-19 pandemic, the CHNA was able to use key informant and focus group interviews, community forums, and a community gallery walk to gather primary data and gain insight into how the community views the health priorities for Pima County residents and inform strategies for improving their health.

Just as the CHNA is a powerful tool for synthesizing health status data in Pima County, the CHIP gives the community the opportunity to provide direction on how to best address the health priorities identified in the CHNA.

I want to thank our Healthy Pima community partners, community coalitions, and task forces for the time and effort, and moreover their commitment that has gone into creating action plans for the key priority areas that make up the CHIP. I also want to thank them for their willingness to continue to bring these action plans to fruition as we move beyond this planning stage. Collective efforts and strong collaboration will be key to our success as we work toward making Pima County one of the healthiest counties in the nation.

Sincerely,

Dr. Theresa Cullen, MD, MS
Pima County Health Director

ACKNOWLEDGEMENTS

Healthy Pima would like to thank and recognize all the community partners who supported and contributed time and expertise to Pima County's 2021 CHNA and the 2022-2024 CHIP. Healthy Pima would especially like to acknowledge Julie Mack with Arizona Complete Health and Alex Fernandez with CODAC, the action group leads, who guided and co-facilitated development of the community action plans within this document.

- Acadia Healthcare
- Activate Tucson
- American Foundation for Suicide Prevention
- University of Arizona Mel and Enid Zuckerman College of Public Health, Center for Rural Health
- Arizona College of Nursing
- Arizona Complete Health
- Arizona Complete Health -CCP
- Arizona Department of Health Services
- Arizona Department of Health Services, Suicide Prevention
- Banner Health
- Banner University Medical Center
- Beyond Foundation
- Carondelet St. Joseph's Hospital
- CBI, Community Bridges
- Cenpatico Integrated Care
- Child and Family Resources
- Child-Parent Centers Head Start/Early Head Start
- City of Tucson - Community Safety Health & Wellness
- City of Tucson - Department of Transportation Planning Team
- Coalition for African-American Health and Wellness
- CODAC 380
- CODAC Health, Recovery, and Wellness
- Community Food Bank of Southern Arizona
- Dean of Nursing Arizona College
- Desert Senita Health Center
- El Rio Health
- Enlightening Hope Project
- Etano Center
- Intermountain Centers
- La Frontera
- La Frontera – RAPP Street Outreach
- Literacy Connects
- Marana Health Care
- Northwest Healthcare
- Northwest Medical Center
- Oro Valley Hospital
- Oxford House
- Palo Verde Behavioral Health
- Palo Verde Hospital
- Pascua Yaqui Tribe Health Services Division
- Pascua Yaqui Tribe, We Embrace Life Suicide Prevention Team
- Pathways of Arizona
- Pima Association of Governments
- Pima Council on Aging
- Pima County, District 1
- Pima County Health Department
- Pima County Health Department, Community Mental Health and Addiction Team
- Pima County Health Department Community Advisory Committee
- Pima County Sheriff's Department
- Santa Cruz Valley Regional Hospital
- Solari Inc. (2-1-1 Arizona)
- Southern Arizona Aids Foundation
- Southern Arizona VA Healthcare System
- Teen Lifelines
- Tenet Healthcare
- The Haven
- The Primavera Foundation
- TMC HealthCare
- Tohono O'odham Nation Health Care
- Tucson Indian Center
- Tucson Medical Center
- Tucson Pima Collaboration to End Homelessness
- Tucson Police Department
- Tucson VA Medical Center
- United Community Health Center
- United Way
- University Medical Center
- University of Arizona - Campus Health
- University of Arizona - College of Medicine - American Indian Research Center for Health
- University of Arizona- College of Nursing
- University of Arizona - Counseling and Psychological Services
- University of Arizona - Dean of Students Office
- University of Arizona - Employee Health and Wellness
- University of Arizona - Life and Work Connections
- University of Arizona - REACH
- University of Arizona - SIROW
- University of Arizona - University Marketing and Communications
- University of Arizona - College of Public Health's Zuckerman Family Center for Prevention and Health Promotion
- University of Arizona Mel and Enid Zuckerman College of Public Health Arizona Prevention Research Center
- University of Arizona Mel and Enid Zuckerman College of Public Health, Center for Rural Health University of Arizona - Health Sciences

EXECUTIVE SUMMARY

Healthy Pima is Pima County's community health improvement planning initiative that is championed by the Pima County Health Department (PCHD), in partnership with community partners. The mission of Healthy Pima is to work together to build a culture of health in Pima County for Everyone, Everywhere, Every Day. Since 2010, Healthy Pima has guided local public health efforts to improve the overall health of Pima County residents in collaboration with local hospitals, community health centers, tribal health departments, and community-based organizations to develop the Community Health Needs Assessment. Healthy Pima also convenes and collaborates with Healthy Pima members, community coalition groups, and community members to develop the Community Health Improvement Plan in response to the key health priorities identified for the County.

The 2022-2024 Pima County Community Health Improvement Plan (CHIP) was developed in response to four key health priorities identified by the Pima County community in the 2021 Community Health Needs Assessment (CHNA). The identified priorities include:

- Substance Use Disorder
- Mental and Behavioral Health
- Access to Care
- Social Determinants of Health (particularly poverty, transportation, and the built environment).

To develop the CHIP, Healthy Pima partnered with existing community coalitions and groups already working to address two of the key priority areas – Substance Use Disorder and Mental & Behavioral Health. During a six-month issue identification and action planning period, these community-led workgroups met regularly to define the priority areas. Action plans were then developed, which included goals, objectives, strategies, and activities, as well as baseline measures. Drawing upon evidenced-based and promising practice, the CHIP action plans will be used to guide community implementation and track progress in addressing the identified health priorities.

In August 2022, PCHD, in partnership with Healthy Pima, convened community partners to share the 2021 CHNA results. It was also an opportunity to engage and invite interested stakeholders to join the Healthy Pima Steering Committee, the Community Health Action Task Force, and/or current and future workgroups. As Healthy Pima membership grows over time, the current action plans will be monitored and augmented, and new actions added, to ensure that the emerging needs of the community are met. These changes will be reflected in CHIP addendums that will describe the progress made each year.

Next steps for the CHIP include forming two additional coalitions that will lead development of the action plans for Access to Care and Social Determinants of Health priorities as the Substance Use Disorder and Mental & Behavioral Health workgroups carry out action plans to reach their goals. The target to begin implementation of current action plans is early calendar year 2023. Progress will be reported on a regular basis to the Healthy Pima Steering Committee. As actions are accomplished and new ones emerge, the CHIP and action plans will be updated and modified to reflect new information and changing community needs.

WHAT IS A CHIP

Healthy communities are created through the cross-cutting efforts of community members, local organizations, and state, city, county, and tribal governing bodies. One way to work toward creating a healthy community and addressing public health issues is through a Community Health Improvement Plan (CHIP). A CHIP is a long-term, systematic effort that is part of a community health improvement process that begins with a community health needs assessment (CHNA). The CHNA serves as a starting point in the community engagement process where community members use data to identify key health needs and issues. While the outcomes of the CHNA and CHIP may be different, they both involve engaging community members to improve the health of residents.

The distinguishing factor of a CHIP versus other health planning efforts is that it places greater emphasis on collaborative participation and community engagement across the community. To create the CHIP, community input is used to develop overarching goals, specific objectives, and evidence-informed strategies as part of a plan oriented toward action. This plan provides community members, leaders, health officials, organizations, governing bodies, health care partners, foundations, representatives of distinct populations, schools, and coalitions a way to come together to strategize to improve health outcomes. By having the community take ownership of the CHIP, resources can be used strategically and more effective strategies can be designed to improve community health. By involving the community in the planning, implementation and monitoring process, there is also increased buy-in and support from the community to ensure successful implementation.

Successful CHIPs have addressed infant mortality, chronic disease, substance abuse, and many other health issues. As a result of the planning process, health departments are able to broaden their reach, and avoid inward-looking approaches by considering different perspectives and experiences. By developing strategies that address prioritized health needs in collaboration with community, improvements in health outcomes are possible.

Completing the CHNA and CHIP fulfills nationally mandated requirements that public health departments must meet and for-profit hospitals are required to do as part of federal funding regulation. A well-developed CHIP can also help define and communicate community priorities and opportunities for community collaboration. Finally, the CHIP is useful when articulating community health priorities to funders, potentially resulting in increased community resources aimed at improving health.

INTRODUCTION

Pima County Snapshot

The following are highlights from the 2021 Pima County Community Health Needs Assessment developed by the University of Arizona, College of Public Health, Arizona Prevention Research Center (AzPRC) through an independent consultancy, and guided by the Pima County's Community Health Needs Assessment Steering Committee. The following data provides a snapshot of the demographics and other relevant health and social descriptive statistics for Pima County. All data sources can be found in the references section.

Geography

According to the AzPRC (2021), Pima County, one of the most southern counties in Arizona, shares an international border, and contains lands that are part of the Tohono O'odham and Pascua Yaqui Tribes. Pima County is comprised of mountain ranges, river valleys, and is part of the Sonoran Desert (AzPRC, 2021).

As the second-most populated county in Arizona, after Maricopa (containing the city of Phoenix), Pima County covers an area of 9,184 square miles. It is comprised of two Tribal Nations (mentioned above), one large unincorporated area, and five incorporated jurisdictions — the city of South Tucson, the city of Tucson, and the towns of Marana, Oro Valley, and Sahuarita (AzPRC, 2021).

Population Density

According to the 2019 Census, as cited in AzPRC (2021), the population is 1,047,279, reflecting a population increase of 6.8% since 2010. The most populated areas reside mainly in the eastern part of the county and include the cities of Tucson and South Tucson, and the towns of Marana, Oro Valley, and Sahuarita. Approximately 34% of Pima County residents live in rural areas (AzPRC, 2021).

Rural populations are at higher risk for factors such as geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, higher rates of chronic illness, and poor overall health compared to urban populations (Food Access Research Atlas, as cited in AzPRC, 2021). Populations in rural areas have historically lacked accessible health care options due to location, affordability, and transportation issues (AzPRC, 2021).

Demographics

Age, Sex, and Race Distribution

Pima County has an older population than the average state population, as well as a larger Hispanic/Latinx population (AzPRC, 2021).

Educational Attainment

The 2019 Census, as cited in AzPRC (2021), shows that nearly nine out of ten people (88%) in Pima County have a high school degree or higher. Pima County has a higher educational attainment than Arizona in general (AzPRC, 2021).

Median Income, Poverty, and Unemployment

According to the AzPRC (2021), Pima County has fewer children and adults living below the Federal Poverty Level (FPL), yet has a higher unemployment rate than the state average. According to the AzPRC, the unemployment rate dropped from 13.9% to 6.6% between April 2020 and April 2021. These rates were higher than normal due to the COVID-19 pandemic. In 2018, the median household income was approximately $56,000, which is lower than the state average of $62,000 (AzPRC, 2021).

Percent of Population without Health Insurance

One in 10 residents (10.3%) in Pima County do not have health insurance (County Health Rankings

and Roadmaps, 2021, as cited in AzPRC, 2021). Most people without insurance are adults 19-55 years old, with low-income households more likely to be uninsured (AzPRC, 2021).

Dental Care Access and Oral Health

In 2020, about half (51.1%) of all adults in Pima County reported that they had visited a dentist or dental clinic for any reason in the past year (Pima Health Data Portal, 2021, as cited in AzPRC, 2021).

Migrants, Languages, and Undocumented Residents

In Pima County, 28.2% of the population speak a language other than English in the home, 30.1% of whom speak English less than "very well" (County Health Rankings and Roadmaps, as cited in AzPRC, 2021). As of 2019, there are approximately 35,000 undocumented residents in Pima County (AzPRC, 2021). Over half (59%) of these residents are uninsured (Kaur, 2017, as cited in AzPRC, 2021).

Veterans

The 2019 Census, as cited in AzPRC (2021) documents that nearly one out of ten (9.6%) people in Pima County are identified as veterans, or as persons who served in the active military, naval, or air service, and were discharged or released under conditions other than dishonorable (U.S. Department of Veteran Affairs, 2019, as cited in AzPRC, 2021). Over a third of veterans (31.3%) in Pima County report having a disability, and 6.3% live below the poverty level (University of Wisconsin Population Health Institute, 2021, as cited in AzPRC, 2021). While Veterans have access to some benefits, including health care and educational stipends, they are not guaranteed other services, like dental insurance, and are more likely than the general population to live with a disability (AzPRC, 2021).

Persons with Disabilities

According to the 2019 Census, as cited by the AzPRC (2021), more than one out of ten people in Pima County live with a disability (15.5% including seniors, and 10.5% excluding anyone over the age of 65). In general, people with disabilities face greater barriers to access health and social services in public spaces, due to a lack of planning for accommodations in built and social environments (AzPRC, 2021).

LGBTQ+ Health

From research conducted by the AzPRC for the 2021 CHNA, key informants, focus groups, community members, and service providers expressed concern about the existing health disparities among LGBTQ+ residents. The AzPRC also found that LGBTQ+ residents experienced increased barriers to care and face discrimination in the community and in their experience with health providers. During data collection, the AzPRC discovered there is a lack of health data about LGBTQ+ identifying populations, indicating a reason as to why structural discrimination within health care might exist. As participants mentioned in interviews and focus groups, without secondary data collection and reporting, health care providers may receive little training or information around gender and sexual identities and how to care for these vulnerable populations. Stigma and discrimination affect quality of care, quality of life within a community, and are influential to a person's overall health and willingness to seek care (AzPRC, 2021).

General Health Status

Leading Causes of Death

In 2019, the top five leading causes of deaths in Pima County were cancer, heart disease, accidents (unintentional injuries), chronic lower respiratory diseases, and cerebrovascular diseases (AzPRC, 2021). In both 2019 and 2020, drug overdose was the leading cause of accidental deaths, followed by blunt force, and motor vehicle crashes (AzPRC, 2021).

Life Expectancy and Premature Death

In 2019, the life expectancy in Pima County was 79.5 years old. Life expectancy is 80 years old in Arizona overall (DE Martinez, 2021, as cited in AzPRC, 2021). The average age adjusted premature mortality rate (number of deaths among residents under age 75 per 100,000 population) from 2017-2019 was 350 in Pima County, compared to 330 in Arizona and 280 among the 90th percentile of U.S. counties (AzPRC, 2021). This rate is notably higher among non-Hispanic/Latinx Black/African American and Native American populations and notably lower among Asians compared to non-Hispanic/Latinx and White populations in Pima County (DE Martinez, 2021, as cited in AzPRC, 2021). Years of Potential Life Lost (YPLL) before age 75 per 100,000 population (age-adjusted) in 2018 was 7,533 in Pima County, compared to 7,120 in Arizona and 6,907 in the USA overall (AzPRC, 2021).

Quality of Life

In 2018, Pima County residents reported an average of 4.3 physically unhealthy and 4.5 mentally unhealthy days per month (AzPRC, 2021). The 90th percentile of all U.S. counties averaged 3.4 and 3.8 physically and mentally unhealthy days, respectively (DE Martinez, 2021, as cited in AzPRC, 2021).

Racial and Ethnic Health Inequities and Income Inequality and The Covid-19 Pandemic

In a December 1, 2020 memorandum, the Pima County Board of Supervisors published the "Resolution Declaring Racial and Ethnic Health Inequities and Income Inequality in Pima County to be Public Health Crisis" (AzPRC, 2021). The resolution describes how the pandemic has highlighted and exacerbated racial and social health inequities by disproportionately impacting communities of color and low-income communities in Pima County and how these inequities have led to a public health crisis (Arizona Secretary of State, 2020, as cited in AzPRC, 2021).

As reported by the AzPRC (2021), the resolution further describes how Hispanic/Latinx, Native American and Black/African American communities, as well as low-income residents, in Pima County continue to experience higher rates of premature death, child and infant mortality, chronic and preventable diseases, and poverty. The report also acknowledges the negative impact of systemic racism and poverty on the social factors that determine a person's health, including access to safe and affordable housing, active recreational opportunities, well-paying jobs, quality early childhood education, clean air and water, and health care and health insurance coverage (AzPRC, 2021).

HISTORY OF HEALTH IMPROVEMENT EFFORTS IN PIMA COUNTY

In early 2010, the Pima County Health Department (PCHD) created an internal Steering Committee to oversee the organization and provide leadership in the development and planning of a countywide community health assessment and improvement process (PCHD, 2018). Following the formation of the Steering Committee, a Community Health Action Task Force (also known as the Healthy Pima Initiative and later rebranded to "Healthy Pima") was formed with a core group of 60 community partner members and was housed in and supported by the PCHD. The Community Health Action Task Force engaged in a comprehensive community health needs assessment and improvement planning process. Following the completion of the first community health needs assessment, the Community Health Action Task Force convened four action groups that would address one of the four priority areas identified by the assessment. These groups developed action plans that would become the foundation for the county's 2013-2017 Community Health Improvement Plan (PCHD, 2018).

In the fall of 2014, the county's second Community Health Needs Assessment was finalized. Once again, health data were collected, analyzed, and reviewed by community members and stakeholders to identify health gaps and select the top health areas that would become the focus of community health planning efforts over the next three years (PCHD, 2018).

In 2016, Healthy Pima members restructured Healthy Pima so that health equity, health literacy, and access to care would become the lens by which all community health planning efforts would be completed (PCHD, 2018).

In 2017, Healthy Pima invited over 350 community partners and members, representing multiple sectors to conduct a review of the 2015 CHNA data. After data was shared with the community, a two-day seminar was held to help Healthy Pima members better understand how to consider equity, access to care, and health literacy as part of the community health improvement planning process (PCHD, 2018). In March of 2017, action groups began a community health improvement process that developed action plans that would become the 2018-2021 CHIP. In February 2018, action-planning meetings transitioned into action item implementation (PCHD, 2018).

Following completion of the third CHIP in 2018, Healthy Pima grew to over 120 community partners across multisector entities (PCHD, 2018). During this period, the future state and role of Healthy Pima was defined and an analysis of key successes and challenges was conducted, which led to defining shared mission and vision statements, which are in use presently. Healthy Pima members identified shared roles and responsibilities for supporting and performing all activities associated with the Healthy Pima Initiative.

DESCRIPTION OF MAPP/CHNA/CHIP PROCESSES

MAPP Process

Healthy Pima is Pima County's community health improvement planning initiative, comprised of stakeholders across sectors within the county, individuals, community-based organizations, and local businesses that have come together to improve community health by mobilizing resources, increasing awareness, promoting policy, system, and environment changes, and taking collective action to advance health equity. Members of Healthy Pima have worked together to improve the health status of the Pima County community since 2010 through the Mobilizing for Action through Planning and Partnership's (MAPP) framework.

MAPP is designed as a community-wide and community-owned strategic planning process to improve public health. This framework helps communities use qualitative and quantitative data to prioritize public health issues, identify resources for addressing them, and take action to improve conditions that support healthy living with input from a broad representation of many organizations and individuals (NACCHO, 2013). MAPP can be thought of as an iterative, flexible guide that can be customized by communities to fit their needs by integrating previous and current work in a community into the process (NACCHO, 2013). Throughout Pima County's current CHNA and CHIP processes, the MAPP method has been tailored to meet the needs of the community health improvement planning processes. Steps of the current CHNA and CHIP processes are categorized into one of the following six phases of the current MAPP cycle.

1. Organize for Success/Partnership Development
2. Visioning
3. Four MAPP Assessments
4. Identify Strategic Issues
5. Formulate Goals and Strategies
6. Action Cycle

Current Health Improvement Planning Efforts in Pima County

In the spring of 2020, a public health emergency was declared due to the COVID-19 pandemic. As all public health efforts were directed toward response efforts, Healthy Pima was temporarily put on hold until the fall of 2020. Healthy Pima's focus upon re-activation was to support the next iteration of the community health needs assessment and development of the current CHIP.

Healthy Pima Planning 2020-2022 Timeline

		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
2020	Strategic Planning Community Surveys conducted									X	X		
2021	Secondary data collection						X	X	X				
	Community Advisory Committee engagement on CHNA design and engagement strategies							X	X	X	X		
	Engagement of community through qualitative data collection o Focus group interviews o Key informant interviews						X	X	X				
	Data analysis and interpretation							X	X	X			
	Analyzed data was shared with the community & activities were used to prioritize the health needs o Community forums o Gallery walk										X		
2022	CHNA finalized and priority health areas identified	X											
	Current efforts in the four priority areas identified	X	X										
	Healthy Pima partnered with the Pima County Suicide Prevention Task Force		X										
	Healthy Pima partnered with the Collaboration Meeting Group			X									
	CHNA data presentations to key stakeholders		X	X									
	First planning meeting to prepare for Kickoff event			X									
	Root cause analysis of issues training for workgroups		X	X	X	X	X						
	Prioritization process utilized by workgroups to select specific health issues of most need within respective health priority			X	X	X	X						
	Goals, objectives, and policy training for workgroups			X	X	X	X	X	X	X			
	Workgroup meetings to develop action plans goals, objectives, strategies, establish measurable baselines, and timelines			X	X	X	X	X	X	X	X	X	
	Finalized Kickoff details and prepared materials							X					
	Hosted Healthy Pima Kickoff event o Community members were invited to join the Healthy Pima Steering Committee, the Healthy Pima Community Health Action Task Force, and the workgroups								X				
	Healthy Pima newsletter distributed										X	X	X
	First Healthy Pima Steering Committee meeting											X	
	Drafting and review of CHIP document			X	X	X	X	X	X	X	X	X	
	CHIP document finalized												X

	MAPP PHASE: Organize for Success/Partnership Development		MAPP PHASE: Four MAPP Assessments (the 2021 CHNA used a modified assessment model)		MAPP PHASE: Formulate Goals and Strategies
	MAPP PHASE: Visioning		MAPP PHASE: Identify Strategic Issues		MAPP PHASE: Action Cycle

CHNA Process

What is a CHNA

A Community Health Needs Assessment (CHNA) refers to a local health assessment that identifies key health needs and issues through systematic, comprehensive collection of quantitative and qualitative data, and analysis.

2021 Pima County CHNA Process

As described by the AzPRC (2021), during the 2021 CHNA process, data was aggregated from secondary sources and primary data was collected to understand, contextualize, and prioritize the health needs of Pima County. The process began with a review of publicly available data sources such as American Community Survey (ACS) and CDC Wonder, combined with data from the Pima County Health Department, the Arizona Department of Health Services, and stakeholder data to describe the demographics, health outcomes, and social determinants of health. The secondary data collection aligned with the Healthy People 2030 Leading Health Indicators and priority areas were described by demographic and geographic characteristics when available (AzPRC, 2021).

Primary data collection, as recounted by the AzPRC (2021), included key informant interviews and focus groups with community members. The PCHD Community Advisory Committee (CAC) was engaged in developing community strategies for primary data collection. CAC members assisted with improving reach into underserved communities. In total, 37 key informants were interviewed, including health advocates, community leaders, and health care providers that represent organizations serving a diverse array of Pima County residents. Focus groups were completed with community members representing varied groups in Pima County. In total, nine focus groups were completed with 54 community members (AzPRC, 2021).

Between September and October 2020, the Pima County Health Department (PCHD) conducted a series of Strategic Planning Surveys and interviews which was included as quantitative secondary data collection for the CHNA. According to the AzPRC, (2021), over 2,100 external stakeholders, community members, and PCHD employees participated. There were 1,528 community surveys, 466 external stakeholder surveys, 137 internal stakeholder surveys completed in the process (AzPRC, 2021).

Health Priorities

The 2021 CHNA process identified the following health needs for Pima County:

- Behavioral and Mental Health
- Substance Use Disorder
- Access to Care
- Social Determinants of Health, particularly transportation, poverty, and the built environment

Behavioral and Mental Health

The AzPRC (2021) defines Mental and Behavioral Health as emotions, behaviors, and biology related to a person's mental well-being. Behavioral and mental health were consistently cited as important issues throughout the CHNA process. The COVID-19 pandemic increased the severity of loneliness and feelings of isolation, decreased access to care, and worsened mental health (AzPRC, 2021).

Substance Use Disorder

The AzPRC (2021) defines Substance Use Disorder (SUD) as the excessive use of alcohol and drugs, including pain medication or illegal drugs. SUD was consistently recognized as a top concern in all phases of primary data collection, and strongly supported by secondary data. SUD worsened during the COVID-19 pandemic and is intricately connected to decreased mental health (AzPRC, 2021).

Access to Care

The AzPRC (2021) defines Access to Care as access to primary health care, specialized health care, and mental health services that are acceptable and appropriate to the diverse needs and background of an individual. Access is reduced by social determinants such as lack of transportation or low income, but also by insurance status, knowledge of services, and structural issues such as discrimination. Participants in all phases of primary data collection consistently referred to access to care as a primary concern (AzPRC, 2021).

Social Determinants of Health

The AzPRC (2021) defines Social Determinants of Health as the conditions in which people live, learn, work, and play that impact a variety of health and quality-of-life risks and outcomes. CHNA participants emphasized the need to create the opportunity for all Pima County residents to thrive. This goes beyond the traditional health care system and encompasses the availability of fresh and healthy foods, access to transportation, safe and affordable housing, access to educational opportunities, and making a living wage, among many other factors (AzPRC, 2021).

CHIP Process

2022 Pima County CHIP Process Overview

Following identification of top health priorities, the community chose top issues to tackle within two priority areas and outlined how to alleviate the issue through an action-oriented plan. This CHIP includes top issues within two priority areas identified by community workgroups. Strategies were developed to address these issues, and baseline measurements were established to track the community's progress. The CHIP is not intended to be the responsibility of a specific organization, but rather the broader community, with Healthy Pima assuming the role of convening community stakeholders to ensure its success. The CHIP is a living document that is iterative and is produced through collaborative effort that relies on collective partnership to achieve goals.

CHNA Data Sharing

The information from the primary and secondary data collection activities in the CHNA process was analyzed and shared with community members during community forums, as well as with the PCHD CAC. In total, three virtual community forums and one in-person gallery walk were held to share the findings from the primary and secondary data collection. Activities were used to engage community members in discussion to prioritize the most important health issues. In total, 102 community members participated in the community forum and gallery walk activities.

Prioritization Sessions

The community forums were conducted virtually via Zoom (due to the coronavirus pandemic) and included two forums in English and one in Spanish. The virtual community forums were 90-120 minutes in length and two forums were held in the evening to encourage participation of community members who work during the day. After a 40-minute presentation of the CHNA methods and results, participants entered breakout rooms to discuss health priorities and possible solutions for 25-30 minutes. Following breakout room discussions, participants then answered questions anonymously and provided input directly from their phone or computer, while compiling and showing the results in real time. The participants provided input on the top health priorities, top social determinant of health priorities, ideas for solving the major health issues identified and leveraging strengths and assets existing in Pima County. At the conclusion of the virtual forums, participants were invited to complete a brief and anonymous demographic survey via a link in the Zoom chat.

An in-person gallery walk was held for community members to provide feedback while observing COVID-19 precautions, including mask use and social distancing. The gallery walk was held at Pima Community College Downtown Campus, which was chosen for its location and accessibility

via car and public transportation. The gallery walk was scheduled from 3-7 p.m., which included part of the evening to allow participation of community members who work during the day. Children were welcomed at the event.

During the event, participants were invited to vote on seven of the top health priorities identified from the key informant interviews, focus groups, and virtual forums. The seven health priorities were: health systems and navigation, social determinants of health, mental health, climate and environment, substance use, chronic disease, and healthy aging. Stations for each health priority were set up in a large conference room. When a participant entered the room, they were provided with a brief introduction to the activity as well as the CHNA methods and purpose. They were also asked to complete a brief and anonymous demographic survey. At each station, participants were able to read information about the health issue and provide written feedback about the issue and potential solutions. All information was provided in both English and Spanish. Forum participants were given five sticker dots and asked to vote on the health priorities they considered most important. Participants were able to use stickers freely and could put multiple stickers on one topic to show increased support for that topic. The gallery was self-paced and participants were able to walk around, read the handouts, give written comments, and vote during the event.

The top health concerns identified through primary data activities were behavioral and mental health, substance use disorder, social determinants of health, access to care, and chronic diseases. The secondary data collection also identified some health priorities that both differed from and coincided with those identified by the primary data activities. The secondary data provided quantitative support for the top health concerns identified through primary data collection. However, there were some additional issues identified through secondary data review that were not emphasized in the primary data collection. Primary and secondary data was aggregated and the combined top health priorities were identified.

Communicating Results of the Community Health Needs Assessment with the Community

The Community Health Needs Assessment was shared with the community in the following ways:

1. Shared with CAC
2. A press release was created and shared with the community announcing that the 2021 CHNA had been completed and the top health priorities were included.
3. Physical copies of the CHNA were sent to key community partners.
4. An announcement with a link to an electronic copy of the CHNA was shared with the Healthy Pima Community Health Action Task Force and on Healthy Pima's Facebook page.
5. A Healthy Pima Kickoff event was held to share the results of the CHNA and for community partners to discuss the results of the CHNA in detail and to solicit participation in the Healthy Pima Steering Committee, the Healthy Pima Community Health Action Task Force, the Community Advisory Committee, and the Workgroups.

Development of CHIP Action Plans

In February and March of 2022, Healthy Pima partnered with two community groups working in the priority areas of Mental and Behavioral Health and Substance Use Disorder, namely the Pima County Suicide Prevention Task Force and the Collaboration Meeting Group. Each group is comprised of local public health system partners and community members and membership is open to anyone.

The two workgroups met from February through November to formulate action plans. Each workgroup met monthly for 1-1.5 hours through Teams or Zoom and identified issues, explored root causes of issues, formulated goals, objectives, and strategies. The group lead facilitated meetings and the Healthy Pima Coordinator led the action planning sections of meetings. During

meetings for each group, Pima County's Community Mental Health and Addiction team provided a deeper dive into the data specific to the priority area of each group. Workgroups worked virtually using the multi-user collaboration platforms MURAL and Google Jamboard to generate ideas for each section of the action plan. Idea generation was followed by group discussion consensus building. Between and during meetings, updates and work plans were made available to workgroup members. The action planning process began with a summary of the identified issues.

Issue Summary

The following section illustrates data from the CHNA that was presented to each workgroup that was pertinent to the particular health priority each workgroup was addressing. Goals, objectives, and activities were tailored to the needs of the community based on the data each group received. Identified solutions will continue to be proposed and vetted with community members in an iterative fashion.

Mental and Behavioral Health

The following from the 2021 CHNA was shared with the Pima County Suicide Prevention Task Force on February 2, 2022.

- In 2018, 13.6% of Pima County adults reported 14 or more days of poor mental health per month, compared to 12.8% and 13% of Arizona and US adults (Pima Health Data Portal, 2021, as cited in AzPRC, 2021).
- In 2020, the mental health provider rate (providers per 100,000 population) was 192 in Pima County. Mental health providers include psychiatrists, psychologists, and licensed clinical social workers. This rate has increased in recent years, which reflects a growing number of available mental health providers. The rate in Pima County is higher than the rate for Arizona (140 providers per 100,000 population)(Pima Health Data Portal, 2021 as cited in AzPRC, 2021).
- In 2020, there were 225 suicide deaths among Pima county residents, 61% of which were by firearm (AzPRC, 2021). Reported suicide deaths decreased 11% from 2019.
- Causes
  - Increase in isolation and stress due to the COVID-19 pandemic.
  - Children and older adults felt mental health impacts most acutely.
- Barriers
  - Lack of mental health service providers.
  - Stigma.
- Solutions
  - Increase access to mental health services.
  - Education and support to decrease stigma.
  - Collaboration among community health centers, hospitals, and mental health specialists to support a continuum of care.

Substance Use Disorder Issue

The following information from the 2021 CHNA and was shared with the Collaboration Meeting Group on March 15, 2022.

- Pima County experienced a significant increase in overdose deaths, especially involving Fentanyl, in recent years (AzPRC, 2021).
- SUD was exacerbated by the COVID-19 pandemic and intricately connected to mental health (AzPRC, 2021).
- In 2020, there were 446 overdose deaths in Pima County, a 32% increase from 2019 (AzPRC, 2021).

- The rate of overdose deaths has doubled since 2011 and Fentanyl is the most common drug involved in overdose, followed by methamphetamine (AzPRC, 2021).
- Causes
  - Ongoing and persistent issue, also identified in the 2018 CHNA.
  - Decline in mental health.
  - Increase in Fentanyl use and contamination.
- Barriers
  - Stigma and discrimination.
  - Limited education on harm reduction strategies.
  - Fear of consequences of seeking care.
- Solutions
  - Community education on stigma reduction, overdose, and substance use.
  - Harm reduction strategies (e.g. Naloxone and Fentanyl test strip distribution).

After reviewing and discussing the data from the CHNA, each workgroup then determined top issues to address and group members completed a poll to indicate their top choices to prioritize for the CHIP.

Determine Root Causes of Health Issues

A root cause analysis activity was completed for the top three issues identified from each group. Both the Substance Use Disorder and Mental and Behavioral Health workgroups identified issues to address. Each group then went through the "5 Whys" process to systematically identify root causes to help determine how different root causes of an issue are related to one another and to determine cause-effect relationships.

Root Cause Analysis: 5 Whys Process

1. The group generated issues to address. The group then voted on the top three issues it wanted to explore in further depth through a root cause analysis activity.
2. Each specific issue was written down on a MURAL board.
3. The group was then asked why the problem was occurring and everyone in the group was given a chance to offer their opinion by writing it on the MURAL board.
4. The group was then asked why the problem stated in #3 was happening.
5. Step # 4 was repeated until the group agreed that the problem's root cause was identified.

Upon completion of the root cause analysis activity, each group relisted their top issues to address, some of which included root cause issues unearthed during the root cause analysis activity. Another poll was taken and each group indicated their top issue to prioritize for the CHIP. For the Mental and Behavioral Health workgroup, the top issue to address was increasing postvention knowledge and services. For the Substance Use Disorder workgroup, the top issue identified was addressing stigma and discrimination around substance use disorder.

Policies, Systems, and Environment Change

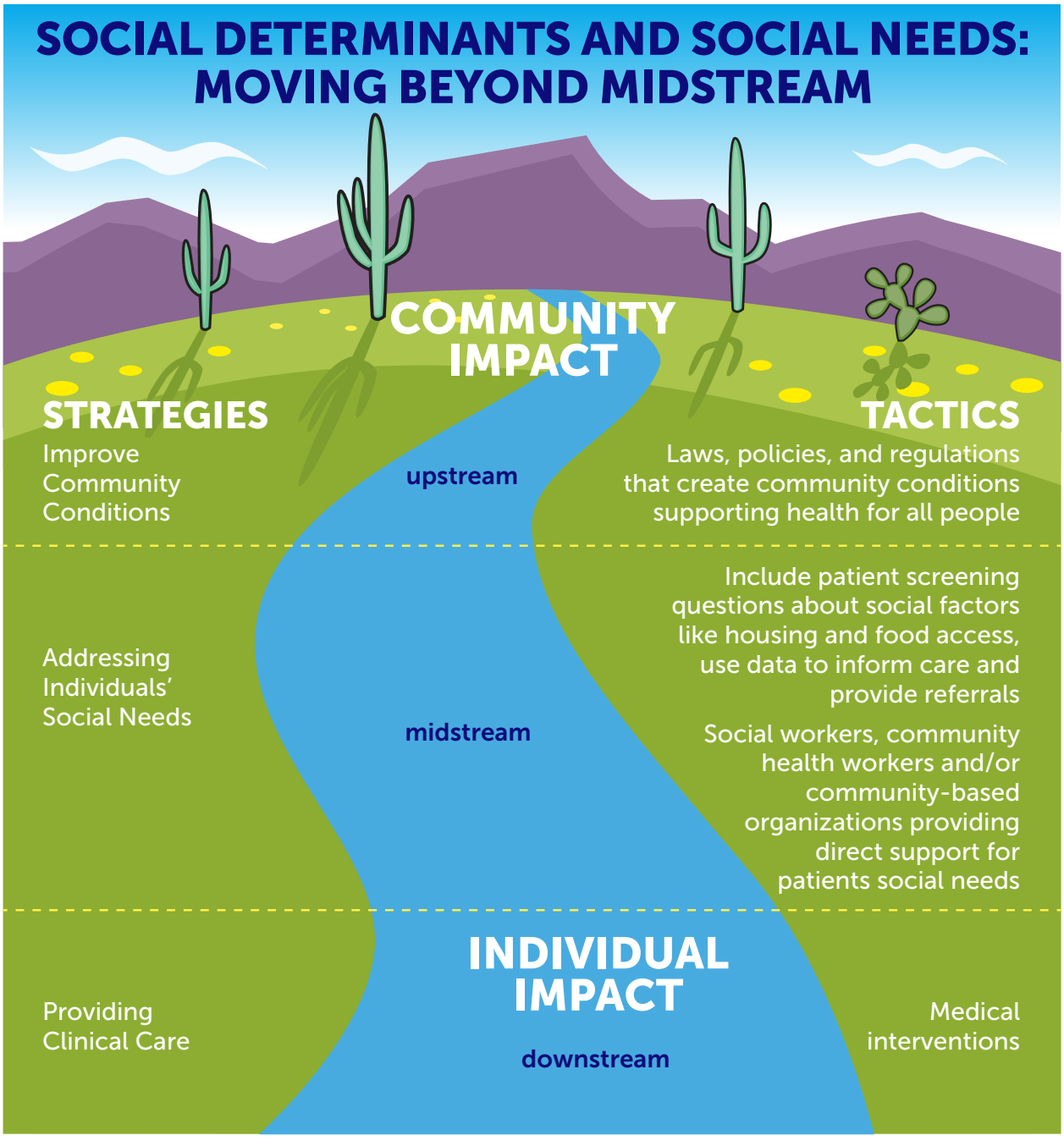
Pima County Health Department's policy team provided a policy training to each group to introduce the potential of identifying policy change strategies to address identified issues. The policy team noted that policy change is a shift in policies, systems, and environment. By changing policy, it is possible to impact the socioeconomic factors that affect health, improve health care accessibility, and make healthy behaviors easier for community members to achieve.

Policies can be both "BIG P" and "little p" policies. "Big P" policies include formal laws, rules, and regulations enacted by officials and official bodies. "Little P" policies are: less formal policies related

to policy administration or implementation. It can include written statements in workplaces, schools, apartments, and grocery stores.

When addressing the factors that impact health, it is not enough to look at clinical care. Health outcomes are primarily driven by health behaviors, social and economic factors, and the physical environment. All of these factors are influenced by policies that have sometimes intentionally or unintentionally failed to address the needs of certain communities. Thus, policy solutions, centered in equity and led by the community, can help address the underlying factors that result in poor health and health disparities.

Health departments can play an important role in policy, systems, and environment change. They can act as a convener and help communities identify potential policy solutions. As part of the CHIP process, community members can identify potential policy changes and action steps needed for such policy change to occur.



Graphic adapted from de Beaumont Foundation and Trust for America's Health. (January 2019) "Social Determinants and Social Needs: Moving Beyond Mindstream"

The following excerpt from Change Lab Solutions was shared with each workgroup prior to discussing policy recommendations for action plans.

> "When people hear the word "policy," they often think of an ordinance made by a city council or a law made by a state legislature. However, both public institutions and private entities make policies. Contracts, organization or business policies, and agency regulations are also policies. For example, many communities have ordinances— made by the city or county council—that prohibit smoking in privately owned apartment buildings. In communities without these laws, landlords can choose to adopt smoke free policies for their properties. In this example, the local ordinance is a public policy that applies to all apartment buildings in the community. The government adopts and enforces the law on behalf of residents. In places without a smoke free ordinance, landlords can adopt and enforce a private policy that affects only their apartment units and tenants. Whether public or private, a policy is 1) a written statement; 2) binding and enforceable; and 3) broadly applicable to a geographic area, type of institution or physical space, and/or group of people. One way to identify policy is to understand what policy is not." (Solutions, n.d.)

After reviewing what policy, systems, and environmental change means, relevant examples pertaining to each respective health priority were shared with each workgroup. The groups then discussed policy examples pertaining to the goals and objectives they were working on. Groups then generated their own policy recommendations to include in the action plans.

CHIP WORK PLANS

The Pima County Suicide Prevention Task Force and the Collaboration Meeting Group are community-led groups that partnered with Healthy Pima to develop action plans for the CHIP. The following outlines the issues, goals, objectives, strategies, policy recommendations, baseline measurements, activities, responsible parties, expected outcomes, timeframes, and assets to be used in the CHIP.

Workgroups used the SMART criteria as a guide to create objectives that were Specific, Measurable, Attainable, Relevant, and Time-Based. This criteria helped workgroups define measurable outcomes to achieve their goals. This criteria also defines how much improvement will take place over a specific period.

In addition to monitoring and evaluating progress around the implementation of the CHIP through output measures at the objective level, county-wide baseline measures at the broader goal level have been identified in the action plans. Healthy People 2030 indicators were used as a guide in identifying relevant and meaningful broader baseline measures.

Priority: Mental and Behavioral Health

Action Plan

During development of the 2021 Community Health Needs Assessment, through the Strategic Planning Survey, members of the community noted behavioral health as one of the leading causes of death in Pima County, including self-harm and suicide (AzPRC, 2021). In response to the community-identified mental and behavioral health priority, the Pima County Suicide Prevention Task Force partnered with Healthy Pima to develop the following action plan:

Issues to Address	Lack of postvention services in Pima County related to suicides. Prevention knowledge and services in Pima County related to suicides.			
Root Causes	• Mental health is not seen the same as physical health. • People do not know what postvention is or how to get this type of care. • Family culture is not supportive of discussion of feelings/mental health. • Some people are treated for a mental health crisis without insurance and do not have coverage for postvention care.			
Goal 1	Increase knowledge and access to services around suicide postvention care in Pima County.			
Objective	By December 31, 2022, the Pima County Suicide Prevention Task Force will identify agencies in Arizona that provide postvention care.			
Strategy 1	Educate community about postvention services in Pima County.			
Policy Recommendation to Alleviate a Health Inequity	Explore postvention opportunities in the 988 infrastructure.			
Baseline Measurement	Rate of Suicides in Pima County: 20.9 deaths per 100,000 people (Pima County Office of Medical Examiner, 2021 Annual Report) (Healthy People 2030 Indicator)			
Tactics/Activities	**Responsible Agency/Person**	**Expected Outcome**	**Timeframe**	**Assests/Resources to be Used**
Invite Suicide Prevention organizations to identify agencies that provide outreach and education. Gather data / research information.	PCHD (develop memo with survey link) Task force sub groups	Database to be shared/ keep current on mental health resource partners Identify gaps - highlight partners	Send out early June 2023	PimaHelpline.org

Utilize LOSS (Local Outreach to Suicide Survivors) teams, modeled after La Frontera's LOSS teams, to provide newly bereaved individuals with resources and support. (this is also a prevention strategy)	Task force and partners	Resources and peer support offered to newly bereaved individuals	Identify appropriate partners by December 2023 Create resource "packets" to distribute via LOSS teams. By December 2023 Recruit LOSS team volunteers to distribute resources by March 2023	One-page resource PimaHelpline.org
Define terms (related to postvention services) for the general public.	Task force sub groups	Common language and education around postvention services	Distribute by December 2023	Suicide Prevention Resource Center Arizona Department of Health Services
Share one-page infographic with bullet points across agencies that may be first to interact with surviving family and/or supports, including emergency medical services and law enforcement.	Collective creation, distributed by PCHD	Give baseline language on postvention across agencies	Develop by July 2023 for fall K-12 distribution	PimaHelpline.Org
Goal 2	Increase knowledge and services around suicide prevention care.			
Strategy 2	Educate the community about prevention services in Pima County.			
Tactics/Activities	**Responsible Agency/Person**	**Expected Outcome**	**Timeframe**	**Assests/Resources to be Used**
Highlight prevention trainings, presentations, etc. available throughout the county to students, employees/ employers, and community members.	Collaborative creation headed by and housed under PCHD	Living database for stakeholders and community members to use to further prevention education training for Pima county community	Complete by December 31, 2023	Pima Helpline.org AZ Suicide Prevention Coalition Department of Health Services, suicide prevention website with statewide events
Create a document/live table of prevention training facilitators (More Than Sad, safeTALK, QPR, ASSIST etc.) in Pima County for stakeholders to more easily contact and coordinate trainings for their organizations.	Collaborative creation headed by and housed under PCHD	Living database for stakeholders to use to further prevention education training for the Pima county community	Complete by December 31, 2023	Pima Helpline.org Mercy Care of Arizona University of Arizona's Life and Work Connections American Foundation for Suicide Prevention La Frontera Tucson Arizona Department of Education

Outreach to school counselors in Pima County.	Task force sub groups	Further prevention education training for Pima county community	Complete by December 31, 2023	Marana Unified School District Trainings Director of Guidance & Counseling in Marana Unified School District Pima County Health Department's Community Mental Health and Addiction Team - Question, Persuade and Refer (QPR) and Youth Mental Health First Aid Trainings for adults who work with youth
Enhance awareness and resources that reduce access to means that can be used to attempt/complete a suicide. (safe medication disposal, med lock boxes/caps, gun locks, safe gun storage etc.)	Task force sub groups	Reduce access to resources that can be used to complete a suicide	Complete by December 31, 2023	Gun Lock Distribution Grants through Arizona Complete Health Pima County Libraries, Abrams Public Health Center, map a med disposal sites Arizona Department of Health Services (ADHS) website for permanent disposal (pharmacies & lobbies) Course - CALM Counseling on Access to Lethal Means (CALM) courses

Priority: Substance Use Disorder

Action Plan

During development of the 2021 Community Health Needs Assessment, members of the community cited that substance use has a significant impact on community health in Pima County, and primary data collection showed that it was related to mental health and access to services. Collectively, CHNA participants believe that many people with substance use disorder struggle with other mental health issues due to a lack of care and existing stigma (AzPRC, 2021).

In response to this community identified substance use disorder issue, the Collaboration Meeting Group partnered with Healthy Pima to develop the following action plan:

Issues to Address	Stigma and discrimination around substance use disorder.
Root Causes	• Old memories cause using in the first place. • The biology of addiction is not understood.
Goal 1	Increase education around centered approaches to treatment to reduce stigma around substance use disorder.
Objective	By December 31, 2023, the Collaboration meeting group will provide education on the biology of addiction to 20 businesses and neighborhood associations in the community to provide dialogue around stigma around Substance Use Disorders and let businesses know what resources are available to them and the unhoused population who camp out in front of their businesses.
Policy Recommendation to Alleviate a Health Inequity	Continue with education on the importance of decriminalizing drug use to encourage treatment pathways in place of incarceration for those who are drug dependent and ensure good samaritan protections remain in place in the state.
Baseline Measurement	Pima County Overdose Deaths Involving Fentanyl: 298 deaths in 2021 (Pima County Office of Medical Examiner, 2021 Annual Report) (Healthy People 2030 Indicator)

Tactics/Activities	Responsible Agency/Person	Expected Outcome	Timeframe	Assests/Resources to be Used
Meet with the organizers of the Mission Plaza neighborhood to set up meetings with businesses in the area so they can learn about resources available to the unhoused population with substance use disorders.	CODAC	Educate neighborhood organizers and business owners in the Mission Plaza neighborhood on resources available to the unhoused population with substance use disorder. Decrease substance use and overdose deaths in the Mission Plaza neighborhood	Meet through July 2023	Informational flyers, business cards
Provide Narcan trainings to business owners in the Mission Plaza Neighborhood.	CODAC	Decrease overdose deaths due to fentanyl in the Mission Plaza neighborhood	January - December 2023	Informational pamphlets, business cards
Provide training to teachers about the rainbow fentanyl and safety precautions.	Community Medical Services	Provide teachers information about rainbow fentanyl. MAT 101 training to decrease fentanyl use in the school- aged population in Pima County	January - December 2023	Informational pamphlets
Visit hotspots around the community for the unhoused population who are active users to educate them around medication-assisted treatment.	CODAC	Education and recruitment to treatment facilities to decrease substance use and overdose deaths in Pima County	January - December 2023	Tucson Police Department
Disperse hygiene kits containing CODAC business cards to active users and the unhoused population.	CODAC	Education and recruitment to treatment facilities to decrease substance use and overdose deaths in Pima County	January - December 2023	Tucson Police Department, hygiene kits, business cards
Provide hats, beanies, gloves to the unhoused population.	CODAC	Education and recruitment to treatment facilities to decrease substance use and overdose deaths in Pima County	January - December 2023	Business cards

On Wednesdays provide community outreach at Grace St. Paul's Episcopal Church so that the unhoused population and active users can make appointments to check into CODAC, offer services, and distribute Narcan, Naloxone, and fentanyl strips.	CODAC	Education and recruitment to treatment facilities to decrease substance use and overdose deaths in Pima County	January - December 2023	Narcan, Naloxone, fentanyl strips, Grace St, Paul's Church
Quarterly Community Resource Fair	Collaboration Meeting Group	Education and recruitment to treatment facilities to decrease substance use and overdose deaths in Pima County	January - December 2023	Pamphlets, naloxone distribution, food banks, shelters, clothing
Goal 2	Increase cross-sector collaboration in order to better serve community members with diagnosed or suspected SUD.			
Objective 2	By December 31, 2023, the Collaboration Meeting Group will meet once per month. By December 31, 2023, the Collaboration Meeting Group will increase agency participation by 10%.			
Policy Recommendation to Alleviate a Health Inequity	Continue with education on the importance of decriminalizing drug use to encourage treatment pathways in place of incarceration for those who are drug dependent and ensure good samaritan protections remain in place in the state.			
Baseline Measurement	Pima County Overdose Deaths Involving Fentanyl: 298 deaths in 2021 (Pima County Office of Medical Examiner, 2021 Annual Report) (Healthy People 2030 Indicator)			
Tactics/Activities	**Responsible Agency/Person**	**Expected Outcome**	**Timeframe**	**Assests/Resources to be Used**
Monthly surveillance activities to gather and compile data on the latest trends regarding overdose fatalities.	Pima County Health Department	Monthly data dashboard presentations to the Collaboration Group	Through December 2023	Office of the Medical Examiner (OME), vital records
Individual agencies share qualitative data and/or trends that they observe as they relate to substance misuse and overdose prevention.	Collaboration Meeting Group	Qualitative data is gathered that supplements and reinforces quantitative data. Additionally, community intel provides PCHD with potential indicators/ emerging trends to monitor in the immediate future	Through December 2023	Anecdotes and other qualitative data gathered by participating agencies
Individual agencies share new and ongoing resources available to community members and other agencies as they relate to substance misuse and overdose prevention.	Collaboration Meeting Group	Community resources are shared that ensures effective/ efficient cross-sector collaboration	Through December 2023	Informational flyers, links, other resources
Regularly provide relevant training opportunities and presentations from subject matter experts as they relate to substance misuse and overdose prevention.	Collaboration Meeting Group	Continuing education and learning opportunities that result in broader knowledge of resources and emerging best practices	Through December 2023	Presentations, trainings, educational materials, resource links, etc

MOVING FORWARD

Healthy Pima will act as the point of contact through its Healthy Pima Coordinators to support and move action plans forward. Healthy Pima's main goals will be to support community engagement through an equity focus and to form the Social Determinants of Health and Access to Care Coalitions to address the remaining health priorities identified in the 2021 CHNA. Another goal will be to revitalize and form new relationships between community partners to ensure engagement of underserved communities with a wide and equitable community representation in future health planning efforts.

Healthy Pima 2023-2024 Timeline

2023	January	• **Select Action Plan Activities for Implementation** Each of the current workgroups are led by a community partner and will continue to be supported by Healthy Pima staff. Each workgroup will begin implementation in January of 2023. The workgroups will focus on the activities detailed in each work plan. Upon completion of the current goals, the workgroups will review the action plan and update it annually as needed. Healthy Pima will serve as the backbone agency to support efforts to ensure that action plans are implemented and monitored as needed. Healthy Pima staff will capture the progress of each focus area through annual CHIP addendums. The CHIP, and addendums, is intended to serve as a living document and may change based on data, resources, and the evolving public health landscape. • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation. • **Share Monthly Healthy Pima Newsletter**
	February	• **Healthy Pima Leadership: Finalize Healthy Pima Steering Committee** An additional structural element that will support successful implantation of the CHIP includes a community-led Healthy Pima leadership team. A full leadership team will provide direction for all CHIP/CHNA/MAPP health improvement planning efforts. • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation. • **Share Monthly Healthy Pima Newsletter**
	March	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation. • **Form Access to Care and Social Determinants of Health Workgroups** Begin action plans that will be included as addendums to the 2022-2024 CHIP. • **Share Monthly Healthy Pima Newsletter**
	April	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Share Monthly Healthy Pima Newsletter**
	May	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Share Monthly Healthy Pima Newsletter**
	June	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Health Equity and Policy Interventions Trainings** Open to all Healthy Pima members, partners, and workgroups. • **Share Monthly Healthy Pima Newsletter**

2023	July	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Share Monthly Healthy Pima Newsletter**
	August	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Share Monthly Healthy Pima Newsletter**
	September	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Share Monthly Healthy Pima Newsletter**
	October	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Finalize Access to Care and Social Determinants of Health Workgroup Action Plans** • **Share Monthly Healthy Pima Newsletter**
	November	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation and development. • **Share Monthly Healthy Pima Newsletter**
	December	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** Ongoing oversight of action plan implementation. Finalize SDOH & Access to Care action plans. • **Finalize CHIP addendums** • **Share Monthly Healthy Pima Newsletter**
2024	January - December	• **Healthy Pima Steering Committee Meeting** • **Healthy Pima Workgroup Meetings** • **Triannual Community Health Action Task Force Meeting** • **Develop 2024 CHNA with Community Partners** • **Share Monthly Healthy Pima Newsletter**

ABBREVIATIONS

ACS American Community Survey

ASIST Applied Suicide Intervention Skills Training

CHIP Community Health Improvement Plan

CHNA Community Health Needs Assessment

LGBTQ+ lesbian, gay, bisexual, transgender, queer, other sexual identities

LOSS Local Outreach to Suicide Survivors

MAPP Mobilizing for Action through Planning and Partnerships

QPR Question, Persuade, and Refer

SMART Specific, Measurable, Attainable, Relevant, and Time-Based

GLOSSARY OF TERMS

988 Infrastructure is the new three-digit dialing code connecting people to the existing National Suicide Prevention Lifeline (now the 988 Suicide and Crisis Lifeline) where compassionate, accessible care and support is available for anyone experiencing mental health-related distress — whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support. This three-digit dialing code was activated on July 16, 2022. Every person in every community nationwide can dial "988" to reach trained crisis counselors who can help in a mental health, substance use or suicide crisis.

American Community Survey (ACS) is a demographics survey program conducted by the U.S. Census Bureau. It regularly gathers information previously contained only in the long form of the decennial census, such as ancestry, citizenship, educational attainment, income, language proficiency, migration, disability, employment, and housing characteristics. These data are used by many public sector, private sector, and not-for-profit stakeholders to allocate funding, track shifting demographics, plan for emergencies, and learn about local communities.

Applied Suicide Intervention Skills Training (ASIST) is a program that teaches participants how to assist those at risk for suicidal thinking, behavior, and attempts. Although many health care professionals use ASIST, anyone 16 years or older can use the approach, regardless of professional background.

Baseline Measure is also known as "the before measurement" is a piece of data that has been taken before any action has been applied to such data.

Behavioral Health refers to not just a person's state of mind but their physical condition.

Big P Policies refers to state or national policy change. Legislation and executive actions, both of which require elected officials' approval, are Big P policies. Increasing the appropriation for the Title V Block Grant is a Big P example. A court decision, such as the Supreme Court's ruling on the Affordable Care Act, can result in a Big P policy change.

Built Environment refers to the human-made physical environment that provides all the human-made physical spaces where we live, recreate, and work. This includes homes, buildings, zoning, streets, sidewalks, open and public spaces, transportation options, infrastructure, and more. These structures and spaces affect our health by bringing pollutants into our environments and by allowing or restricting access to transportation, social interactions, and physical activity. For example, it can influence physical activity if there are inaccessible or nonexistent sidewalks and bicycle or walking paths. This can contribute to sedentary habits that lead to poor health outcomes such as obesity, cardiovascular disease, diabetes, and some types of cancer.

Child Mortality (also known as under-five mortality rate) refers to the probability of a child dying between birth and exactly 5 years of age, expressed per 1,000 live births.

Collective Action is action taken together by a group of people whose goal is to enhance their condition and achieve a common objective.

Community Forum is like a public meeting, where members of the community come together at a central location to share their ideas, opinions and concerns about a specific topic or a variety of topics. It is a way of consulting members of the community and is part of the community engagement process. A community forum provides the opportunity to provide a two-way flow of information. Community forums can be used for providing an overview of an issue and having members of the community respond; gathering large amounts of information in a short period of

time; raising the awareness of the issue; collecting the community's ideas, beliefs, suggestions or responses to an issue(s); select a course of action supported by the community; identifying new stakeholders, leaders, champions and advocates.

Disability is a physical or mental impairment that substantially limits one or more major life activities.

Federal Poverty Level The federal poverty level (FPL), or the "poverty line", is an economic measure used to decide whether the income level of an individual or family qualifies them for certain federal benefits and programs.

Focus Group Interview is a group interview that involves a small number of demographically similar people or participants who have other common traits and/or experiences. Their reactions to specific evaluator-posed questions are studied. Focus groups are used to better understand people's reactions to political issues or participants' perceptions of shared experiences.

Gallery Walk is an active strategy that utilizes learning stations that display information related to the issue(s) being discussed.

Harm Reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.

Health Equality is equal treatment and availability of health care services for all people. The goal of equality is to promote fairness, but it can only work if everyone starts from the same place and needs the same things. Realistically, people with diseases like diabetes or physical disabilities, and people who live in communities where health care services are limited, will need different things to achieve and maintain their overall level of wellness.

Health Equity means ending institutional and discriminatory barriers that lead to health inequities and inequality. This includes factors within the health care system, such as racism and sexism, as well as factors outside the health care system, such as poverty and unequal distribution of resources. It refers to the availability of health care while taking in account the other factors that influence health such as employment, housing, transportation, education, socio-economic status, food access, etc. When health equity is achieved, no one is excluded because of a pre-existing health condition or external circumstances. Health equity acknowledges that everyone does not start from the same place or need the same things.

Health Inequity is a systematic difference in the health status of different population groups. These inequities have significant social and economic costs to both individuals and societies.

Health Literacy can refer to an individual and an organization. Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Healthy People 2030 Leading Health Indicators (LHIs) are a small subset of high-priority Healthy People 2030 objectives selected to drive action toward improving health and well-being. Most LHIs address important factors that impact major causes of death and disease in the United States. They help organizations, communities, and states across the nation focus their resources and efforts to improve the health and well-being of all people. Healthy People 2030 includes 23 LHIs.

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade.

Hispanic a person of Latin American descent and especially of Cuban, Mexican, or Puerto Rican origin living in the U.S.

Income refers to the money that a person or entity receives in exchange for their labor or products.

Infant Mortality is the death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births.

Key Informant Interview is a qualitative in-depth interview with people who know what is going on in the community. The purpose of key informant interviews is to collect information from a wide range of people—including community leaders, professionals, or residents—who have first-hand knowledge about the community.

Latinx a person of Latin American origin or descent (used as a gender-neutral or non-binary alternative to Latino or Latina).

Little P Policies are typically at the department or agency level and generally address organizational practices, agency priorities, internal and external distribution of resources, and regulations. These types of policy changes can create quick wins and sometimes lead to larger changes that typically are not as labor- or time-intensive as Big P policy changes.

Med Lock Boxes are locked medication storage containers that help safeguard medications in the home.

Med Lock Cap is a locking cap that represents a tamper evident, abuse deterrent solution for safely storing prescription medications in the home. It is meant to help mitigate the risk of drug diversion and misuse/abuse of prescription medications in the home.

Mental Health pertains entirely to a person's psychological state.

Migrant(s) person(s) who moves from one place to another, especially in order to find work or better living conditions.

More than Sad Training This training teaches students, parents, and educators to recognize signs of mental health distress in students and refer them for help.

Mortality Rate the relative frequency of deaths in a specific population during a specified time, often cited as the percentage of human deaths during a public health crisis.

PimaHelpline.org is a community-driven and community-made resource. It is a centralized place for Pima County residents to find mental health, substance use, and addiction treatment, services, and support.

Political Determinants of Health if social determinants of health (SDOH) are the social factors impacting our health, political determinants of health are the policy choices that led to those SDOH in the first place.

Postvention refers to interventions for bereaved survivors, community members, caregivers, and health care providers to destigmatize suicide, assist with the recovery process, and serve as a secondary prevention effort to minimize the risk of future suicides due to complicated grief, contagion, or unresolved trauma.

Poverty is about not having enough money to meet basic needs including food, clothing and shelter.

Premature Death is a measure of years of potential life lost due to death occurring before the age of 75.

Primary Data is a type of data that is collected by researchers directly from main sources through interviews, surveys, experiments, etc.

Qualitative Data can be observed and recorded. This data type is non-numerical in nature. This type of data is collected through methods of observations, one-to-one interviews, etc.

Quantitative Data is information that can be counted or measured—or, in other words, quantified—and given a numerical value.

Question, Persuade, and Refer (QPR) Training is for suicide prevention and is a brief educational program designed to teach "gatekeepers"-those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, and coaches), the warning signs of a suicide crisis and how to respond.

Root Cause Analysis is the process of discovering the root causes of problems in order to identify appropriate solutions.

safeTALK is a training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention.

Secondary Data refers to any dataset collected by any person other than the one using it.

Secondary Prevention Effort screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.

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

Stakeholders refers to either an individual, group or organization that is impacted by the outcome of a project. Anybody who can affect or is affected by an organization, strategy or project. Any people or groups who are positively or negatively impacted by a project, initiative, policy, or organization.

Steering Committee a committee that decides on the priorities or order of business of an organization or group and manages the general course of its operations.

Stigma is when someone views you in a negative way because you have a distinguishing characteristic or personal trait that is thought to be, or actually is, a disadvantage (a negative stereotype). Stigma can lead to discrimination. Discrimination may be obvious and direct, such as someone making a negative remark about your mental illness or your treatment. It also may be unintentional or subtle, such as someone avoiding you because the person assumes you could be unstable, violent or dangerous due to your mental illness.

Strategic Issues are fundamental policy choices or critical challenges that must be addressed in order for a community to achieve its vision. When addressing "strategic" issues, a community is being proactive in positioning itself for the future, rather than simply reacting to problems.

Strategic Planning is a process in which leaders define their vision for the future and identify their project/organization/group's goals and objectives. The process includes establishing the sequence in which those goals should be realized so that the stated vision can be reached.

Systemic Racism includes the policies and practices entrenched in established institutions, which result in the exclusion or promotion of designated groups. It differs from overt discrimination in that no individual intent is necessary.

Undocumented Residents anyone residing in any given country without legal documentation. It includes people who entered the U.S. without inspection and proper permission from the government, and those who entered with a legal visa that is no longer valid.

Unintentional Injuries refers to injuries that were unplanned. The most common unintentional injuries result from motor vehicle crashes, falls, fires and burns, drowning, poisonings and aspirations.

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