Listening Sessions Report

2018-2023 Community Health Improvement Plan (CHIP)

Health Improvement Partnership of Maricopa County (HIPMC)

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Acknowledgements

The Health Improvement Partnership of Maricopa County (HIPMC) and Community Alliance Consulting, LLC would like to thank the following agencies and organizations for participating in the Community Health Improvement Plan (CHIP) Listening Sessions and contributing to this report:

- **Arizona Commission for the Deaf and Hard of Hearing**
- **Blue Cross Blue Shield Health Choice (Medicaid Provider)**
- **ClipDart**
- **Cihuapactli Collective**
- **Department of Economic Security**
- **Family Tree Healthcare**
- **Food Forest Cooperative**
- **Native Health**
- **No Kid Hungry**
- **Phoenix Food Co-op**
- **Rehoboth Place**
- **Unlimited Potential**
- **Valley of the Sun YWCA**

To learn more about the CHIP and HIPMC work, please visit hipmc.org.

Executive Summary

The Community Health Improvement Plan (CHIP) of Maricopa County is a community-wide action planning effort coordinated by the Maricopa County Department of Public Health (MCDPH) to address current public health priorities. As outlined in the 2017 Community Health Needs Assessment (CHNA), the current public health priorities are Early Childhood Development, Access to Care, and Access to Healthy Food. The Health Improvement Partnership of Maricopa County (HIPMC), in collaboration with Community Alliance Consulting, LLC (CAC), conducted a series of three listening sessions to collect information about previous and ongoing CHIP efforts related to the three public health priority areas, and to determine what role the CHIP may have had in these efforts.

"The HIPMC has been a bridge to all the work being done all over the county."

-Listening session participant

In addition to their contribution to the CHIP priority areas, participants were also asked what they thought were benefits of participating in the HIPMC. Of the 22 participants engaged in the listening sessions, **networking** was by far the most referred to benefit of participating in the HIPMC. Other benefits shared included:

- Learning about one another's organizations and efforts, as well as the types of resources, efforts, and programs that are happening in Maricopa County to support communities
- Meeting with other professionals who have a similar mindset
- Becoming more engaged in data

HIPMC partners also achieved several activities that were designed to impact the CHIP priorities. The following outcomes were achieved by multiple organizations in the HIPMC:

- Increased navigation and referrals
- Community-wide gains in knowledge
- Empowered neighborhoods

Background

Purpose

The Community Health Improvement Plan of Maricopa County is a community-wide action planning effort coordinated by the Maricopa County Department of Public Health (MCDPH) to address the public health priorities determined by the Community Health Needs Assessment. As outlines in the 2017 Community Health Needs Assessment (CHNA), the current public health priorities are **Early Childhood Development**, **Access to Care**, and **Access to Healthy Food**. The purpose of planning is to set priorities, coordinate and target resources, and define coordinated actions of the public health system members to promote health. The Community Health Improvement Plan (CHIP) identifies strategies that are likely to have the largest impact on improving the quality of life for all Maricopa County residents, particularly the most vulnerable, by reducing preventable illness and death.

The Health Improvement Partnership of Maricopa County (commonly referred to as the **HIPMC**) is a collaborative effort between Maricopa County Department of Public Health (MCDPH) and over 100 public and private organizations. HIPMC member organizations collectively address the identified priority health issues and implement the CHIP. Many participants are from organizations that have been involved since the CHNA process began, while others continue to join as the CHIP takes shape.

The purpose of this report is to summarize the findings from a **series of three Listening Sessions**; one focused on each of the three priority areas. The Listening Sessions were used to collect information about previous and ongoing CHIP efforts related early childhood development, access to health care, and access to healthy food, and to determine what role the CHIP may have had in these efforts. Listening sessions were conducted on June 14-15, 2023.

Methods

A series of three Listening Sessions were planned with HIPMC partners as a component of the 2018 – 2023 CHIP cycle evaluation. Each Listening Session (LS) was focused on one of the three priority areas: **Early Childhood Development**, **Access to Care**, and **Access to Healthy Food**. Participants were recruited through the HIPMC ongoing communications, and were employed or volunteer representatives of the organizations that comprise the HIPMC.

A semi structured questionnaire was co-created by MCDPH and Community Alliance Consulting, the evaluation and facilitation firm supporting the project based on the essential exploratory questions and insights gleaned from program team. The questions were open-ended and broad in scope to give participants the opportunity to highlight the experiences without guidance or leading from the facilitator. A note taker was present as a backup facilitator and to support the participants. The sessions were conducted in English, among allied professionals, during work hours.

Each session began with a verbal consent process that explained the purpose of the LS series and data protection assurances. Once the participants had an opportunity to ask questions, all participants agreed to be listened to, have notes taken based on what they share, and that the notes will be stored on a secure server.

The sessions began with introductions and friendly banter. This is intended to bring levity to the group after the lengthy introduction and consent process. The questions were custom designed to measure HIPMC outcomes, barriers to implementation, and elicit ways MCDPH can further support HIPMC efforts. Probes were pre-generated and developed responsively using reflexive listening strategies to deepen the exploration of each question.

Listening Sessions were conducted securely via Zoom, a password protected meeting platform. The technology worked smoothly, and participants were able to view one another via camera, if desired. Sessions were scheduled for 90 minutes, and actual meeting time ranged from 72 to 88 minutes. The average meeting length was 79 minutes.

Immediately following each LS, the facilitator team discussed any recurring or notable themes from the session. The note taker then cleaned up their notes and saved them to a secure server.

The analyzing evaluator coded each set of notes for common themes, and individual session themes. Any important outlier perspectives were also highlighted. An auditing evaluator then performed a secondary assessment of the same data sets. Both evaluators then met to compare their outcomes, to strengthen the analysis and description of the common areas, and to tease out any areas of divergence. When evaluators observed data differently, the team discussed the nuances to come to a mutual agreement of interpretation. Using the research questions as a guide, several themes emerged. Due to the small number of focus groups conducted, no software tools were needed for analysis.

As with all qualitative data collection, there is a potential for the facilitators to subconsciously influence the participants' response, or the interpretation of their response. Given this limitation, the facilitation and evaluation team members have extensive training in recognizing and reducing bias, and are experts and educators on the subjects of bias and reliable evaluation research processes.

Participation

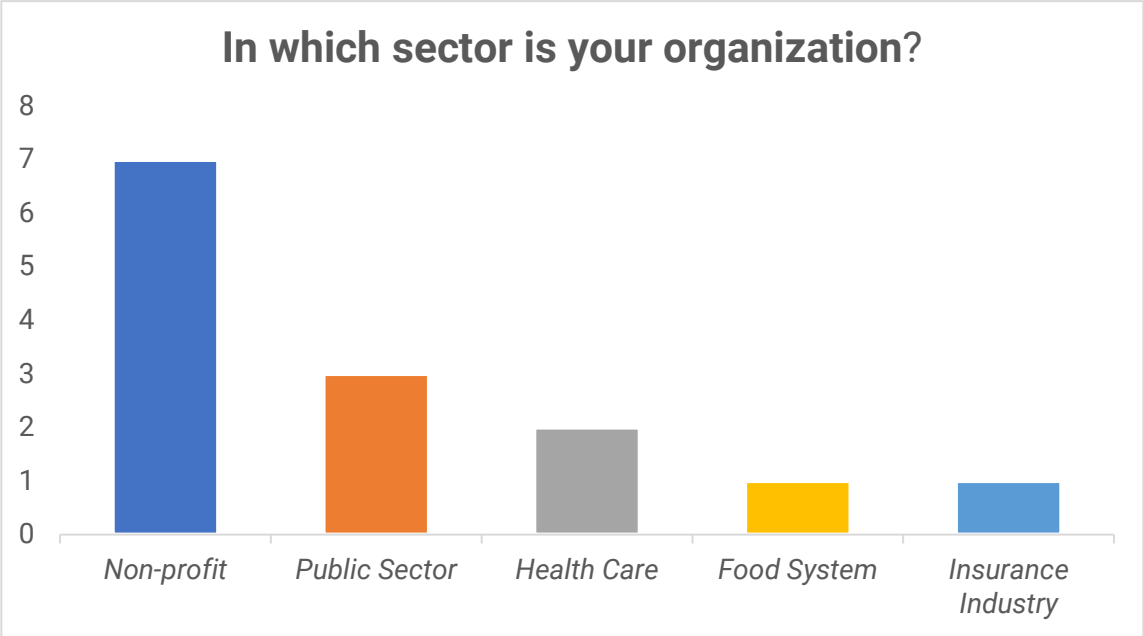
There were 22 participants engaged through a series of three online Listening Sessions. Representatives from the MCDPH Offices of Community Empowerment and Epidemiology observed the sessions to provide background context when applicable, and to learn directly from participants.

Listening session topic	No. Participants	No. Surveyed
Early Childhood Development	6	6
Access to Care	8	5
Access to Healthy Food	8	4

Number shortened to No.

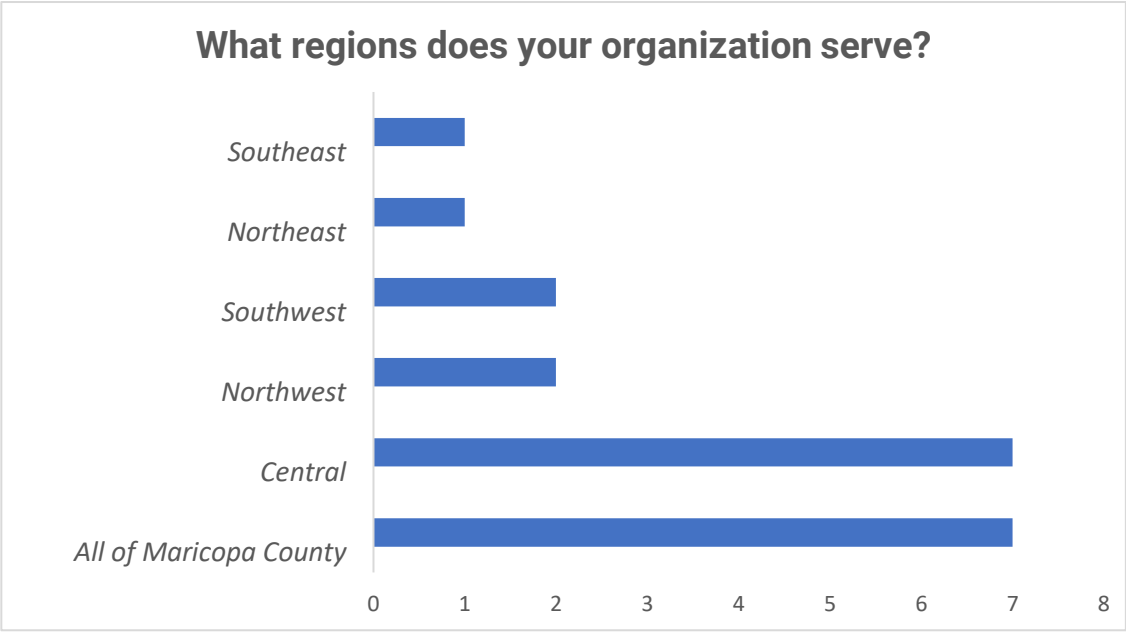
At the end of each listening session, participants were asked to complete a demographic survey. The survey was focused on the organization, rather than the individual participant. Although participants were strongly encouraged to complete the survey, there was no way to ensure that they completed it. There were 15 respondents to the demographic survey, and not all participants answered every question.

One hundred percent of participants from the Early Childhood group took the demographic survey (n=6). There were five responses from the Access to Health Care group (n=8) and four from Access to Healthy Food (n=8).



Half of respondents self-identified as working in the non-profit sector or at a grassroots organization. Other sectors mentioned included the public sector or government, health care or hospitals, the insurance industry, and one participant wrote in that they are a member of local food production system.

Participants were next asked which regions of Maricopa County they served. Respondents were permitted to select as many responses as applied. The most common responses were “All of Maricopa County” and “Central Maricopa”. All regions of Maricopa County were represented. Participants were also invited to write-in a response if they served a different area not offered as an answer choice. One write-in respondent wrote “South Phoenix” and another “Tempe”. Two respondents wrote in that they serve the entire “State of Arizona.”



The demographic survey inquired about any other MCDPH coalition, partnership, or program that the organization may support. Participants were able to select as many partnerships as applicable. The most commonly selected partnership(s) were the regional Community Action Boards through the Health Disparities grant representing the Central, Northwest, and Southeast regions (7). Other selected partnerships were Building Bridges to Health (a vaccine immunization equity team) (3), as well as South Phoenix Health Start (a home visiting program) (2).

The HIPMC and Community Alliance Consulting (CAC) would like to thank the following organizations for participating in the listening sessions. The following participant list is not associated with the organizations who did nor did not take the demographic survey. Some organizations attended multiple sessions, and some organizations sent multiple representatives to the same session.

Listening session participant organizations:

- **Arizona Commission for the Deaf and Hard of Hearing**
- **Blue Cross Blue Shield Health Choice (Medicaid Provider)**
- **ClipDart**
- **Cihuapactli Collective**
- **Department of Economic Security**
- **Family Tree Healthcare**
- **Food Forest Cooperative**
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For a list of weblinks provided by demographic survey respondents that showcase the work they have done (or are currently doing), please see the Appendix p.28.

The final survey question asked participant respondents if they had any other feedback for MCDPH about their participation in the HIPMC. There were eight responses that were generally positive, enthusiastic, and expressive of gratitude. There was no action-oriented specific feedback.

Early Childhood Development

The partners who make up the Health Improvement Partnership of Maricopa County (HIPMC) provided an array of services during the 2018 – 2023 Community Health Improvement Plan (CHIP) to support early childhood development. These services included Early and Periodic Screening, Diagnostic, and Treatment (**EPSDT**) assessments and **well child** visits, **children's rehabilitation** visits, and **complex medical care coordination**.

Home visiting services were brought to women, during gestation until baby's second birthday. This program addresses social determinants of health, empowerment, education, and early childhood literacy.

Parents were educated about developmental **milestones specific to deaf children** and children with hearing loss. These parents also learned about a variety of communication modalities available. Parents attended advocacy workshops where they learned how to participate and support their child's **IEP** process. Over 50 families were provided with referrals to the Arizona Early Intervention Program (**AZEIP**).

An opportunity has also been offered to **serve as the authority on how data is collected** from children with hearing loss, such as advisement on tools and assessments.

The Best for Babies conference was held in the spring of 2023, which provided essential **professional development** training. The facilitation of **endorsing toddler medical specialists** took place.

Child care services for children birth to five were provided at 11 licensed locations across Maricopa County, including one **new location** in Maryvale. **EMPOWER**, a prevention program that works to address health across 11 specific domains, is implemented all referenced locations. One of the domains is water safety, and all locations provided **swim lessons for all children** in attendance. Drowning prevention is an organizational priority.

Child care providers were **trained to meet licensing** requirements. **Scholarship funds** are also provided to students of early childhood education. Children also received services from **AZEIP**.

Education for state level law makers about the benefits of child care was delivered. Important child care landscape players have been connected for the purpose of collaboration.

Barriers

One barrier experienced by partners was a **drop in referrals to DES among Native Americans**. While referrals to DES in general have decreased, the drop among Natives is significantly greater. For this reason, one partner was struggling to meet their outreach numbers.

Staffing in early childhood is an ongoing challenge. Early childhood educators are typically **underpaid**. As the profession in general is undervalued, early childhood education centers do not receive any funding from state or federal entities to provide training or certification. All staff development is done internally.

During the Pandemic, child care centers and Head Start locations on Tribal lands were closed. According to one participant, in general, it can be difficult to get services on Tribal Nations.

"There's weird tricks you need to know to get services on the Res. You have to know the culture and language. It can be hard for [Tribal residents] to trust outsiders, especially when it comes to talking to our children. 'What if the outsider doesn't understand certain things?' It was hard on a personal level to give my children therapies when I was on AZEIP."

Culturally responsive and appropriate care was also important for the deaf community.

"If the parent of the child is deaf, cultural factors need to be considered. There are issues among professionals and differences in philosophies about communications. Not all modalities prefer [American Sign Language]. A lot of barriers to culturally appropriate care arise based on misconceptions about communication. Access to communication for deaf parents is not available, ASL interpreters for example. There is a lack of communication overall to deaf adults."

The **lack emphasis of education as a cultural value** was present in some communities served, due to the community's challenges related to social determinants of health. These same communities were also challenged by a **lack of linguistic accessibility**, as most services are available primarily in English.

One participant mentioned the challenge of potential collaborators being stuck in **silos**. More communication overall was desired.

Lack of financial resources is a barrier. The funds from MCDPH provide opportunities for networking currently, but one participant was concerned about what will happen once the project is complete and the funds are expended. Payroll and writing new grants is the focus, which makes it difficult to reach excellence in program delivery.

The **number of therapeutic foster families available** for children's placement has dropped significantly since the Pandemic. On a related note, the vetting process for new therapeutic foster families has become so arduous that the process is turning viable families away.

Partners in Early Childhood Development

The following partners (listed alphabetically) were mentioned by LS participants as being excellent collaborators in the early childhood development space:

- **Accountable Care Organizations (in general)**
- **Arizona Early Childhood Education Association**
- **Arizona Department of Education (ADE)**
- **Arizona Early Intervention Program (AZEIP)**
- **Arizona State Schools for the Deaf and Blind**
- **Arizona State University**
- **Calenden**
- **Children's Action Alliance (CAA)**
- **Children's Hospital**
- **Courts (County, Municipal, State)**
- **Department of Child Safety (DCS)**
- **Department of Developmental Disabilities (DDD)**
- **First Things First**
- **Glendale Strong Families**

- **Healthy Families**
- **Infant and Toddler Mental Health Coalition of Arizona**
- **Raising Special Kids**
- **Southwest Human Development**
- **Valley of the Sun United Way**

Benefits of the HIPMC

Partners in attendance were asked what kind of benefits they had experienced related to their participation in the HIPMC.

"Growing together and partnering to serve the community."

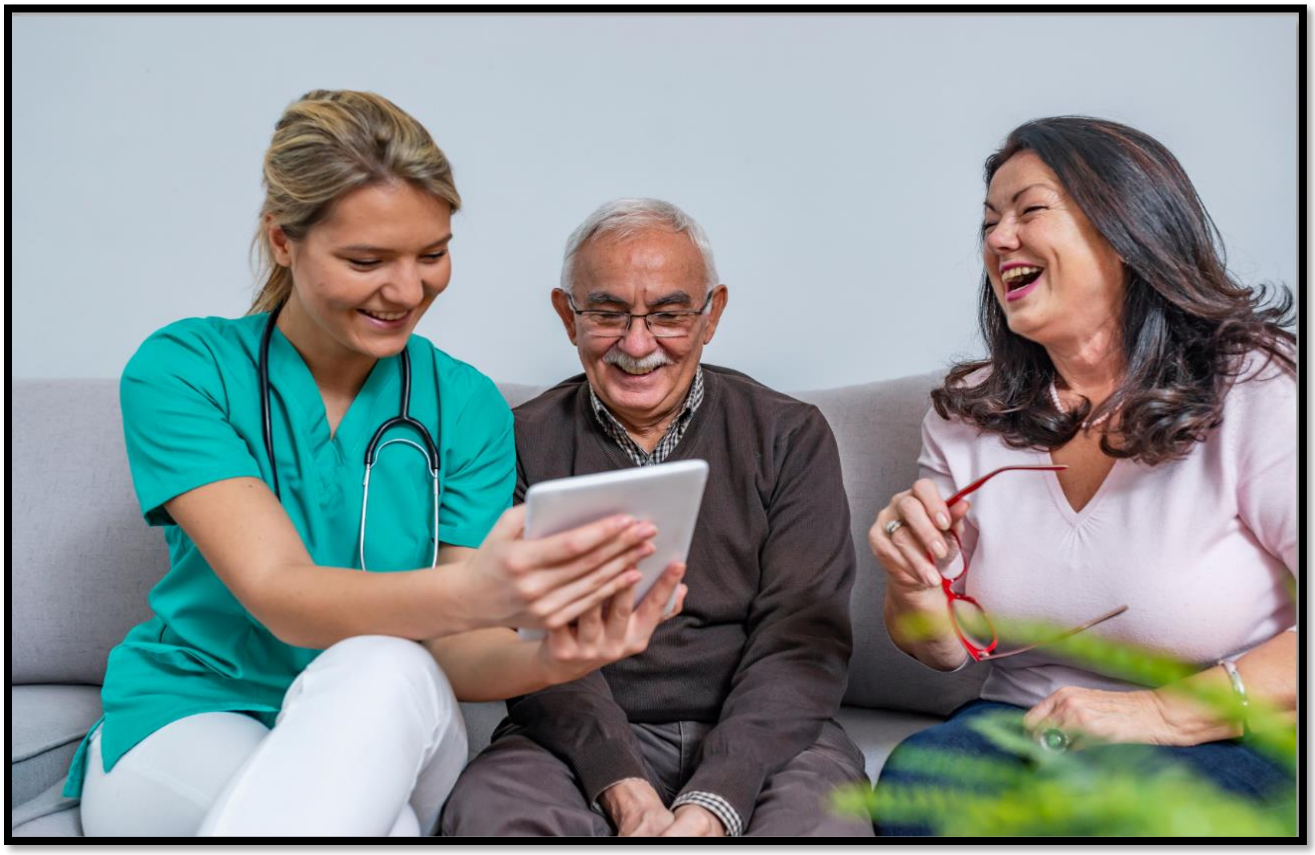
Networking and learning with other who share the same passion was a major benefit for HIPMC participants. A common theme was **learning about what else is happening** in the community, and what resources may be available. **Opportunities to collaborate** currently or in the future come to life at HIPMC meetings. One participant mentioned they really like reading the HIPMC **newsletter**.

MCDPH Support Opportunities

Future facilitated conversations were requested. Specifically, one partner wanted opportunities to learn more about health care initiatives and how child care organizations can work with health care providers and insurance companies.

Hyper-local data (by zip code) was requested. A **dashboard specific to children birth to five** and available resources was suggested. Mapping of child care deserts was another idea generated.

Access to Care



The Health Improvement Partnership of Maricopa County (HIPMC) partners convened to discuss how they've facilitated access to care, and provided many examples from the 2018 – 2023 Community Health Improvement Plan (CHIP). These services included many partnerships, programs, and tailored population support.

One HIPMC participant discussed how a non-profit organization provides access to hair care as a part of whole health. **Free barber services** are paired with access to **health care applications and referrals**, in addition to other **community resources**.

"Hair care is part of health care, part whole health care and mental health care. It's hard to go out there and feel and be your best if you are not connecting with the person in the mirror."

Another participant discussed how they are currently preparing to launch a wellness center. A part of this preparation work includes conducting a **highly localized community needs assessment**, to ensure the programs and services designed will meet the needs of the specific community served.

Referrals for AZEIP services were provided within child care centers to connect young children to occupational, physical, and behavioral therapies.

Currently ramping up is a back to school campaign partnership with Arizona Health Care Cost Containment System (AHCCCS). The purpose is to outreach to parents and **increase adherence to well visits** among students. A diaper campaign is also run annually. Other efforts from the last CHIP cycle include text message health promotion campaigns, mammogram promotion campaigns, staging wellness days at clinics, and attending health fairs. Customers are also offered benefits education for their insurance plan to make sure they know what is available and can maximize their own health supports.

Internal policies have been implemented to develop a culture of empowering staff to address root causes and **social determinants of health**. Staff are specifically trained to address gaps in care, identify barriers to care, and extend and improve support and care in these areas to feasibly have an impact. Clinical specialists are available to support customers with complex medical care cases.

Another organization reported attending health fairs, where they provided **blood pressure screenings** and **cholesterol checks**. Access to these screenings was increased during the Pandemic to increase access to important health monitoring methods during a time when a lot of health care centers were closed.
An agency trains and certifies **Community Health Workers** to provide community education on prenatal care, cancer prevention, and tobacco related education.

A **community therapy** program has been developed, where Community Health Workers provide emotional support to families that are stressed or transitioning. This program focuses on teaching coping strategies.

One participant described being a part of a **systems change** initiative specific to mental health. This entails facilitation of listening sessions with community members geared toward barriers to accessing care, with the intention of crafting policy recommendations. **Amplifying mental health** in each conversation, whether with a hospital partner or in the community.

Barriers

The effects of the **Pandemic** provided myriad, serious barrier for Access to Care, especially during 2020 and 2021. It was very difficult for community members to seek health care when it was difficult to discern which health care providers were open, and which were closed. While the expansion of telehealth was an excellent advancement to increase the availability of health care in general, that also presented a new set of barriers. Not all patients have access to the technology needed, and there are some health care methods that can only be delivered in person.

Expansion and use of telehealth caused **major operational changes** within organizations. Telehealth visits are still at around 15% of all patients. This has caused organizations to consider permanent changes for staff duties, billing procedures, and use of electronic platforms.

The **unwinding of the Public Health Emergency** act has long reaching and unintended effects. The need for funds among disparate health care centers has led to a serious increase in fraud, specifically among Natives in sober living houses. Agencies have been found to double bill patients' coverage to increase their pay out. Efforts have been made to contact patients who have been frauded, and **facilitate their Medicaid renewals** (and assisting with denials).

Classroom management was a challenge for some educators, due to behavioral health struggles.

"They are not prepared to be in school. I am seeing kids expelled from elementary school, even preschool due to their behaviors. How do we stop that? We need to have the kids play outside, give them access to their siblings and relatives. They missed out on a lot of events, they don't know how to behave in society. Even in high academic schools we see drugs, alcohol, and depression."

Partners in Access to Care

The following partners (listed alphabetically) were mentioned by LS participants as being excellent collaborators in facilitating access to care for community members:

- **Advocacy groups (in general)**
- **Andre House**
- **Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid program)**
- **Community members – repeat visitors for care**
- **Governor's Office**
- **Maricopa County Department of Public Health**
- **Nourish Phoenix**
- **Rising Youth Theater**
- **Senior Centers (in general)**
- **Social Spin**

One partner mentioned that they are just in the beginning stages of a community needs assessment, and therefore will be expanding on partnerships in the near future.

Benefits of the HIPMC

One of the resounding benefits touted by participants was the **network sharing** and **collaboration opportunities** made possible through attending the HIPMC.

"How can we work together and collaborate, because we are all of the same mindset to serve the community."

Partners provided examples of supporting one another's efforts. One of the community center based participants had an **ongoing event scheduled** with the community barber program to bring haircuts to seniors once a month.

"The HIPMC has been a bridge to all the work being done all over the county."

During the Pandemic, women who had been receiving their prenatal care at Phoenix Indian Medical Center (PIMC) were not able to deliver there. Although they lived and worked in the Valley, many had to go and deliver on the Reservation they were from. Unfortunately, many were not eligible for health care benefits. Participation in networking can help alleviate these gaps in care.

"Meeting other organizations, we can benefit from helping with their gaps in service and bring value to others."

When members of the Salt River Pima Maricopa Indian Community or Gila River Indian Community move to the Phoenix Valley, they automatically lose their nutritional support or child care support benefits, and must reenroll through the state and federal programs. Many are not aware of this, and participating in networks like the HIPMC also assists with connecting community members to many resources access points in the county.

MCDPH Support Opportunities

Participants appreciated the connection to the HIPMC and **networking opportunities**. They also wanted access to **trainers** who support and understand the work they are doing.

Session attendees also shared that they would like continued **guidance and promotion of the data** available to community members, especially data related to social determinants of health.

Access to Healthy Food

The Health Improvement Partnership of Maricopa County (HIPMC) partners shared efforts conducted during the 2018 – 2023 Community Health Improvement Plan (CHIP) to address access to healthy food.

One participant described coordinating healthy eating and **healthy lifestyle events**, especially those that promote **community dialogue**. Several **action groups** have been convened. For example, based on the data that describe 26% of African American youth have not had a vegetable in the last week, compared to 10% of overall youth, food buses will be sent into areas in South Phoenix that are food insecure.

"We provide support for communities womb to tomb, which includes our food justice initiatives and our food forest."

One participant is an **ancestral foods based chef**, and the organization facilitates **culturally relevant Community Sustained Agriculture** (CSA) boxes, recipes, and **food demonstrations**. The organization supports a **one acre farm** and **100 citrus trees**. One of the organization's main missions is to make culturally relevant, historically relevant, and local foods accessible to the community. Their food products are going into food distribution packages along with education related to herbal and food medicines. The intention is to heal communities by leveraging the organization's own ecosystem of sustainability through the catering business.

"In the food forest context, we're talking about access to food but also the engagement of being in the land, in the dirt. It's so valuable, beyond what we can articulate. From youth to grown adults we invite you, come to food forest and ask questions. Logistics are necessary, but the human connection is there."

One organization provides **fresh vegetable totes for members of senior centers**. The organization facilitates the entire process, from ordering to distribution, utilizing volunteers and community based partnerships. The **Healthy Roots** program is facilitated by Community Health Workers at the local garden space. The organization also supports farmers at Spaces of Opportunity.

Since 2019, one organization has been **working with urban small scale local farmers to build their capacity**. Next, they are looking to develop a certification program and associated scholarships. This effort will include a demonstration farm and education in sustainable practices.

One non profit group was assisting with facilitation of **free breakfast in the classroom** for kids. This group also supports **summer meals** and **family congregate meal** opportunities. Connections to **SNAP** and **WIC** enrollment are facilitated through community engagement and meals to **address the gap in those eligible for benefits and those enrolled**. This includes **dispelling myths and misconceptions** about benefit enrollment.

One group in the last five years has facilitated a community garden. Two years ago, the garden program had one participant. Now there are 25, including children who are growing up participating. Included with the garden are educational efforts.

"We are trying to teach every day we can eat healthy and have an opportunity to garden. Let's take care of it every time we pass through. We want to see if we can have more classes about healthy communities. The garden is two years old. It has all kinds of different veggies. We love lemongrass. We want to bring information back to our community. It's an opportunity to connect with the earth. Our body needs energy from healthy food."

Educational efforts have been recently more successful; after the impact of the Pandemic attendance is finally back up.

"There has been an observable increase in our summer programs. We used to have five to seven in a class. We would have to look for other participants to maintain a classroom. Now we have waiting lists! There are over 25 in each classroom, and we are trying to expand our services. Maybe next summer we will have two sessions."

Attendees also shared with excitement **environmental changes** that they are facilitating. A local store is going to implement **Double-Up Food Bucks** and has agreed to **buy their produce locally** from Arizona. Double-Up Food Bucks participation has increased 15% since last March through the educational and promotional efforts of Community Health Workers.

Barriers

While the goal is to provide families with healthy food through efforts like food pantries, that is not always possible. Sometimes the **shelf stable foods are not the healthiest** to be distributed the community, and may be less culturally relevant.

Conversely, another participant described that because they offer culturally relevant, less common foods, success can be difficult. **Nutrient dense and culturally relevant foods are scarce**.

"How do we weave together our effort in a food system that was not built to support localized, culturally meaningful production?"

For small scale growers, there is a need for **access to cold storage and kitchen space**. Small scale growers also encounter **challenges preserving their farm lands**.

One partner discussed **how difficult it has been for them to partner with elementary school systems** due to their level of business. The participant felt that if they were able to make that connection, they would have a bigger impact. A few school based gardens have been executed, but there is more room for impact. The session participant felt that onsite food pantries would be valuable.

Many families have relied on food pantries since the Pandemic for their regular acquisition of food. Unfortunately, **food pantries are running out**, and families are going hungry.

One agency representative mentioned that the organization's **capacity to involve volunteers** has been inadequate. Another described that it is challenging for organization to follow the **waves of financial resources, which may not be consistent**.

There was a concern among food security session attendees about the **need to communicate effectively with the public** about what resources do exist. Attendees were not sure which platforms are the best. The sentiment was that no one should be a gatekeeper of information, and that as a group organizations can work together and get the information to those who need it. Participants described finding means to **bring the information to community members where they are, on the weekends**, and not during the day during the work week.

Understanding the barriers to care from the perspective of community members was mentioned. A suggested method to learn more through a cultural lens of the community would be to facilitate an **art exhibit** on the topic, and invite contributions like painting or poetry on the theme of resiliency.

One participant mentioned that food security is inseparable from the issue of obesity, which is an incredibly complex issue to address. There are many layers involved in the obesity epidemic, including genetics, trauma, and patterns of incarceration. Obesity cannot be addressed as a standalone issue.

"We here in Arizona are 8th in the world for incarceration. How many families are living without an adult? Who is going to help with the burden of reentry into society? We must be fostering love and connection through food."

Partners in Access to Healthy Food

The following partners (listed alphabetically) were specified by LS participants as being instrumental in facilitating access to healthy foods for community members:

- **City of Phoenix**
- **Keep Phoenix Beautiful**
- **Local food producers (in general)**
- **Local universities (in general)**
- **Maricopa County**
- **Mayo Clinic**
- **National Food Security Act**
- **Not-for-profit food producers**
- **Pinnacle Prevention**
- **Quetzal Coop**
- **Sana Sana Foods**
- **SNAP Outreach teams (in general)**
- **Spaces of Opportunity**
- **St. Mary's Food Bank**
- **Sun Produce Coop**
- **Urban Indigenous Food Coalition**
- **Wildfire SNAP Outreach**

Benefits of the HIPMC

The most common benefit mentioned of participating in the HIPMC was **connection**.

"You meet others doing the work. Ideas and projects stem from that. It's powerful."

Understanding what is happening in the health promotion community was also important to participants.

"I appreciate being able to know who's doing what in which areas of the city. And being able to share our work. We're in it – we're going to celebrate [our work] a lot. And sharing helps with that."

MCDPH Support Opportunities

Listening session participants want to know what the **priorities of the food system** community may be. Participants saw an opportunity for MCDPH to support the effort of **mapping out farmers, producers, their standards**, and connecting producers to more resources. Producers want **education** and **partnerships**.

Listening session participants reported that they would also like MCDPH to continue **funding** different ideas in the community, and **facilitating the use of data** in the general sense. Attendees would like to see MCDPH use **asset-based frameworks** in their efforts.

MCDPH must also **continue to work to earn trust** from members of the community, especially when it comes to collecting health data. Hiring from diverse backgrounds was important to respondents.

"The faces should represent the community."

Overlapping Themes

Recurring Themes

There were several areas of HIPMC partner work during the last CHIP cycle (2018 – 2023) that resonated among partner discussions.

Many organizations provided **navigation and the facilitation of referrals** for community members. Partners mentioned connecting community members to supportive, resources in general and also specified referrals to EPSDT, AZEIP, SNAP, and WIC. Partners also facilitated AHCCCS enrollment and support for persons responding to denials. Provision of direct resources such as food boxes also occurred within multiple contexts and among many organizations.

Education across the social-ecological spectrum is taking place. Some organizations are providing health education directly to community members about healthy eating, coping strategies, disease prevention, and how to enroll in services. Other organizations are focused on educating mid-level members of the system, such as farmers and civil servant entities, while some HIPMC members are focused on educating lawmakers. Intentional conversations are taking place around raising awareness of mental health among peer organizations as well.

Quite a bit of **community building and mobilization** is taking place, as evidenced by locally oriented and community-guides needs assessment, community events, facilitation of community dialogue, and subsequent launching of specific action groups. A related effort is the cultivation, promotion, and distribution of culturally and historically relevant foods.

Systems change efforts were present in all HIPMC LS. Partners spoke about crafting community-guided policy recommendations for mental health supporting organizations and health care entities. Other systems change initiatives were focused on the food system, such as connecting farmers with distribution options and government payment systems, as well as facilitating the purchase of local produce for procuring organizations.

Notable Barriers

There were several barriers that resounded among LS participants. As this Community Health Improvement Plan (CHIP) took place from 2018 – 2023, the **COVID-19 Global Pandemic** absolutely influenced and stressed all HIPMC work partners. The Pandemic was responsible for many of the enduring barriers to the community-level health improvement work. One such

barrier was the **inadequate staffing** of participant organizations, which carried over into the volunteer spaces. Multiple organizations described that they cannot retain reliable staff and the **volunteer supply** has seriously dwindled. The COVID-19 Pandemic also affected **participation numbers**, and instigated number of **major operational changes** that have challenged organizations to grow while meeting an increased demand for services.

On a related note, organizational representatives shared they are faced with **inadequate funding** in general. While organizations who benefitted from the recent wave of federal resources related to the COVID-19 emergency and recovery were grateful for the opportunities, the knowledge that this **influx of resources is temporary** can threaten organizational stability. Multiple LS participants described "looking around the corner" and spending a lot of time writing grants and preparing financially for program continuity. LS participants described that many **food pantries are running out of food**, and families are going hungry.

Participants from all LS described the **need to communicate effectively with the public** about the resources that are available to them. Communications need to be through the channels they already access, and according to participants the **information should be brought directly to community members where they are**, "on the weekends".

"[Outsiders] on the Res don't know how to greet families or introduce themselves. It feels like they're being disrespectful. Introducing yourself is important. Share your name, where you're from, what you're doing, and why. This applies across Indian communities. You have to accept the cup of water, even if you don't drink it. To be able to play the [assessment, therapy] games with the children and determine their meeting of milestones, you need to earn [parents'] trust."

2018 – 2023 HIPMC Outcomes

During HIPMC meetings, partners spoke enthusiastically about the **connection** they experienced. **Networking** was by far the most referred to benefit of participating in the HIPMC. **Members loved learning** about one another's organizations and efforts, as well as the types of **resources**, efforts, and programs that are happening in Maricopa County to support communities. **Meeting with other professionals who have a similar mindset** was very important to HIPMC participants.

HIPMC participants were really excited about the **collaboration opportunities** that arise from HIPMC meetings. In addition to hopeful opportunities and sharing resources, some actual collaborations have come out of the HIPMC where partners are **co-delivering services and actively partnering** to support communities**. Gaps in service have also been addressed** with this type of synergy.

Another direct result of the HIPMC activity is that local organizations in the public health system have become **more engaged in data** across the board. HIPMC members reported an increase in the use of data provided by MCDPH, and there was an observable thirst for more data and more training to use it. Organizational representatives also said they would love to see the available dashboards continue to be promoted.

The organizations that comprise the HIPMC also achieved a number of activities that were designed to impact the priorities determined by the CHIP. The following efforts were achieved by multiple organizations in the HIPMC:

- **Increased navigation and referrals**: Members of the HIPMC were focused on increasing the number of community members with appropriate screenings, medical treatment, well care, health insurance, behavioral health care, food resources, economic benefits, and more.
- **Community-wide gains in knowledge**: Information, awareness, and training was provided across the socio-ecological spectrum of the community, from individual members, to mid-level systems and networks, to policy and law makers.
- **Empowered neighborhoods**: Local communities have mobilized to self-reflect, set goals, and move to action and make change. These efforts increase the level of community ownership in local efforts and ensure the cultural appropriateness of activities offered.

MCDPH Support

As host of the HIPMC, steward of the CHIP, and author of the cyclical Community Health Needs Assessment (CHNA), the Maricopa County Department of Public Health has many opportunities to continue supporting this interdisciplinary work and support the public health landscape. Partners suggested several ideas for future support.

Serving as a convener was a resounding theme during LS discussions. Organizational representatives shared that they love networking opportunities, and hope there will be more of them. Specific requests were facilitated networking opportunities between child care providers and health care and health insurance partners, as well as facilitation of introductions of food producers to members of the public health system in general.

Continued professional development and **training** was requested.

Partners had many suggestions and priorities related to data. One request was that MCDPH continue to provide guidance on the use of their available online data sets, promote awareness of the sets, and even **facilitate use of MCDPH's mySidewalk data sets**. Further exploration of Maricopa County was also desired. Participants specifically requested "**hyper local data**" by zip code, a **dashboard specific to zero to five** populations, and the **mapping of farmers and food producers** by their growing standards (such as conventional, certified organic, or naturally grown). Finally, further research of the food system's priorities was requested.

Appendix

Partner Websites

The following websites were provided by partners who responded to the HIPMC LS demographic survey.

Organization	Weblink(s) Provided
Blue Cross Blue Shield Choice (Medicaid Provider)	https://itmhca.org https://www.healthchoiceaz.com/
Cihuapactli Collective	https://www.cihuapactlicollective.org https://www.sanasanafoods.com
Department of Economic Security	https://des.az.gov/services/child-and-family/child-care https://des.az.gov/azeip https://des.az.gov/about/office-of-tribal-relations
Family Tree Health Care	https://www.familytreehealthcare.com/
Food Forest Cooperative	https://www.instagram.com/ffc_phx/ https://www.facebook.com/ffcphx
Valley of the Sun YWCA	https://ywcaaz.org/systems-change/