2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Flagstaff/Northeast & Verde Valley Regions, Arizona

Sponsored by
Flagstaff Medical Center

in collaboration with
Verde Valley Medical Center

Northern Arizona Healthcare

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Prepared by
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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment — a follow-up to a similar study conducted in 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Flagstaff Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

This joint assessment for Flagstaff Medical Center (FMC) and Verde Vally Medical Center (VVMC) was conducted on behalf of Northern Arizona Healthcare by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

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

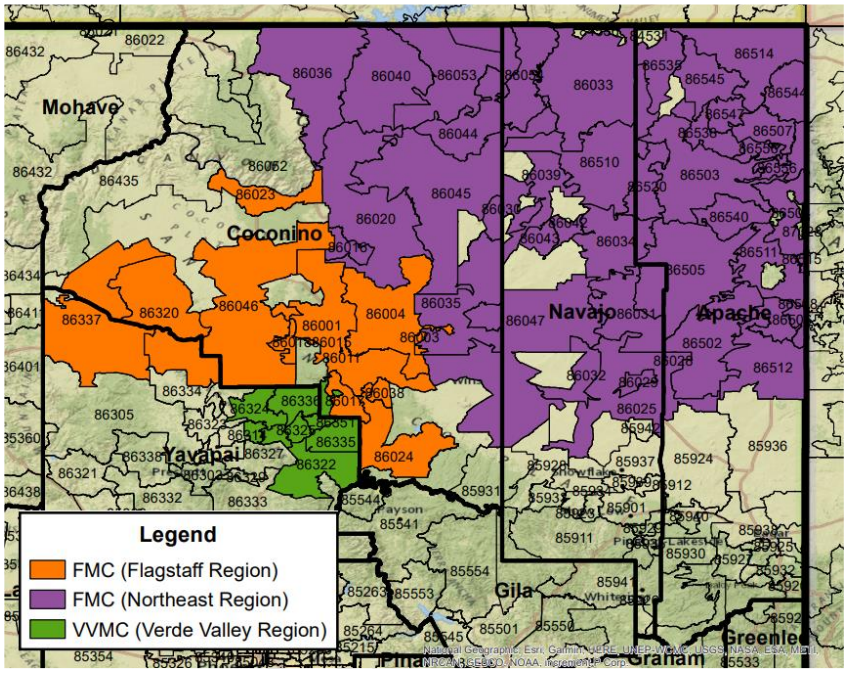
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Total Area” in this report) is defined as each of the residential ZIP Codes comprising the Flagstaff and Northeast regions (the service area of Flagstaff Medical Center), as well as the Verde Valley Region (the service area of Verde Valley Medical Center). This community definition — determined based on the ZIP Codes of residence of more than 70 percent of recent patients of Flagstaff Medical Center and approximately 90 percent of recent patients of Verde Valley Medical Center — is illustrated in the adjacent map.



The Flagstaff and Northeast Regions together make up the **FMC Service Area** *(secondary data: Coconino, Navajo & Apache Counties)*

The Verde Vally Region makes up the **VVMC Service Area** *(secondary data: Yavapai County)*

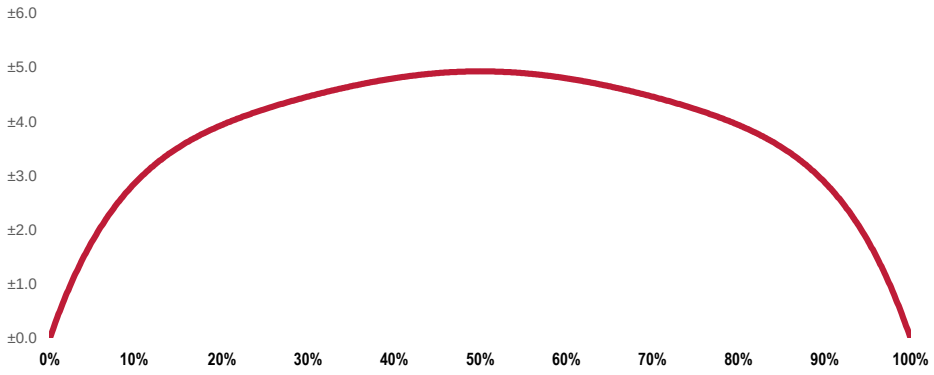
Sample Approach & Design

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

The sample design used for this effort consisted of a stratified random sample of 406 individuals age 18 and older in the Total Area, including 120 in the Flagstaff Region, 84 in the Northeast Region, and 202 in the Verde Valley Region. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 406 respondents is ±4.9% at the 95 percent confidence level.

Expected Error Ranges for a Sample of 406 Respondents at the 95 Percent Level of Confidence



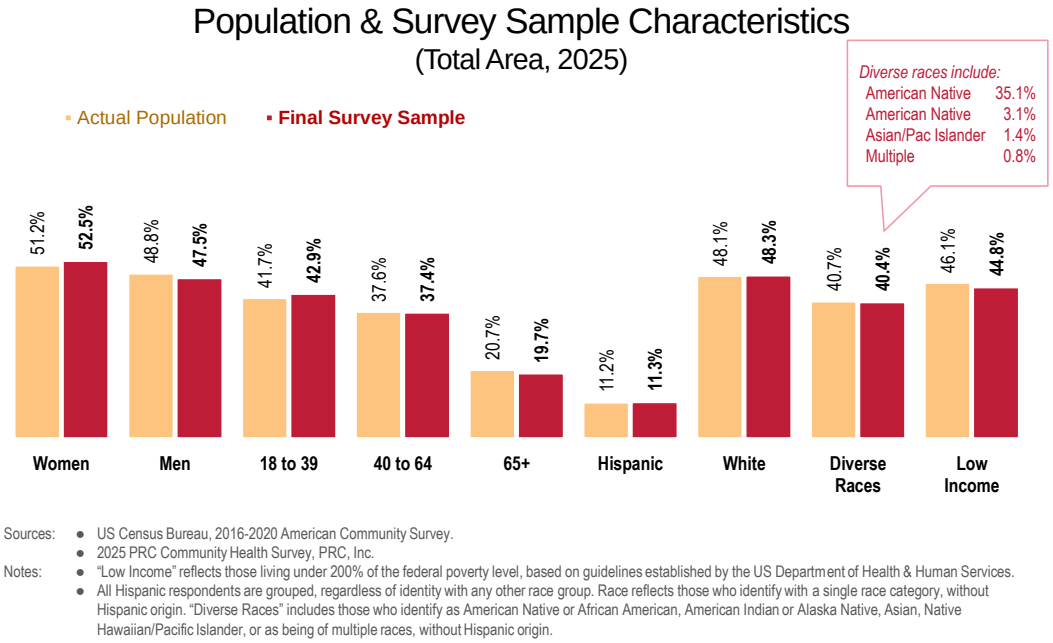
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 406 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% ± 2.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% (50% ± 4.9%) of the total population would respond "yes" if asked this question.

Sample Characteristics

Once all interviews were completed, these were combined and weighted to best reflect the area as a whole. To accurately represent the population studied, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses might contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics might have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Total Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

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

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

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 101 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	12
Health Care Leaders	46
Social Services Providers	9
Other Community Leaders	34

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Although Northern Arizona Healthcare solicited input from public health representatives, none was received. Final participation included representatives of the organizations outlined below.

- Arizona State University
- Camp Verde Unified School District
- Cashmere Properties, LLC
- Catholic Charities – Cottonwood
- City of Clarkdale
- City of Flagstaff
- City of Sedona
- City of Winslow
- Clarkdale-Jerome School District
- Coconino County
- Cottonwood-Oak Creek Schools
- Flagstaff Emergency Physicians
- Flagstaff Family Food Center
- Holbrook Ranch
- Housing Solutions of Northern Arizona
- Melvin Consulting, PLLC
- Native Americans for Community Action
- North Country HealthCare
- Northern Arizona Healthcare
- Northern Arizona Healthcare Medical Group
- Northland Family Help Center
- Page Hospital
- Poore Medical Clinic
- San Juan Southern Paiute Tribe
- Sedona-Oak Creek Unified School District
- Southside Community Association
- Terros Health
- TGen North
- The Peaks
- Town of Camp Verde
- TransIntimate
- Verde Valley Caregivers Coalition
- Williams Unified School District #2
- Winslow Indian Health Care/Dilkon Medical Center
- Yavapai County

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

Public Health, Vital Statistics & Other Data

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

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

Note that secondary data reflect county-level data for Coconino, Apache, and Navajo counties (representing the FMC Service Area) and Yavapai County (representing the VVMC Service Area).

Benchmark Comparisons

Trending

A similar survey was administered in the Flagstaff Region and Verde Valley Region in 2022 by PRC. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available *(note that these survey comparisons reflect only the Flagstaff and Verde Valley Regions)*. Historical data for secondary data indicators for the four-county area are also included for the purposes of trending.

Arizona Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing sources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

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

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

Determining Significance

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

Information Gaps

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

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

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

Public Comment

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

IRS Form 990, Schedule H Compliance

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

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	26
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	114
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	136

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths – Including Prostate Cancer, Female Breast Cancer, Colorectal Cancer ▪ Cancer Prevalence (VVMC Service Area) ▪ Female Breast Cancer Screening [Women 50-74]
DIABETES	▪ Diabetes Deaths ▪ Kidney Disease Deaths
DISABLING CONDITIONS	▪ Alzheimer’s Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Stroke Deaths
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care (FMC Service Area) ▪ Infant Deaths ▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash Deaths ▪ Homicide Deaths (FMC Service Area)
MENTAL HEALTH	▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* ranked as a top concern.

— *continued on the following page* —

AREAS OF OPPORTUNITY (continued)	
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths ▪ Asthma Prevalence
TOBACCO USE	▪ Cigarette Smoking ▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

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

It is also important to note that the **Social Determinants of Health** are a cross-cutting issue that impact all of the above and also ranked highly among key informants' concerns.

Hospital Implementation Strategy

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

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

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, Total Area results are shown in the larger, gray column.
- The columns to the left of the Total Area column provide comparisons among the regions and between the two hospital service areas, identifying differences for each as "better than" (🌞), "worse than" (🌧), or "similar to" (☁) the opposing area.
- The columns to the right of the Total Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Total Area compares favorably (🌞), unfavorably (🌧), or comparably (☁) to these external data.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2022. **Trending for survey data reflect only the Flagstaff and Verde Valley Regions** (excluding the Northeast Region, which is a recent addition to the survey sample).

OTHER (SECONDARY) DATA INDICATORS:

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

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

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

SOCIAL DETERMINANTS	DISPARITY AMONG REGIONS: Flagstaff Region	Northeast Region	Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	1.4	5.3	1.8	3.5	1.8	**2.7** [Four-County Data]	2.9	3.9		
Population in Poverty (Percent)	17.7	27.2	12.6	23.0	12.6	**18.4** [Four-County Data]	12.8	12.4	8.0	
Children in Poverty (Percent)	18.7	34.4	17.8	28.3	17.8	**24.8** [Four-County Data]	17.0	16.3	8.0	
No High School Diploma (Age 25+, Percent)	8.0	14.4	7.5	11.6	7.5	**9.6** [Four-County Data]	10.9	10.6		
Unemployment Rate (Age 16+, Percent)	3.8	5.8	3.0	4.7	3.0	**3.9** [Four-County Data]	3.5	3.9		10.1
% Unable to Pay Cash for a $400 Emergency Expense	36.2	54.8	40.0	46.1	40.0	**44.6**		34.0		27.9
Housing Cost Exceeds 30% of Income (Percent)	29.9	16.6	27.6	22.9	27.6	**25.2** [Four-County Data]	28.0	29.3	25.5	
% Unhealthy/Unsafe Housing Conditions	16.5	14.7	13.7	15.6	13.7	**15.1**		16.4		13.1
Population With Low Food Access (Percent)	32.5	48.6	35.8	41.7	35.8	**39.3** [Four-County Data]	26.8	22.2		
% Have Access to the Internet	97.3	91.0	95.5	94.0	95.5	**94.4**				
"Not At All Comfortable" Accessing the Internet	2.7	5.0	2.4	3.9	2.4	**3.5**				

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
OVERALL HEALTH	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
% "Fair/Poor" Overall Health	14.8	24.7	15.6	20.0	15.6	**18.9**	19.2	15.7		18.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

	better	similar	worse

	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
ACCESS TO HEALTH CARE	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
% [Age 18-64] Lack Health Insurance	18.4	13.0	10.3	15.5	10.3	**14.5**	13.5	8.1	7.6	9.6
% Cost Prevented Physician Visit in Past Year	28.1	12.7	14.8	20.0	14.8	**18.7**	12.1	21.6		17.0
% Cost Prevented Getting Prescription in Past Year	19.5	6.7	16.0	12.7	16.0	**13.5**		20.2		13.3
% Difficulty Getting Appointment in Past Year	41.8	15.3	38.5	27.7	38.5	**30.4**		33.4		
% Transportation Hindered Dr Visit in Past Year	15.5	23.1	10.0	19.5	10.0	**17.2**		18.3		10.4
% Language/Culture Prevented Care in Past Year	4.9	2.2	0.7	3.5	0.7	**2.8**		5.0		
% Difficulty Getting Child's Health Care in Past Year			23.4	2.0	23.4	**6.2**		11.1		5.7
Primary Care Doctors per 100,000	82.0	54.7	55.3	67.1	55.3	**62.0** [Four-County Data]	66.5	74.9		

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG REGIONS: Flagstaff Region	Northeast Region	Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
% Routine Checkup in Past Year	54.4				71.4		74.5	65.3		55.1
% [Child 0-17] Routine Checkup in Past Year			67.2	92.6	67.2			77.5		80.2
% Rate Local Health Care "Fair/Poor"	33.8	7.6	23.1	20.0	23.1	**20.8**		11.5		24.5

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER	DISPARITY AMONG REGIONS: Flagstaff Region	Northeast Region	Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	122.2	185.2	306.6	156.6	306.6	**221.9** [Four-County Data]	177.3	182.5	122.7	200.2
Lung Cancer Deaths per 100,000						**38.5** [Four-County Data]	34.1	39.8	25.1	
Female Breast Cancer Deaths per 100,000						**32.2** [Four-County Data]	25.7	25.1	15.3	
Prostate Cancer Deaths per 100,000						**30.6** [Four-County Data]	21.2	20.1	16.9	
Colorectal Cancer Deaths per 100,000						**22.6** [Four-County Data]	16.5	16.3	8.9	
Cancer Incidence per 100,000	336.1	322.8	395.3	328.0	395.3	**365.1** [Four-County Data]	376.6	442.3		

CANCER (continued)	DISPARITY AMONG REGIONS: Flagstaff Region	Northeast Region	Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
Lung Cancer Incidence per 100,000	26.2	23.8	43.2	24.7	43.2	35.3 [Four-County Data]	41.6	54.0		
Female Breast Cancer Incidence per 100,000	105.0	78.9	127.5	89.1	127.5	109.8 [Four-County Data]	113.0	127.0		
Prostate Cancer Incidence per 100,000	73.9	73.2	73.9	73.5	73.9	73.7 [Four-County Data]	76.4	110.5		
Colorectal Cancer Incidence per 100,000	25.9	32.6	31.0	29.9	31.0	30.5 [Four-County Data]	30.8	36.5		
% Cancer	10.9	7.8	15.2	9.3	15.2	10.7	13.8	7.4		11.3
[Women 50-74] Breast Cancer Screening (Percent)	64.1	61.9	64.4	62.9	64.4	63.6 [Four-County Data]	72.7	76.5	80.5	

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY AMONG REGIONS: Flagstaff Region	Northeast Region	Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	24.9	60.3	34.3	44.3	34.3	39.9 [Four-County Data]	33.8	30.5		28.6
% Diabetes/High Blood Sugar	7.1	15.6	11.6	11.5	11.6	11.6	11.4	12.8		10.1

	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
DIABETES (continued)		**Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**		**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
Kidney Disease Deaths per 100,000	7.6	23.6	15.2	16.3	15.2	**15.8** [Four-County Data]	11.6	16.9		10.3

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
							vs. AZ			
% 3+ Chronic Conditions	18.1				25.5	**20.3**		38.0		
% Activity Limitations	24.4	24.5	29.1	24.5	29.1	**25.6**		27.5		28.2
Alzheimer's Disease Deaths per 100,000	22.6	31.8	67.4	27.6	67.4	**44.9** [Four-County Data]	37.8	35.8		38.2

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
HEART DISEASE & STROKE	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
Heart Disease Deaths per 100,000	105.2	214.7	302.5	165.0	302.5	**224.9** [Four-County Data]	198.9	209.5	127.4	191.9
% Heart Disease	3.2	2.9	7.3	3.1	7.3	**4.1**	6.2	10.3		6.7

	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
	Flagstaff Region	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**		**vs. AZ**	**vs. US**	**vs. HP2030**	
Stroke Deaths per 100,000	23.8	57.8	66.4	42.4	66.4	**52.9** [Four-County Data]	45.7	49.3	33.4	42.7
% Stroke	2.7	3.4	5.8	3.0	5.8	**3.7**	3.2	5.4		2.8
% High Blood Pressure	23.8	32.2	33.2	28.3	33.2	**29.5**	33.4	40.4	42.6	30.3
% High Cholesterol	19.3	12.1	29.0	15.5	29.0	**18.8**		32.4		22.4
% 1+ Cardiovascular Risk Factor	69.4	89.2	86.4	79.9	86.4	**81.5**		87.8		79.2

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
INFANT HEALTH & FAMILY PLANNING	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
No Prenatal Care in First 6 Months (Percent of Births)	7.0	9.2	5.8	8.1	5.8	**7.2** [Four-County Data]	9.2	6.1		
Teen Births per 1,000 Females 15-19	11.2	28.9	20.2	19.4	20.2	**19.6** [Four-County Data]	18.7	16.6		
Infant Deaths per 1,000 Births	22.8	7.6	6.7	6.7	6.7	**6.6** [Four-County Data]	5.4	5.6	5.0	7.2

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
INJURY & VIOLENCE	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
Unintentional Injury Deaths per 100,000	90.9	177.8	85.0	138.3	85.0	**115.1** [Four-County Data]	81.3	67.8	43.2	85.6
Motor Vehicle Crash Deaths per 100,000	26.5	61.7	17.4	45.7	17.4	**33.4** [Four-County Data]	17.9	13.3	10.1	
Homicide Deaths per 100,000	5.8	16.5	3.0	11.6	3.0	**7.8** [Four-County Data]	8.0	7.6	5.5	6.2

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
MENTAL HEALTH	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
% "Fair/Poor" Mental Health	31.9	19.1	17.3	25.1	17.3	**23.2**		24.4		23.9
% Diagnosed Depression	31.7	14.4	25.2	22.5	25.2	**23.2**	18.0	30.8		27.5
Suicide Deaths per 100,000	30.0	45.0	33.9	38.2	33.9	**36.3** [Four-County Data]	21.0	14.7	12.8	29.4
Mental Health Providers per 100,000	247.8	106.8	213.2	170.7	213.2	**189.2** [Four-County Data]	182.0	313.6		
% Unable to Get Mental Health Services in Past Year	12.1	9.0	8.6	10.5	8.6	**10.0**		13.2		12.6

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA		Total Area	TOTAL AREA vs. BENCHMARKS			
	Flagstaff Region	Northeast Region	Verde Valley Region	FMC Service Area	VVMC Service Area		vs. AZ	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	30.7	28.8	23.7	29.7	23.7	**28.2**		30.0		19.6
% No Leisure-Time Physical Activity	14.4	33.3	23.8	24.4	23.8	**24.2**	21.3	30.2	21.8	21.3
% [Child 2-17] Physically Active 1+ Hours per Day			14.1	31.7	14.1	**27.6**		27.4		
Recreation/Fitness Facilities per 100,000	14.5	3.5	10.2	8.5	10.2	**9.2** [Four-County Data]	11.1	12.3		
% Overweight (BMI 25+)	42.7	73.2	56.5	58.5	56.5	**58.1**	66.4	63.3		59.9
% Obese (BMI 30+)	20.3	40.3	22.3	30.7	22.3	**28.7**	31.9	33.9	36.0	25.8
% [Child 5-17] Overweight (85th Percentile)						**43.0**		31.8		
% [Child 5-17] Obese (95th Percentile)						**17.5**		19.5	15.5	

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
ORAL HEALTH	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
Dentists per 100,000	83.3				67.8	**72.7** [Four-County Data]	66.3	73.5		
% Dental Visit in Past Year	55.1	55.3	60.7	55.2	60.7	**56.5**	60.7	56.5	45.0	62.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA			TOTAL AREA vs. BENCHMARKS			
RESPIRATORY DISEASE	**Flagstaff Region**	**Northeast Region**	**Verde Valley Region**	**FMC Service Area**	**VVMC Service Area**	**Total Area**	**vs. AZ**	**vs. US**	**vs. HP2030**	**TREND**
Lung Disease Deaths per 100,000	27.7	62.4	101.1	46.7	101.1	**70.4** [Four-County Data]	48.3	43.5		65.8
Pneumonia/Influenza Deaths per 100,000	12.0	26.2	19.7	19.8	19.7	**19.7** [Four-County Data]	12.9	13.4		18.5
% Asthma	22.2	21.5	12.6	21.9	12.6	**19.6**	10.3	17.9		12.8
% COPD (Lung Disease)	9.7	4.3	5.9	6.9	5.9	**6.6**	5.8	11.0		5.6
% Sleep Apnea	11.1	17.6	13.4	14.6	13.4	**14.3**				

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SEXUAL HEALTH	DISPARITY AMONG REGIONS: Flagstaff Region	DISPARITY AMONG REGIONS: Northeast Region	DISPARITY AMONG REGIONS: Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	DISPARITY BY SVC AREA: VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	143.4	186.5	153.4	166.5	153.4	**160.6** [Four-County Data]	298.8	386.6		
Chlamydia Incidence per 100,000	600.1	766.3	166.6	691.0	166.6	**460.9** [Four-County Data]	552.5	492.2		
Gonorrhea Incidence per 100,000	138.4	255.4	24.9	202.4	24.9	[Four-County Data]	190.7	179.0		

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SUBSTANCE USE	DISPARITY AMONG REGIONS: Flagstaff Region	DISPARITY AMONG REGIONS: Northeast Region	DISPARITY AMONG REGIONS: Verde Valley Region	DISPARITY BY SVC AREA: FMC Service Area	DISPARITY BY SVC AREA: VVMC Service Area	Total Area	TOTAL AREA vs. BENCHMARKS: vs. AZ	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	61.8	118.8	34.8	92.9	34.8	**67.6** [Four-County Data]	23.6	15.7		40.1
% Binge Drinking	32.8	20.9	28.7	26.5	28.7	**27.0**	14.5	30.6	25.4	23.4
Unintentional Drug-Induced Deaths per 100,000	22.8	45.6	26.6	35.3	26.6	**31.5** [Four-County Data]	33.5	29.7		13.2
% Used a Prescription Opioid in Past Year	18.3	19.8	12.8	19.1	12.8	**17.5**		15.1		14.4
% Personally Impacted by Substance Use	55.6	46.3	48.0	50.7	48.0	**50.1**		45.4		40.9

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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TOBACCO USE	DISPARITY AMONG REGIONS			DISPARITY BY SVC AREA		Total Area	TOTAL AREA vs. BENCHMARKS			
	Flagstaff Region	Northeast Region	Verde Valley Region	FMC Service Area	VVMC Service Area		vs. AZ	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	26.3	22.5	28.4	24.2	28.4	25.2	10.0	23.9	6.1	14.5
% Use Vaping Products	22.0	17.3	12.3	19.5	12.3	17.8	7.1	18.5		10.6

For secondary data indicators, Yavapai County data is used for the VVMC Service Area. Coconino County data is used for the Flagstaff Region, Apache/Navajo County data is used for the Northeast Region, and the three counties combined are used for the FMC Service Area.

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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DATA CHARTS & KEY INFORMANT INPUT

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

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

COMMUNITY CHARACTERISTICS

Population Characteristics

Total Population

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

Total Population
(Estimated Population, 2019-2023)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Coconino, Apache & Navajo Counties (FMC Service Area)	318,067	39,764.16	8
Yavapai County (VVMC Service Area)	241,656	8,122.93	30
Four-County Total (Total Area)	559,723	47,887.09	12
Arizona	7,268,175	113,655.40	64
United States	332,387,540	3,533,298.58	94

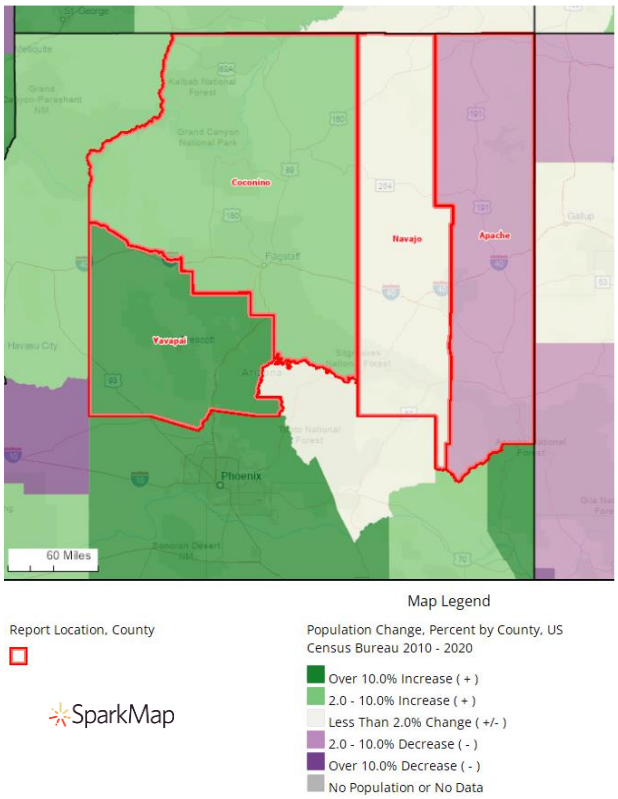
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Population Change

A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources. The following chart and map illustrate the changes that have occurred in the Total Area between the 2010 and 2020 US Censuses. [COUNTY-LEVEL DATA]

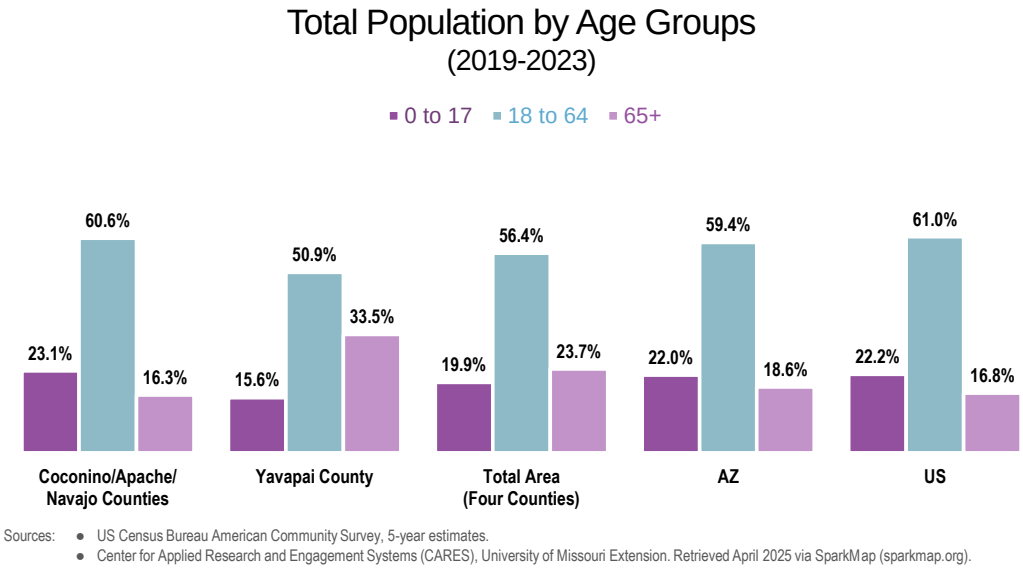
Change in Total Population
(Percentage Change Between 2010 and 2020)

Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).



Age

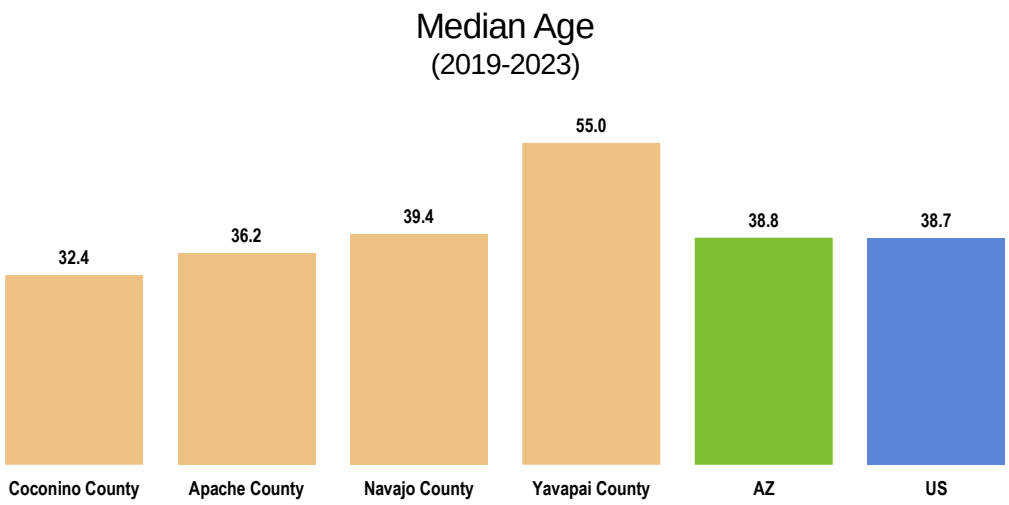
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]



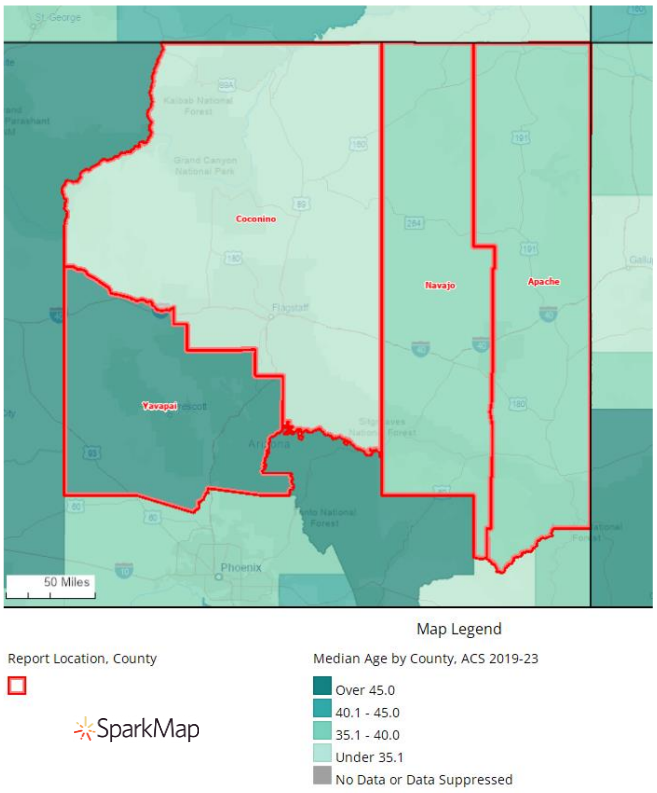
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Median Age

Note the median age of our population, relative to state and national medians. (A composite median is not available for the Total Area as a whole.) [COUNTY-LEVEL DATA]



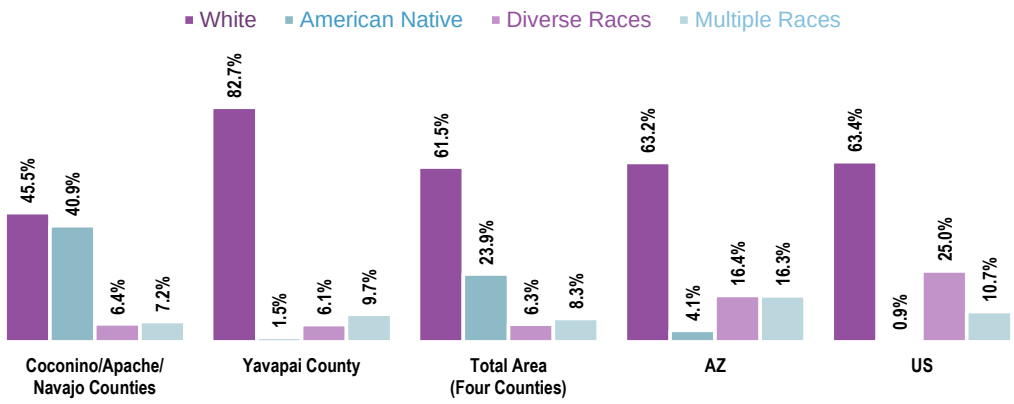
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).



Race & Ethnicity

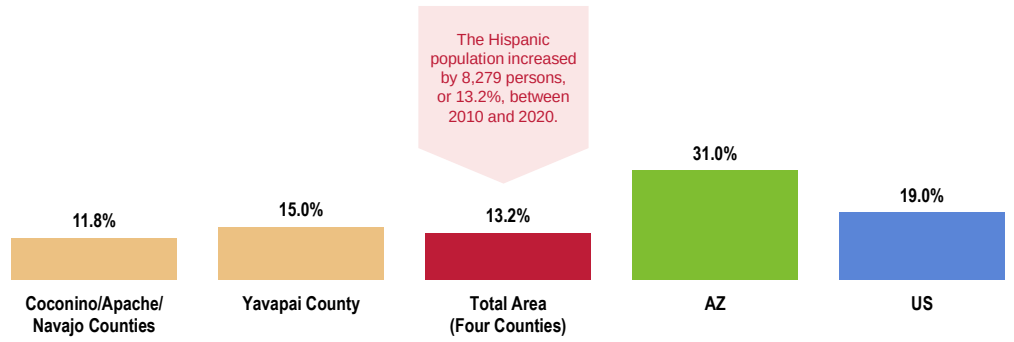
The following charts illustrate the racial and ethnic makeup of our community. Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race. [COUNTY-LEVEL DATA]

Total Population by Race Alone
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Hispanic Population
(2019-2023)



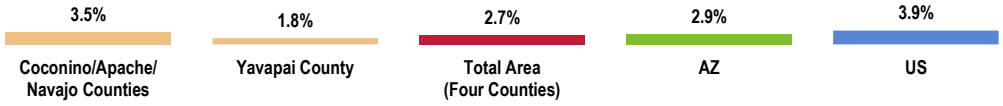
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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

Linguistic Isolation

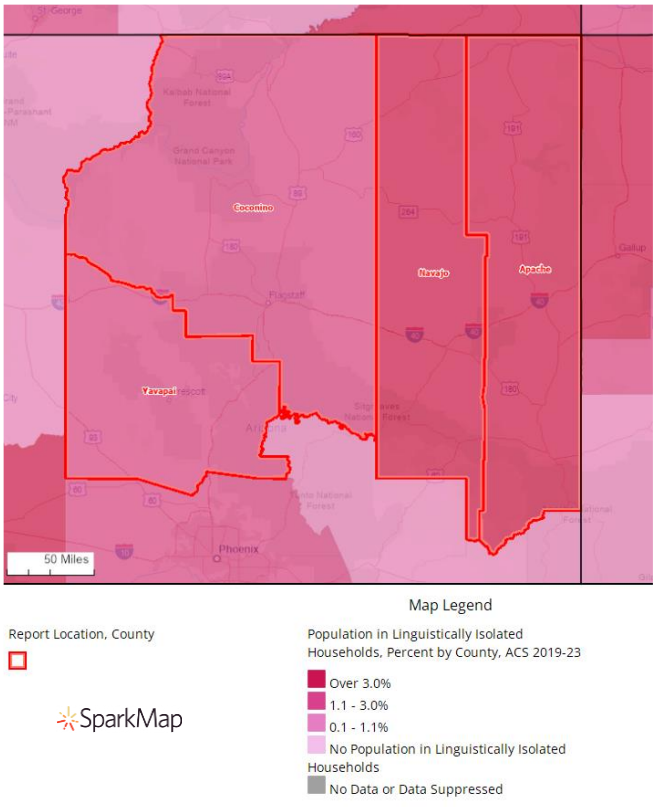
This indicator reports the percentage of the population age 5 years and older who live in a home in which: 1) no person age 14 years or older speaks only English; or 2) no person age 14 years or older speaks a non-English language but also speaks English “very well.” [COUNTY-LEVEL DATA]

Linguistically Isolated Population
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speaks a non-English language and speak English "very well."



Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

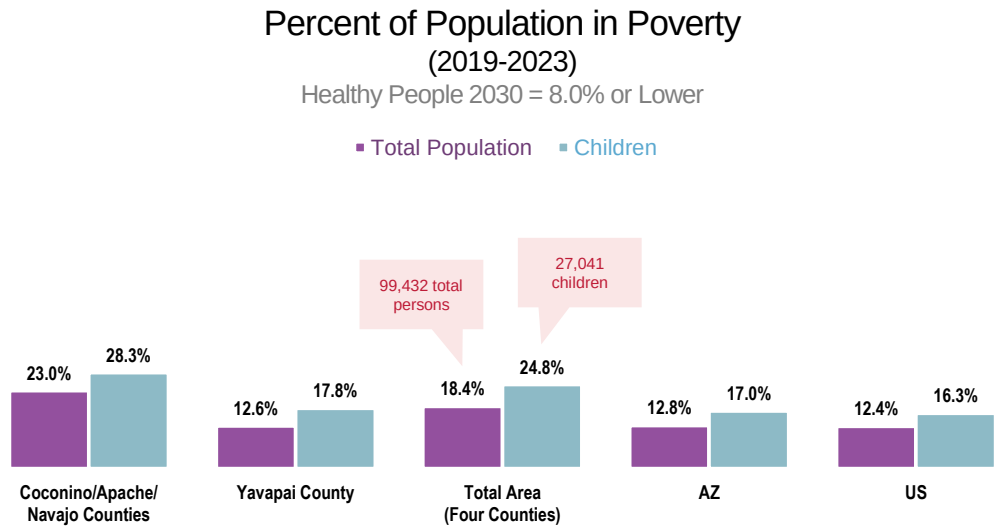
Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

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

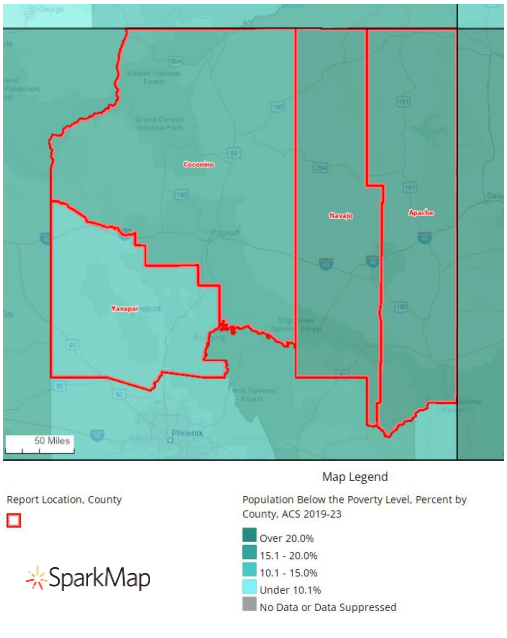
Income & Poverty

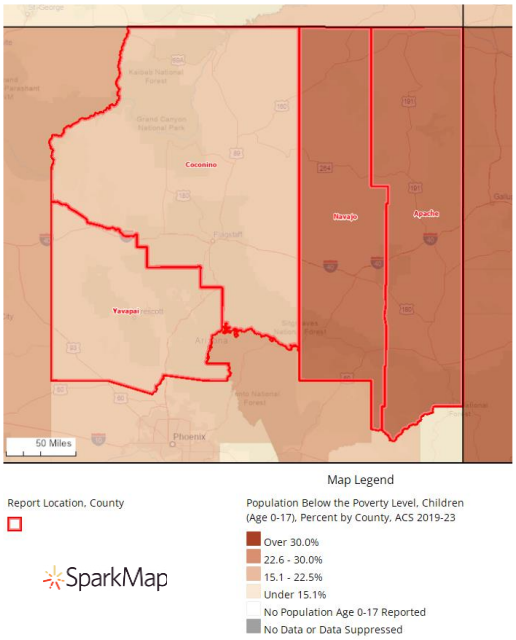
Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health. The following chart outlines the proportion of our population below the federal poverty threshold (for the total population as well as only among children) in comparison to state and national proportions. [COUNTY-LEVEL DATA]



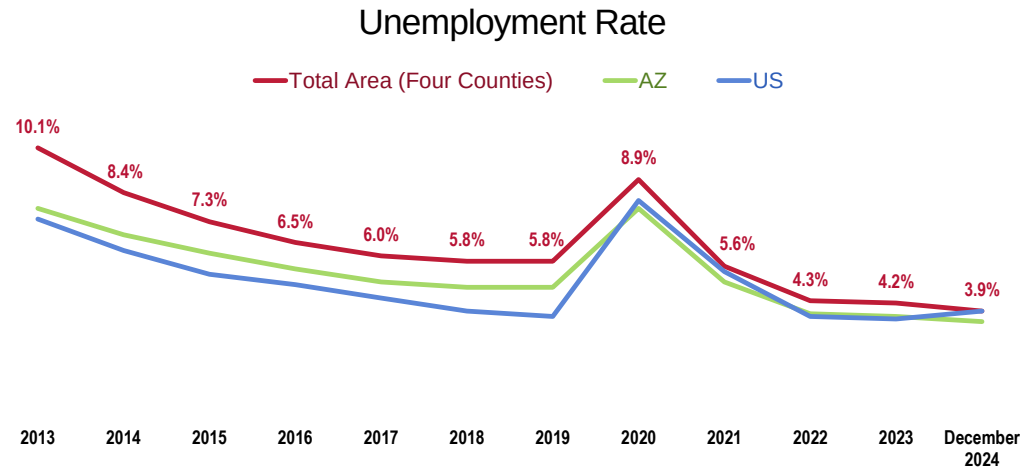
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople





Employment

According to data derived from the US Department of Labor, the unemployment rate in the Total Area as of December 2024 was 3.9%. [COUNTY-LEVEL DATA]



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

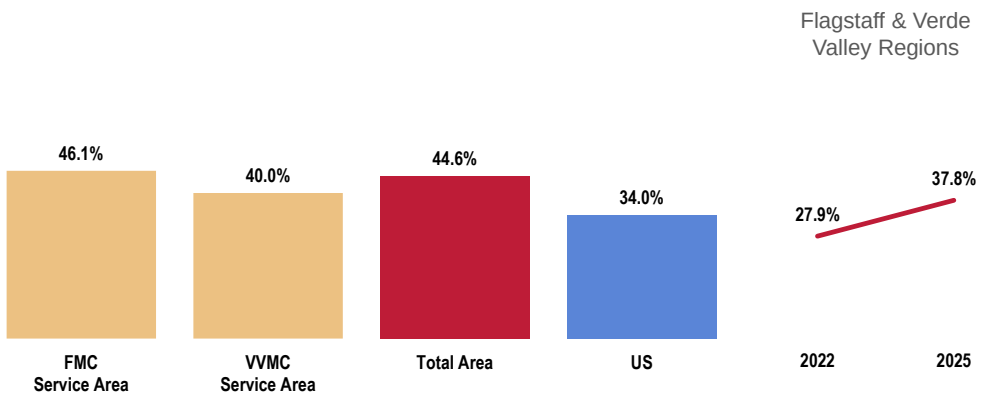
Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

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

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

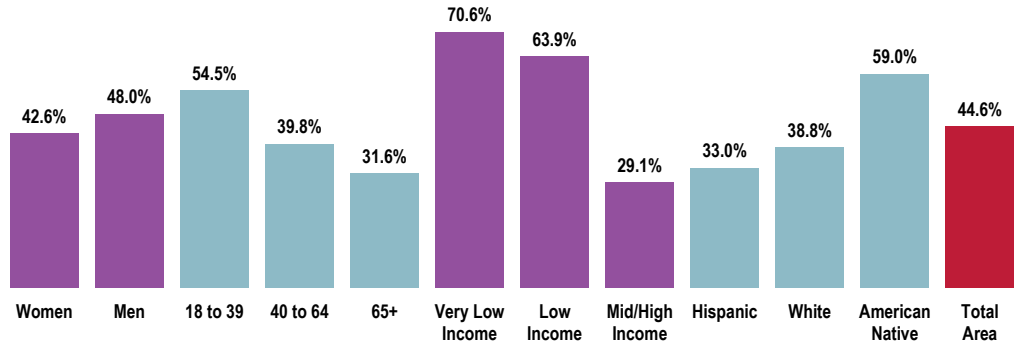
Do Not Have Cash on Hand to Cover a $400 Emergency Expense



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 30]
- 2023 PRC National Health Survey, PRC, Inc.

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

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 30]

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

INCOME & RACE/ETHNICITY

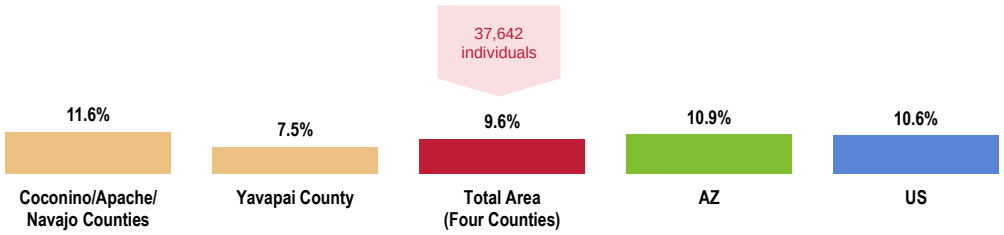
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

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

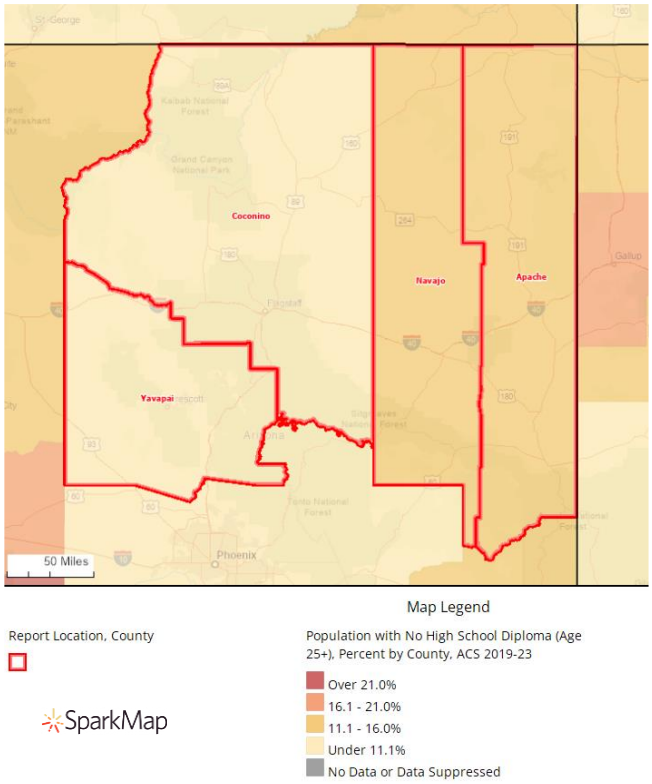
Education

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

Population With No High School Diploma
(Adults Age 25 and Older; 2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).



Housing

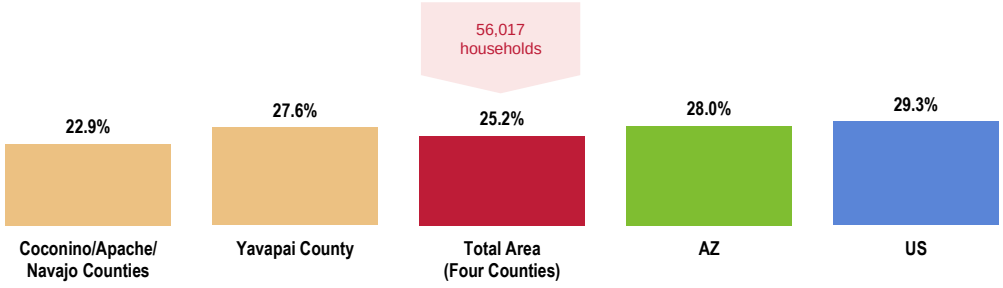
Housing Burden

"Housing burden" reports the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income.

The following chart shows the housing burden in the Total Area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. [COUNTY-LEVEL DATA]

Percent of Individuals for Whom Housing Costs Exceed 30% of Household Income (2019-2023)

Healthy People 2030 = 25.5% or Lower



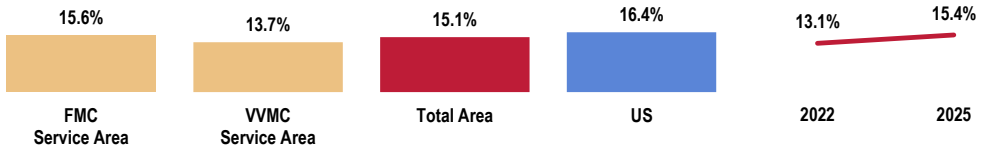
Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Unhealthy or Unsafe Housing

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

Unhealthy or Unsafe Housing Conditions in the Past Year

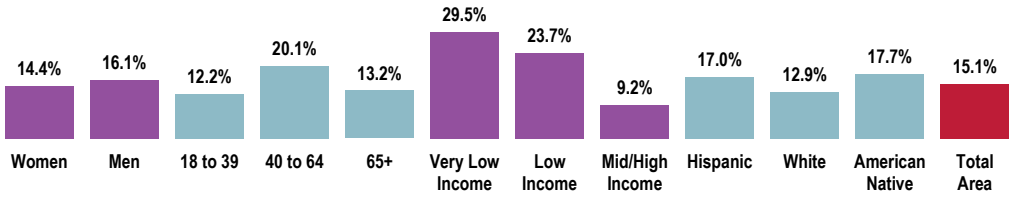
Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.

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

Unhealthy or Unsafe Housing Conditions in the Past Year
(Total Area, 2025)

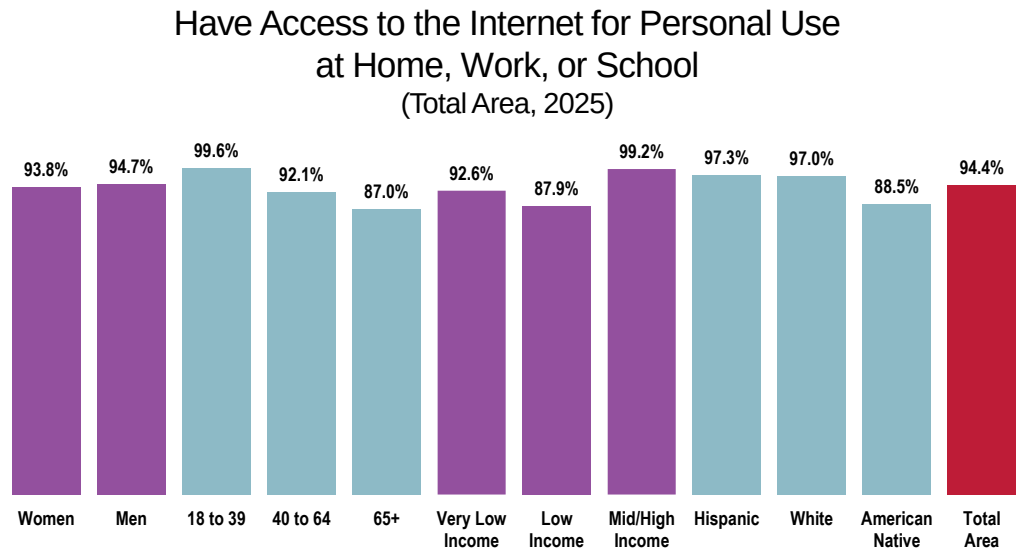


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 31]

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

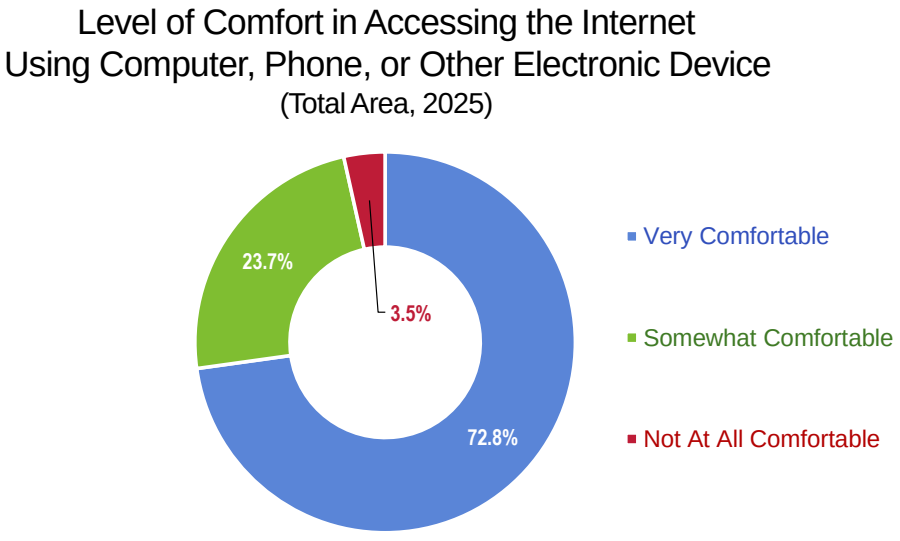
Internet Access

PRC SURVEY ► "Do you currently have access to the internet for personal use, either at home, work, or school?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

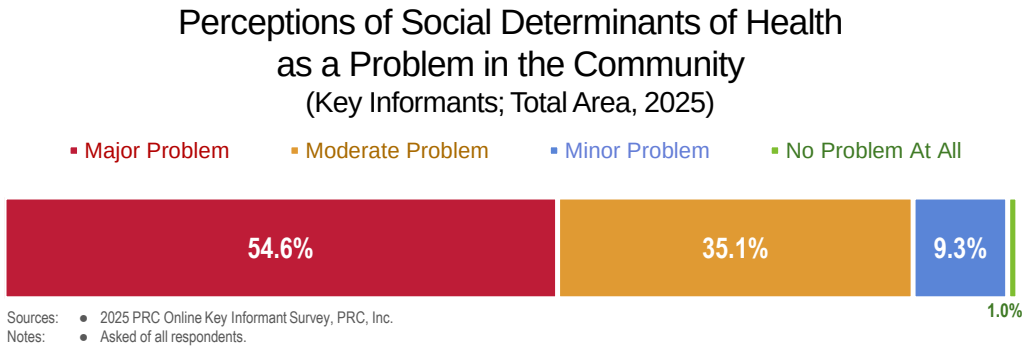
PRC SURVEY ► "In general, how comfortable are you accessing the internet using a computer, phone, or other electronic devices? Would you say: very comfortable, somewhat comfortable, or not at all comfortable?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: ● Asked of all respondents.

Key Informant Input: Social Determinants of Health

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



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

Housing

In terms of the AZSVI (Arizona Social Vulnerability Index) and our area census tracts (which can be found on the ADHS website, dashboard for AZSVI) ranks high for housing and income. These local stats also address this. It is difficult to secure housing in Flagstaff because the average rent for a two-bedroom apartment in is $1,987 a month, and to not pay more than 30% of gross income on housing, a household must earn $79,480 annually (Housing Solutions of Northern AZ – Rental Attainability Report, 2024). Flagstaff's 10-year Housing Plan reported the following: "Since 2011, the median sales price of a home rose by 119%, while the Area Median Income rose by only 16%" and "Nearly half (47%) of Flagstaff residents are low-income, earning no more than $55,350 annually." These statistics help paint the picture of housing vulnerability scores in the Flagstaff and Coconino County census tracts. — Social Services Provider (FMC Service Area)

Housing is always a problem in our community. Residential treatment programs are very limited. — Physician (FMC Service Area)

Housing is extremely expensive, and it is pricing out many families and working people. Places that expect a high level of education pay less than the larger cities, which have a lower cost of living. — Health Care Leader (FMC Service Area)

Housing in Sedona is not attainable for persons who are middle class or lower-income. This has caused stress on our school district, which is 100% free and reduced-price lunch, and has declining enrollment. All agencies who employ essential workers are struggling to hire because of the cost of housing. Most Sedona employees live in outlying Verde Valley area and commute, which adds to pollution, household cost, stress, lack of community cohesiveness. — Community Leader (VVMC Service Area)

Housing, cost of living, proximity to reservation, homelessness, substance abuse. — Health Care Leader (FMC Service Area)

The cost of living is way too high. The homeless population and shelter capacity is high, which leads to illness and deaths related to lack of housing. — Health Care Leader (FMC Service Area)

Social determinants of health play a major role in our community, as cost of living and access to resources is extremely limiting. Because of this, health outcomes tend to be poor — especially for lower-income communities in the region. — Social Services Provider (FMC Service Area)

High cost of living and lack of affordable housing. — Health Care Leader (FMC Service Area)

In the Verde Valley, lack of affordable and low-income housing especially impacts older adults on fixed, low incomes — all affecting their quality of life and access to health care. — Social Services Provider (VVMC Service Area)

Cost of living is very high in Flagstaff. The cost of postsecondary education has skyrocketed over the last 20 years. — Health Care Leader (FMC Service Area)

The Verde Valley is in a housing crisis. We have a shortage of housing, both rental and home ownership, especially in the middle housing (80% to 120% AMI). And the cost of available housing is too high. We have a very solid K-12 and community college in the Verde Valley. The concern is the decreasing funding for education in Arizona overall and the growth of school vouchers that take money out of public education. Because we have a strong tourism industry, income levels are often too low to be able to live comfortably in the region. Our environment is not a social determinant of health — we have a lot of outdoor activities. — Community Leader (VVMC Service Area)

> Not enough low-cost housing anywhere in our area. Employees often travel long distances to work here. — Community Leader (VVMC Service Area)
>
> Cost of housing is a significant problem for our community. Housing is health care. — Social Services Provider (FMC Service Area)
>
> Housing availability and affordability are severe issues, school enrollment is dropping to dangerous levels, wages in the hospitality sector are low. — Community Leader (VVMC Service Area)
>
> The high cost of living and low wages affect my community more than other groups. Also, there are biases that people are not even aware they have. — Community Leader (FMC Service Area)
>
> We have a diverse community with SDOH factors that are major drivers to health behaviors (good and bad) and are more likely to account for the predictors of health for any given population. Cost of living in Flagstaff is high. Cost of health care has skyrocketed. Only 41% of high school grads pursue postsecondary education. Implicit bias still runs rampant in our town and health care campus; those marginalized will not engage the system until critical health events develop, thus health literacy gaps between providers and patients remain equal in regards to the role SDOH plays in our region. — Physician (FMC Service Area)

Income/Poverty

> The income level is low, and we have such limited resources. If you don't drive or have a car, I can't imagine how you would get groceries, let alone access care. We don't have many gyms or safe roads for walking. — Community Leader (VVMC Service Area)
>
> 2020 census data show large areas of lower socioeconomic populations in northern Arizona and Flagstaff. — Health Care Leader (FMC Service Area)
>
> The gap between wealthy and non-wealthy families in Flagstaff is pretty noticeable, and unfortunately it results in a plethora of disparities — whether that's related to students who live in areas without reliable internet connection for completion of their school assignments (e.g. students working on projects from a cell phone in their vehicle), to lack of access to healthy foods or access to food altogether (a well-known issue for children who are in school and spend weekends on the reservation with little or no food), to having the financial resources to purchase books, go on outdoor adventures, and so many more determinants which ultimately influence a child or an adult's quality of life and overall health. Housing, I feel, is its own separate significant issue in our community and should be tackled independently with its own set of resources and efforts. The housing issue in Flagstaff impacts earners and families across the earning spectrum. — Health Care Leader (FMC Service Area)
>
> Low-income families. — Community Leader (FMC Service Area)
>
> Gentrification and geographic restrictions are pushing low-income residents out and into peripheral areas. — Social Services Provider (FMC Service Area)
>
> High percentage of individuals living in poverty; excessive cost of housing; substance misuse and lack of treatment; high incidence of unsheltered individuals. — Community Leader (FMC Service Area)
>
> There is a lot of poverty, especially child poverty, in our area. More and more giant apartment complexes are being built. These are managed by corporations and have strict rules. That sort of management costs a lot, and there are often add-ons that the residents don't need but are charged for, anyway. This makes housing less affordable rather than more affordable and housing security worse because corporations are less likely to be kind to people struggling to pay their rent. Thankfully, we now have a much better minimum wage than previously. The city's internal open spaces are being transformed into built environments, and there are more roads being built. This makes it a less livable city and a more unpleasant one. Schools are struggling with poor financing. — Physician (FMC Service Area)
>
> We have substantial poverty and insufficient support services. — Community Leader (VVMC Service Area)

Access to Care/Services

> Distance to care, quality of transportation options to access the care, availability of providers. — Health Care Leader (FMC Service Area)
>
> All of those factors have a direct impact on a patient's access to care. There is a lack of political will to effectively address these problems, which contributes to health care inequities. — Health Care Leader (FMC Service Area)
>
> Not enough shelter beds for individuals experiencing homelessness, where we can take victims who need help relocating after domestic violence, housing support for those who are on the verge of being evicted, and access to resources for employment to help with steady income and potential education support. — Health Care Leader (FMC Service Area)
>
> Service providers struggle to build capacity to meet demand. Funding sources are shrinking. — Social Services Provider (VVMC Service Area)

Awareness/Education

> We have significant challenges with health literacy, poverty, substance abuse, and access to health care. — Physician (FMC Service Area)

> An informed discussion about the influences of health vs. determinants of health is required to start the discussion. Many of the chronic disease burdens are attributable to these negative influences. A medical model cannot solely address these issues but rather an ongoing and broader conversation between those directly impacted and the service providers. — Community Leader (FMC Service Area)
>
> Poor translation from hospitalization to community. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> The Navajo Nation faces significant challenges related to the social determinants of health (SDOH), which are the conditions in the environments where people are born, live, work, and play that affect their health outcomes. These factors are often deeply influenced by historical, cultural, and systemic issues. The belief in and challenges surrounding these determinants are crucial in understanding the overall health disparities experienced within the Navajo Nation. — Health Care Leader (FMC Service Area)
>
> We have a vast Native American population, wide geographic spread, a high cost of living. Poor health literacy in many segments of our population. — Physician (FMC Service Area)
>
> It is well-known and widely documented that the 2SLGBTQ+ community has poorer access to housing, income, and education and has experienced discrimination from the police and other agencies, resulting in poorer mental and medical health outcomes. — Community Leader (FMC Service Area)

Chronic Disease

> Because they're a problem everywhere and lead to exacerbation of underlying health and chronic conditions. — Health Care Leader (FMC Service Area)
>
> I believe these are the basis for most chronic diseases, mental health issues, nutrition and health needs. Social determinants of health also are more likely to impact already vulnerable populations and create/contribute to inequality. — Social Services Provider (FMC Service Area)
>
> Significant contributor to morbidity and mortality in the community and greater in the Arizona area. — Health Care Leader (FMC Service Area)

Unhoused Population

> A large population of people who are unhoused have substance use issues or mental health challenges. This population is often not connected in the community with proper support. Yes, there are resources, but persons to help connect people to those resources is a critical need. Additionally, social support is critically important in overall health and well-being, and it seems to be lacking. The current economy is forcing folks to improperly address these needs. — Social Services Provider (VVMC Service Area)
>
> The epidemic of unhoused people. — Physician (FMC Service Area)

Rural Community

> Rural location; difficult access to educational and job opportunities while remaining at home or with family. Also, impacts of alcohol/substance abuse, which lead to higher rates of trauma. — Health Care Leader (FMC Service Area)

Discrimination

> Discrimination, housing, and income are major social determinates relating to Native Americans. — Health Care Leader (FMC Service Area)

Prevention/Screenings

> Social determinants of health care are a major problem in our community due to lack of screening across primary care providers and other care providers or facilities. — Health Care Leader (FMC Service Area)

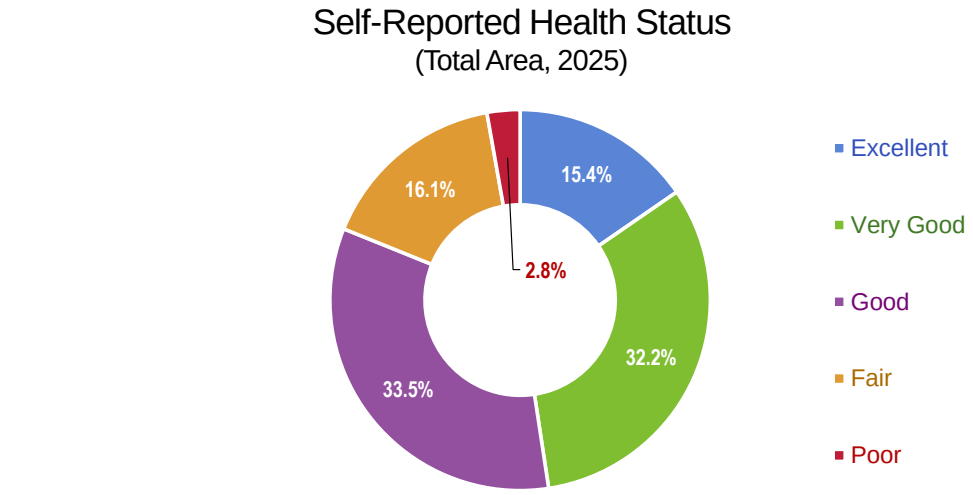
Tourism

> We are a tourist community, and our focus is on that and not the needs of our residents. — Community Leader (VVMC Service Area)

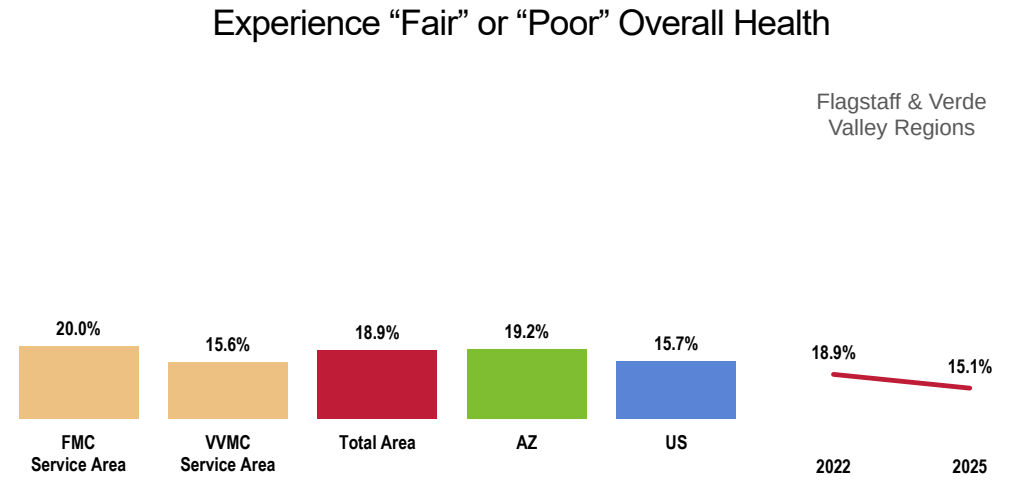
HEALTH STATUS

Overall Health

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

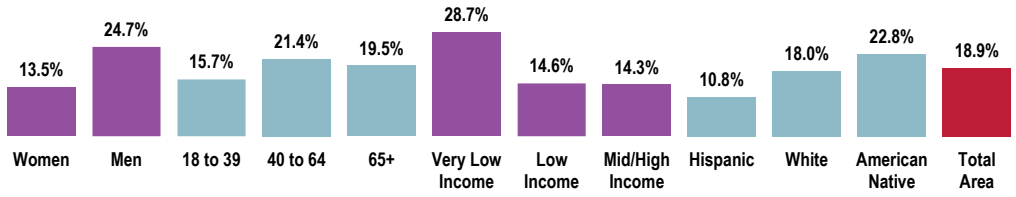


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 3]
Notes: ● Asked of all respondents.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 3]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 3]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

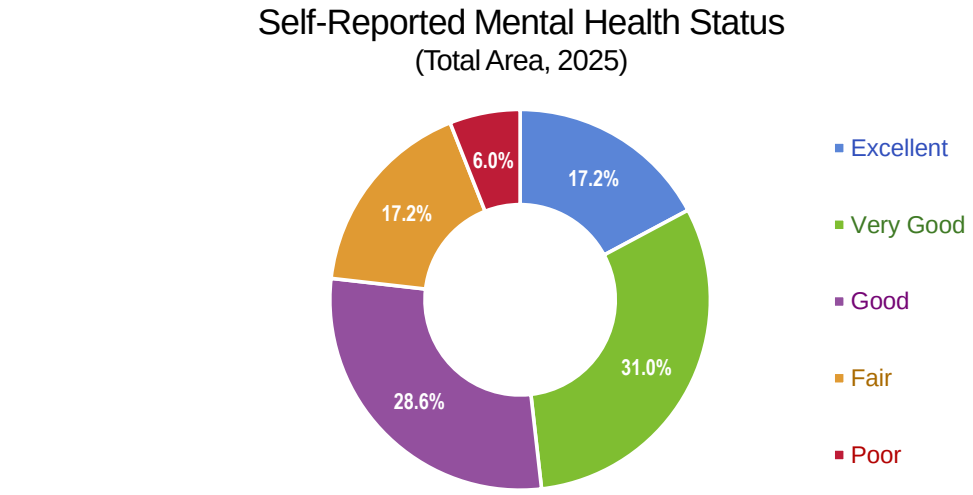
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

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

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

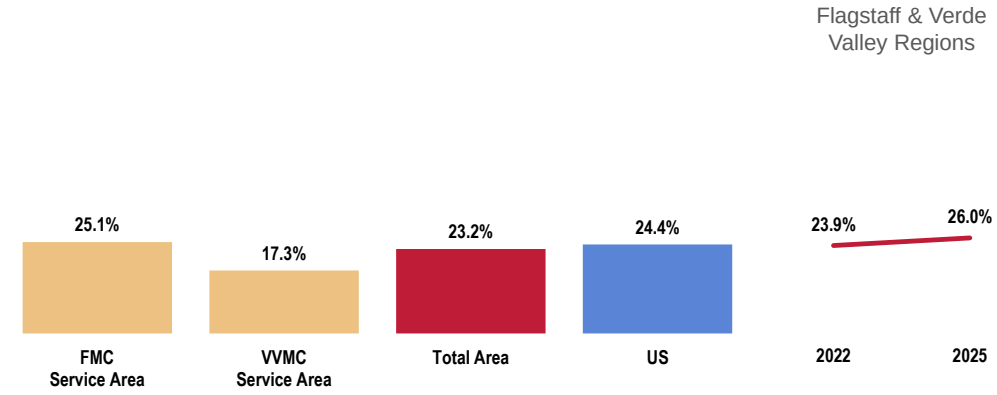
Mental Health Status

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health



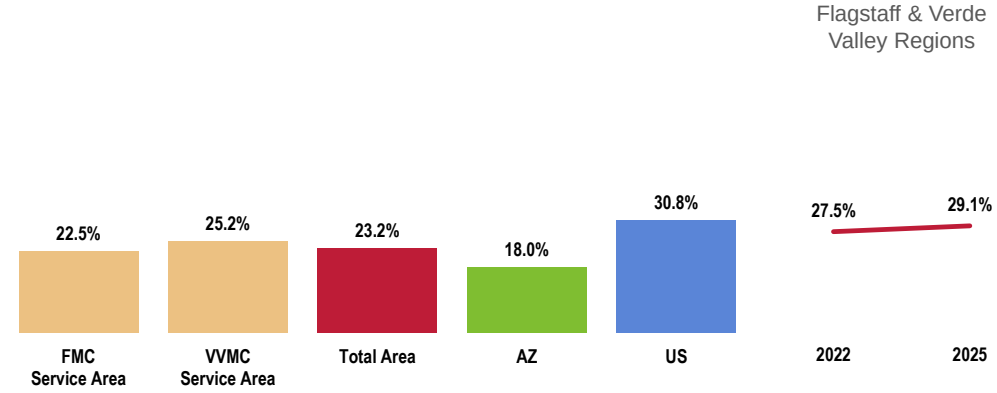
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Diagnosed Depression

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

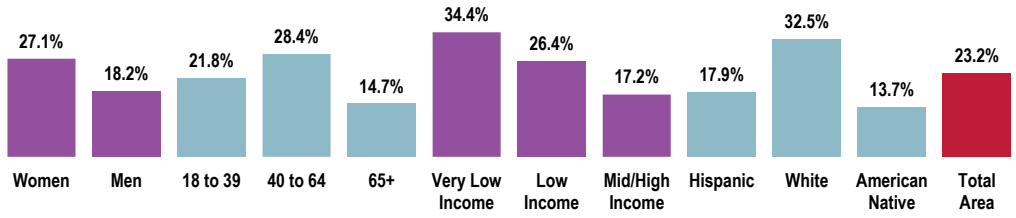
Have Been Diagnosed With a Depressive Disorder



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 27]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Have Been Diagnosed With a Depressive Disorder
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 27]

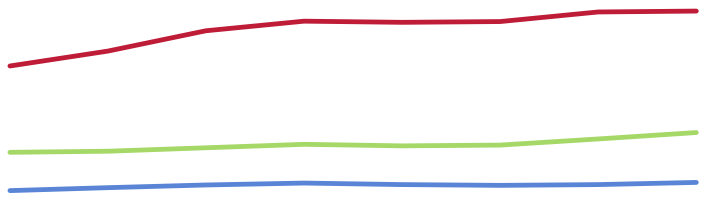
Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Suicide

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	29.4	31.3	33.9	35.1	34.9	35.0	36.2	36.3
AZ	18.5	18.6	19.1	19.5	19.3	19.4	20.2	21.0
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

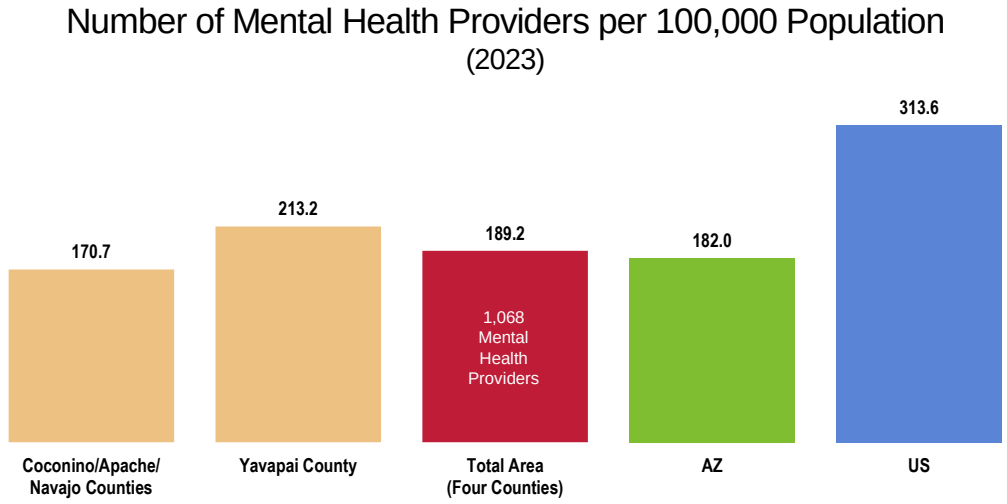
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Mental Health Treatment

Access to Mental Health Providers

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

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

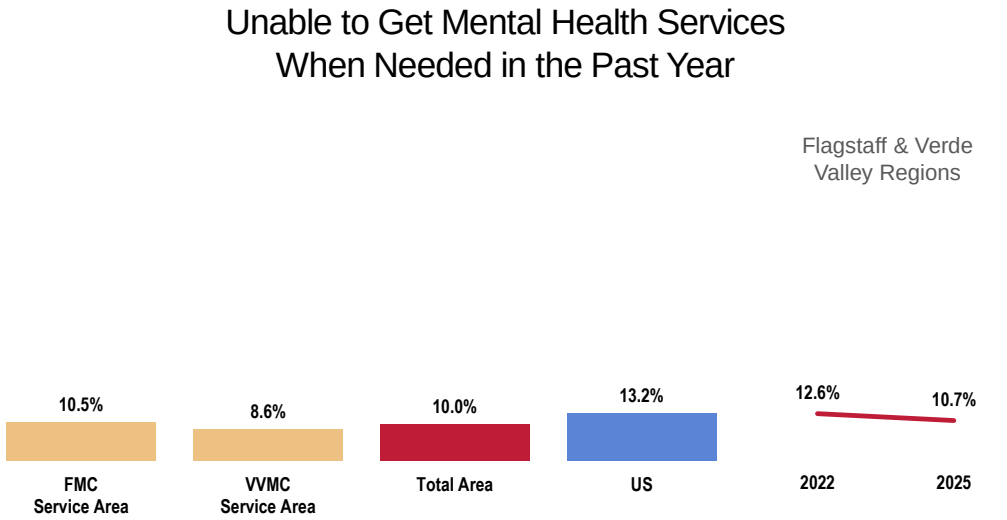


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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

Difficulty Accessing Mental Health Care

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 28]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(Total Area, 2025)

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 28]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

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

Perceptions of Mental Health as a Problem in the Community
(Key Informants; Total Area, 2025)

Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Care/Services

> Very limited access to behavioral and mental health care and support. Providers, inpatient and outpatient, substance use programs, and pediatric and adolescent care. — Health Care Leader (FMC Service Area)
>
> Finding a provider. — Health Care Leader (VVMC Service Area)
>
> Access to outpatient services. Long wait times for admissions, especially for violent patients. — Physician (FMC Service Area)
>
> Long wait times for appointments. Folks getting charged for providers to fill out standard forms for FMLA, benefits, or accommodations required by employers. — Health Care Leader (FMC Service Area)
>
> Very hard to get in with a provider. Lack of space and money put toward supporting the growth of mental health support. — Health Care Leader (FMC Service Area)
>
> Lack of psychiatric care beds, lack of OP behavioral health resources. Patients are brought to the emergency department, as there are no other options for care. — Health Care Leader (FMC Service Area)
>
> Difficult with access to care — can take weeks or months to see a provider with limited providers in the community. Not a lot of diversity for patient choice to where they receive care. High rates of mental health and patients unwilling to participate in treatment, which drives higher rates of T36 involuntary treatment in the community and the jails. High rates of readmission to the ER and psychiatric inpatient. High level of alcoholism and deaths related to alcoholism. — Health Care Leader (FMC Service Area)
>
> Access to care in a reasonable amount of time. — Health Care Leader (FMC Service Area)
>
> No resources for treatment. — Health Care Leader (FMC Service Area)

Access to care. Lack of crisis intervention services that prevent hospitalization/jail. — Health Care Leader (FMC Service Area)

24/7 access to a spectrum of providers. Proactive screening in youth. Family education. — Health Care Leader (FMC Service Area)

Lack of behavioral health services and lack of insurance coverage for mental health care. — Health Care Leader (FMC Service Area)

There are limited beds in Flagstaff for inpatient mental health care. — Health Care Leader (FMC Service Area)

Outpatient services for mental health and a mental health crisis center. — Health Care Leader (VVMC Service Area)

Receiving treatment in a timely manner. — Community Leader (FMC Service Area)

Lack of access to care. There are not enough providers. — Community Leader (VVMC Service Area)

Abject lack of access to care. It is very difficult to find a psychiatrist/therapist. Many are not taking new patients or insurance. Even NAH hasn't been offering outpatient care; the whole community seems mostly to rely on the Guidance Center. There are few local inpatient beds, leading to transfers to other communities. There are few if any IOP/PHP programs, again leading to having to travel to Phoenix. Care has been pushed off to teleproviders, who won't actually prescribe medications, making that the responsibility of the PCPs, who are not generally comfortable with that, again erecting even more barriers to care. There is poor integration of resources. For example, an acute behavioral emergency may involve LEOs, who are about 50% trained in this. This leads to legal entanglements. Then Terros, an independent entity with very variable skillsets, evaluates, then patients sit in the ED, are transferred, and have to sort our long-term care themselves. — Physician (FMC Service Area)

Sometimes there are long waits for psychiatry, and there are almost always long waits for psychology services, especially for people without sufficient funds to pay out-of-pocket. Many therapists are not contracted with insurance, so one has to pay out-of-pocket and then seek reimbursement for their expenses from their medical insurance. Insurance companies are required to pay for mental health services, but denying these reimbursements is a common way for them to shirk that responsibility. — Physician (FMC Service Area)

Access to multidisciplinary providers, follow-up, and awareness. — Physician (FMC Service Area)

Lack of access. Alcoholism is rampant, and treatment is difficult to get. BH treatment is difficult to obtain. — Physician (FMC Service Area)

Lack of care (sometimes by choice), housing, food insecurity, and social connections. — Social Services Provider (VVMC Service Area)

Adequate and coordinated outpatient psychiatric services to better manage patient care and conditions in order to prevent patients from escalating back to acute care episodes. — Health Care Leader (FMC Service Area)

Continuous access with no restrictions from payors. — Social Services Provider (VVMC Service Area)

No coordinated care system. — Community Leader (VVMC Service Area)

High turnover rate at Spectrum and lack of private practice psychiatric services. — Physician (VVMC Service Area)

Accessing high quality care. There is a growing number of NPs, but the care they provide is often mediocre. The training they receive is hugely variable and often lacking. We need more psychiatrists (physicians), especially child and adolescent fellowship-trained psychiatrist physicians. — Physician (FMC Service Area)

Lack of inpatient psychiatric treatment in town. Often, these patients are required to transfer out of town or out of state. — Physician (FMC Service Area)

Inpatient treatment capacity. — Health Care Leader (FMC Service Area)

Open/available beds for a higher level of care due to individuals rating high for DTS/DTO. Detox beds available for individuals ready to seek support and next steps. Quick turnaround for counseling/follow-up post-crisis. — Health Care Leader (FMC Service Area)

A lack of services and political will to keep significantly mentally unhealthy individuals off the streets and in care centers. — Community Leader (FMC Service Area)

Not enough facilities in our area for mental health support. Need to travel to the Phoenix area. — Community Leader (VVMC Service Area)

Not enough therapists or services. — Community Leader (VVMC Service Area)

Lack of providers and a lack of residential treatment. — Community Leader (FMC Service Area)

Access to care. There are limited resources available for adults and children. — Health Care Leader (FMC Service Area)

Access to mental health services and stigma. — Health Care Leader (FMC Service Area)

Access to Care for Uninsured/Underinsured

Lack of insurance coverage for those with mental health needs. Lack of sufficient providers and facilities to care for those with mental illness. — Community Leader (VVMC Service Area)

Lack of access to care for those with low incomes or issues related to mental health. Transportation or people to follow up on them. — Health Care Leader (FMC Service Area)

> No health insurance available for lower and middle class. No experienced doctors in our area. — Community Leader (FMC Service Area)

Awareness/Education

> Lack of education and programs. — Community Leader (VVMC Service Area)
>
> Invisibility. Community and provider misunderstanding, bias, and lack of awareness. There is episodic care but a lack of meaningful transitional services. No long-term solutions. Flagstaff does not have an integrated plan with city, county NGOs and tribal partners. — Community Leader (FMC Service Area)
>
> The care team does a wonderful job intervening when immediate mental health crises are occurring, but most social services don't know they can call this team directly and involve them outside of the police. There is also a stigma around the effectiveness of the guidance center and whether or not clients should be referred there. — Social Services Provider (FMC Service Area)

Denial/Stigma

> People do not seek assistance or support because there is a negative stigma attached to admitting you have a mental health issue. — Community Leader (FMC Service Area)
>
> Mental health is stigmatized by our society. There are limited resources available to help people with this need. — Health Care Leader (FMC Service Area)

Lack of Culturally Appropriate Care

> Efforts to address mental health in the Navajo Nation must include culturally appropriate care, community-driven initiatives, and improved access to services, with a focus on reducing stigma, promoting mental wellness, and providing holistic treatment options that integrate traditional practices. — Health Care Leader (FMC Service Area)
>
> Recruiting Native American clinicians to work with Native American patients. Funding to facilitate traditional interventions. — Health Care Leader (FMC Service Area)

Affordable Care/Services

> There are not enough affordable options. Rent is also expensive in Flagstaff, so I imagine there is some correlation. There should be many modality options that take gender, race, and culture into account. — Social Services Provider (FMC Service Area)

Bullying

> Increase in bullying, harassment, physical attacks, and open discrimination in Flagstaff. Since the November election in our local LGBTQ+ community, there have been higher rates of suicide, depression, and anxiety. — Community Leader (FMC Service Area)

Government/Politics

> Poorly regulated county-funded agency overseeing SMI and T36 process. No accountability for legal matters. Limited resources for outpatient mental health. Extensive ED utilization for this population, occupying critical emergency department space waiting for services to be available OR agencies taking responsibility for the care delivery that is expected from them. — Health Care Leader (FMC Service Area)

Income/Poverty

> High rates of poverty, abuse, or alcohol use disorder within the family. Generational trauma. Rural locations with low access to specialized care, such as pediatric, behavioral health, strong CBT, or other counseling services. — Health Care Leader (FMC Service Area)

Suicide Rates

> Suicide. We have a high rate of suicide locally, and this stems from mental health issues and substance abuse. Limited access to mental health care in the region. — Physician (FMC Service Area)

Co-Occurrences

> Depression and substance abuse. — Health Care Leader (FMC Service Area)

Unhoused Population

> Homelessness and drugs. — Community Leader (VVMC Service Area)

Impact on Quality of Life

> Impacts quality of life for the individual and family members. — Social Services Provider (VVMC Service Area)

DEATH, DISEASE & CHRONIC CONDITIONS

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

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

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

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

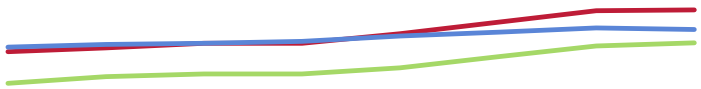
Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

Heart Disease Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	191.9	195.0	198.4	198.7	206.2	215.1	224.3	224.9
AZ	166.9	172.3	174.3	174.4	179.3	188.1	196.5	198.9
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	42.7	46.4	47.4	48.1	48.4	50.8	52.5	52.9
AZ	35.7	37.3	38.2	39.0	40.7	42.8	45.1	45.7
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

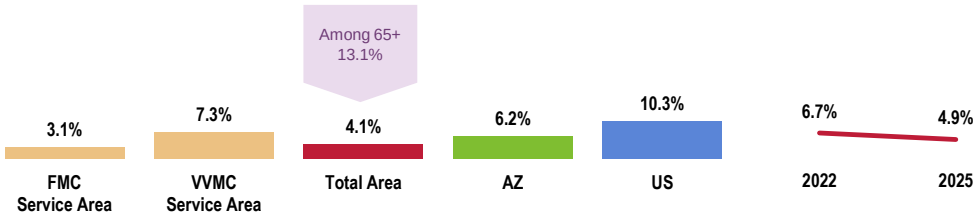
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Prevalence of Heart Disease & Stroke

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

Prevalence of Heart Disease

Flagstaff & Verde Valley Regions



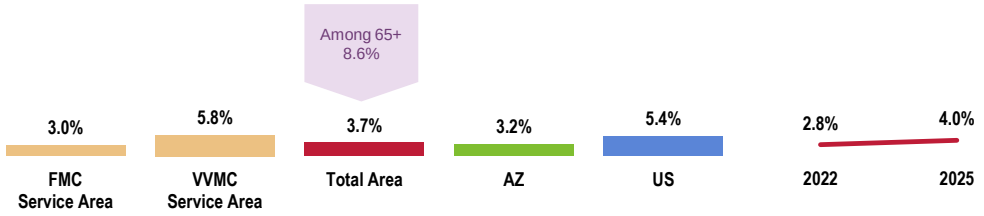
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 12]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

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

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

Prevalence of Stroke

Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 13]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

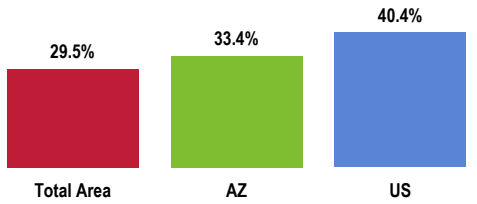
Blood Pressure & Cholesterol

PRC SURVEY ► "Have you ever suffered from or been diagnosed with high blood pressure?"

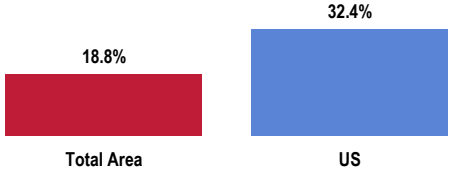
PRC SURVEY ► "Have you ever suffered from or been diagnosed with high blood cholesterol?"

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 14-15]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(Flagstaff & Verde Valley Regions)
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol
(Flagstaff & Verde Valley Regions)

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 14-15]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

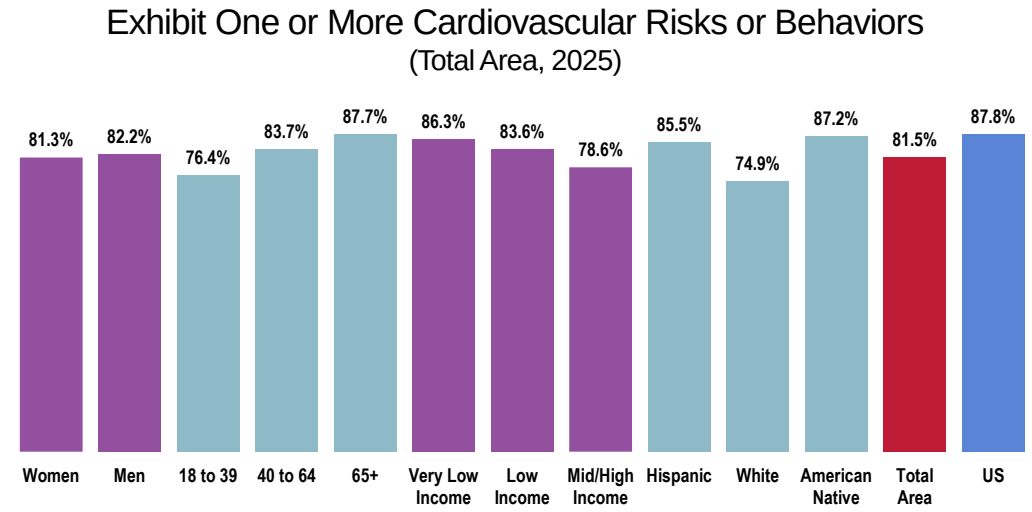
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

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

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

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

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

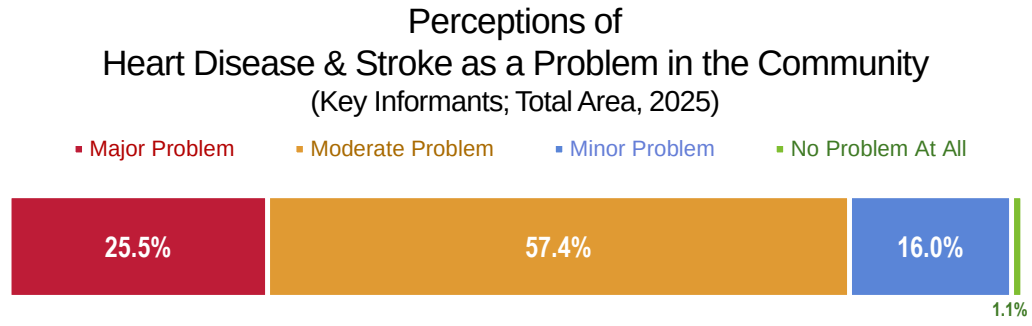


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 51]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

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



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Aging Population

> Large number of elderly residents. — Community Leader (VVMC Service Area)
>
> Older population. — Community Leader (VVMC Service Area)
>
> From anecdotal information shared with me by community members and colleagues, Sedona has an aging demographic where this may be more common. — Community Leader (VVMC Service Area)
>
> Our population is aging. — Community Leader (VVMC Service Area)
>
> Heart disease is a major problem in every community. Arizona has an older population. — Physician (FMC Service Area)

Lack of Providers

> Lack of cardiologists. — Health Care Leader (FMC Service Area)
>
> Again, not enough practitioners. — Community Leader (VVMC Service Area)
>
> My husband had a major heart situation, and there were no cardiologists in the Verde Valley at the time for him to see. He was flown to Phoenix, where he had quadruple bypass surgery. The surgeon was surprised he was alive when he arrived. — Community Leader (VVMC Service Area)
>
> Lack of community providers, lack of follow-up care, and variable resources for emergency care in VVMC. — Health Care Leader (VVMC Service Area)
>
> We do not have enough cardiologists or neurologists in Flagstaff. — Physician (FMC Service Area)

Access to Care/Services

> Long transfer times, lack of community awareness. Ideally we would have more resources (endovascular) which is constrained by the difficulty of recruiting and providing such expensive care. Instead, the focus has been on efficient transfers to Phoenix. Without enough specialist providers, clinic wait times are too long. Both of these diseases are driven by traditional risk factors, getting back to lack of overall reliable primary care. — Physician (FMC Service Area)
>
> Although there are cardiac providers in Cottonwood, if patients require surgery, they travel to the Phoenix area. — Community Leader (VVMC Service Area)
>
> Distance to health care as weighed against the need for rapid response to improve outcomes. — Health Care Leader (FMC Service Area)
>
> Patients have to go out of town to find good doctors or doctors who will see them within four months. — Community Leader (VVMC Service Area)

Impact on Quality of Life

> These are frequent chronic conditions in our community that appear to affect overall baseline health and limit participation in work and ultimately result in comorbidities. — Health Care Leader (FMC Service Area)
>
> Impacts quality of life and access to health care. — Social Services Provider (VVMC Service Area)

Incidence/Prevalence

> High prevalence of risk factors (obesity, diabetes, hypertension, chronic kidney disease); dietary factors (limited access to healthy food); limited access to health care (infrastructure, geographic barriers, language and cultural barriers); socioeconomic challenges (poverty, unemployment and low education levels; substance/alcohol abuse); chronic nature of the condition. — Health Care Leader (FMC Service Area)
>
> Heart disease and stroke are major problems in our community due to ongoing increases in high blood pressure, obesity, and other major risk factors, which are related to social determinants of health. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> Cardiovascular disease is the leading cause of death among American Indians and Alaskan Natives. Heart diseases are higher for American Indians and Alaskan Natives. Heart disease rates are about 50% higher among the 5.2 million people in the US who identify as American Indian and Alaskan Native compared to their white counterparts. More than one-third of their death attribute to cardiovascular disease occur before 65. — Health Care Leader (FMC Service Area)

Cancer

ABOUT CANCER

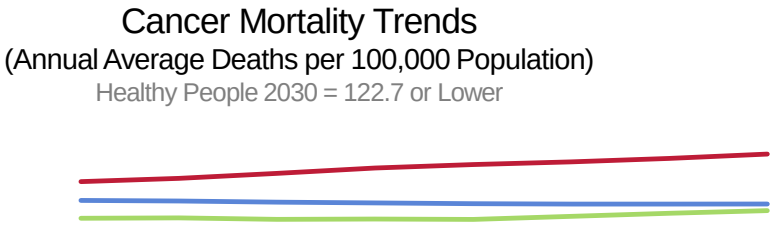
The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education,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

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

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

Cancer Deaths

The following chart illustrates cancer mortality (all types) in the Total Area. [COUNTY-LEVEL DATA]

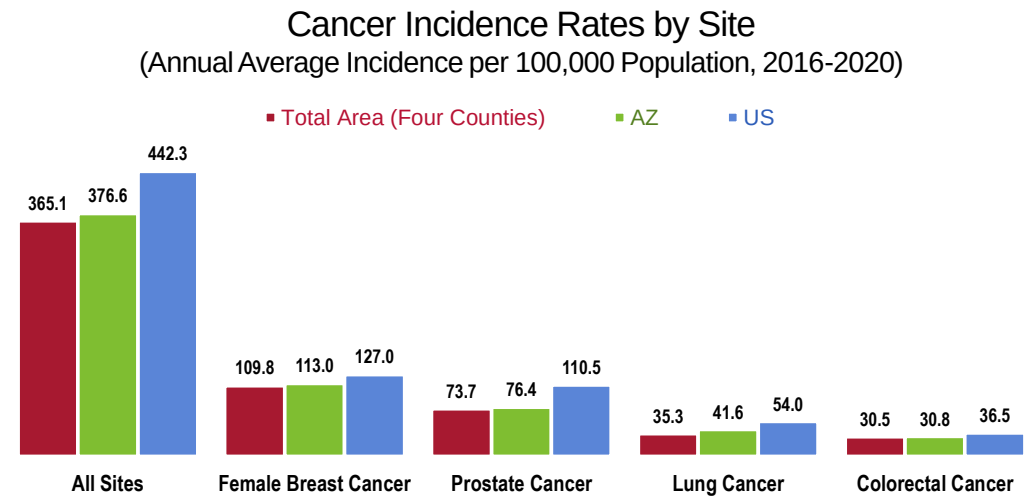


	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	200.2	202.7	206.7	211.1	213.7	215.7	218.4	221.9
AZ	171.3	171.6	170.4	170.6	170.5	172.9	175.3	177.3
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Cancer Incidence

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



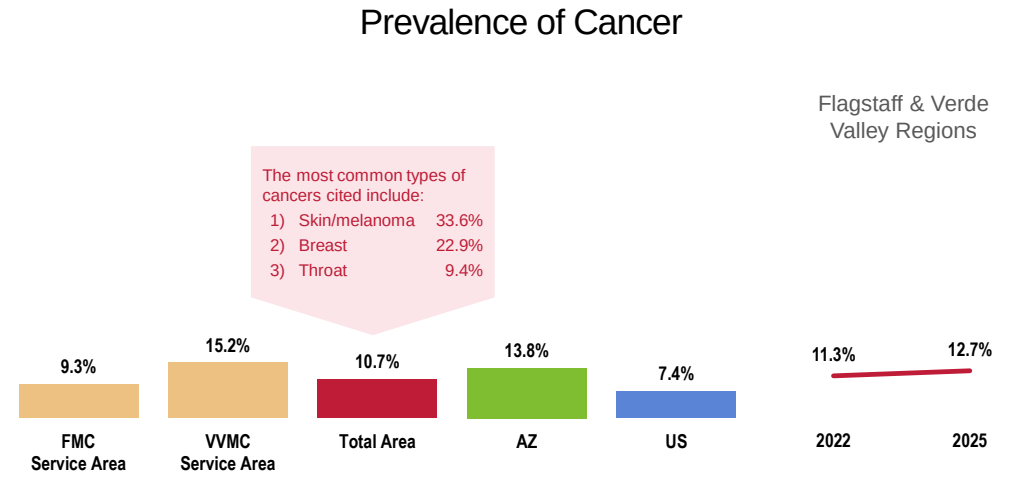
Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

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

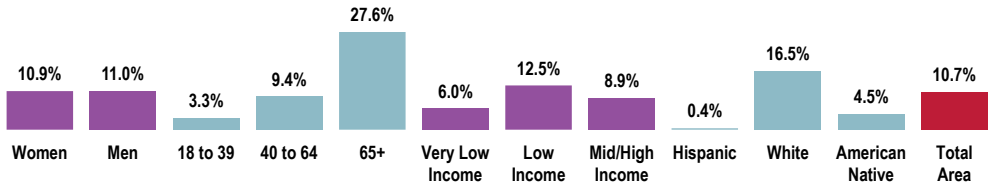
PRC SURVEY ► "Which type of cancer were you diagnosed with most recently?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 17-18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Cancer
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 17]
Notes: ● Asked of all respondents.

Mammograms

FEMALE BREAST CANCER

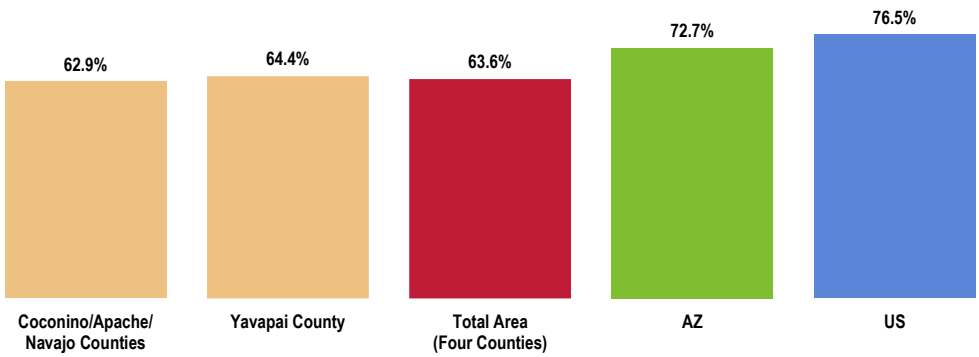
The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

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

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

The following indicator outlines the percentage of women age 50 to 74 who have received a mammogram in the past two years. Mammography is important as a preventive behavior for early detection and treatment of health problems. Low screening levels can highlight a lack of access to preventive care, a lack of health knowledge, or other barriers. [COUNTY-LEVEL DATA]

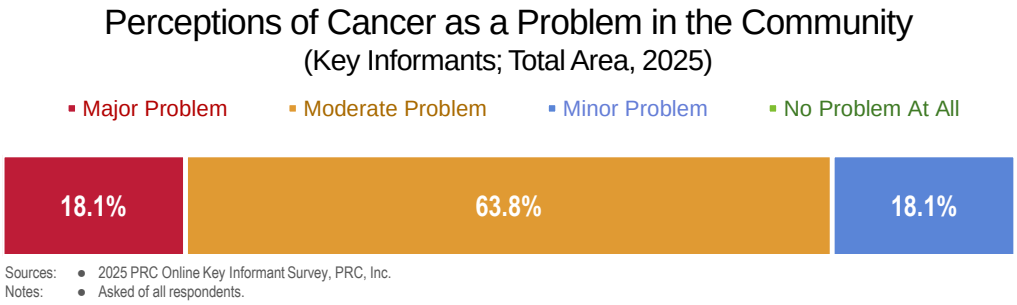
Mammogram in Past Two Years
(Women 50-74; 2022)
Healthy People 2030 = 80.5% or Higher



Sources: ● Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Cancer

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



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

Access to Care/Services

> The distance, cultural perceptions, and lack of care in the Navajo Nation contribute to a higher amount of later-stage cancers when they are discovered. Environmental factors may also increase the incidence of cancer among Navajo Nation residents (abandoned surface uranium mines, lack of running water, lack of electricity). — Health Care Leader (FMC Service Area)
>
> We have limited access to oncology, particularly to clinical trials and latest treatments, yet with downwinders and other risks, we see a significant cancer burden. — Physician (FMC Service Area)
>
> Lack of wraparound oncology care. Remote locations in which we serve. Lack of services in our geographic location. — Health Care Leader (FMC Service Area)
>
> Many friends with cancer travel to Phoenix for care since it's not available in Flagstaff. — Health Care Leader (FMC Service Area)
>
> Access to oncology care and getting into the system. Not all types of cancer care or specialty care are available. Travel and lodging expenses for referral care. — Community Leader (FMC Service Area)

Incidence/Prevalence

> I've known of many cases of friends and family who have traveled to the Phoenix area to deal with their cancer treatment. — Community Leader (VVMC Service Area)
>
> WIHCC, Inc. has supported the Tuba City Health Care Corporation's Oncology Center, and the number of patients from the area to include across the NN is evident for all age groups and both genders. While we don't have a cancer registry, it would be an important referenced document for soliciting funding from various organizations that support cancer. — Health Care Leader (FMC Service Area)
>
> No one dies of old age anymore; they all seem to die of cancer. — Community Leader (VVMC Service Area)
>
> Because it seems we have an increased cancer rate in the Verde Valley based on colloquial information. — Community Leader (VVMC Service Area)

Prevention/Screenings

> Not enough screening opportunities or qualified doctors in our area. — Community Leader (VVMC Service Area)
>
> Lack of access to cutting-edge prevention, detection, and treatment services for all populations. — Community Leader (FMC Service Area)
>
> As primary care providers are conducting annual wellness visits and/or preventative care visits, there is a continued need for screening for cancers and closing the loop on referrals. There is opportunity to improve and optimize primary care visits to convert sick to well visits and to screening appropriately for cancers and other preventative quality care gaps. — Health Care Leader (FMC Service Area)

Lack of Providers

> Lack of providers in Flagstaff. — Community Leader (FMC Service Area)
>
> Significant changes over the past year. Improving, though still insufficient provider bandwidth and linear accelerator refresh pending. — Health Care Leader (FMC Service Area)

Aging Population

> From anecdotes shared with me by community members and colleagues who have to travel to PHX for treatment services, Sedona also has an aging population demographic where cancer is a more likely occurrence. — Community Leader (VVMC Service Area)

Built Environment

> Issues with technology in Sedona being down and the reputational impacts of that. Most people feel they have to go to Phoenix to get care. — Community Leader (VVMC Service Area)

Respiratory Disease

ABOUT RESPIRATORY DISEASE

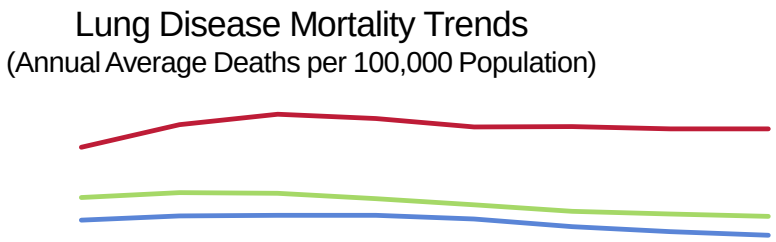
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million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

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

Lung Disease Deaths

The mortality rate for lung disease in the Total Area is summarized below, in comparison with Arizona and national rates. [COUNTY-LEVEL DATA]

Note: Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	65.8	71.4	74.1	73.0	70.9	71.0	70.4	70.4
AZ	53.0	54.3	54.1	52.7	51.3	49.6	48.9	48.3
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Note ● Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

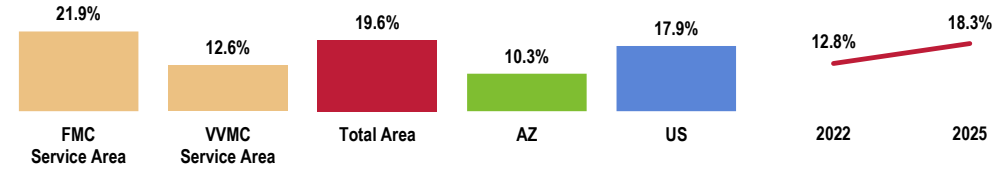
Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"

Prevalence of Asthma

Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 10]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

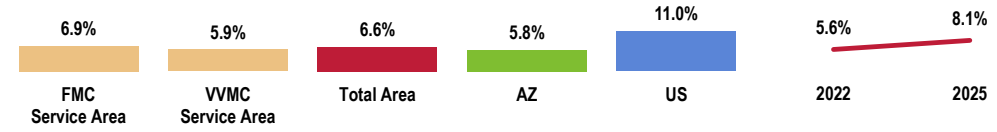
Notes:
- Asked of all respondents.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► "Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Flagstaff & Verde Valley Regions

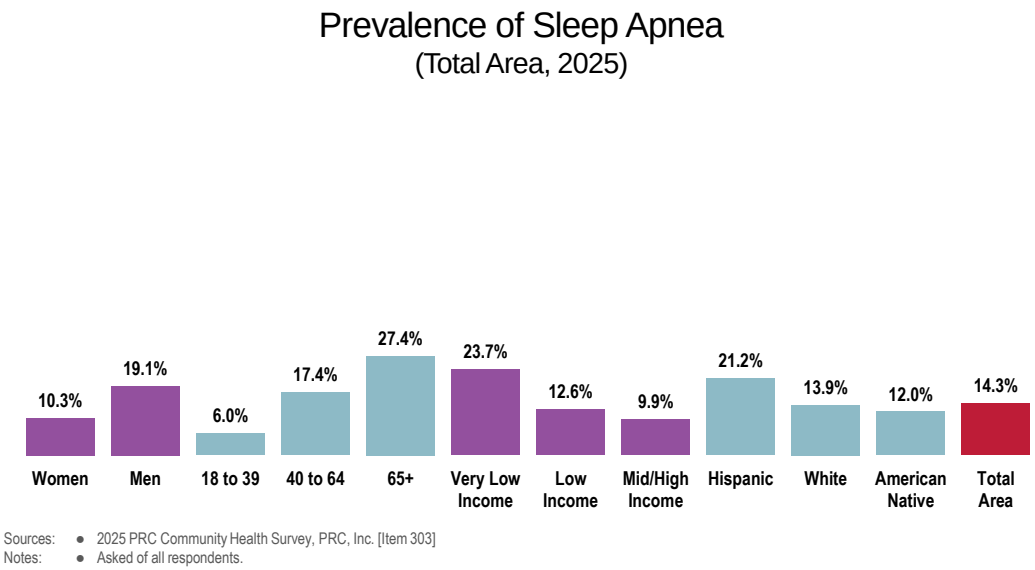


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 11]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

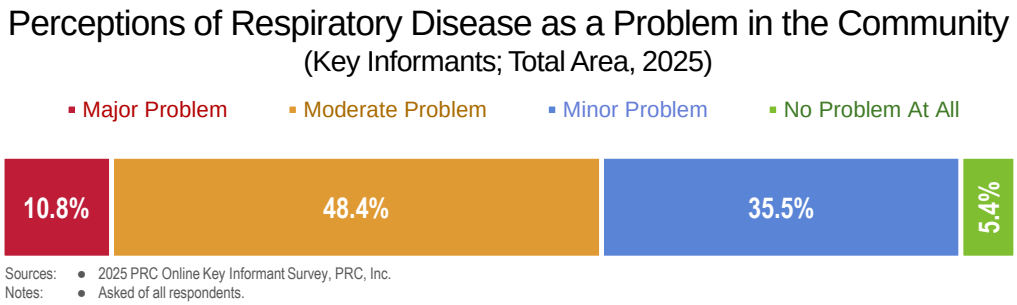
Sleep Apnea

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



Key Informant Input: Respiratory Disease

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



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

Incidence/Prevalence

> Respiratory diseases are indeed a significant concern in many communities, including the Navajo Nation, where various factors contribute to a higher incidence of respiratory problems. The belief that respiratory diseases are a major problem is grounded in the longstanding health challenges and unique environmental, socioeconomic, and cultural factors that impact the health of individuals in the Navajo Nation. — Health Care Leader (FMC Service Area)
>
> The cold and flu season gets worse and worse. — Health Care Leader (VVMC Service Area)
>
> We live at high altitude, so many people with chronic respiratory illnesses have to wear oxygen. In addition, there are very few pulmonologists available to help care for adults with respiratory illnesses and there are no pediatric pulmonologists in the region. — Physician (FMC Service Area)

Lack of Specialists

> There are few, if any, pulmonary care doctors who are here long enough to understand the problems associated with the higher elevation. — Community Leader (FMC Service Area)

> Lack of specialists. — Community Leader (VVMC Service Area)

Co-Occurrences

> When hunger and extreme poverty are at play, respiratory diseases become inherently more dangerous. Even for community members facing food insecurity, taking days off of work because of respiratory diseases can disproportionately affect them, as their ability to afford to take days off is limited. — Social Services Provider (FMC Service Area)

Access to Care/Services

> Difficulty with access to primary care, thus increased demands on the emergency department for delivery of care. Proximity to reservation with higher prevalence to COVID outbreaks. — Health Care Leader (FMC Service Area)

Comorbidities

> We have high levels of comorbid diseases, including diabetes. — Community Leader (VVMC Service Area)

Injury & Violence

ABOUT INJURY & VIOLENCE

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

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

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

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

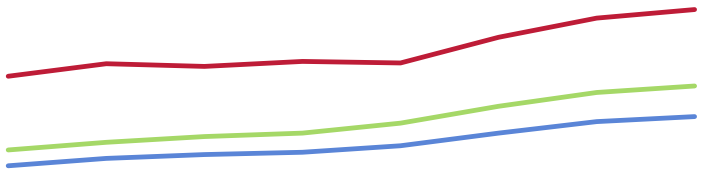
– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

Unintentional injury is a leading cause of death. The chart that follows illustrates unintentional injury death rates for the Total Area, Arizona, and the US. [COUNTY-LEVEL DATA]

Unintentional Injury Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



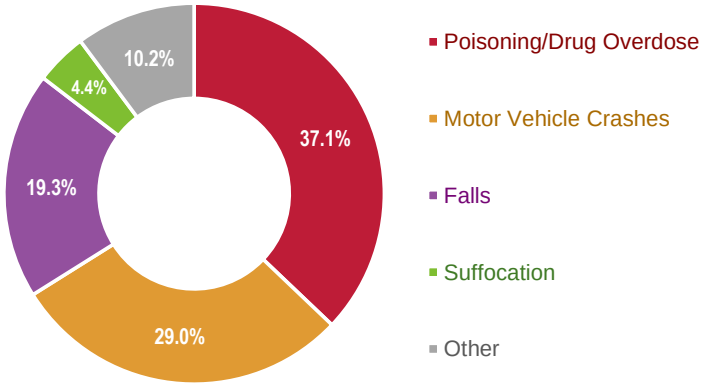
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	85.6	91.2	90.0	92.3	91.6	102.8	111.3	115.1
AZ	53.0	56.4	58.9	60.5	64.9	72.4	78.4	81.3
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Leading Causes of Unintentional Injury Deaths

The leading causes of unintentional injury deaths in the Total Area are shown below. [COUNTY-LEVEL DATA]

Leading Causes of Unintentional Injury Deaths
(Total Area [Four Counties], 2021-2023)



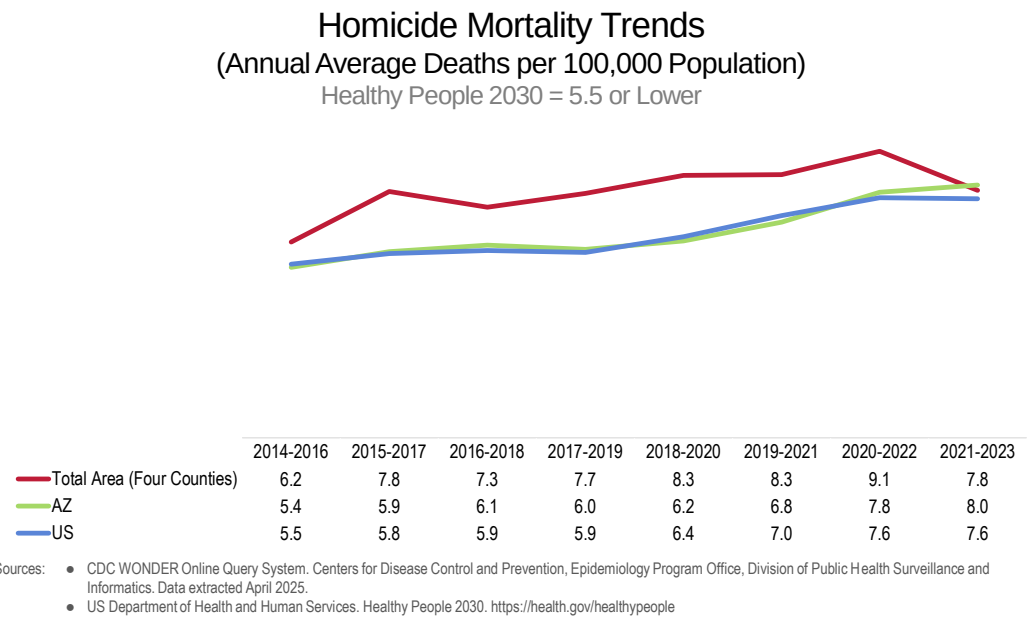
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Intentional Injury (Violence)

Homicide Deaths

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

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

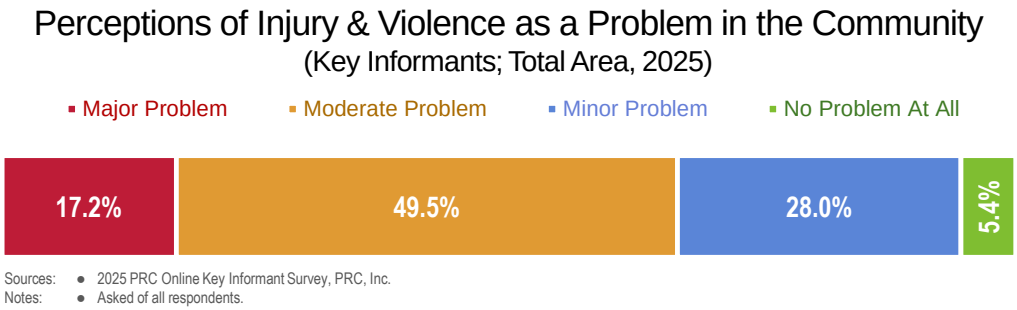


	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	6.2	7.8	7.3	7.7	8.3	8.3	9.1	7.8
AZ	5.4	5.9	6.1	6.0	6.2	6.8	7.8	8.0
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Injury & Violence

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



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Incidence/Prevalence

> Coconino County has one of the highest rates of trauma and physical violence in the state. — Community Leader (FMC Service Area)
>
> Increase in workplace violence and health care worker assault. — Health Care Leader (FMC Service Area)
>
> We serve hundreds of victims of crime annually in shelter services and holistic supportive services such as counseling and legal advocacy, which are community-based services. SA/SV, DV, HT, and child abuse. — Social Services Provider (FMC Service Area)
>
> There was a 60% increase in violent crime this year. — Community Leader (FMC Service Area)

Recreational Injuries

> From Sedona police reports. Also, Sedona Fire has a high number of hospital transports every day from our emergency department to other communities. Most medical issues here are injuries from outdoor activities in the forest or from elderly population. — Community Leader (VVMC Service Area)
>
> Trauma from locational activities, such as skiing. Occupational injuries due to work forces. Other things that are influences on health are not having affordable housing, the cost of food, drugs, and depression. — Community Leader (FMC Service Area)

Prevention/Intervention

> These issues require a multifaceted response that includes prevention, intervention, and community support. Factors contributing to high rates of injury and violence include socioeconomic challenges, substance abuse, limited access to health care, and historical trauma. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> Domestic violence is a rampant issue in the LGBTQ+ community, but most community resources specialize in providing domestic violence and sexual assault within heterosexual contexts. — Community Leader (FMC Service Area)

Unhoused Population

> There are large numbers of folks who are unhoused or are at risk of being unhoused in the community. This is a major factor leading to injury and violence. — Social Services Provider (VVMC Service Area)

Domestic/Family Violence

> Our police reports show the terrifying level of domestic violence. — Community Leader (VVMC Service Area)

Funding

> The lack of funding and programs that are culturally relevant to Native Americans. — Health Care Leader (FMC Service Area)

Income/Poverty

> Mostly socioeconomic status and drug/alcohol elements. — Physician (FMC Service Area)

Alcohol/Drug Use

> Substance abuse. — Health Care Leader (FMC Service Area)

Gun Violence

> Gun violence. — Health Care Leader (FMC Service Area)

Diabetes

ABOUT DIABETES

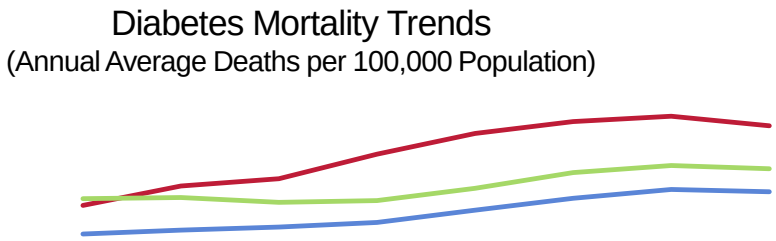
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

Diabetes Deaths

Mortality attributed to diabetes is shown in the following chart. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	28.6	31.3	32.4	35.8	38.8	40.5	41.2	39.9
AZ	29.5	29.7	29.0	29.2	31.0	33.2	34.2	33.8
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

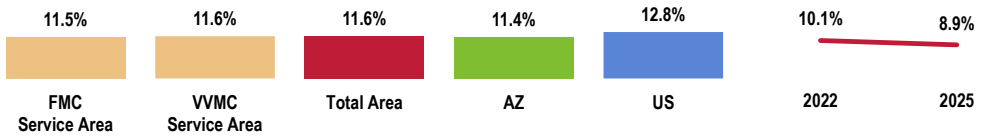
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Prevalence of Diabetes

PRC SURVEY ► "Have you ever suffered from or been diagnosed with diabetes, not counting diabetes only occurring during pregnancy?"

Prevalence of Diabetes

Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

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

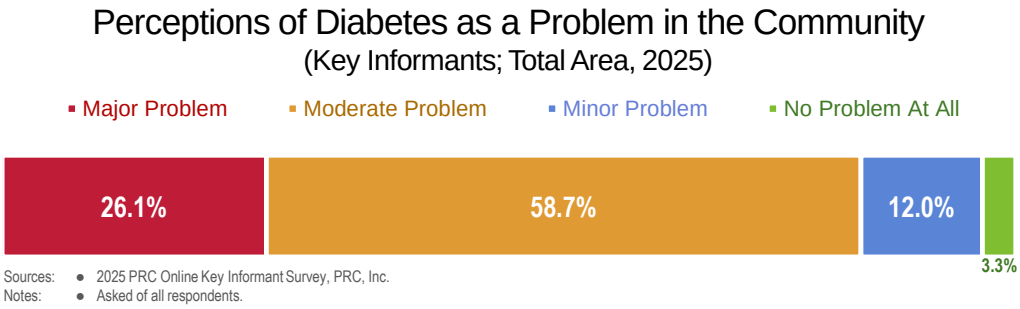
Prevalence of Diabetes
(Total Area, 2025)

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]

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

Key Informant Input: Diabetes

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



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

Nutrition

> The habit of drinking sugary drinks. — Community Leader (VVMC Service Area)
>
> Food deserts. — Community Leader (VVMC Service Area)
>
> Nutrition, access to healthy food, and the affordability of healthy food. — Social Services Provider (FMC Service Area)
>
> Food insecurity and access to healthy foods. Access to safe fitness centers or active lifestyle opportunities. Cultural food norms impacting dietary choices. — Health Care Leader (FMC Service Area)
>
> People being unable to afford healthy foods. Parents only being able to take their kids to fast-food places. Having no access to fruits and vegetables. — Health Care Leader (FMC Service Area)
>
> High cost of living making healthy food choices potentially expensive. Long waits to establish PCP care. Limited resources for actual diabetic education, particularly between visits. Geographic distances people may need to travel, combined with potential loss of easy access to telecare. — Physician (FMC Service Area)
>
> The high percentage of Native American people who live in our region and the lack of healthy food options. Food desert. — Community Leader (FMC Service Area)

Awareness/Education

> Poor understanding of nutritional and lifestyle impacts. — Community Leader (VVMC Service Area)
>
> Diabetic education and the ability to translate that into dietary choices that help manage their disease. — Physician (FMC Service Area)
>
> Education about the disease process and lifestyle modification. Access to CGM and insulin pumps. — Health Care Leader (FMC Service Area)

Access to Care/Services

> PCPs and public information. — Community Leader (FMC Service Area)
>
> Distance from health care services, including education and pharmacies, for non-Flagstaff residents. — Health Care Leader (FMC Service Area)
>
> Regular access to care and diet counseling. — Physician (FMC Service Area)

Incidence/Prevalence

> Proximity to reservation, where diabetes is prevalent. — Health Care Leader (FMC Service Area)
>
> High prevalence of diabetes. The Navajo Nation has the highest rates of type 2 diabetes. Limited access to health care. Areas that are remote, with large traveling distances, and food insecurity and poor nutrition. — Health Care Leader (FMC Service Area)

Diagnosis/Treatment

> The biggest challenges for people with diabetes include receiving all clinical standards of care related to diabetes, like ensuring the patient has completed a retinal eye exam, foot exam, neuropathy screening, depression screening, and others. For the most part, patients have their HbA1c completed, but adherence and self-management education and support continue to be challenges. — Health Care Leader (FMC Service Area)

Lack of Physical Activity

> Biggest challenges are with exercise. The majority of them could not get or find the motivation to work out. They would need more education on wellness and fitness. Educate more how diabetes affects the body. — Community Leader (FMC Service Area)

Affordable Medication/Supplies

> High expenses for medications. — Social Services Provider (FMC Service Area)

Disease Management

> Noncompliance and cost of care. — Physician (FMC Service Area)

Insurance Issues

> Insurance coverage. — Health Care Leader (FMC Service Area)

Lack of Culturally Appropriate Care

> Access to diabetes programs that are culturally relevant. — Health Care Leader (FMC Service Area)

Obesity

> Obesity is a contributing factor. Misinformation about diabetes, lack of awareness and education to treat it, and limited specialty providers for diabetes. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> High prevalence of diabetes in the population we serve, especially our Native American population. — Health Care Leader (FMC Service Area)

Disabling Conditions

ABOUT DISABILITY & HEALTH

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

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

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

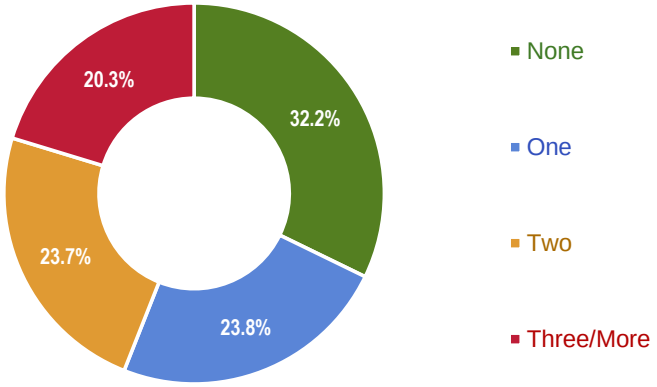
Multiple Chronic Conditions

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

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Sleep apnea
- Stroke

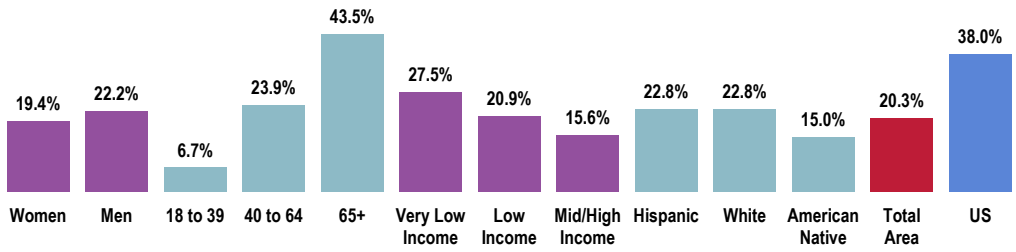
Number of Chronic Conditions
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 306]

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

Have Three or More Chronic Conditions
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 306]
- 2023 PRC National Health Survey, PRC, Inc.

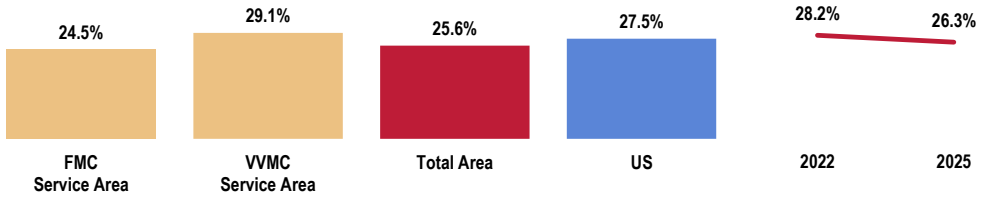
Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, sleep apnea, and stroke.

Activity Limitations

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

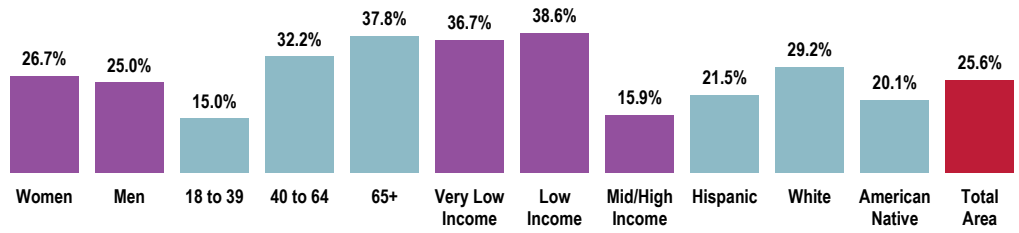
Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem

Flagstaff & Verde Valley Regions



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 29]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

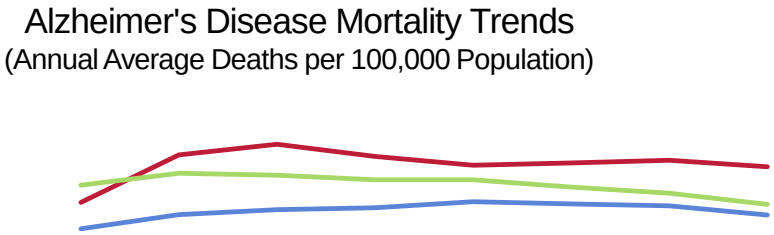
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 29]
Notes: ● Asked of all respondents.

Alzheimer's Disease Deaths

Mortality attributed to Alzheimer's Disease is shown in the following chart. [COUNTY-LEVEL DATA]

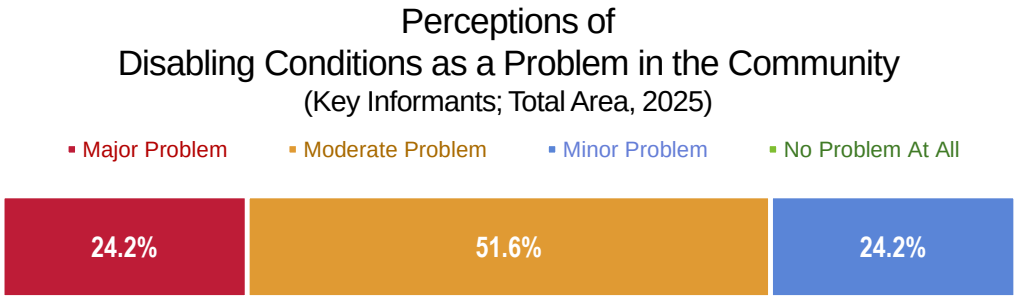


	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	38.2	47.2	49.2	46.9	45.3	45.7	46.2	44.9
AZ	41.5	43.7	43.4	42.5	42.5	41.1	39.9	37.8
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Key Informant Input: Disabling Conditions

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



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Incidence/Prevalence

> Many people in the community have some form of limitation (physical, mental, external, emotional, etc.) that limits their ability to access the proper resources to live a healthy lifestyle. That also affects their ability to access and utilize healthy and culturally relevant foods that meet their dietary needs. Without those, the cycle continues and leads to more disease and limitations. — Social Services Provider (FMC Service Area)
>
> There are a great many people with permanent disabilities struggling to survive in Flagstaff. Some of this arises from poverty, some of it from the high altitude resulting in people needing oxygen. Some of it arises from accidental injury, which is more common in communities with high poverty rates. — Physician (FMC Service Area)

> Meals on Wheels cannot keep up with the demand for their services. — Community Leader (VVMC Service Area)
>
> We have a significant amount of individuals and children with disabling conditions and limited access to resources. — Health Care Leader (FMC Service Area)
>
> Chronic pain, as well as mental health, are major issues in this community. Our agency serves vulnerable populations, and these are two of the biggest challenges related to health. — Social Services Provider (VVMC Service Area)
>
> We see this often with the population we serve, specifically chronic pain and breathing disorders. Over the past several years, we have often been sheltering at least one elderly person a year with signs of dementia or loss of hearing/vision. — Social Services Provider (FMC Service Area)

Access to Care/Services

> Limited primary care and access to non-medical models of care. No awareness of dementia care or caretaker services to support them. Some bias to opening access for referral care or type disabling or disease burden. — Community Leader (FMC Service Area)
>
> Access to care, especially elder care/memory care. — Physician (FMC Service Area)
>
> There are few specialists and few resources, including treatment centers. Most residents go to Phoenix for care, and many leave the area for better health care. — Community Leader (VVMC Service Area)
>
> Need to travel to faraway places for decent care. For example, we need to drive to Flagstaff for quality orthopedic services. — Community Leader (VVMC Service Area)
>
> Health care access and availability. Navajo communities are in remote, rural areas with limited access to medical facilities, specialized care, and transportation. Underfunding, inadequate staffing, and overburdened facilities also have impacts. For individuals with disabling conditions, the lack of accessible and adequate health care makes it difficult for them to receive necessary treatments, rehabilitation, and specialized care. — Health Care Leader (FMC Service Area)

Aging Population

> We have many elderly people living here. — Community Leader (VVMC Service Area)
>
> Our population is older, and there are not enough agencies or care workers to help. — Community Leader (VVMC Service Area)
>
> Older population. — Community Leader (VVMC Service Area)
>
> We have a higher percentage of older adults in our area compared to Arizona and the national average. — Social Services Provider (VVMC Service Area)

Stress

> Chronic stress results in increased chronic health conditions, like fibromyalgia and other autoimmune disorders. Chronic disabling conditions are disproportionately present in the LGBTQ+ community when compared to the overall population. — Community Leader (FMC Service Area)

Impact on Quality of Life

> These are conditions that challenge the quality of life of our older adult population and frequently limit their ability in accessing health care, behavioral health services. — Social Services Provider (VVMC Service Area)

Diagnosis/Treatment

> Possibly underdiagnosed people and the high cost of care. — Health Care Leader (FMC Service Area)

Follow-Up/Support

> We have no community support groups. The care we provide tends to be family-by-family. — Physician (FMC Service Area)

BIRTHS

ABOUT INFANT HEALTH

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

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

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

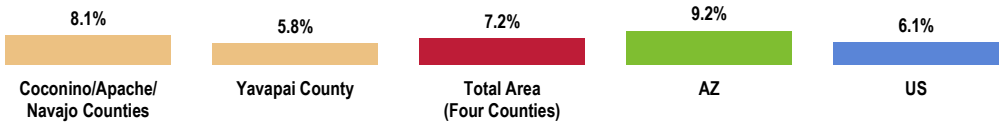
Birth Outcomes & Risks

Lack of Prenatal Care

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

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

Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births, 2017-2019)



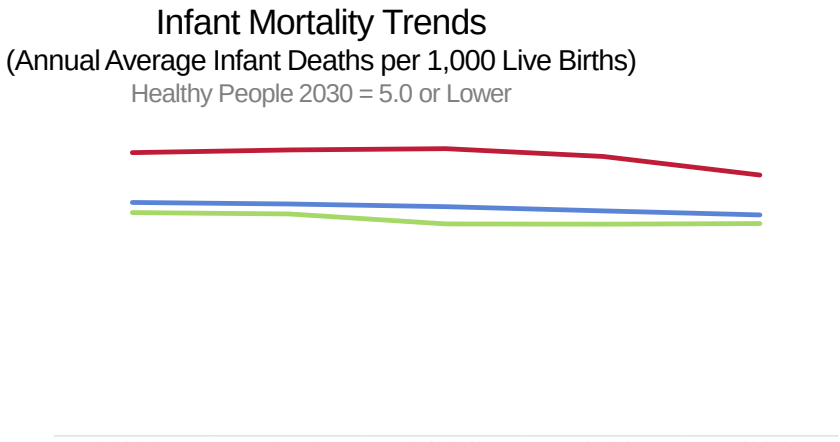
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who do not obtain prenatal care before their seventh month of pregnancy (if at all).

Infant Mortality

Infant mortality includes the death of a child before his/her first birthday, expressed as the number of such deaths per 1,000 live births.

The following chart shows the number infant deaths per 1,000 live births in the Total Area. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area (Four Counties)	7.2	7.2	7.3	7.1	6.6
AZ	5.7	5.6	5.4	5.4	5.4
US	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2025.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Family Planning

ABOUT FAMILY PLANNING

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

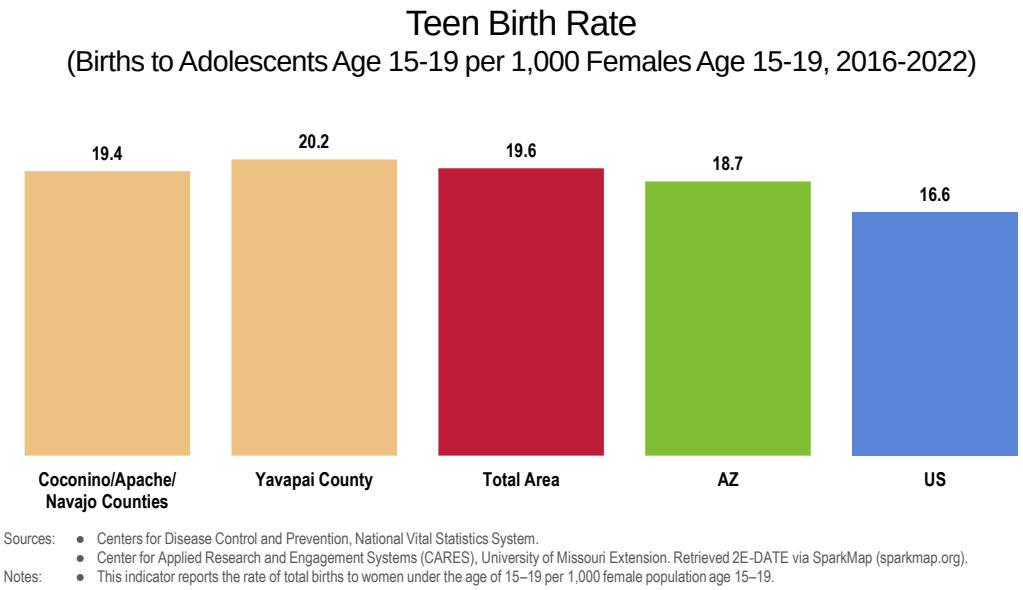
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

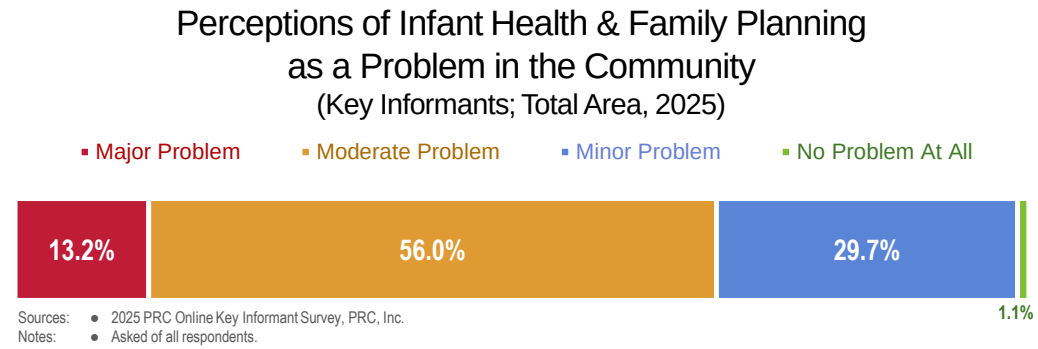
Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines the teen birth rate in the Total Area, compared to rates statewide and nationally. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]



Key Informant Input: Infant Health & Family Planning

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



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

Access to Care/Services

> Navajo Nation has several vital programs and resources to address infant health and family planning, but challenges such as geographic isolation, cultural barriers, and limited access to health care remain. By increasing access to care, expanding education, strengthening community involvement, and addressing the underlying social determinants of health, the Navajo Nation can make significant strides in improving infant health outcomes and promoting effective family planning. — Health Care Leader (FMC Service Area)
>
> We forget about the youth in our community. Babies are born here significantly under the poverty level and in remote areas of Yavapai County with limited access to care. — Community Leader (VVMC Service Area)
>
> Pediatrics. — Health Care Leader (VVMC Service Area)

> There is no pediatric/infant care at VVMC. All patients are sent to Flagstaff or the valley. — Health Care Leader (VVMC Service Area)
>
> Outpatient neurology, particularly for minors (children), is essentially nonexistent in northern Arizona. — Physician (FMC Service Area)

Lack of Providers

> Shortage of providers. Not a pediatric wing at the hospital, and most children with serious illnesses get transferred to the children's hospital. — Community Leader (VVMC Service Area)
>
> Not enough providers or access. — Health Care Leader (FMC Service Area)

Discrimination

> Rampant discrimination in adoption and family planning policies. Lack of statewide protective laws and lack of company benefits that support family planning in the LGBTQ+ community. — Community Leader (FMC Service Area)

Funding

> There are limited funds available to provide support in infant health and family planning, specifically programs that are culturally relevant to the American Indian community. — Health Care Leader (FMC Service Area)

Premature Births

> The high rate of premature births in communities of color, specifically in the Black community. — Community Leader (FMC Service Area)

Maternal Mortality

> Maternal mortality continues to rise, and congenital syphilis is also on the rise. — Health Care Leader (FMC Service Area)

Aging Population

> Older population. Little demand. — Community Leader (VVMC Service Area)

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

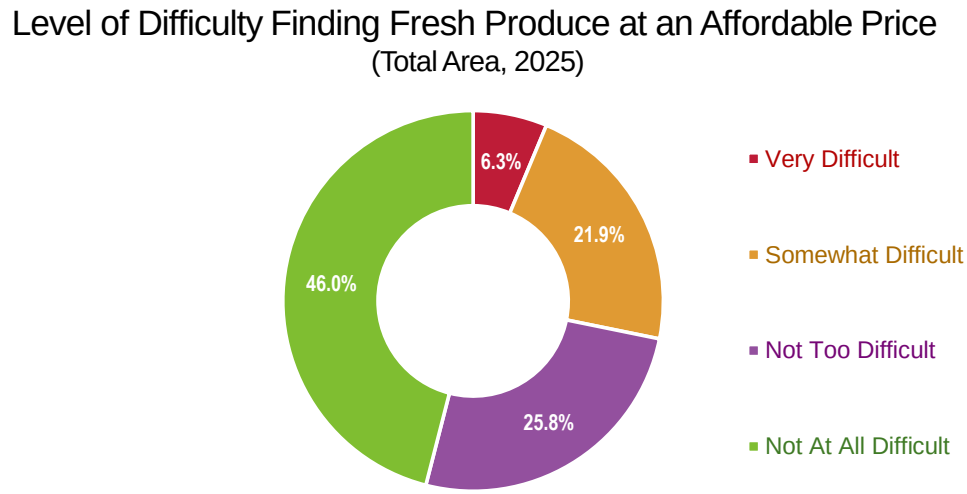
Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy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

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

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

Difficulty Accessing Fresh Produce

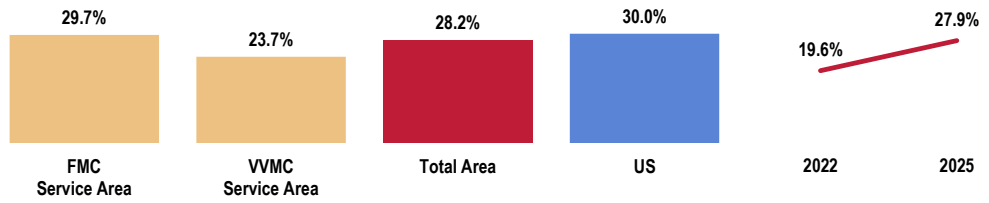
PRC SURVEY ► "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: ● Asked of all respondents.

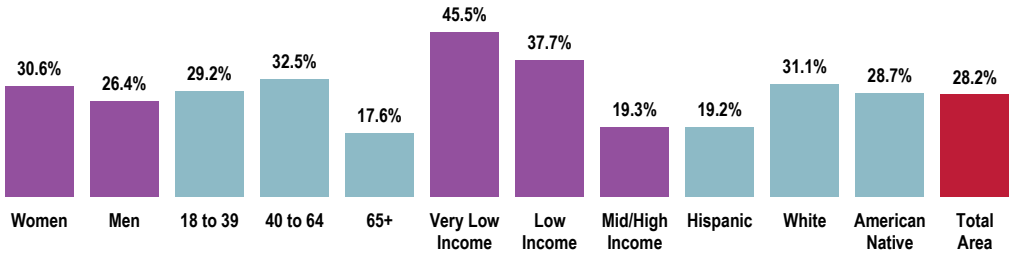
Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce

Flagstaff & Verde Valley Regions



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 24]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

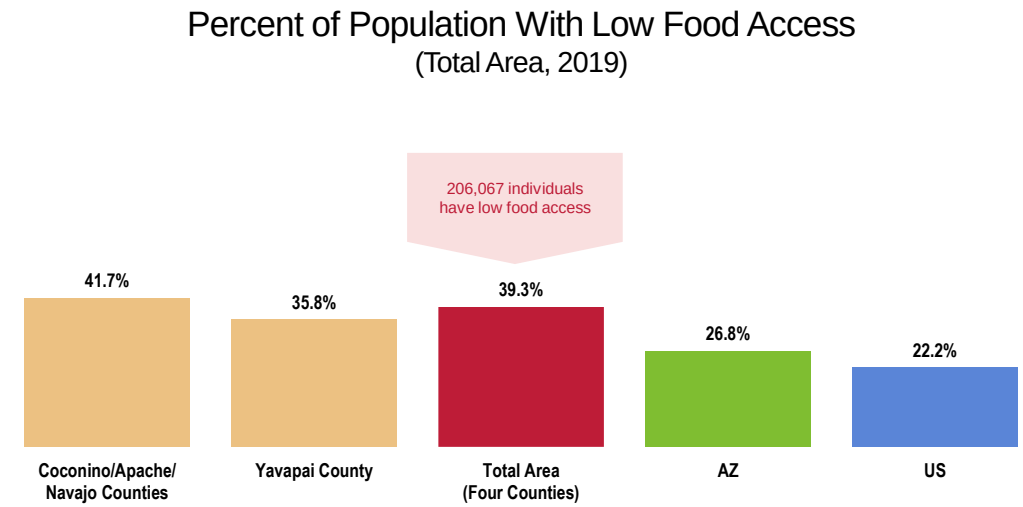
Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: ● Asked of all respondents.

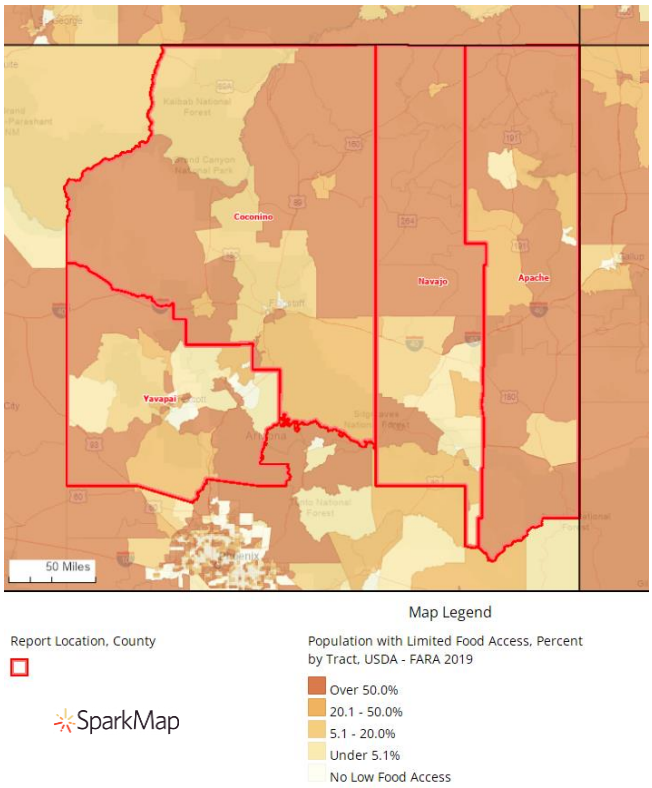
Low Food Access

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



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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



Physical Activity

ABOUT PHYSICAL ACTIVITY

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

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

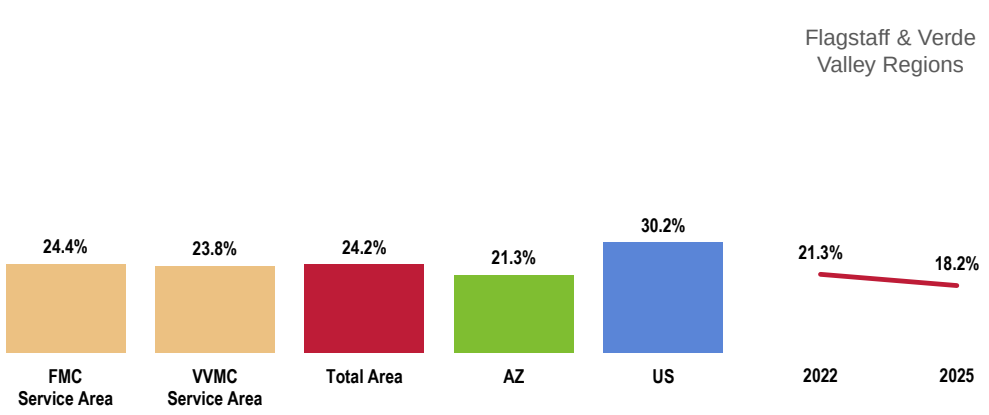
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

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

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower

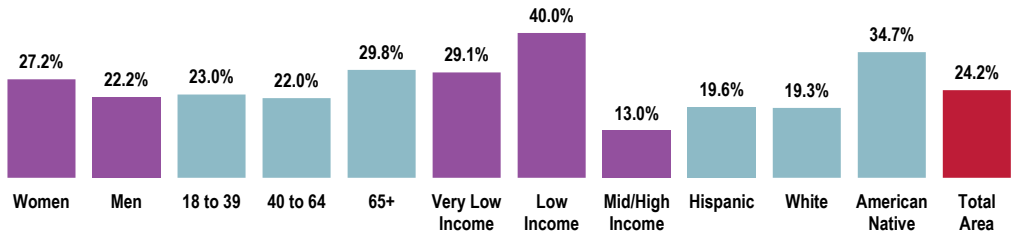


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 25]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Children's Physical Activity

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

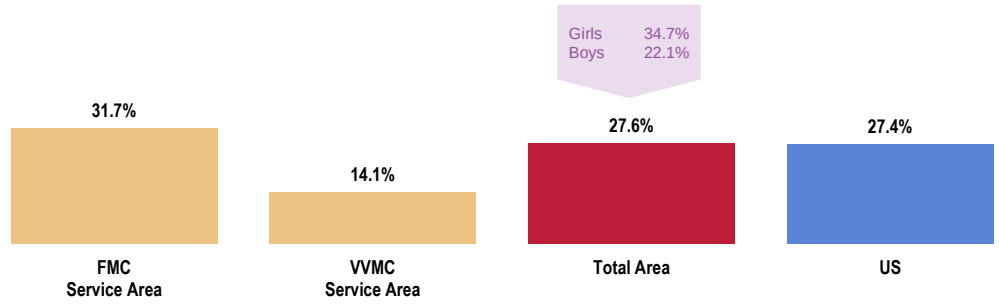
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

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

PRC SURVEY ► "During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day

(Children 2-17)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 47]
- 2023 PRC National Health Survey, PRC, Inc.

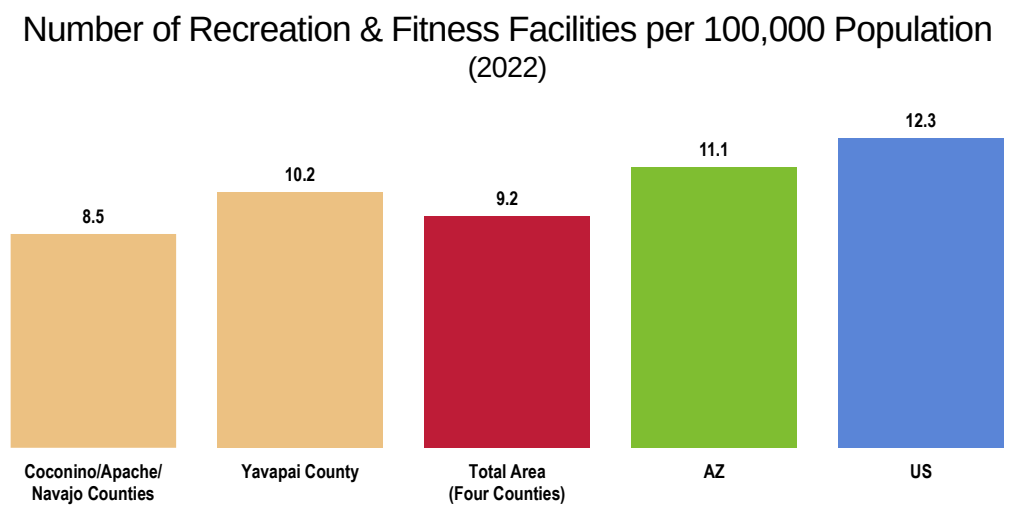
Notes:
- Asked of all respondents with children age 2 to 17 at home.
- Reflects children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity Facilities

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

The following chart shows the number of recreation/fitness facilities for every 100,000 population in the Total Area. This is relevant as an indicator of the built environment's support for physical activity and other healthy behaviors. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.*

Weight Status

ABOUT OVERWEIGHT & OBESITY

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

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

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

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

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

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

Adult Weight Status

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

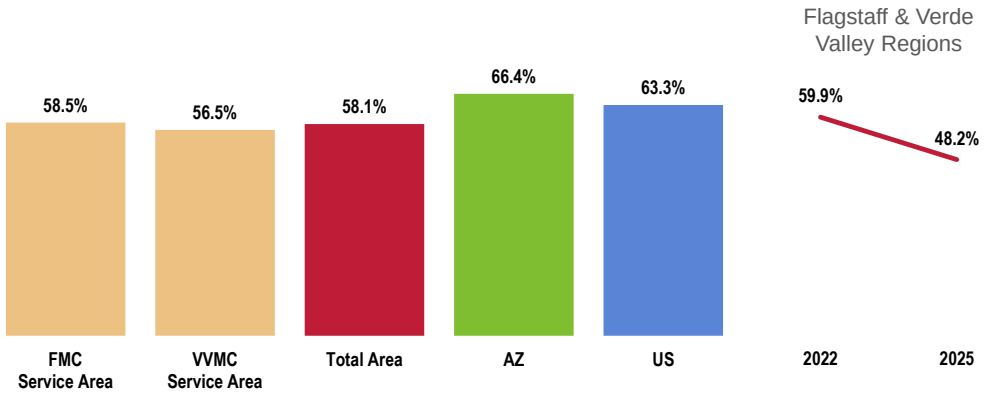
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

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

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

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

Prevalence of Total Overweight (Overweight and Obese)



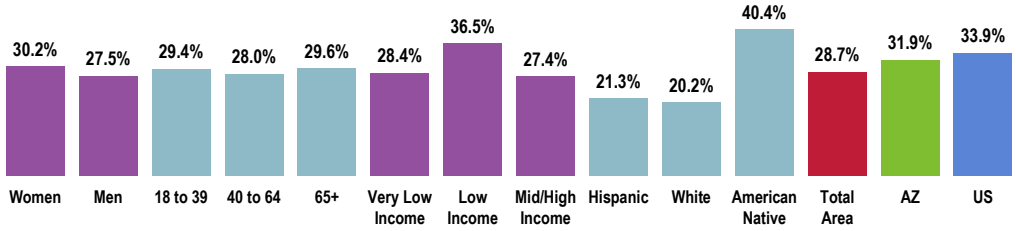
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Prevalence of Obesity

(Total Area, 2025)

Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

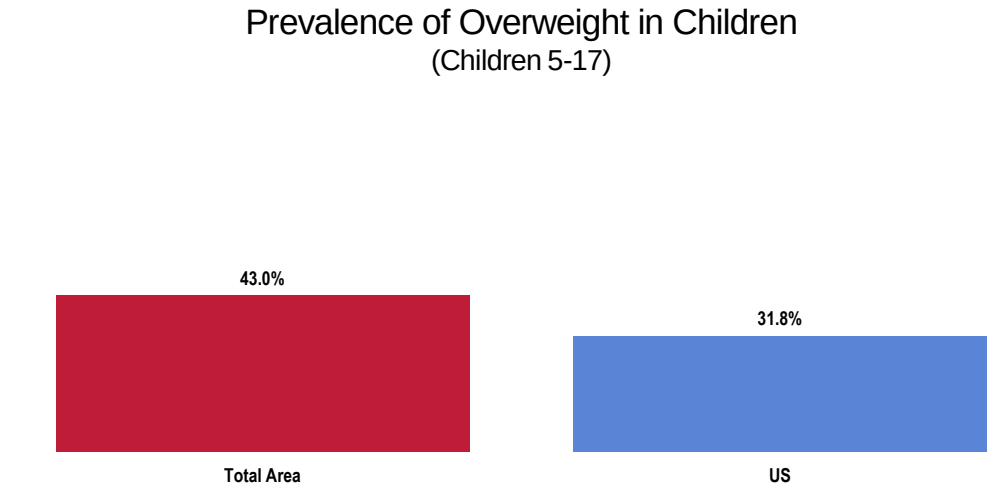
- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ► "How much does this child weigh without shoes?"

PRC SURVEY ► "About how tall is this child?"

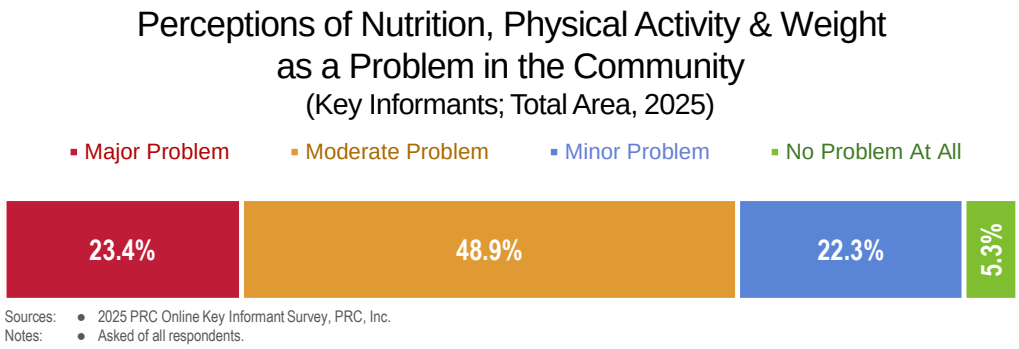


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 54]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

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



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

Access to Affordable Healthy Food

> Nutrition: Healthy foods are very expensive in northern Arizona in general. Fruits and vegetables are often not particularly fresh by the time they reach Flagstaff and further outlying communities, especially the Navajo reservation. Many people work several jobs or work and attend school so don't have time to prepare healthy food. Physical activity: There is a good bus service in Flagstaff which then requires one to walk on either end of the bus ride. This is a great way to get exercise, but because Flagstaff is turning itself into a car-only city, people don't use the buses or walk very much. The more cars there are on the roads, the less people want to walk because it's very unpleasant to walk on the giant streets like they have in Phoenix and like we now have in Milton, Butler, High Country Trail, Route 66, etc. Flagstaff also lacks parks for children to play in in a lot of areas where there are high concentrations of children, such as around all these giant apartment buildings. — Physician (FMC Service Area)
>
> Limited access to healthy foods, reliance on processed foods, cultural barriers to nutrition and physical activity, low levels of physical activity, high rates of obesity and chronic diseases, socioeconomic challenges, etc. Addressing the challenges related to nutrition, physical activity, and weight in the Navajo Nation will require continued collaboration, increased access to resources, and a focus on cultural sensitivity to ensure sustainable health improvements. — Health Care Leader (FMC Service Area)
>
> Lack of fresh fruits and vegetables at affordable prices. — Health Care Leader (FMC Service Area)

Income/Poverty

> Because northeastern Arizona has higher rates of poverty and food insecurity than the rest of the state, individuals and families are having to compromise on health to pay for rent, mortgages, health expenses, transportation, and other expensive utilities. Convenience and affordability become high priorities when food insecurity and poverty are at play, which plays a big role in the long-term nutrition and health of our community. In addition, the lack of kitchen resources, refrigeration, and full-service grocery stores in northeastern Arizona makes healthy eating less accessible. — Social Services Provider (FMC Service Area)
>
> Low-income families. — Community Leader (FMC Service Area)
>
> Socioeconomics, geography, and education. — Physician (FMC Service Area)

Lifestyle

> Being overweight, limited affordable access to physical exercise/gyms, and lack of affordable healthy foods. The convenience around food is cheap, quick, and/or unhealthy when time is limited. Stress is high within family systems. Alcohol use is contributing to weight gain. — Health Care Leader (FMC Service Area)
>
> Obesity and poor diet contribute to medical issues, particularly in our Native American population. — Physician (FMC Service Area)
>
> Poor nutrition, physical activity, and weight issues promote heart disease, diabetes, cancer, and more. — Social Services Provider (VVMC Service Area)

Awareness/Education

> Uneducated population regarding lifestyle and diet impacts. — Community Leader (VVMC Service Area)

> Education and resources, especially for underserved portions of our communities, most significantly children with socially and economically challenged family backgrounds. — Health Care Leader (FMC Service Area)
>
> Education. — Physician (FMC Service Area)

Access to Care/Services

> Access to licensed nutritionists and the cost of physical therapy. Putting too much hope and faith into "miracle" weight loss drugs. — Health Care Leader (FMC Service Area)
>
> I would say that there needs to be more resources for these issues. — Community Leader (VVMC Service Area)

Cultural/Personal Beliefs

> Cultural foods, family culture, and a lack of access to healthy foods and safe places to be active, such as fitness centers, trails, etc. — Health Care Leader (FMC Service Area)

Funding

> Lack of funding and culturally relevant programs for Native Americans. — Health Care Leader (FMC Service Area)

Unhoused Population

> Many people in our community in Flagstaff are homeless and lack food security. — Community Leader (FMC Service Area)

Substance Use

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

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

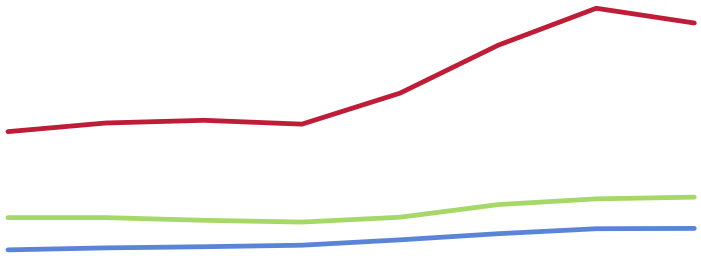
– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol Use

Alcohol-Induced Deaths

Alcohol-induced mortality is shown in the following chart. [COUNTY-LEVEL DATA]

Alcohol-Induced Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 10.9 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	40.1	42.3	43.0	42.1	49.9	62.0	71.3	67.6
AZ	18.4	18.4	17.7	17.3	18.5	21.7	23.1	23.6
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

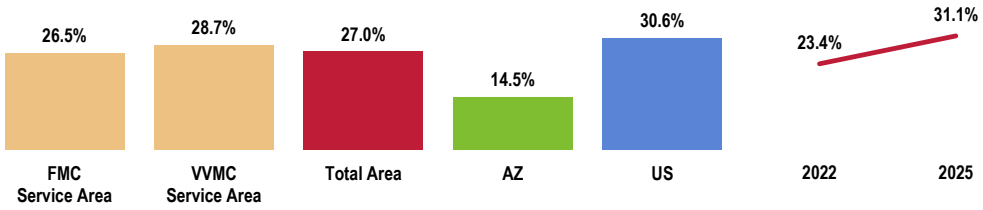
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Binge Drinking

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

Engage in Binge Drinking
Healthy People 2030 = 25.4% or Lower

Flagstaff & Verde Valley Regions



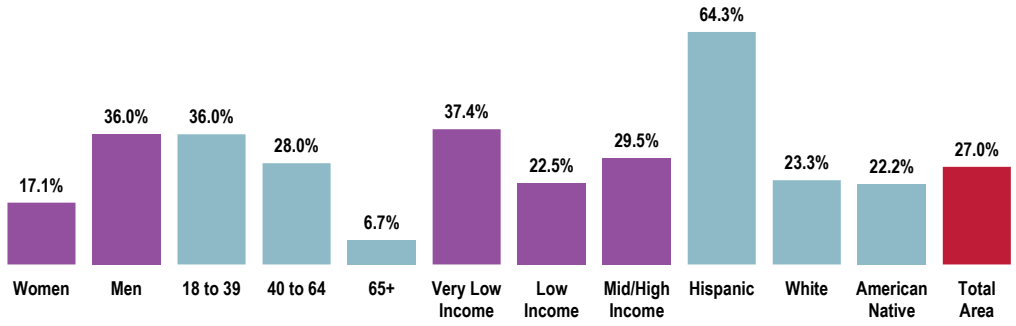
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Binge drinking reflects the percentage of persons age 18 years and over who drank 5 or more drinks on a single occasion (for men) or 4 or more drinks on a single occasion (for women) during the past 30 days.

Engage in Binge Drinking

(Total Area, 2025)

Healthy People 2030 = 25.4% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Binge drinking reflects the percentage of persons age 18 years and over who drank 5 or more drinks on a single occasion (for men) or 4 or more drinks on a single occasion (for women) during the past 30 days.

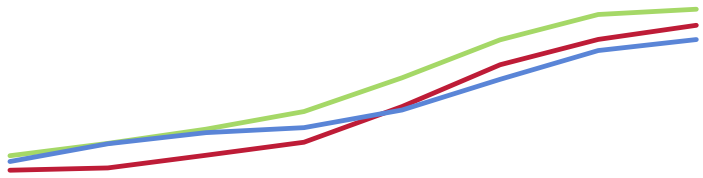
Drug Use

Unintentional Drug-Induced Deaths

Unintentional drug-related mortality is shown in the following chart. [COUNTY-LEVEL DATA]

Unintentional Drug-Induced Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area (Four Counties)	13.2	13.4	15.0	16.7	21.2	26.5	29.7	31.5
AZ	15.0	16.5	18.4	20.6	24.8	29.6	32.8	33.5
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

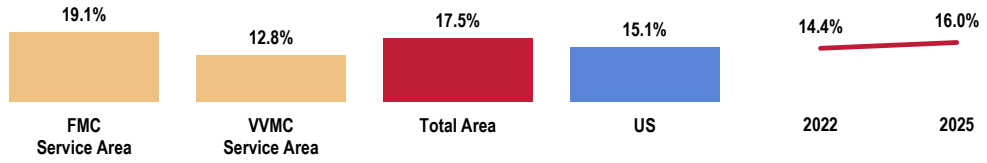
Use of Prescription Opioids

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

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

Used a Prescription Opioid in the Past Year

Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- 2023 PRC National Health Survey, PRC, Inc.

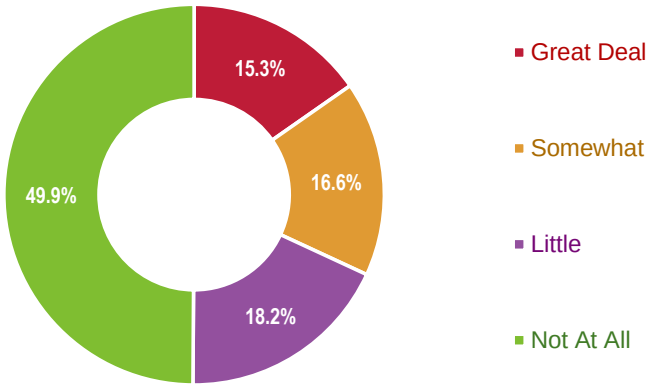
Notes:
- Asked of all respondents.

Personal Impact From Substance Use

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

Degree to Which Life Has Been Negatively Affected by Substance Use (Self or Other's)

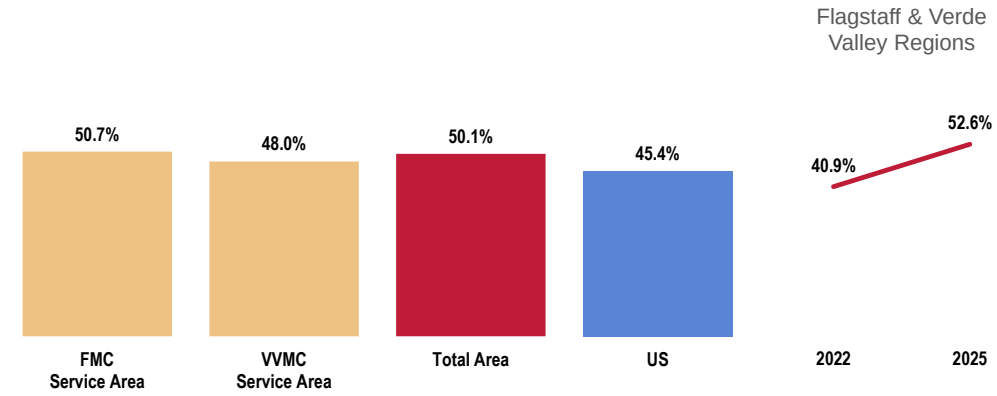
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 23]

Notes:
- Asked of all respondents.

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)

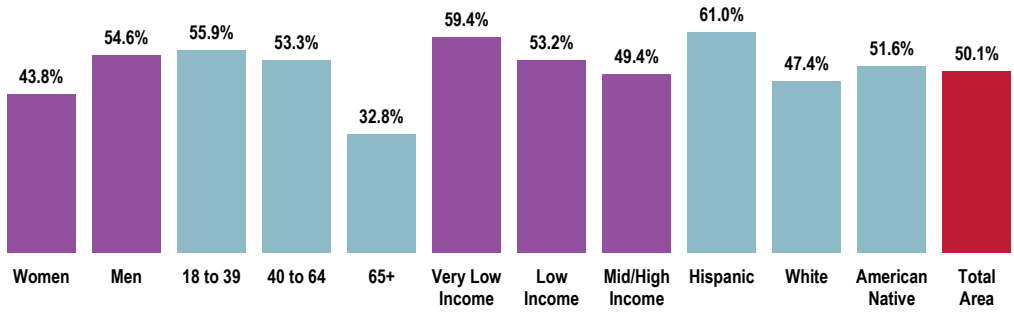


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 23]
- 2023 PRC National Health Survey, PRC, Inc.

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

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)

(Total Area, 2025)

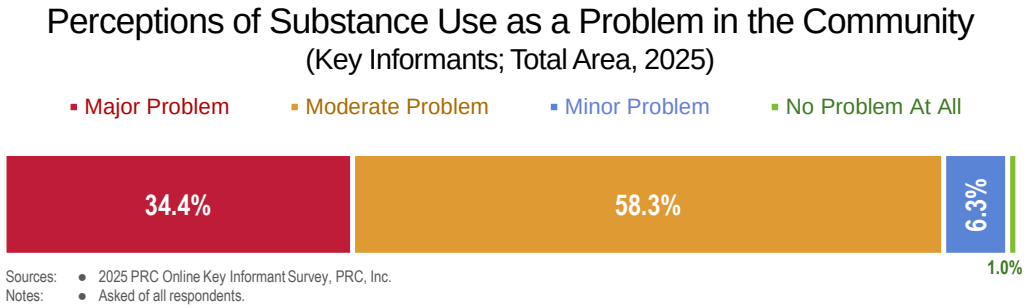


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 23]

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

Key Informant Input: Substance Use

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



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

Access to Care/Services

> There are quite a few organizations working with people with substance abuse disorders, and they are not fully integrated to work with each other. The Guidance Center has limited services to address the mental health need associated with substance abuse. — Health Care Leader (FMC Service Area)
>
> Same as with mental health services: limited beds and scattered independent entities I suspect are underresourced. Health literacy, access to care, and the high cost of living. — Physician (FMC Service Area)
>
> Lack of facilities and medical practitioners. Unsheltered individuals have additional burdens in accessing treatment. — Community Leader (FMC Service Area)
>
> Access to immediate care. — Community Leader (FMC Service Area)
>
> Lack of treatment. No sobering centers. Inadequate resources to treat alcohol abuse. — Health Care Leader (FMC Service Area)
>
> Access to resources and available substance abuse treatment. — Health Care Leader (FMC Service Area)
>
> There is truly no wraparound services for substance abuse treatment in our geographic service area. — Health Care Leader (FMC Service Area)
>
> Lack of community-based detox. Patients are brought to the emergency department. — Health Care Leader (FMC Service Area)
>
> The lack of services. There are such limited services that it's hard to even refer community members, some of whom really want and could use this help. Anywhere locally. — Social Services Provider (FMC Service Area)
>
> Some locations will not take clients until they are fully sober. Access to detox beds and access to follow-up after detox discharge. — Health Care Leader (FMC Service Area)
>
> Inpatient programs are typically full, and the only option locally for those utilizing AHCCCS is a 28-day program, which does not seem long enough to get the resources into place that will be needed for long-term recovery, nor enough time for people to learn the tools needed to abstain. I'm unsure of the quality of local programs, as well; I haven't spoken with clients who have utilized the services recently. — Social Services Provider (FMC Service Area)
>
> Accessing substance abuse treatment is a significant challenge in the Navajo Nation, where several barriers make it difficult for individuals to seek help and receive the care they need. These barriers are rooted in a combination of cultural, logistical, systemic, and economic factors that limit access to quality treatment services. — Health Care Leader (FMC Service Area)
>
> Accessing care. Cost, privacy issues, judicial system. — Community Leader (VVMC Service Area)

Lack of Providers

> Limited outpatient providers. — Physician (FMC Service Area)
>
> Lack of providers and the cost. — Community Leader (VVMC Service Area)
>
> Treatment specialists and support/training for primary care. — Physician (FMC Service Area)

Awareness/Education

> There is a lack of meaningful dialogue with practitioners and patients. Successful models outside of Arizona need to be considered and determined if they could apply in Flagstaff. Negative narratives that shrink already-limited funding. Limited leadership or community partnerships to integrate funding, services, and solutions or ideas. — Community Leader (FMC Service Area)

> Knowledge of available programs, access to available programs, transportation, and motivation. Root causes of substance use. — Social Services Provider (FMC Service Area)

Alcohol/Drug Use

> Fentanyl. The turnover of staff and admins at the hospital in Cottonwood. Lack of specialized medicine in our area. — Community Leader (VVMC Service Area)

> Alcohol and fentanyl use are high. Alcohol-related illnesses and deaths are high. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> This is a big drinking town, and our Native American neighbors are not equipped to handle the toxin. — Health Care Leader (FMC Service Area)

Lack of Culturally Appropriate Care

> Legitimate programs that offer culturally relevant care to Native Americans, opposed to fraudulent claims. — Health Care Leader (FMC Service Area)

Outreach

> Proactive outreach to individuals experiencing substance abuse. — Social Services Provider (FMC Service Area)

Disease Management

> The desire to participate. — Physician (FMC Service Area)

Income/Poverty

> Low income. — Community Leader (FMC Service Area)

Stress

> Ongoing stressors triggering continued substance use. — Community Leader (FMC Service Area)

Tobacco Use

ABOUT TOBACCO USE

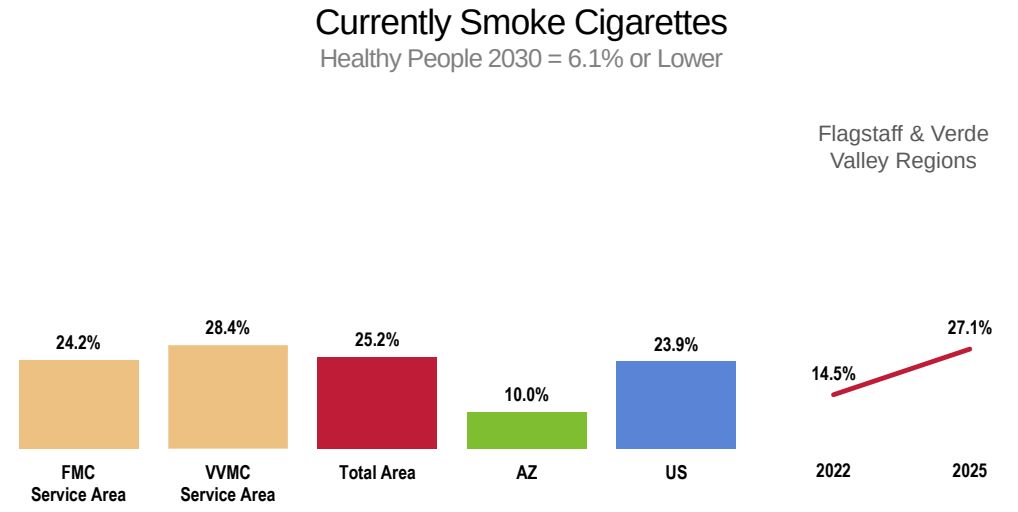
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including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

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

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

Cigarette Smoking

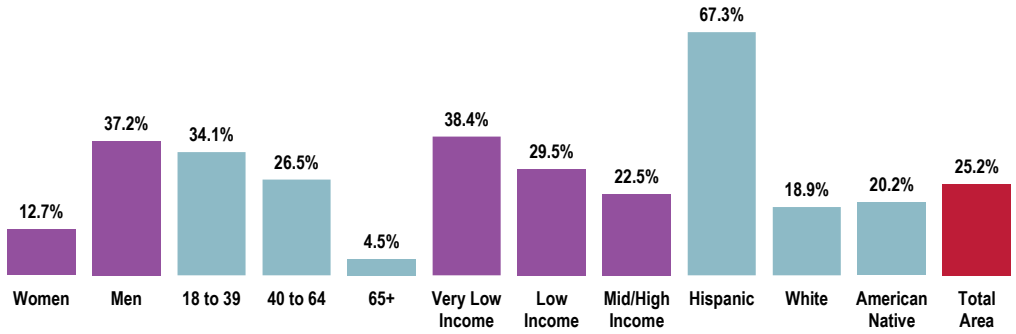
PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 19]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Currently Smoke Cigarettes
(Total Area, 2025)
Healthy People 2030 = 6.1% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 19]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

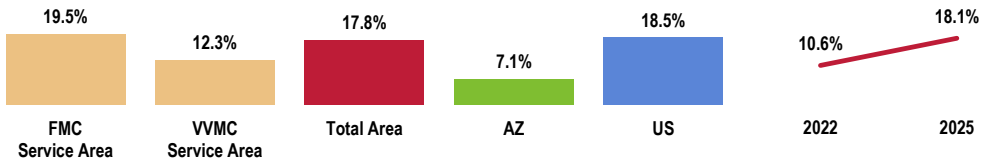
Notes:
- Asked of all respondents.
- Includes those who smoke every day or on some days.

Use of Vaping Products

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

Currently Use Vaping Products
(Every Day or on Some Days)

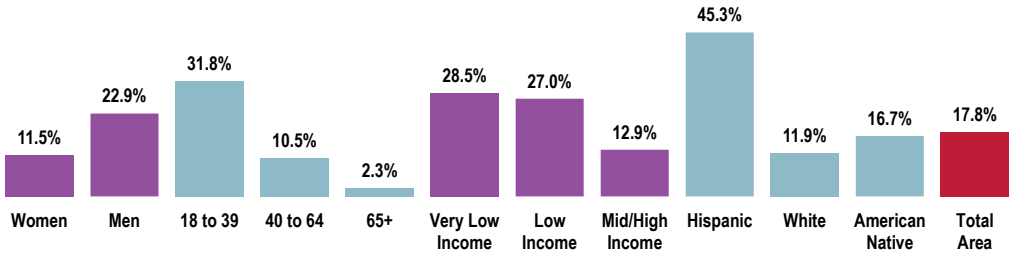
Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Currently Use Vaping Products
(Total Area, 2025)

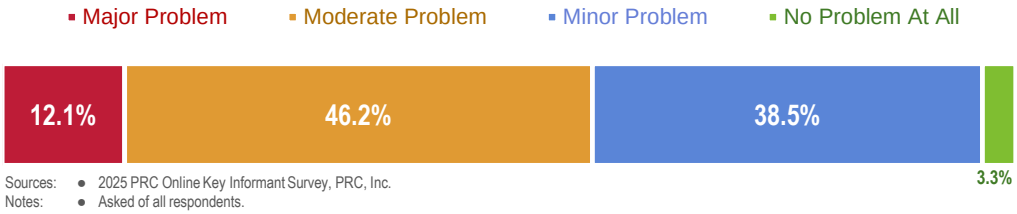


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 20]
Notes: • Asked of all respondents.
• Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

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

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants; Total Area, 2025)



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Cigarettes

> Flagstaff Public Schools has an increased use of vapes by students, especially in high school. The increasing number of smoke shops in the Flagstaff area. — Health Care Leader (FMC Service Area)
>
> Tobacco use is related to other determinants of care. However, vaping in teens and children is a major problem that doesn't get enough attention. We see substantial effects on mood and behavior, addiction behaviors, shoplifting, and likely a gateway to other substances. The idea that vaping is "better than smoking" is a fantasy promulgated by the same producers of tobacco products. — Physician (FMC Service Area)

Impact on Quality of Life

> Tobacco use is considered a major problem within the Navajo Nation for a variety of reasons, ranging from health impacts to cultural and social challenges. Like many Indigenous communities across the United States, the Navajo Nation has experienced an increasing prevalence of tobacco use, particularly commercial tobacco products, which pose serious health risks. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> I do know that many LGBTQ+ people use tobacco due to high levels of daily stress. — Community Leader (FMC Service Area)

Incidence/Prevalence

> There continues to be a significant population that uses tobacco products. — Physician (FMC Service Area)

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

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

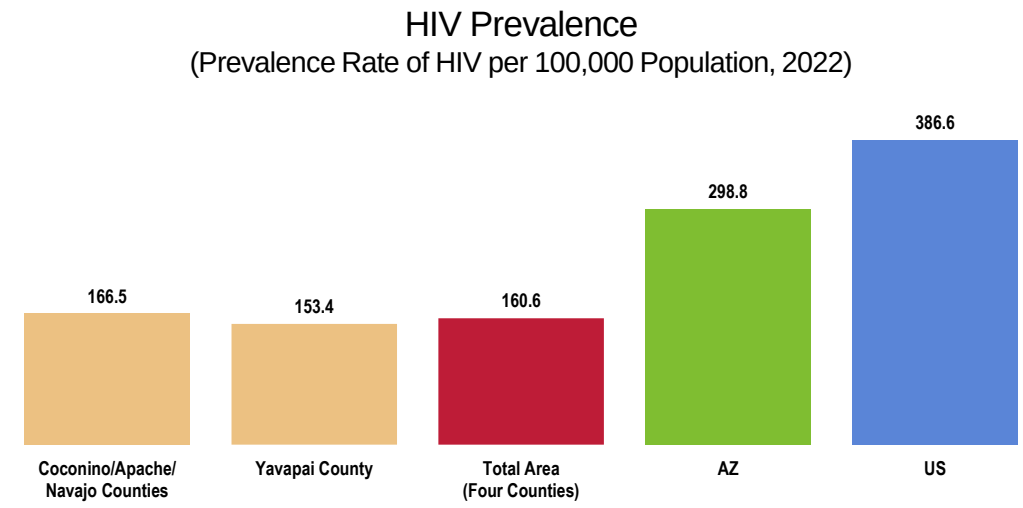
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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

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

HIV

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



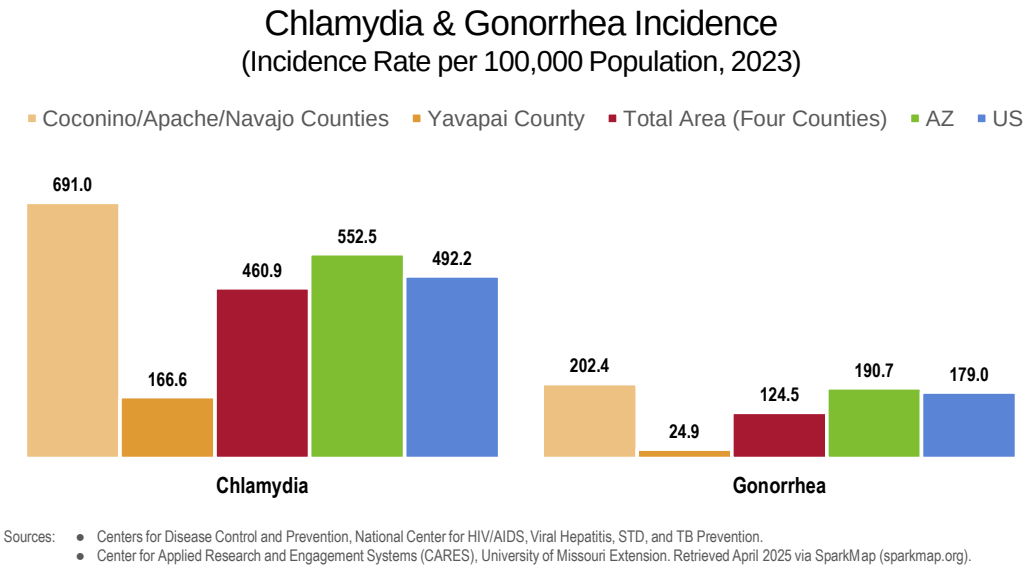
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

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

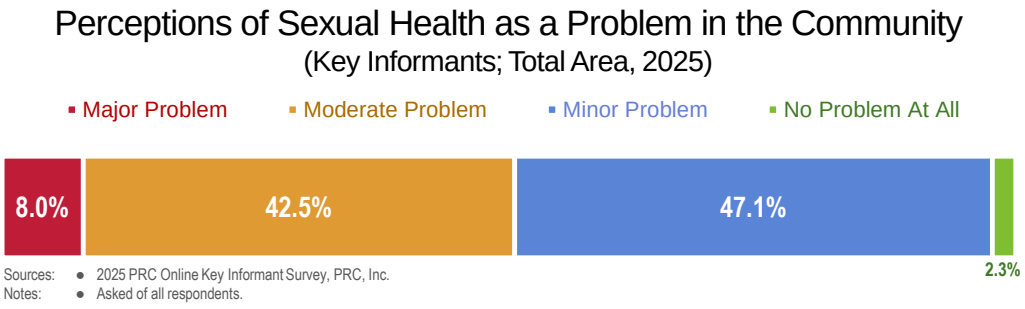
Anyone who is sexually active can get gonorrhea. **Gonorrhea** can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

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



Key Informant Input: Sexual Health

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



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

Awareness/Education

> Need more education for young people who think they are invincible to sexual diseases. Increase this education in our schools. — Community Leader (VVMC Service Area)
>
> Arizona does not offer comprehensive sex education. — Community Leader (VVMC Service Area)

Cultural/Personal Beliefs

> Sexual health is a significant concern in the Navajo Nation, influenced by various cultural, social, and economic factors. The Navajo people face a number of beliefs and challenges related to sexual health, which can affect individuals' well-being and the community as a whole. — Health Care Leader (FMC Service Area)

Lack of LGBTQ+ Informed Care

> One need of the LGBTQ+ community locally is that health providers are more knowledgeable about PrEP, DoxyPEP, and other means of STI prevention without judgment. — Community Leader (FMC Service Area)

Vulnerable Populations

> Syphilis has increased in the Navajo Area region between 2015 and 2022, a 2,114% increase. — Health Care Leader (FMC Service Area)

Lack of Providers

> These issues are increasingly problematic in our community, and yet the number of providers is quite limited. — Physician (FMC Service Area)

Prevention/Screenings

> Inadequate state/county monitoring of STDs. — Health Care Leader (FMC Service Area)

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

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

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

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

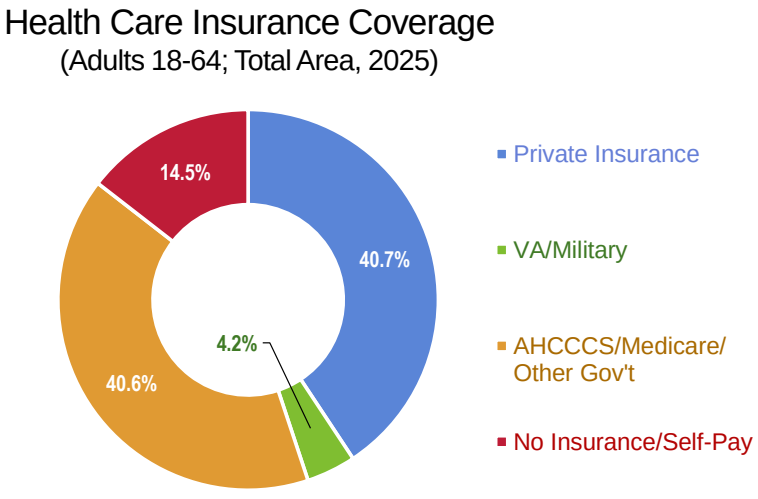
Lack of Health Insurance Coverage

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

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, AHCCCS, or VA/military benefits?"

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

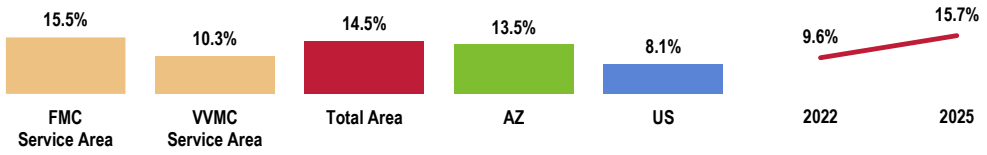
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
Notes: ● Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower

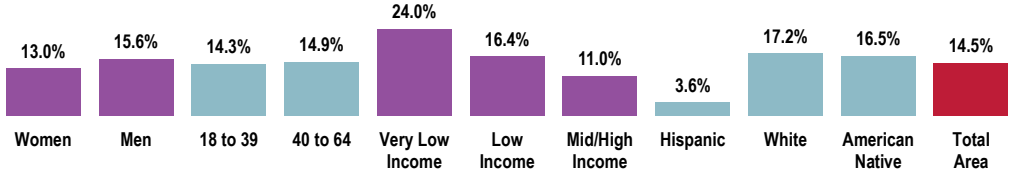
Flagstaff & Verde Valley Regions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; Total Area, 2025)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

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

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

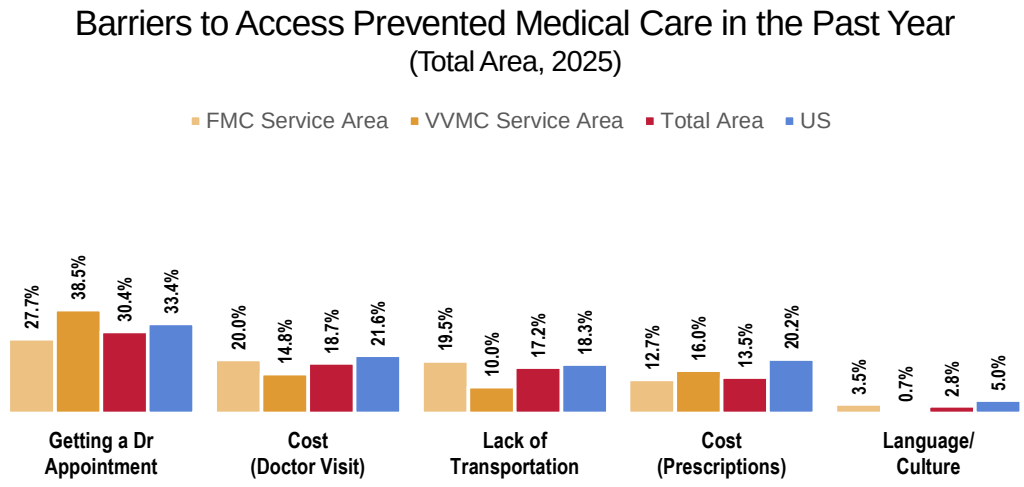
PRC SURVEY ► "Was there a time during the past 12 months when you had difficulty getting an appointment to see a doctor?"

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

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

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

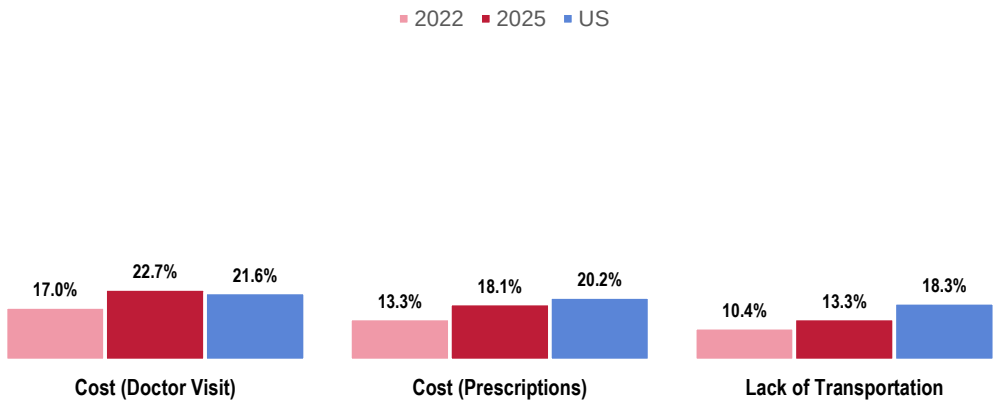
The percentages shown in the following charts reflect the total population, regardless of whether medical care was needed or sought.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 5-7, 301-302]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Barriers to Access Prevented Medical Care in the Past Year
(Flagstaff & Verde Valley Regions)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 5-7]

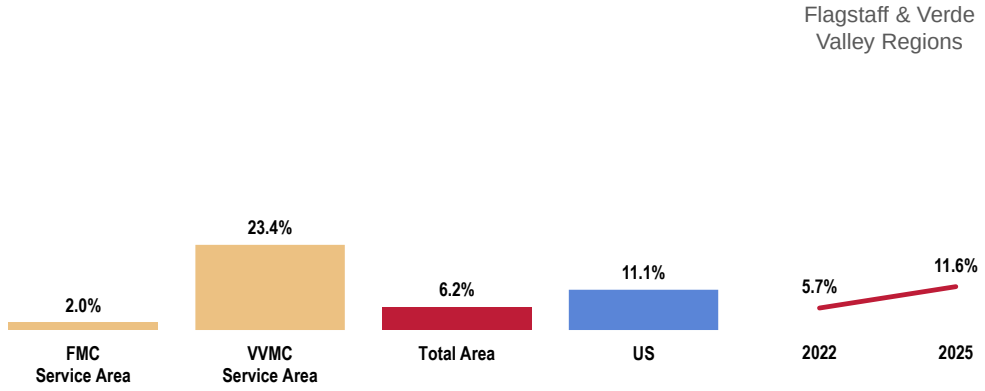
Notes:
- Asked of all respondents.
- Only three of the five tested barriers were included in the 2022 survey.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care for this child but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

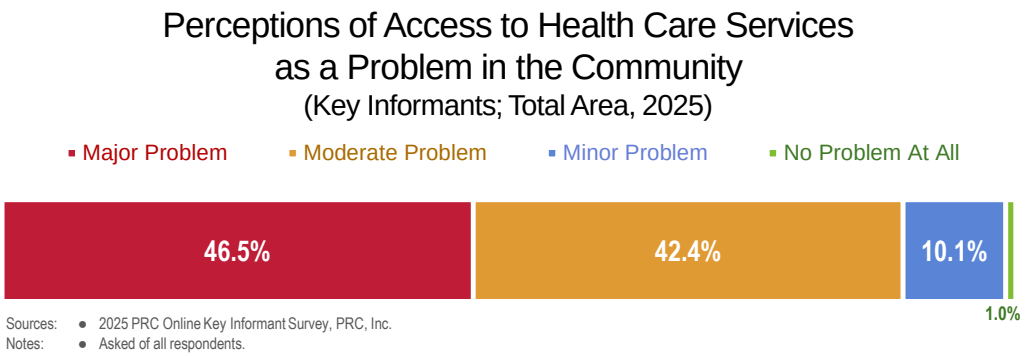


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 45]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

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



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

Access to Care/Services

The availability of providers, given the large service area and relatively small population centers, creates the perception that this region is medically underserved. It may not be proportionately, statistically, or practically true, but it is the perception, and perception can hugely impact a person's experience attempting to get health care services. — Health Care Leader (FMC Service Area)

Fragmented care services. Provider and health care worker shortages, especially in mental health, pain management, population health, and community health care workers. — Physician (FMC Service Area)

Getting the runaround while trying to get behavioral health support. — Community Leader (FMC Service Area)

Access to services takes a long time and is far away. — Community Leader (VVMC Service Area)

Availability of providers, transportation, and Medicaid funding. — Community Leader (VVMC Service Area)

Lack of services locally. Must travel to receive most medical, mental, and emergency health services. — Community Leader (VVMC Service Area)

Lack of available resources, inadequate capacity for timely care, and difficulty recruiting providers to the Northern Arizona market. — Health Care Leader (FMC Service Area)

Availability of primary care providers, inpatient capacity at hospitals, and ability to attract and retain providers/staff due to cost of living. — Health Care Leader (FMC Service Area)

Access to timely primary care. Access to mental health services, outpatient and inpatient, is significantly limited (crisis level). Substance abuse management for chronically intoxicated and potentially homeless individuals is nonexistent. — Health Care Leader (FMC Service Area)

The biggest challenges related to accessing health care services include insufficient insurance coverage or lack of understanding of their insurance benefits. Health care staffing shortages, transportation, and work-related barriers. — Health Care Leader (FMC Service Area)

Insurance coverage and appointment availability. — Health Care Leader (FMC Service Area)

The length of time to be seen by a provider. — Health Care Leader (VVMC Service Area)

Very long wait times for appointments and other services, such as referrals. — Physician (FMC Service Area)

There are often long wait times to be seen at the emergency department and at the local community health center. Even if you do see a provider, the information given to patients seems to be lacking, and bedside manner is also of concern. AHCCCS patients have limited treatment options. Also, we do not have enough specialists in our area to accommodate the Northern Region that travels to see these providers. — Social Services Provider (FMC Service Area)

Our community has to travel out of town to receive adequate health services. — Community Leader (FMC Service Area)

Social determinants of health that prevent connection to health care and health information. — Social Services Provider (VVMC Service Area)

For quality care, we need to travel to Phoenix Valley. It takes too long to get an appointment with providers here in the Yavapai Valley. — Community Leader (VVMC Service Area)

Access to health resources, including critical care facilities and health professionals during health emergencies, such as the previous pandemic. — Community Leader (FMC Service Area)

> Long emergency department wait times due to overcrowding and boarding. — Physician (FMC Service Area)

Lack of Providers

> Shortage of primary care providers. Lack of health insurance for many residents. — Community Leader (VVMC Service Area)
>
> Lack of primary care or specialty care after-hours or on weekends. — Physician (FMC Service Area)
>
> Lack of primary care providers and not enough specialists. — Community Leader (VVMC Service Area)
>
> Lack of referrals and access to specialty services. NAH may not recognize regional referrals, or they are not accepted. — Community Leader (FMC Service Area)
>
> Availability of providers. — Health Care Leader (VVMC Service Area)
>
> Primary care services. It is so hard to get an appointment with a primary care physician. Telehealth works to a certain point, but it does not reduce the need of a time-appropriate, in-person appointment. — Health Care Leader (FMC Service Area)
>
> Primary care services are in severely short supply. — Physician (VVMC Service Area)
>
> Very difficult to get a primary care appointment. My wife has a 12-month wait for a colonoscopy, and we are looking at going to Phoenix to get a faster appointment. — Health Care Leader (FMC Service Area)
>
> Primary care. — Community Leader (VVMC Service Area)
>
> Having the available medical staff at your clinic locations to serve our older demographic. Many patients have to drive to the Phoenix area for care. The area does not have a "coordinated entry system" to place mentally ill, addicted, homeless persons into care/recovery services or housing. — Community Leader (VVMC Service Area)
>
> Lack of primary care providers. Lack of adequate subspecialty care due to inadequate numbers of subspecialty physicians, most prominently gastroenterologists. If Medicaid is substantially cut, there will be extreme poor health outcomes to many in our area, as this is an area of high poverty, poor health, and poor health literacy among Medicaid recipients. — Physician (FMC Service Area)
>
> Not enough practitioners. Additionally, it appears practitioners can only schedule and spend minimal time with patients. It's horrifying. — Community Leader (VVMC Service Area)
>
> Not enough qualified doctors. I was a patient of a doctor for several years. When he retired, they referred me to another cardiologist in the system. I made an appointment. At the appointment, he sat at his computer and reviewed the information. He then asked me why I was there. I told him my symptoms and concerns. He then said, "There is nothing I can do for you today. Come back in six months." I then found new medical care with another organization. — Community Leader (VVMC Service Area)
>
> Lack of specialty doctors, primary care physicians, and available beds when admission is warranted. Lack of senior living and associated continuity of care. — Community Leader (VVMC Service Area)
>
> Retention of providers and nursing staff. The availability of specialized services. Contracting costs for providers and nurses have increased due to an inability to recruit providers in rural areas, as well as no housing availability. — Health Care Leader (FMC Service Area)
>
> Insufficient number of primary care providers to address need and ensure timely access to care. Poor reputation due to inconsistent follow-up (whether for access to care, follow-up to care, and even following up with people applying for jobs). Mental health and drug issues also are an issue. — Community Leader (VVMC Service Area)
>
> Limited specialty providers. Wait times for appointments. — Health Care Leader (FMC Service Area)
>
> The need for additional providers and specialists. — Health Care Leader (FMC Service Area)

Vulnerable Populations

> Socioeconomic access to care, particularly related to native population groups. Great geographical distances to reach care. Limited access to physicians, particularly primary care, but also specialists. This is compounded by the high cost of living, limited housing options, making recruitment challenging compared with similar markets. There is a particular pattern in our region, then, to replace physicians with less-skilled APPs who are more available and less expensive, but with the result that care is pushed further to the specialists and further reducing timely access to specialty care. — Physician (FMC Service Area)
>
> From the community members I interact with, here are the two biggest challenges I see: 1. Dental care. For those experiencing homelessness and extreme poverty, I see the lack of dental care availability as the largest health care priority. If you are on AHCCCS, then you have to go through North Country, who are largely understaffed and oversubscribed to meet the needs of the community. 2. Diet-related diseases. From our perspective, diet-related diseases are a large challenge in the community. Because of high rates of food insecurity and the lack of access to healthy foods, education, cooking tools, and refrigeration, diet-related diseases continue to be persistent across the region. — Social Services Provider (FMC Service Area)
>
> Limited income in the LGBTQ+ community and discrimination/harassment results in poor social determinants of health. — Community Leader (FMC Service Area)

Transportation

> Transportation, insurance, and wait times. Appointments are booked out far. — Social Services Provider (FMC Service Area)
>
> Need more support for transportation, more funding to make it more available. Need more medical staffing for primary care and specialty care – too difficult to drive to Phoenix to get a more timely appointment. Need NAH to collaborate more with community-based support services to better address the social determinants of health. — Social Services Provider (VVMC Service Area)

Affordable Insurance

> Cost of insurance, cost of care, and threats to AHCCCS funding. — Health Care Leader (FMC Service Area)

Affordable Same Day Services

> Affordable same-day services. — Community Leader (VVMC Service Area)

Awareness/Education

> Information regarding social determinants of health, health issues related to Native Americans, health disparities, and health equity. — Health Care Leader (FMC Service Area)

Lack of Specialty Care

> Specialist waiting lists. Primary care provider shortage, though this is improving. BH/mental health and alcohol treatment. — Physician (FMC Service Area)

Lifestyle

> One of the more predominant issues is wellness in regard to healthy habits and drug and ETOH support. — Health Care Leader (FMC Service Area)

Transgender Care

> Transgender care for the LGBTQ+ community. — Health Care Leader (FMC Service Area)

Primary Care Services

ABOUT PREVENTIVE CARE

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

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

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

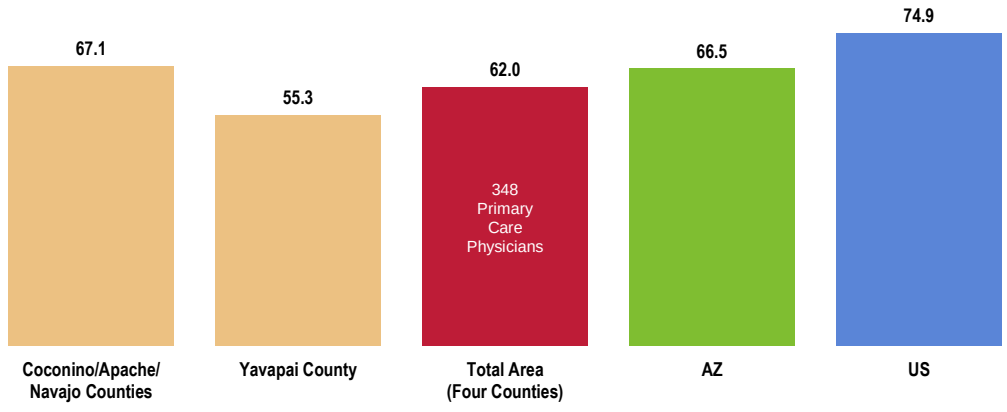
– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

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

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

Number of Primary Care Physicians per 100,000 Population
(2021)



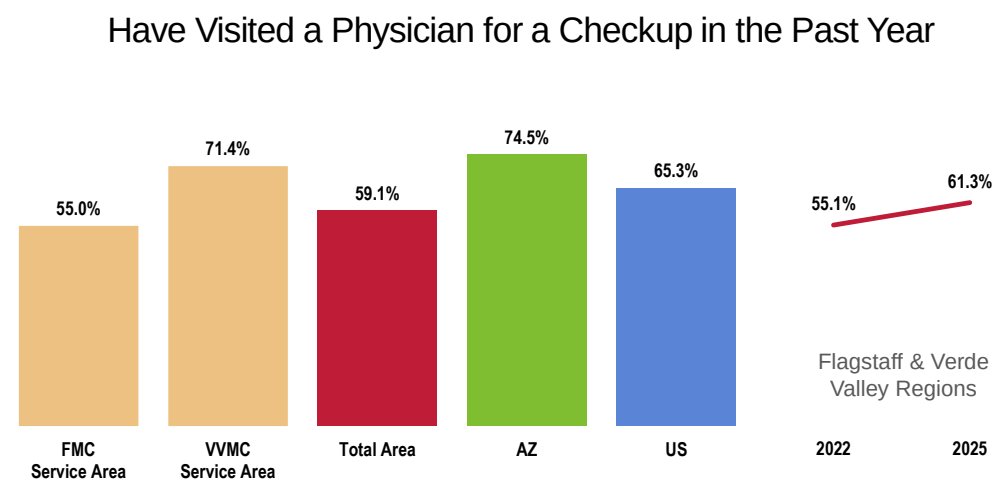
Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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

Utilization of Primary Care Services

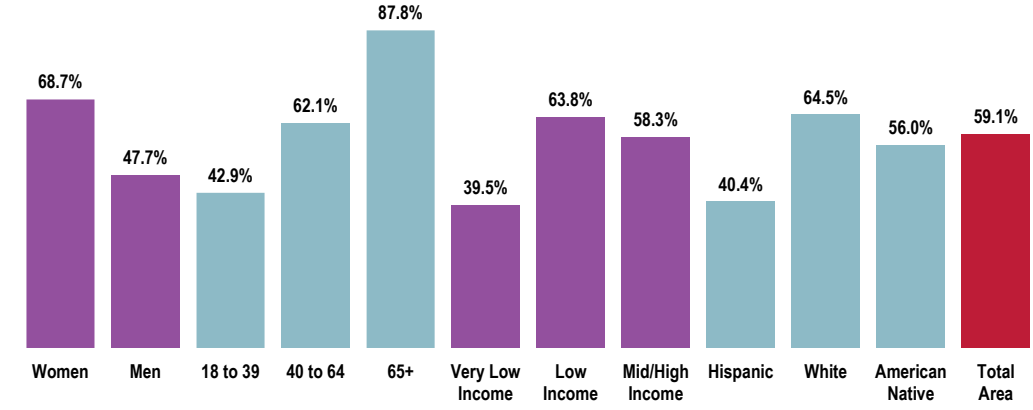
Adults

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 8]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

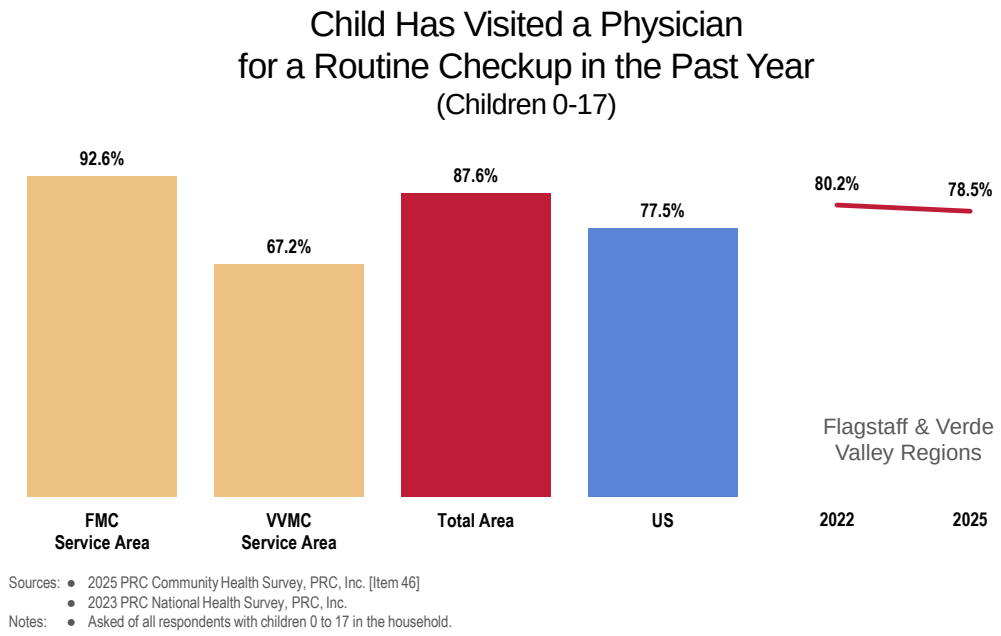


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 8]

Notes:
- Asked of all respondents.

Children

PRC SURVEY ► "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 46]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

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

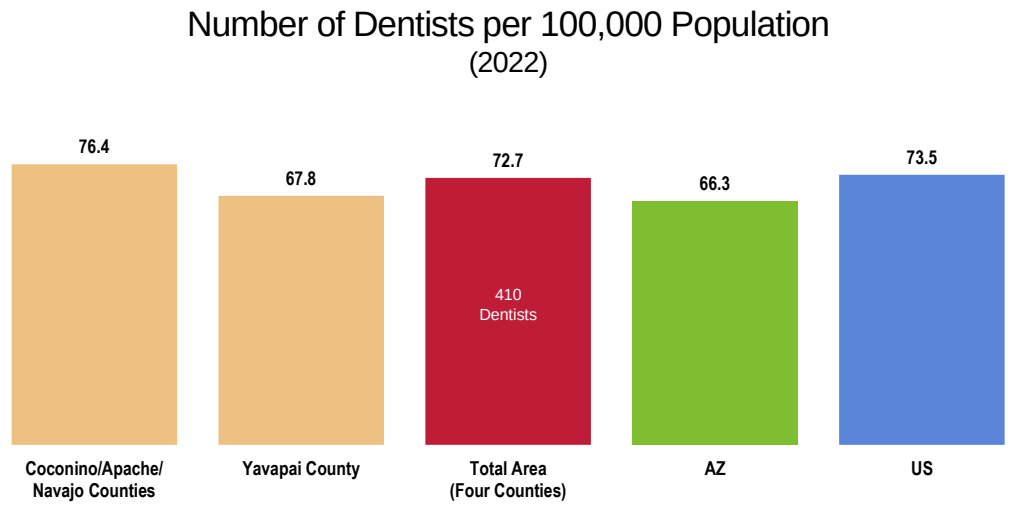
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching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

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

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

The following chart outlines the number of dentists for every 100,000 residents in the Total Area. [COUNTY-LEVEL DATA]

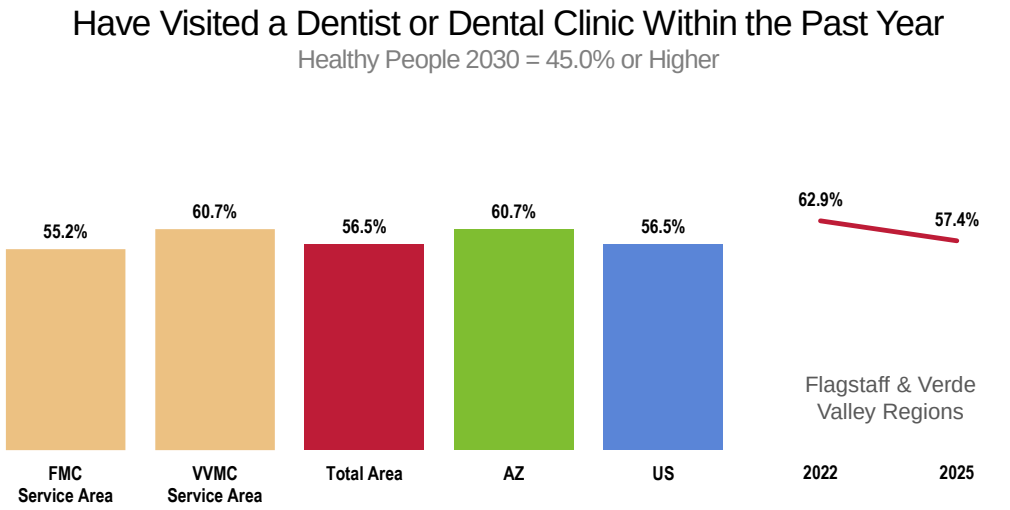


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Dental Care

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

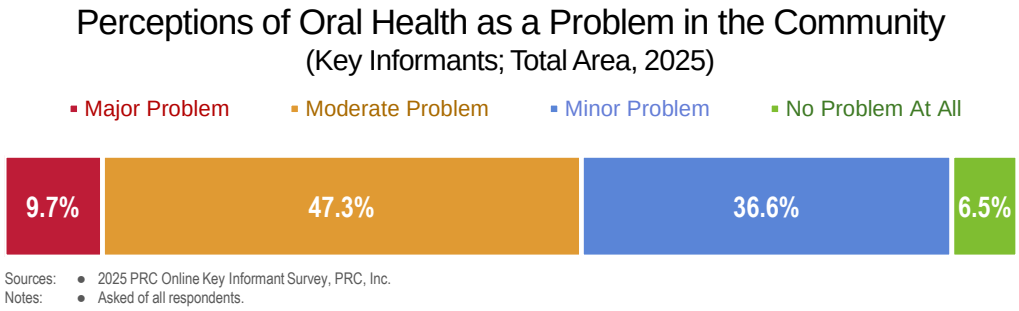


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Arizona data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

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



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

Access to Care/Services

> Minimal coverage. Access for dental care. — Health Care Leader (FMC Service Area)
>
> Access to dental care, especially emergent care. — Physician (FMC Service Area)

Cultural/Personal Beliefs

> The belief in oral health as a lesser priority in the Navajo Nation is shaped by cultural, economic, and social factors. Overcoming these challenges requires a community-driven approach that combines education, increased access to care, and integration of oral health into overall health and wellness program. — Health Care Leader (FMC Service Area)

Past Experience

> People have bad experiences with dentists and orthodontists, so they choose not to go on a regular basis or not at all. Poor daily oral hygiene. Lack of awareness around the significance of how oral hygiene impacts overall physical health. — Health Care Leader (FMC Service Area)

Access to Care for Uninsured/Underinsured

> Few people have any or sufficient dental insurance. — Community Leader (VVMC Service Area)

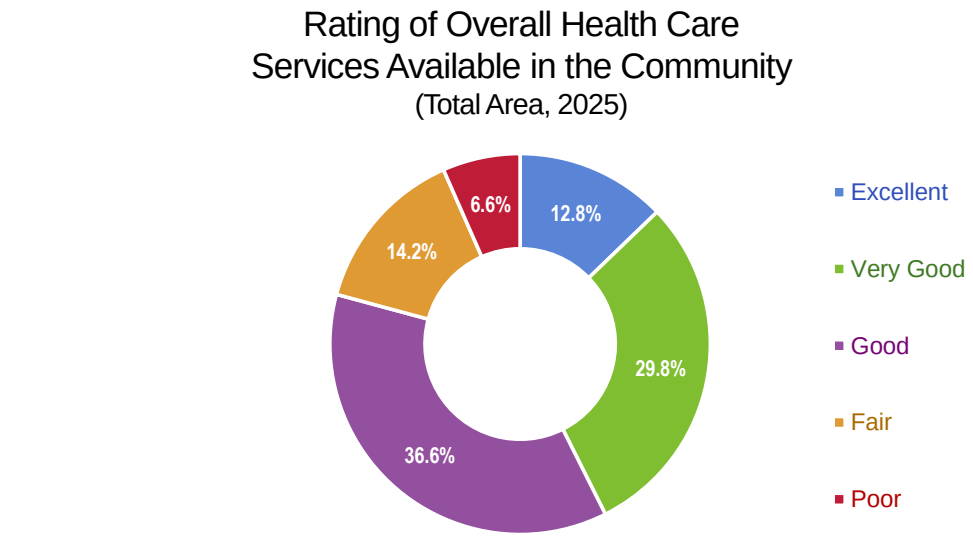
Affordable Care/Services

> Cost of care and cost of insurance. The county stopped providing services. — Health Care Leader (FMC Service Area)

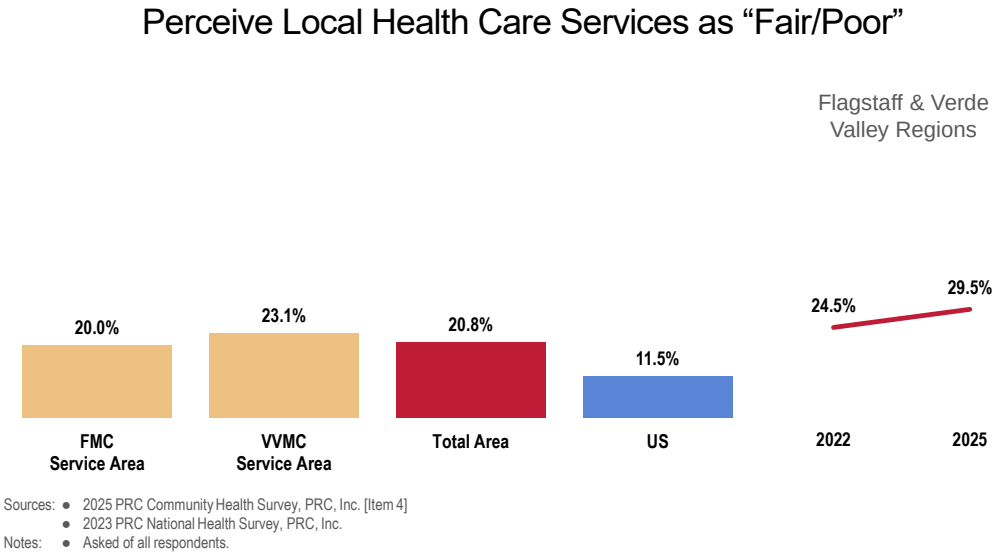
LOCAL RESOURCES

Perceptions of Local Health Care Services

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



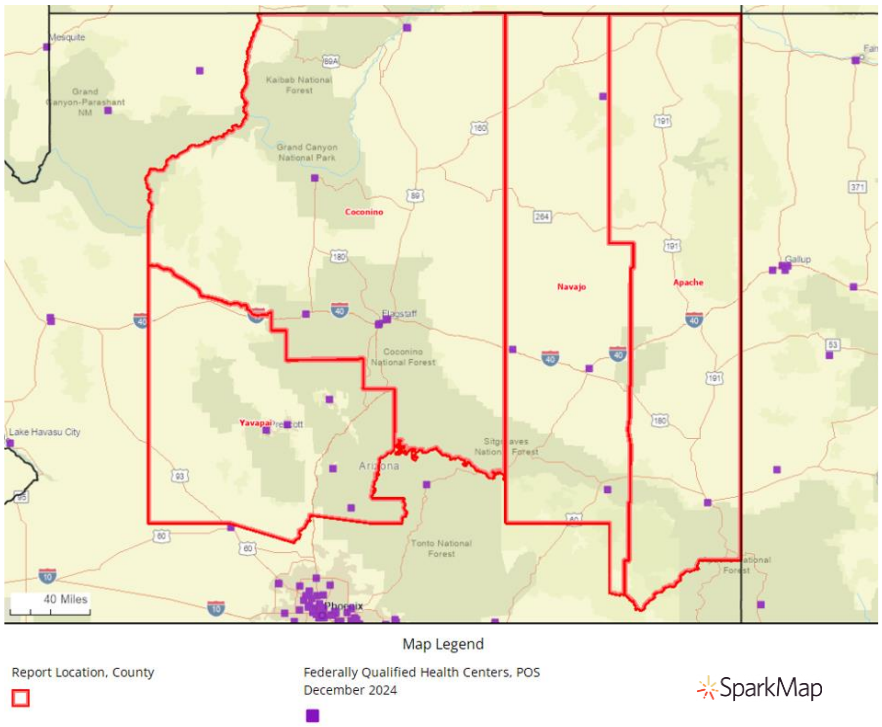
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Total Area as of December 2024. [COUNTY-LEVEL DATA]



Resources Available to Address Significant Health Needs

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

Access to Health Care Services

- A New Dawn Arizona
- Affirming You Therapy
- Arizona Complete Health
- Arizona Health Care Cost Containment System
- Arizona Health Zone
- Arizona State Veterans' Home
- Blue Cross Blue Shield
- Camp Verde Immediate Care
- City of Flagstaff
- Coconino County Health and Human Services
- Community and Tribal Support Agencies
- Community Based Organizations
- Community Health Center of Yavapai
- Concierge Care
- Copper Canyon Health
- Cottonwood Medical Center
- County Health Department
- Doctors' Offices
- Equality Health
- Flagstaff Family Food Center
- Flagstaff Medical Center
- Flagstaff Shelter Services
- Food Banks/Pantries
- Guidance Center
- Hospitals
- Indian Health Services
- Institute for Healthcare Improvement
- Little Colorado Medical Center
- Medicaid/Medicare
- Native American for Community Action Healthcare
- Nonprofits
- North Country HealthCare
- Northern Arizona Behavioral Health
- Northern Arizona Council of Governments
- Northern Arizona Healthcare
- Northern Arizona Healthcare Medical Group
- Northern Arizona University Health Services
- Northland Family Help Center
- Peak Cardiology
- Polara
- Poore Medical Center
- Residency Follow-Up Clinic
- Sacred Peaks
- San Carlos Healthcare Corporation
- Sedona Medical Center
- Sedona Urgent Care
- Spectrum Healthcare
- Telehealth
- TransIntimate
- Urgent Care Clinics
- Verde Valley Cancer Center
- Verde Valley Caregivers
- Verde Valley Medical Center
- Verde Valley Rural Health Network
- Winslow Indian Health Care Center
- Yavapai Community Libraries
- Yavapai County
- Yavapai County Community College
- Yavapai County Community Health Services

Cancer

- Arizona Oncology
- Banner Health
- Cancer Centers of America
- Cancer Support Community of Northern Arizona
- City of Hope
- Doctors' Offices
- Equality Health
- Flagstaff Medical Center
- Food Banks/Pantries
- Indian Health Services
- Mayo Clinic
- North Country HealthCare
- Northern Arizona Cancer Support Community
- Northern Arizona Healthcare
- Northern Arizona University Health Services
- Pathfinder
- Phoenix Children's Hospital
- Thermography Screens
- Tuba City Regional Healthcare

Diabetes

- American Diabetes Association
- Community and Tribal Support Agencies
- Community Health Center of Yavapai
- Congressional Funded Diabetes Program for Amer Indians
- Doctors' Offices
- Equality Health
- Flagstaff Family Food Center
- Flagstaff Medical Center
- Indian Health Services
- Just Move It Events
- Navajo Nation Department of Health
- Navajo Nation Diabetes Program
- No Cost Formulary w/GLP-1 and SGLT2
- North Country HealthCare
- Northern Arizona Healthcare
- Northern Arizona Healthcare Medical Group
- Pathfinder
- Sacred Peaks
- Tribal Resources
- Winslow Indian Health Care Center
- Yavapai County Health Department

Disabling Conditions

- Community Health Center of Yavapai
- Dental Offices
- Flagstaff Family Food Center
- Flagstaff Medical Center
- Haven Health
- Health and Human Services
- Hospice
- Indian Health Services
- Insurance
- Medicaid/Medicare
- Mountain Line Bus Service
- Navajo Nation Department of Health
- Navajo Nation Division of Social Services
- Navajo Nation Special Education
- Navajo Nation Vocational Rehabilitation
- Next Steps Prosthetics
- North Country HealthCare
- Northern Arizona Behavioral Health
- Northern Arizona Council of Governments
- Northern Arizona Healthcare
- Northern Arizona University Health Services
- Physical Therapists
- Poore Medical Center
- Safeway
- Sedona Medical Center
- Spectrum Healthcare
- St. Mary's Food Bank
- The Peaks
- Verde Valley Caregivers
- Verde Valley Medical Center
- Verde Valley Sanctuary
- Veterans Affairs
- Yavapai Community Libraries
- Yavapai County Community Health Services

Heart Disease & Stroke

- Doctors' Offices
- Equality Health
- Flagstaff Medical Center
- Healthy Native Youth Initiative
- Indian Health Services
- Native American for Community Action Healthcare
- Navajo Nation Department of Health
- North Country HealthCare
- Northern Arizona Healthcare
- Northern Arizona Healthcare Medical Group
- Peak Cardiology
- Sacred Peaks
- Tuba City Regional Health Care
- Verde Valley Medical Center
- Winslow Indian Health Care Center

Infant Health & Family Planning

- Community Health Center of Yavapai
- Doctors' Offices
- First Things First
- Flagstaff Medical Center
- Indian Health Services
- Native American for Community Action Healthcare
- North Country HealthCare
- Northern Arizona Healthcare
- Sacred Peaks
- Winslow Indian Health Care Center

Injury & Violence

- City of Phoenix
- Coconino County Attorney's Office
- Flag and Coconino PD
- Flagstaff Medical Center
- Flagstaff Police Department
- Indian Health Services
- Law Enforcement
- Native American for Community Action Healthcare

- Navajo Nation
- Navajo Nation Department of Health
- Navajo Nation Family Services and Domestic Violence
- Navajo Nation Sexual Assault Services
- Northern Arizona Behavioral Health
- Northern Arizona Care and Services After Assault
- Northern Arizona Healthcare
- Northland Family Help Center
- Sacred Peaks
- Urgent Care Clinics
- Verde Valley Sanctuary
- Victim Witness
- Winslow Indian Health Care Center

Mental Health

- Academic and Faith Based Organizations
- Affirming You Therapy
- Arizona Complete Health
- Balance
- Catholic Charities
- Charlie Health
- Child and Family Support Services
- Community Action Teams
- Community Alliance, Response & Engagement Program
- Community Bridges
- County Attorney's Office
- Doctors' Offices
- Domestic Abuse Shelter
- Flag and Coconino PD
- Flagstaff Medical Center
- Flagstaff Shelter Services
- Food Banks/Pantries
- Guidance Center
- Homeless Shelter
- Hospitals
- Indian Health Services
- Law Enforcement
- Mental Health Support Groups
- National Suicide Prevention Lifeline
- Native American for Community Action Healthcare
- Native American Rehabilitation Association
- Navajo Nation Behavioral Health Services
- Navajo Nation Suicide Prevention Programs
- Nonprofits
- North Country HealthCare
- Northern Arizona Behavioral Health
- Northern Arizona Healthcare
- Northern Arizona Regional Behavioral Health Authority
- Northern Arizona University Health Services
- Northland Family Help Center
- Paper Tiger Psychiatry
- Phoenix Mental Health and Wellness
- Polara
- Poore Medical Center
- Private Therapists
- Red Rock
- Sacred Peaks
- Southwest Behavioral Health
- Spectrum Healthcare
- Terros
- The Guidance Center
- Traditional Healer
- TransIntimate
- VA Prescott
- Verde Valley Caregivers
- Verde Valley Homeless Coalition
- Victim Witness
- Virtual Sector
- Winslow Indian Health Care Center
- Yavapai County Community Health Services

Nutrition, Physical Activity, & Weight

- AquaPlex
- Arizona Health Zone
- Aspire Clinic
- Churches
- Coconino County Health and Human Services
- County Resources
- DMC
- Flag Fridges
- Flagstaff Family Food Center
- Flagstaff Public Schools
- Food Banks/Pantries
- Hilton Athletic Club
- Hopi Tutskwa
- Jay Lively Ice Rink
- Just Move It Events
- Louie's Cupboard
- Manzanita Outreach
- Native American for Community Action Healthcare
- Navajo Nation Behavioral Health Services
- Navajo Nation Diabetes Program
- Navajo Nation Public Health Programs
- Navajo Nation WIC Program
- Navajo Nation Youth Program
- North Country HealthCare
- Northern Arizona Healthcare
- Northern Arizona University Health Services
- Sacred Peaks

- Senior Centers
- Supplemental Nutrition Assistance Program
- Terra BIRDS
- Winslow Indian Health Care Center
- Yavapai County Community Health Services
- YMCA

Oral Health

- Community Health Center of Yavapai
- Dental Offices
- Hobson Dental
- Indian Health Services
- North Country HealthCare
- Northern Arizona Orthodontist
- Poore Medical Center
- Preventive Programs

Respiratory Diseases

- Community and Tribal Support Agencies
- Community Health Center of Yavapai
- County Health Department
- Flagstaff Medical Center
- Indian Health Services
- Navajo Nation Department of Health
- Navajo Nation Environmental Protection Agency
- Navajo Nation Public Health Programs
- Navajo Nation Tobacco Control Program
- Northern Arizona Healthcare
- Veterans Affairs

Sexual Health

- Coconino Community Health Ryan White Program
- Community Health Center of Yavapai
- County Resources
- Flagstaff Medical Center
- Indian Health Services
- Native American for Community Action Healthcare
- Navajo Nation Department of Health
- Navajo Nation Family Planning Services
- Navajo Nation HIV/STD Prevention Program
- Navajo Nation WIC Program
- Online
- Sacred Peaks
- Winslow Indian Health Care Center

Social Determinants of Health

- Behavioral Health
- Boys and Girls Club
- Catholic Charities
- Catholic Community Services
- City of Flagstaff Housing Programs
- City of Sedona
- CMS Innovation Programs
- Coconino County Health and Human Services
- Coconino County Health Department
- Coconino County Workforce Development Programs
- Community Action Teams
- Community Health Center of Yavapai
- County Health Department
- County Resources
- DMC
- Equality Health
- Flag and Coconino PD
- Flagstaff Family Food Center
- Flagstaff Shelter Services
- Food Banks/Pantries
- FrontDoor
- Goodwill
- Growing in Beauty
- Habitat for Humanity
- Homeless Shelter
- Hope Cottage
- Hospitals
- Housing Solutions
- Indian Health Services
- Joe Montoya Senior Center
- Manzanita Outreach
- Market of Dreams
- Native American for Community Action Healthcare
- Navajo Nation Community Health Workers
- Navajo Nation Department of Health
- North Country HealthCare
- Northern Arizona Council of Governments
- Northern Arizona Healthcare
- Northern Arizona Housing Solutions
- Northern Arizona University Health Services
- Northland Family Help Center
- Sacred Peaks
- Salvation Army
- Sedona Community Center
- Shelter Services
- Southside Comm Assoc Resilient Black Roots Program
- St. Vincent de Paul
- State Education Funding
- Supplemental Nutrition Assistance Program

- TransIntimate
- Verde Valley Caregivers
- Verde Valley Homeless Coalition
- Verde Valley Rural Health Network
- Winslow Indian Health Care Center
- Yavapai Community Libraries
- Yavapai County Community Health Services
- YMCA

Substance Use

- AA/NA
- Arizona Complete Health
- Charlie Health
- City of Flagstaff
- Coconino County Health and Human Services
- Community Alliance, Response & Engagement Program
- County Attorney's Office
- Doctors' Offices
- Flag and Coconino Police Department
- Flagstaff Medical Center
- Flagstaff Shelter Services
- Food Banks/Pantries
- Guidance Center
- Homeless Shelter
- Indian Health Services
- Native American for Community Action Healthcare
- Navajo Nation Behavioral Health Services
- Navajo Nation Family Assistance Program
- Navajo Nation Recovery Centers
- Navajo Nation Substance Abuse Prevention and Treatment
- North Country HealthCare
- Northern Arizona Behavioral Health
- Northern Arizona Healthcare
- Polara
- Rainbow Recovery
- Solari
- Sonoran Prevention Works
- Southwest Behavioral Health
- Spectrum Healthcare
- Steps to Recovery
- Terros
- The Guidance Center
- Verde Valley Medical Center
- Yavapai County Community Health Services

Tobacco Use

- Arizona Department of Health Services
- Arizona Smokers' Helpline
- Coconino County Health and Human Services
- Flagstaff Public Schools
- Guidance Center
- Indian Health Services
- Navajo Nation Behavioral Health Services
- Navajo Nation Health Education and Promotion
- Navajo Nation Public Health Programs
- Navajo Nation Tobacco Control Program
- Southwest Behavioral Health
- Spectrum Healthcare
- Yavapai County Community Health Services

APPENDICES

HOSPITAL-SPECIFIC SUMMARY TABLES

Flagstaff Medical Center Service Area

SOCIAL DETERMINANTS	FMC Service Area	FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	**3.5**	2.9	3.9	
Population in Poverty (Percent)	**23.0**	12.8	12.4	8.0
Children in Poverty (Percent)	**28.3**	17.0	16.3	8.0
No High School Diploma (Age 25+, Percent)	**11.6**	10.9	10.6	
Unemployment Rate (Age 16+, Percent)	**4.7**	3.5	3.9	
% Unable to Pay Cash for a $400 Emergency Expense	**46.1**		34.0	
Housing Cost Exceeds 30% of Income (Percent)	**22.9**	28.0	29.3	25.5
% Unhealthy/Unsafe Housing Conditions	**15.6**		16.4	
Population With Low Food Access (Percent)	**41.7**	26.8	22.2	
% Have Access to the Internet	**94.0**			
"Not At All Comfortable" Accessing the Internet	**3.9**			
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

OVERALL HEALTH	FMC Service Area	FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ	vs. US	
% "Fair/Poor" Overall Health	**20.0**	19.2	15.7	
		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
% [Age 18-64] Lack Health Insurance				
% Cost Prevented Physician Visit in Past Year				
% Cost Prevented Getting Prescription in Past Year				
% Difficulty Getting Appointment in Past Year				
% Transportation Hindered Dr Visit in Past Year				
% Language/Culture Prevented Care in Past Year				
% Difficulty Getting Child's Health Care in Past Year				
Primary Care Doctors per 100,000				
% Routine Checkup in Past Year				
% [Child 0-17] Routine Checkup in Past Year				
% Rate Local Health Care "Fair/Poor"				
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

CANCER	FMC Service Area	FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ	vs. US	vs. HP2030
Cancer Deaths per 100,000	**156.6**	177.3	182.5	122.7
Cancer Incidence per 100,000	**328.0**	376.6	442.3	
Lung Cancer Incidence per 100,000	**24.7**	41.6	54.0	

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
Female Breast Cancer Incidence per 100,000	**89.1**	113.0	127.0	
Prostate Cancer Incidence per 100,000	**73.5**	76.4	110.5	
Colorectal Cancer Incidence per 100,000	**29.9**	30.8	36.5	
% Cancer	**9.3**	13.8	7.4	
[Women 50-74] Breast Cancer Screening (Percent)	**62.9**	72.7	76.5	80.5
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
Diabetes Deaths per 100,000	**44.3**	33.8	30.5	
% Diabetes/High Blood Sugar	**11.5**	11.4	12.8	
Kidney Disease Deaths per 100,000	**16.3**	11.6	16.9	
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

	FMC Service Area	FMC SERVICE AREA vs. BENCHMARKS		
DISABLING CONDITIONS		vs. AZ	vs. US	vs. HP2030
% 3+ Chronic Conditions	**18.5**		38.0	
% Activity Limitations	**24.5**		27.5	
Alzheimer's Disease Deaths per 100,000	**27.6**	37.8	35.8	
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ	**vs. US**	
Heart Disease Deaths per 100,000	**165.0**	198.9	209.5	127.4
% Heart Disease	**3.1**	6.2	10.3	
Stroke Deaths per 100,000	**42.4**	45.7	49.3	33.4
% Stroke	**3.0**	3.2	5.4	
% High Blood Pressure	**28.3**	33.4	40.4	42.6
% High Cholesterol	**15.5**		32.4	
% 1+ Cardiovascular Risk Factor	**79.9**		87.8	
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
No Prenatal Care in First 6 Months (Percent of Births)	**8.1**	9.2	6.1	
Teen Births per 1,000 Females 15-19	**19.4**	18.7	16.6	
Infant Deaths per 1,000 Births	**6.7**	5.4	5.6	5.0
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
Unintentional Injury Deaths per 100,000	**138.3**	81.3	67.8	43.2
Motor Vehicle Crash Deaths per 100,000	**45.7**	17.9	13.3	10.1
Homicide Deaths per 100,000	**11.6**	8.0	7.6	5.5
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
% "Fair/Poor" Mental Health	**25.1**		24.4	
% Diagnosed Depression	**22.5**	18.0	30.8	
Suicide Deaths per 100,000	**38.2**	21.0	14.7	12.8
Mental Health Providers per 100,000	**170.7**	182.0	313.6	
% Unable to Get Mental Health Services in Past Year	**10.5**		13.2	
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	**FMC Service Area**	**vs. AZ**	**vs. US**	**vs. HP2030**
% "Very/Somewhat" Difficult to Buy Fresh Produce	**29.7**		30.0	
% No Leisure-Time Physical Activity	**24.4**	21.3	30.2	21.8
% [Child 2-17] Physically Active 1+ Hours per Day	**31.7**		27.4	

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
Recreation/Fitness Facilities per 100,000	**8.5**	11.1	12.3	
% Overweight (BMI 25+)	**58.5**	66.4	63.3	
% Obese (BMI 30+)	**30.7**	31.9	33.9	36.0
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
Dentists per 100,000	**76.4**	66.3	73.5	
% Dental Visit in Past Year	**55.2**	60.7	56.5	45.0
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

		FMC SERVICE AREA vs. BENCHMARKS		
RESPIRATORY DISEASE	**FMC Service Area**	**vs. AZ**	**vs. US**	**vs. HP2030**
Lung Disease Deaths per 100,000	**46.7**	48.3	43.5	
Pneumonia/Influenza Deaths per 100,000	**19.8**	12.9	13.4	
% Asthma	**21.9**	10.3	17.9	
% COPD (Lung Disease)	**6.9**	5.8	11.0	
% Sleep Apnea	**14.6**			
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

SEXUAL HEALTH	Area	FMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
HIV Prevalence per 100,000	166.5	298.8	386.6	
Chlamydia Incidence per 100,000	691.0	552.5	492.2	
Gonorrhea Incidence per 100,000	202.4	190.7	179.0	
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

SUBSTANCE USE	FMC Service Area	FMC SERVICE AREA vs. BENCHMARKS	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000	92.9	23.6	15.7	
% Binge Drinking	26.5	14.5	30.6	25.4
Unintentional Drug-Induced Deaths per 100,000		33.5	29.7	
% Used a Prescription Opioid in Past Year			15.1	
% Personally Impacted by Substance Use			45.4	
For secondary data indicators, Coconino, Apache, and Navajo County data are used for the FMC Service Area.		better	similar	worse

TOBACCO USE	FMC Service Area	FMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
% Smoke Cigarettes	24.2	10.0	23.9	6.1
% Use Vaping Products	19.5	7.1	18.5	
		better	similar	worse

Verde Valley Medical Center Service Area

		VVMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ		
Linguistically Isolated Population (Percent)	**1.8**	2.9	3.9	
Population in Poverty (Percent)	**12.6**	12.8	12.4	8.0
Children in Poverty (Percent)	**17.8**	17.0	16.3	8.0
No High School Diploma (Age 25+, Percent)	**7.5**	10.9	10.6	
Unemployment Rate (Age 16+, Percent)	**3.0**	3.5	3.9	
% Unable to Pay Cash for a $400 Emergency Expense	**40.0**		34.0	
Housing Cost Exceeds 30% of Income (Percent)	**27.6**	28.0	29.3	25.5
% Unhealthy/Unsafe Housing Conditions	**13.7**		16.4	
Population With Low Food Access (Percent)	**35.8**	26.8	22.2	
% Have Access to the Internet	**95.5**			
"Not At All Comfortable" Accessing the Internet	**2.4**			
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

		VVMC SERVICE AREA vs. BENCHMARKS		
OVERALL HEALTH	**VVMC Service Area**	**vs. AZ**	**vs. US**	**vs. HP2030**
% "Fair/Poor" Overall Health	**15.6**	19.2	15.7	
		better	similar	worse

ACCESS TO HEALTH CARE	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	**10.3**	13.5	8.1	7.6
% Cost Prevented Physician Visit in Past Year	**14.8**	12.1	21.6	
% Cost Prevented Getting Prescription in Past Year	**16.0**		20.2	
% Difficulty Getting Appointment in Past Year	**38.5**		33.4	
% Transportation Hindered Dr Visit in Past Year	**10.0**		18.3	
% Language/Culture Prevented Care in Past Year	**0.7**		5.0	
% Difficulty Getting Child's Health Care in Past Year	**23.4**		11.1	
Primary Care Doctors per 100,000	**55.3**	66.5	74.9	
% Routine Checkup in Past Year	**71.4**	74.5	65.3	
% [Child 0-17] Routine Checkup in Past Year	**67.2**		77.5	
% Rate Local Health Care "Fair/Poor"	**23.1**		11.5	

For secondary data indicators, Yavapai County data is used for the VVMC Service Area.

better | similar | worse

CANCER	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS		
		vs. AZ	vs. US	vs. HP2030
Cancer Deaths per 100,000	**306.6**	177.3	182.5	122.7
Cancer Incidence per 100,000	**395.3**	376.6	442.3	
Lung Cancer Incidence per 100,000	**43.2**	41.6	54.0	

CANCER (continued)	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Female Breast Cancer Incidence per 100,000	127.5	113.0	127.0	
Prostate Cancer Incidence per 100,000	73.9	76.4	110.5	
Colorectal Cancer Incidence per 100,000	31.0	30.8	36.5	
% Cancer	15.2	13.8	7.4	
[Women 50-74] Breast Cancer Screening (Percent)	64.4	72.7	76.5	80.5
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

DIABETES	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Diabetes Deaths per 100,000	34.3	33.8	30.5	
% Diabetes/High Blood Sugar	11.6	11.4	12.8	
Kidney Disease Deaths per 100,000	15.2	11.6	16.9	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

DISABLING CONDITIONS	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
% 3+ Chronic Conditions	25.5		38.0	
% Activity Limitations	29.1		27.5	
Alzheimer's Disease Deaths per 100,000	67.4	37.8	35.8	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

HEART DISEASE & STROKE	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Heart Disease Deaths per 100,000	**302.5**	198.9	209.5	127.4
% Heart Disease	**7.3**	6.2	10.3	
Stroke Deaths per 100,000	**66.4**	45.7	49.3	33.4
% Stroke	**5.8**	3.2	5.4	
% High Blood Pressure	**33.2**	33.4	40.4	42.6
% High Cholesterol	**29.0**		32.4	
% 1+ Cardiovascular Risk Factor	**86.4**		87.8	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
No Prenatal Care in First 6 Months (Percent of Births)	**5.8**	9.2	6.1	
Teen Births per 1,000 Females 15-19	**20.2**	18.7	16.6	
Infant Deaths per 1,000 Births	**6.7**		5.6	5.0
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

INJURY & VIOLENCE	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000	85.0	81.3	67.8	43.2
Motor Vehicle Crash Deaths per 100,000	17.4	17.9	13.3	10.1
Homicide Deaths per 100,000	3.0	8.0	7.6	5.5
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

MENTAL HEALTH	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	17.3		24.4	
% Diagnosed Depression	25.2	18.0	30.8	
Suicide Deaths per 100,000	33.9	21.0	14.7	12.8
Mental Health Providers per 100,000	213.2	182.0	313.6	
% Unable to Get Mental Health Services in Past Year	8.6		13.2	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
% "Very/Somewhat" Difficult to Buy Fresh Produce	23.7		30.0	
% No Leisure-Time Physical Activity	23.8	21.3	30.2	21.8
% [Child 2-17] Physically Active 1+ Hours per Day	14.1		27.4	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Recreation/Fitness Facilities per 100,000	10.2	11.1	12.3	
% Overweight (BMI 25+)	56.5	66.4	63.3	
% Obese (BMI 30+)	22.3	31.9	33.9	36.0
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

ORAL HEALTH	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Dentists per 100,000	67.8	66.3	73.5	
% Dental Visit in Past Year	60.7	60.7	56.5	45.0
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

RESPIRATORY DISEASE	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Lung Disease Deaths per 100,000	101.1	48.3	43.5	
Pneumonia/Influenza Deaths per 100,000	19.7	12.9	13.4	
% Asthma	12.6	10.3	17.9	
% COPD (Lung Disease)	5.9	5.8	11.0	
% Sleep Apnea	13.4			
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

SEXUAL HEALTH	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
HIV Prevalence per 100,000	153.4	298.8	386.6	
Chlamydia Incidence per 100,000	166.6	552.5	492.2	
Gonorrhea Incidence per 100,000	24.9	190.7	179.0	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

SUBSTANCE USE	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000	34.8	23.6	15.7	
% Binge Drinking	28.7	14.5	30.6	25.4
Unintentional Drug-Induced Deaths per 100,000	26.6	33.5	29.7	
% Used a Prescription Opioid in Past Year	12.8		15.1	
% Personally Impacted by Substance Use	48.0		45.4	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

TOBACCO USE	VVMC Service Area	VVMC SERVICE AREA vs. BENCHMARKS vs. AZ	vs. US	vs. HP2030
% Smoke Cigarettes	28.4	10.0	23.9	6.1
% Use Vaping Products	12.3	7.1	18.5	
For secondary data indicators, Yavapai County data is used for the VVMC Service Area.		better	similar	worse

EVALUATION OF PAST ACTIVITIES

NAH 2022-2025 CHNA IMPLEMENTATION PLAN STATUS REPORT
Not Started | Completed | In Progress
October 30, 2024

SIGNIFICANT HEALTH NEED	STATUS	NOTES
ACCESS TO CARE		

Increase access points and capacity for primary care services	**In Progress**	• Flagstaff primary care provider total has grown from 9 to 11 since 2022 and will grow upon opening of the new site in January 2025
		• Verde primary care provider total has grown from 17 to 20 since 2022
		• Care Management:
		  ○ Implemented screening tool for Social Determinants of Health
		  ○ Expanded outpatient social worker employment in Verde Valley
		  ○ Implemented Transitional Care Management processes with NAHMG clinics for post-discharge follow-ups within 7 days of discharge
		• Call center / Patient Access / Scheduling staffing has increased by 12 FTE since 2022
		• Use of remote patient monitoring has expanded from 94 to 134 patients since 2022

Increase access to outpatient clinic and ambulatory care settings	**In Progress**	• Opening Urgent Care at expanded Primary Care site in Flagstaff in January 2025 • Evaluating further Urgent Care expansion in our markets • Added Pulmonary Clinic in Flagstaff and soon starting in Cottonwood • Growth in services in Verde Valley to include: expanded Interventional Cardiology, ENT, Electrophysiology, expanded Orthopedics, outpatient Neurology, Addiction Medicine, behavioral health therapists, and addition of OB midwives. • Evaluating Rheumatology in Verde Valley

Develop a Virtual Care Platform	**In Progress**	• Went live with AmWell platform to expand geographic reach for virtual visits • Primarily providing virtual visits with specialty coverage and remote patient monitoring to outlying areas in Cardiology and Primary Care • Patient ability to self-schedule virtual visits went live in 2022 • Participated in the Arizona Telemedicine Council and the State Broadband Action Plan Team meetings (when they've occurred) and continue engage in City and County officials on TeleHealth issues • Outreach work is underway to enhance rural virtual care access
CHRONIC DISEASE (CV DISEASE / CANCER / NEUROSCIENCES)		
Enhance Neurosciences Services	**In Progress**	• Added 1 outpatient neurologist, 1 neurohospitalist, and 1 Neuro APP who serves as NAH's Stroke Coordinator • Enhanced neurology access across the system by complementing employed neurology providers with TeleNeuro capabilities, including addition of TeleNeuro Hospitalist rounding over the weekend • No material expansion of neurology services for outlying facilities to date
Support cardiovascular programs designed to keep patients out of the hospital	**In Progress**	• Continued resource investment in HF Clinic and clinical consensus group • Continued resource investment in INR Clinic in collaboration with NAH Pharmacy • Established TAVR Surgical Intervention Clinic • Remote Patient Monitoring and Remote Therapeutic Monitoring for CV patients has increased from 90 to 131 since 2022
Oncology Development & Recruitment	**In Progress**	• Established NAH-owned Medical Oncology / Infusion services in Flagstaff • Added 2 employed Radiation Oncology physicians to help expand available appointments at our two locations • Continuing to recruit oncology providers in both primary markets • Stabilization of providers for Breast, Head/Neck, and Lung Cancers

BEHAVIORAL HEALTH AND SUBSTANCE USE		
Provide services to increase awareness and access to address general Mental and Behavioral Health needs	**Completed**	• Have developed strong partnership with Charlie Health (Intensive Outpatient Treatment) and have enhanced relationships with Southwest Behavioral Health and The Guidance Center, as a means to better coordinate post-discharge care. In addition, working to collaborate with Hickory Network, which is a detox residential facility. • Improved promotion of screenings for depression and substance use by incorporating depression and substance abuse screenings into Patient Health Questionnaires for Primary Care and Inpatient. Also have AUDIT-C screening tool that is used in ED / Trauma for substance use assessment.
Increase outpatient behavioral health offerings	**In Progress**	• Restarted Transcranial Magnetic Stimulation (TMS) treatment for outpatient depression patients in July 2024 • Still recruiting for outpatient Psychiatry Clinic. Outpatient psychology clinic visits occur today, with significant portion of those visits conducted via Virtual Visit platform • Received renewal award for DUI / Drug Court treatment program services • Opened Addiction Medicine clinic in the Verde Valley (Recovery Clinic at Northern Arizona Healthcare Cottonwood) in November 2024