Maricopa County 2017 CCHNA Focus Group Report

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Maricopa County CCHNA Focus Group Report

Overview

The Office of Evaluation and Partner Contracts at the Southwest Interdisciplinary Research Center (SIRC) partnered with the Maricopa County Department of Public Health (MCDPH) and other community health partners to conduct a series of 36 focus groups with medically underserved populations across Maricopa County. This study is part of the Coordinated Maricopa County Community Health Needs Assessment (CCHNA) designed to identify priority health issues, resources and barriers to care within Maricopa County through a community-driven process known as Mobilizing for Action through Planning and Partnerships (MAPP)[1]. Of the four primary components of the MAPP framework, the focus groups were specifically targeted toward the Community Themes and Strengths and Forces of Change Assessments.

This report details the final results of all three cycles of 36 focus groups conducted between September 2015 and June 2016.

Methods & Samples

The focus group component of the community health needs assessment moved through five phases: (1) initial review of literature; (2) focus group discussion guide development; (3) focus group recruitment and securement; (4) focus group data collection; and (5) report writing and presentation of findings.

Recruitment and Securement

Participants/Inclusion Criteria. Each focus group included 6-12 participants and lasted approximately 90 minutes allowing for substantial, high quality collection of data while remaining productive and respectful of participants' time. When necessary, backup participants (i.e., waitlists) were established to ensure adequate group size if attrition issues arose. Because groups with more than 12 participants presented time, facilitation, and transcription challenges in Cycle 1, fewer participants were confirmed for each group in Cycles 2 and 3 to increase the quality of the discussion. All participants had to be and were 18 years of age or older.

As requested in the Request for Proposal and in consultation with MCDPH/CCHNA project staff, 36 focus groups with particular target populations were conducted. **This report includes data and analysis of all 36 groups**.

[1] See http://www.naccho.org/topics/infrastructure/mapp/ for additional information on the MAPP process.

Appendices B-D contain the list of those populations accessed, recruited, and secured during each cycle, as well as the specific locations in which the groups were held. These populations were selected to help ensure inclusion among often underrepresented and underserved groups. Appendix E provides a general map of where each focus group was held with Maricopa County.

Because participants could identify with more than one of these populations, they were asked not to participate in multiple groups; however, the multiplicity of identities was captured and will be discussed in greater depth throughout this report.

Recruitment. *Purposive sampling*, which involves the attraction and selection of individuals who meet certain inclusion and do not meet certain exclusion criteria, was used to recruit participants. Diversity in age, gender, race/ethnicity, physical ability, and other background factors was emphasized in recruitment.[2]

Recruitment materials included flyers and media announcements (specifically targeted to the populations of interest and offered in both English and Spanish). These materials were distributed and stratified across the East, West, and Central regions of Maricopa County. Flyers were specifically tailored to the populations of interest and posted in local "hot spot" areas—where the targeted demographic group was overrepresented—and posted at community locations (e.g., career services centers, libraries, schools, etc.) near where the focus group would be held. Efforts (virtual and in-person) were made to include participants recruited through a wide range of networks and associations in each group. These recruitment materials were provided to MCDPH.

Participants were able to register for the groups via paper sign-up sheets or online through an online survey questionnaire platform. They were sent reminders and a confirmation letter, including logistical information such as time, date, and directions, prior to each focus group. Each participant was contacted by phone the day before the group to confirm participation, to clarify any logistical questions, and to minimize attrition issues.

Focus Group Data Collection

Thirty-six focus groups were conducted between September 25, 2015 and June 1, 2016. A total of 367 adults participated, ranging in age from 18 to 92 years (mean/average = 50 years). See Table 1 for additional participant characteristics.

[2] For more on purposive sampling see: Berg, B. L. (2009). *Qualitative research methods for the social sciences* (7th ed.). Boston: Allyn & Bacon or Padgett, D. K. (2008). *Qualitative methods in social work research* (2nd ed.). Thousand Oaks: Sage Publications.

Table 1. Summary of Participant Characteristics (n=367).

Characteristic	Number	%
Gender		
Male	110	31%
Female	235	66%
Transgender	10	3%
Identifies as LGBTQ	34	11%
Race/ethnicity		
American Indian/Alaska Native	44	12%
Asian/Pacific Islander	38	11%
Black/African American	47	13%
Hispanic/Latino	154	43%
White	90	25%
Education		
Less than high school	72	21%
High school/GED	64	18%
Some college/Associates degree	129	37%
Bachelor degree or higher	85	24%
Marital Status		
Married	163	44%
Widowed, separated, or divorced	81	22%
Never married	76	21%
Living with partner	34	9%
Parent of child under age 18	169	46%
Qualified for free/reduced lunch	97	*81%
Employment		
Full-time	85	24%
Part-time	52	15%
Unemployed	108	30%
Retired	82	23%
Unable to work	28	8%
Insurance**		
Employer-provided	79	22%
Directly purchased	21	6%
Medicaid/AHCCCS	130	35%
Medicare	70	19%
Uninsured	41	11%
Residence		
Phoenix	165	45%
East Valley	82	22%
West Valley	78	21%
Wickenburg	14	4%
Gila Bend	12	3%

Note: Due to some missing data (e.g., skipped or unanswered questions) and multiple response options, numbers do not always add to 367 or 100 percent. Percentages reported are calculated from the total number of participants who answered that specific question.

*Of those with children in grades K-12.

** Other types of insurance (e.g., military, high deductible, Indian Health Service/tribal care, etc.) were each selected by fewer than 20 participants and are not included here.

Consent. Per ASU-Human Subjects Institutional Review Board (IRB) requirements, participants were fully informed of any risks, benefits and expectations associated with their participation. They were asked to sign an IRB approved consent form in order to participate and were provided with a copy of the form for their records. SIRC's copy of the form was kept separate from and unlinked to any personal data provided by the focus group participants.

Incentives and Supervision of Children. Each participant received a $45 gift card as a stipend ($15 per half hour of discussion participation) and refreshments (a light meal and healthy beverages) as incentives for their participation. This amount was deemed ethical as it was sufficient to achieve participation without being coercive. The stipend was deemed as gratuitous not as not as reward (see Grant & Sugarman, 2004). To minimize barriers to participation, supervision of children was provided for each focus group as needed by SIRC graduate and undergraduate students who held an active Fingerprint Clearance Card.

Facilitation. Focus groups were moderated by trained facilitators who were SIRC staff. Each focus group had at least one facilitator and one note-taker. Groups were offered in English and Spanish when necessary. All facilitators and note-takers received training regarding the discussion guides, using audio and video recording equipment, and running focus groups prior to data collection to ensure consistency in the facilitation process across groups.

Venues. SIRC worked with existing community partners to identify and reserve appropriate locations for focus groups. Venues selected were ADA compliant, convenient to the targeted participants, and located along public transportation routes to further minimize barriers to participation among the populations of interest. Venues were selected to ensure sufficient project reach within each of the identified regions of Maricopa County (East, West, and Central).

Record-Keeping. Focus groups were recorded using a multi-microphone audio recording device and two video recording devices, which also recorded audio tracks. Note-takers also recorded notes during the session in case of audio or video device failure and to note interruptions in recordings. Supplemental questionnaires were used to match participants' answers across audio and video recordings. This matching allowed researchers to analyze themes among the data by a multitude of characteristics (e.g., gender, age, health insurance coverage), rather than being limited to analysis based solely on the primary characteristic(s) by which the groups were stratified (e.g., race, ethnicity, sexual orientation).

Transcription. Audio recordings were professionally transcribed by subcontractors and returned to SIRC within soon after completion of each focus group so that summaries and analysis could be completed while the information and context was still fresh. The transcriptions were coded and analyzed by multiple SIRC researchers in order to reduce the bias in interpretation.

Supplementary Questionnaire. Because age, marital status, place of residence/geographic proximity to resources, insurance coverage, and other variables (e.g., sense of social cohesion, community involvement and

empowerment) can have important impacts on individual and community health and quality of life as well, focus group participants were asked to complete a supplementary questionnaire that assessed such factors. The questionnaire for each focus group participant was labeled by participant number (1-12); the number on the questionnaire corresponded to the number listed on each participant's name tent. When combined with visual evidence from the video recording, this allowed SIRC researchers to match participants' focus group input with their responses to the questionnaire without capturing any personally identifying information (e.g., name or contact information).

Qualitative Analysis. Participant responses were coded using a template coding approach for content analysis[3] in NVivo qualitative data analysis software (QSR International Pty Ltd. Version 10, 2012). The template coding approach begins with establishing codes of interest generally prior to data collection and analyses. Ten codes were determined and utilized to elucidate commonalties and differences among participant responses (see Table 2 for codes and descriptions). The codes were then explored further regarding subthemes that could be identified and described in the report(s). Additionally, multiple persons coded the responses to decrease the potential bias and error in the coding process.

[3] For more information on template coding approaches see: Padgett, D. K. (2008). *Qualitative methods in social work research* (2nd ed.). Thousand Oaks: Sage Publications.

Table 2. Codes and descriptions.

Code	Description
Quality of Life	Reflections on one's current situation, health, environment, community; fulfillment of expectations; met needs or desires. What people want for their lives and the extent to which they feel they have achieved fulfillment of those wants.
Community Assets	Strengths and resources. Can be tangible – people; places; structures; services available or provided – or intangible – social connections; social capital; neighborhood values; trust.
Community Concerns	Things people would like to improve in their communities or that they feel are less than ideal. Unmet community needs. Gaps in services. Disconnections between individuals and power structures. Perceptions of threats to others' wellbeing.
Threats to and Opportunities for Community Health	Health-specific. Related to individuals' physical or mental wellbeing. Can be positive or negative. Can be related to prevention, treatment or maintenance. Can be individuals, structures or organizations that threaten or promote community health.
Healthcare Needs	Gaps in healthcare services. Examples of unmet healthcare desires.
Healthcare Choices	What people are currently doing for healthcare (prevention, treatment or maintenance). Places people are going. Services being sought or accessed.
Healthcare Experiences	Personal examples or examples shared of friends' or family members' experiences with healthcare providers, organizations or professionals.
Healthcare Barriers	Anything that people perceive or actually experience as inhibiting their access to or ability to receive or benefit from healthcare services.
Prevention Strategies	Anything people are doing to be healthy and prevent illness, injury or other physical or mental health conditions.
Suggestions for Improvement	Tangible solutions or alternatives presented by participants as ways to improve individual or community health or healthcare services.

Overall Research Findings

Similar findings emerged among each iteration of data collection and analysis. Thus, the findings summarized below, and the supporting quotations, are combined across all three cycles of the CCHNA.

Quality of Life

Factors most consistently highlighted as important to participants' quality of life, included:

- Social connections and sense of community
- Access to healthcare and other services
- Agency (independence, ability and opportunity; the capacity of individuals to act in a given environment)
- Mental and physical health

Additional contributors to quality of life included:

- Financial security
- Positive outlook/attitude
- Awareness/knowledge of community resources
- Dignity, respect, and acceptance
- Good families
- Exercise (e.g., access to parks and recreation opportunities; bike lanes)
- Sense of safety/security (e.g., positive relationships with law enforcement)
- Education/opportunities for children's success

In the words of participants…

> *I believe that quality of life has two essential elements which are the psychological aspect and the material aspect because one without the other wouldn't be enough to have a quality of life. If you're not psychologically well, with values and respect, or you don't have a plate of food, a shelter; then I believe we wouldn't have a right balance in our lives.*
>
> --Spanish-speaking participant (Adult females)

> *Basically for me, it means that any need that I require or anything that I want to do should be readily available for me to do it, or the resources that I need to either be able to get to 'em right there within my community or to know where to go.*
>
> --Participant (Adults without children)

I think quality of life would be to live without fear. That means to have all services available and even more with the persecution immigrants suffer.

--Spanish-speaking participant (Adult males)

I think it means being able to enjoy the things that you like to do. Having the health and the stamina to do that with. Being able to have the time. To me, quality of life is family, and being able to do all that with family. Be healthy enough, energetic enough, have the time to give to your family members. To me, that's a big – to me that's what quality of life is. Not missing out on anything.

--Spanish-speaking participant (Adults with children under age 18)

Being able to express all the potentials that we have. And we have a lot of potentials. But if I can't really express it out, that's not a good quality. But if I have the ability to move, the ability to play, the ability to serve the community, the ability to participate in different activities and I actually can do that – that's a good quality of life

--Participant (Asian American adults)

To me quality of life means having a healthy, happy family…being able to take care of one another, being able to be productive in their community, being able to live a life that allows healthy decision-making for children and for family and the extended family.

--Participant (Adults with children under age 18)

Quality of life is to have health insurance, to have a comfortable place where you can sleep, eat, and be safe knowing that nothing is going to happen, and that you can leave your door open and no one will come in.

--Spanish-speaking participant (Older adults, 65-74)

The knowledge that you're safe in your community. Almost everyone knows everyone. You can come outside; feel secure. If you need help, it's there.

--Participant (Adults without children)

It's hard to care about being physically healthy when you're not happy, or you just feel like there's an invisible ceiling, there's a road block everywhere. I think it starts with the mental health. I think that's number one.

--Participant (African-American adults)

I think that life quality means to have a decent job, a good salary, having a united family and lots of love --doing exercise too.

--Spanish-speaking participant (Low-income adults)

Having space to exercise easily, not have to drive two hours outta the way to go running, or feeling okay to run.

--Participant (LGBTQ adults)

Something that includes the holistic part of the individual. Spiritual, mind, body. Not just one target area….I think the health system compartmentalizes it a lot. I think that's where we get lost.

--Participant (Native American adults)

Community Assets

Participants were able to identify many strengths and resources that they valued in their communities. Regarding relationships, participants spoke of a general **sense of community and inclusion** (e.g., lack of judgment), the **diversity** of their communities (e.g., age and culture), community members' **friendliness** and **willingness to help others**, and the importance of **networks** (i.e., relationships among community members).

Community members noted that the **availability of spaces and programs for activities** were important. They highlighted assets such as community activities, classes, and events (especially for youth and seniors). They also commented that they valued their local parks, mountains, bike paths, and the beauty and cleanliness of their neighborhoods.

Regarding services, participants remarked about the importance of **convenient and available resources** (e.g., community centers, health clinics, senior centers, gyms, grocery stores and libraries). They also mentioned feelings of **safety** and peace in their neighborhoods (specifically police and fire presence and lack of noise, sirens, crime, and traffic).

Specific people and organizations, or types of people and organizations, were seen as community assets as well, particularly **community advocates** or those who help people navigate systems and those organizations that provide some sort of necessary social support or assistance. Specific organizations mentioned included the YMCA, Boys & Girls Club, Hospice, Duet, Ability360, Maricopa Workforce Connections, St. Mary's Food Bank, St. Vincent de Paul, Head Start, and public housing communities (e.g., Luke, Krohn).

General organizations/services mentioned:

- Art programs and displays
- Clothing donation centers
- Community centers (where kids can go for activities while parents are working)
- Community health centers
- Schools
- Sports teams (baseball, soccer, basketball)
- Health centers (hospitals, Urgent Cares, free clinics)
- Neighborhood associations
- Block watches

- Neighborhood newsletters
- Neighborhood Ministries
- Free dental clinics
- Churches
- Women and family resource centers
- Community gardens and farmers' markets
- Bike lanes, parks, mountains, walking and hiking trails

In the words of participants…

> *What I like most about my community is the co-generational aspect. I live right across the street from my auntie and my grandma. It's nice to have that access, and a lot of the places where I spend my time, also, and volunteer are co-generational spaces for young and old alike. Everybody learns from each other and helps each other.*
>
> --Participant (African American adults)

> *I would say my favorite thing about being part of this community is just the variety of resources that we have here. Access to good schools and education for my son. It's important.*
>
> --Participant (Lower income adults)

> *I am proud because my community is always clean, we have parks that are in excellent conditions and I think that is very important for the children, for their security.*
>
> --Spanish-speaking participant (Adults with children)

> *I like that my community has a lot of parks, and you can find free recreation for kids, for adults. I like the library system, and the…city brochures, or something to tell you all the things that are going on, like winter, fall, spring, summer, and a lot of things that are even free, or really, really cheap.*
>
> --Participant (Adults with children)

> *My neighbors are really nice, really neighborly, and so if there was—especially where I live, there's a lot of break-ins, or just stuff, and they'll warn you. They'll call you, so they give you a heads up.*
>
> --Participant (Young adults, 18-30)

> *One thing in this community that I've gotta give praise for is that people are starting to stand up and fight against hatred and unjust ways. People are starting to get vocal and stand out and start talking.*
>
> --Participant (LGBTQ Adults)

We trust others, so that we know that our kids can go out and play safely in the park and that they can run knowing that the area is illuminated, that the traffic is quiet, and that we can all help each other.

--Spanish-speaking participant (Low-income adults)

Community Concerns

There were common concerns noted across the cycles. General concerns centered on a **lack of social cohesion**, **participation** in community events, and access to information/available **community resources**. Racism, **discrimination**, and a lack of respect for others were highlighted as issues that eroded sense of community and participation in the community. Participants also worried about **bad decision making among youth** (e.g., drugs, gangs, lack of values, lack of knowledge about healthy decision making).

Related to health, participants felt their communities had a **lack of culturally competent health care providers** (specifically highlighted by LGBTQ, Native American, and Hispanic/Latino groups). They also noted their **lack of access to insurance, doctors, and dentists**. Financial hardships were a common concern and were tied to access issues. **Diabetes** (particularly in Native American and African American communities), **substance abuse**, and **lack of healthy, affordable food** options were also mentioned, as was **inadequate transportation** services (particularly for the elderly, disabled, and poor).

The following concerns were also discussed:

- Dangerous drivers
- Drugs and crime
- Environmental issues (e.g., litter, pollution/poor air quality, pests, animal waste, insufficient shade/greenery)
- Gentrification and housing costs
- Inadequate employment opportunities
- Lack of quality, affordable childcare
- Barriers to access for the physically disabled (i.e., doctor's offices, recreation centers)
- Minimal opportunities for physical activity (associated costs, lack of recreational spaces, parks etc.)
- Predatory or destructive businesses (liquor stores, unhealthy restaurants, payday loans)
- Lack of assistance for those with barriers to legal status and non-English speakers

In the words of participants…

> *I say they should clean up on the drugs, help the homeless out, and basically more things for children to do, and the teenagers. The teenagers are making wrong decisions because the company they keep and the environment they're in. If they had more things to do around here, I feel like it would be a little better place for them.*
>
> --Participant (Adults with children)

> *The nearest grocery store, any direction, you can go for miles, and you're not gonna find it, but you'll find 17 Circle K's. When you're hungry, that's all you've got to eat, and it's not right. Then I would say just gentrification. Give people a chance to live where they work so they can make a living, and stop pushing people out. People can't afford to earn any money to eat and have any balance in their lives.*
>
> --Participant (African American adults)

> *The communication factor…one thing I've noticed—I've been in Arizona for a year and a half—is that there are a ton of resources around, but people don't know about those resources.*
>
> --Participant (LGBTQ Adults)

> *There are not a lot of opportunities for African Americans here. However, I see there being a lot for Native Americans, Hispanics, and of course, Whites.*
>
> --Participant (African-American adults)

> *A lot of times with people that are having issues where they're falling through the cracks or they need an advocate or whatever, a lot of times they've got family to step in and pick up that role. I think, especially in the LGBT community, that's where not everybody's family's on board. That's why it's so important to have that community and those resources.*
>
> --Participant (LGBTQ adults)

Threats to and Opportunities for Community Health

Participants shared threats and opportunities for community health. The number of **threats** listed outnumbered the mentions of opportunities. A common threat was poor treatment from doctors. Some noted that they often felt like they were wasting time and money because doctors did not really help. Participants feared being misdiagnosed, receiving the wrong medications or over-medicating, and not being respected because they are on AHCCCS or because of their gender identity or other characteristics. Medications and healthy foods were also noted as expensive in their communities.

This related to a noted threat of confusing procedures and documentation concerns regarding health care. Participants feared that they were contacting the wrong departments for help with payments and paperwork. They noted a lack of communication and coordination among medical staff. They mentioned issues with transferring medical documents between health centers. Also, concerns arose regarding complicated forms and requirements and confusing language on contracts and insurance documents.

A number of inadequacies were discussed as well. Participants noted inadequacy in health and nutrition education/literacy, inadequacy in insurance coverage, and inadequacy in school systems. They felt schools served unhealthy foods and that they did not teach necessary life and coping skills (e.g., job searching, stress management). Regarding insurance, there appeared to be a lack of coverage for alternative health care, dental care, and vision care.

Time was a common theme regarding threats. Participants commented about long wait times for services, including specialty health care. Participants also cited procrastination and laziness in seeking care. They noted that people whom feel healthy do not schedule checkups, and that many people wait until there is an emergency to seek help. Others noted that they would seek care for their children but delay care for themselves. Finally, they remarked that renewing and maintaining benefits also takes a long time and they would have to take time away from work as well.

Two common themes arose regarding **opportunities**. First, participants noted that there do exist organizations and resources available for immigrants; examples were translation services and assistance completing forms. Second, participants felt they were in some ways gaining in individual agency and power to direct own healthcare.

In the words of participants…

> *I'm gonna tell you why I haven't seen the doctor for 24 years. Okay? I'm afraid of them … that they won't give me the right medicine, that they'll do something to me and make me worser. I don't trust them …*
>
> --Participant (African American adults)

I come from another country. I don't know how here hospital works, and they gave me different intake forms. Sometimes, I have language barrier to talk to doctor to describe my conditions, symptoms, make me feel worse.

--Participant (Asian American adults)

Lots of paperwork. Lots of trying to study, trying to understand, what does this really mean? Cuz when I was filling it out, I was like, this is written in a language of alien code and now way I can understand.

--Participant (LGBTQ adults)

Healthcare Needs

A number of themes regarding healthcare needs arose from the participants' responses. They reported feeling that the healthcare system was disjointed and wanted **better communication and greater coordination across providers**. They highlighted that doctors were too specialized or tended to look only at particular issues related to their specialty. Participants remarked often getting referred back and forth between all different types of doctors for one issue. They found it difficult to get to the right person and found the process of transferring records and documents between providers unpleasant and cumbersome. The system was seen as hard to navigate and was seen to require a significant amount of personal effort and persistence. There was additional concern that doctors might overlook possible drug interactions from other prescriptions as well since they did not coordinate care across the system or take additional time to review past records and prescriptions.

Eligibility restrictions, insurance issues, and a lack of low costs options for care were issues as well. Regarding lower cost options, they desired **more free or discounted services, less expensive specialists, and lower deductibles**. Some participants noted challenges from having incomes that were just above the low-income requirements for subsidies and discounts. Persons who did not qualify for AHCCS coverage but identified as low-income noted difficulties in paying for coverage (e.g., copays and deductibles) and out of pocket medical expenses. Some participants lacked health insurance and others felt the process of attaining insurance, specifically understanding restrictions, was confusing and complicated. They also noted difficulties in travelling for care because of the coverage they had.

Participants remarked that most resources were available but located in Phoenix/downtown making it difficult for people outside of those communities to access services. They noted needing **more information and access to resources in the outlying communities**. More resources were also wanted in multiple languages.

Participants wanted **more dedicated, respectful doctors and staff**. They felt that their doctors did not listen to their needs, that they looked down on them as patients, and that doctors tried to push pills. They also felt that their care providers did not stick to the medical appointment schedules.

Overall, participants desired **increased access to mental, dental, and vision health services**. Participants cited examples of people going to Mexico for dental care. Others mentioned that specialists were not accessible in their geographic location. One group noted a need to have psychologists in schools.

Access to healthier food and nutrition information was also wanted. They felt food stamps did not adequately allow them to purchase enough healthy food. Some noted a lack of grocers that sold healthy food. Produce was noted as expensive, and participants desired discounts. They also wanted information on how to maintain health through nutrition rather than medical care only.

Finally, participants noted a need for **greater access to affordable medical transportation**. These issues were particularly salient for those who have to travel long distances for services or do not drive (elderly, disabled, those without vehicles or gas money).

In the words of participants…

> *I would also say access to well-priced health care, and I say this because at the moment I'm a stay-at-home mom and I'm studying, and the reason why I'm working is because the cost of healthcare is so expensive now. I just can't afford to stay at home with my kids even though my husband works and he has a good job. Yeah, it's just the cost of health is very expensive. It would be nice to have it more reasonable.*
>
> --Participant (Adults with children)

> *I think they need – we need more medical transportation. The one I use is VMT, and they're the only one that will pick you up. The other ones, you got to have a case manager call in for you to make an appointment to go anywhere. I'm not a kid. I'll do it myself. Medical transportation is really needed.*
>
> --Participant (Native American adults)

> *Sometimes the access is more limited to the Hispanic community if these workshops and services are only in English, and that discourages people. I've known about cases like that, psychological services, I've known about a lot of individuals who need services, and it's very hard for them to have a psychologist in Spanish. And sometimes they have an interpreter and the interpreter is not so good either.*
>
> --Spanish-speaking participant (Adult males)

> *She had been to the emergency room. All these people were prescribing different drugs on top of what she was already taking. They never said to stop anything. Nobody was ever reading her chart. Nobody ever read her chart.*
>
> --Participant (Caregiver)

> *If you want specialized care, you pay more for a co-pay. If you go to your PCP and he charges you $25 to see him, and then he says 'oh, you got a special skin problem that you need to go see a specialist for' because they don't know exactly what it is, then you gotta pay another $50 to go see the specialist. You're talking about $75, and you almost have to—like for me, I would have to wait another paycheck with all the other stuff I have. Just so that I budget. Okay, I'm gonna save $25 this paycheck and then $50 next paycheck and then I can go make my appointment.*
>
> --Participant (Native American adults)

Healthcare Choices

General themes arose regarding health care choices made by the participants. Participants noted that they get most of their healthcare information online. Popular websites included: WebMD, Drugs.com, Mayo Clinic, Google, Medscape, Arizona Medical Board, AARP, Ask.com, Dr. Oz, and Facebook. Other common sources of information included: Arizona 211, health fairs, family members, newspapers, televisions programs/advertisements, word of mouth, magazines, and literature received in the mail. Others highlighted that they attended health fairs and workshops.

AHCCCS was the most common insurance provider discussed. Regarding care, participants often sought care from free clinics, urgent cares and the emergency room. Several people used healthcare providers in other states or countries. For example, lack of affordable healthcare and inadequate insurance coverage drove some individuals to seek services in Mexico where services were less expensive. Pharmacies were often used for immediate assistance, flu shots, and physicals.

Others spoke of their focus on diet and eating. Some used mobile phone applications to monitor eating. Some utilized homeopathic treatments and/or natural remedies. Finally, participants highlighted the need to be an advocate for yourself and others. They commented that they would conduct their own research or provide their own records to ensure adequate care was provided.

In the words of participants…

> *My mom is a really big source for me. I'll tell her, "Oh no. I feel this, this, and this." She's like, "Oh, well you know growing up there's a bunch of homeopathic remedies that they use." My mom's from Mexico so they didn't go to the doctor a lot….I use that a lot because it's either I can go and do these specific things that my mom states or I can go and pay a couple hundred dollars to visit a doctor and then pay for whatever prescription they're giving me.*
>
> --Participant (Hispanic/Latino adults)

> *If something serious happened to me, really serious—cuz I've had bad issues in this state. I would not go to a hospital here. I'd get on a plane….I wouldn't ever go to a hospital in this state, ever….I just wanted to say I've had a lot of bad things happen to me here. I don't think that Arizona has very good healthcare.*
>
> --Participant (Older adults, 65-74)

> *I just try to ride the sickness out, basically, is what I try to do.*
>
> --Participant (Hispanic/Latino adults)

> *My husband goes on different chat groups, and that's how information is shared that way. When he did one of his transition surgeries, it was with a doctor in San Francisco that's really well known…It was a $10,000 surgery. Yeah, so it's an underground network. Then, the web. I don't know what we did before the web.*
>
> --Participant (LGBTQ adults)

The Department of Public Health is an exceptionally great resources because they should have all the information that can ideally direct you where you want to go. Similarly, information lines at 211, and things like that, and of course, the Internet because everybody knows now—well, within our age group, typically, can have their fingertips on their phone. Granted, you have to be careful of WebMD because you can look for an ear infection and it'll tell you you have brain cancer or something horrible. It's very reliable, but I mean, take it with a grain of salt. It is an exceptionally easy resource to get.

--Participant (Young adults, 18-30)

We have a free clinic right there by us and that's where we usually go if our kids need vaccines or anything like that. We're pretty much good on our medical and stuff. We have a regular PCP.

--Participant (Hispanic/Latino Adults)

Go to Nogales, Sonora, and see the doctor in Mexico because I don't qualify for any insurance here. If I pay for the insurance at work it is very expensive and I don't qualify for AHCCCS because I don't have children at home.

--Spanish-speaking participant (Low-income adults)

Healthcare Experiences

Participants told numerous stories relating to their experiences with the healthcare system. While many were positive experiences (e.g., *I have a doctor who is absolutely fantastic…my doctor has never had any problems. I've not had any problems getting referrals to specialists… I think the medical attention around here has been absolutely fantastic*), across the cycles it appeared that twice as many stories were negative as were positive based on reasons such as those listed next as healthcare barriers.

Healthcare Barriers

Participants identified several barriers to healthcare (see Table 4 for a list of barriers by subpopulation). **Distrust of medical providers** was frequently mentioned. Participants commented about their lack of relationship with doctors. They felt doctors did not listen to their needs and noted that their experiences were rushed. They felt doctors were not knowledgeable about nutrition or alternative care options and reported that they could often find better information about their issues online.

Financial limitations were noted as a barrier to healthcare. Participants listed the costs of copays, prescriptions, specialists, insurance, healthy foods, recreational programs, and medical costs in general. They felt medical costs were not considerate of people with fixed incomes. Participants noted the dilemma of choosing the health/wellness of children over self because of limited funds. Some remarked that they did not find out about costs until after the services had been received. Participants expressed fears of receiving unexpected or unaffordable bills in the mail. Additionally, paying for medical costs was noted as a lower priority compared to paying for food and housing.

Participants noted **lack of access to existing resources** and healthcare as a barrier. Issues around long wait times, inadequate hours of operation, time constraints, citizenship status, transportation, and resources being only available online. They also expressed frustration with their preferred doctors' offices not accepting new patients. Participants noted having **incomplete insurance coverage** as a barrier, specifically lacking dental or vision care, or they did not qualify due to their income or number of hours worked.

Negative experiences or fears were expressed regarding experiences with the healthcare system. Some participants expressed feelings that doctors do more harm than good or encourage the use of more pills than necessary. They observed disconnects in communication among doctors, nurses, and patients. Some noted feeling disrespected, shamed, or untrusted by healthcare providers. Some participants noted a lack of cultural competency in their healthcare experiences. These negative experiences were often connected to a fear of seeking healthcare or receiving results from tests.

Health literacy was also a barrier to healthcare. Participants reported feeling that the medical system was difficult to navigate. One particular difficulty noted was with finding a doctor. Other difficulties were expressed regarding navigating paperwork and websites. Additionally, participants discussed a lack of information available regarding proper preventive measures.

Other barriers mentioned included:

- Lack of services/stigma for mental illness
- Fears surrounding undocumented non-citizenship status
- Lack of childcare during appointments and community health education programs
- Fear of employer retributions for taking sick time to receive care

In the words of participants…

> *A lack of results. You go so many times and then some doctors – they never say, "I don't know what's wrong with you." They just might not say anything and then just prescribe you something, and then you're like, "Well I just sat here all this time and paid you this money for you to tell me to do nothing?" I'll just stay at home and figure this out myself.*
>
> --Participant (Adults with children)

> *And the other aspects are money and fear because I have heard from Mexicans and Hispanics saying, "I don't want to go to the doctor because I don't want to receive bad news, I'm okay." And you go to the doctor; I've heard a lot of those comments when people say, "No, I don't want to go to the doctor, for what? They can tell me I'm sick, and I'm going to die in two months? I prefer not to do that; I'm okay."*
>
> --Spanish-speaking participant (Adult males)

In a couple weeks, I have an appointment, which I'm just like, I don't want to take my daughter, but I'm wondering who's gonna watch them for me.

--Participant (Native American adults)

We don't do it because of the cost. It is not easy to have medical insurance because the majority of jobs don't offer those protections, even if you have to pay a fee, the employer doesn't provide a medical plan for you. So what can you do to get one? It is very expensive to buy one. It is very costly to pay; that's why we don't go.

--Spanish-speaking participant (Adult females)

The way that the healthcare plan has you locked with particular providers is ridiculous, especially when it's not in private care. I use AHCCCS. I use public insurance, basically. I should have a more wide range of specialists that I could see, and it should be easier for me to get to the specialist. I shouldn't need to go get a referral from over here, get a referral from over here, just to see this one doctor. To me, that's ridiculous.

--Participant (African American adults)

People are so busy and so stressed, their life is go, go, go. You don't have time… Like, the way the culture is set up is that in order to – you know, it kind of goes hand in hand. In order to have a good quality of life, you have to work hard, get a good job, you have to go to school, you have to do all these things. Um, but you do that and you're constantly going that you're not able to enjoy it. Um, and so it's kind of like you have a catch 22, where you're working really hard but then it's costing you other health benefits of, you know, taking time for your diet, taking time for exercise, taking time to mentally destress or participate with your community. So, um, I think that framing of our culture really plays a big part of, in what kind of health problems we see.

--Participant (Asian American adults)

The minute you say you're over 60 you all of a sudden become stupid… You could be the sharpest person again on the world at 85 years old and they're gonna talk to you like you're absolutely stupid. They're gonna try to treat you like you're stupid when you go in the hospital. They're gonna try to order tests for you they're gonna try to do things like you're stupid. You've gotta watch what you're doing. Because like I say, all of a sudden they hear an age and you've got all these mental problems and you can't handle your own stuff…

--Participant (Caregivers)

We live in a world where food that's not great for you costs $0.59, but anything that is worth eating and healthy for your body costs $10. Sick people have to make a decision if they're going to pay their electricity bill or pay for their medication for the month….it's easier to make your money stretch to eat unhealthy and not have a gym membership in order for your kids to be able to have anything in their belly or to have a roof over their head. You just give one up for the other because it's easier. It costs less. It's faster.

--Participant (Adults with children under age 18)

I have AHCCCS Emergency. It only covers me if I have an accident and I have to be hospitalized. But if I have an illness I don't have any coverage so where am I supposed to go?

--Spanish-speaking participant (Low-income adults)

Doctors will ask embarrassing questions. I know it's in an attempt to build rapport with me as a patient, but…you ever come across those lists where it's like "ten questions not to ask a gay person or a trans person?" It's like they ask questions that are at the top of that list. They even list themselves as LGBT specialists and they still ask stupid questions.

--Participant (LGBTQ adults)

I'm a transgender man. Getting treatment is impossible. If I need a well-woman exam…one, my insurance is not gonna cover it. Two, I don't think any doctor is gonna take me.

--Participant (LGBTQ adults)

I just knew that when you're sick, you go to the doctor. Other than that, I didn't know you were supposed to have well-checks, do preventative maintenance. Even though I was a mechanic for years and we preached preventative care for your vehicle…I never thought to apply that to a person.

--Participant (Adults with children under age 18)

I actually had a manager say to me one time: "You're not allowed to call in sick, at all, ever." I know that's illegal for an employer to say, but that's what they told me.

--Participant (LGBTQ adults)

You almost have to be unemployed so that you can qualify for state insurance so that you can get your stuff paid for. A lot of people complain about being on AHCCCS or having low-cost health insurance, but for those of us who can't get on that, I feel like—my husband and I both work full-time and we have five kids that we're trying to support. We can't afford prescriptions like someone who isn't working and who has AHCCCS, has access to all that stuff so much easier than we do trying to come up out-of-pocket every month to pay our insurance, to pay our high deductibles….I feel like you have to not work and have kids in order to get decent insurance.

--Participant (Adults with children under age 18)

Prevention Strategies

Participants identified a number of ways that they attempted to maintain or improve their health. **Physical activity** was noted as an important prevention strategy. Activities mentioned included: Walking/jogging, gyms, yoga classes, bike riding, and sports for children. They mentioned a need for affordable and accessible sports programs for children.

Eating healthy was another prevention strategy mentioned. They noted a need to decrease sugar in their families' diets and a need to balance nutrition. Some did or desired to grow food at home. They wanted healthier school lunches. Some participants discussed the importance of preparing raw and healthy meals.

Preventative care services were noted as an important strategy. Some participants highlighted the importance of massages. Immunizations/vaccinations were cited as important. Also, dental care and mental health check-ups were deemed useful in aiding overall health and quality of life.

Education regarding health care and nutrition was the final theme unearthed regarding prevention strategies. Participants educated themselves regarding drug interactions, nutrition, and navigating the healthcare system. Many expressed a desire to be aware of the existing healthy food resources in their communities.

In the words of participants…

> *I find I don't drink sodas as much as I used to anymore. I'll take a sip, and I'll say, oh man, this is too sweet. I dilute it with water now or put a bunch of ice in it and dilute it. It's helping. If you tasted my Kool-Aid, it's almost like just drinking colored water. I'm getting used to it.*
>
> --Participant (Native American adults)

> *I get up every day and prepare my green shakes and all that. I go to walk and do some exercise, and I believe that is healthy for me. I don't eat a lot of wheat because I know that's not good for my health.*
>
> --Spanish-speaking participant (Older adults, ages 50-64)

> *We do that in my community, we have a group, and we do exercise one day per week. We do exercise with our children, and they like to do it. And we also prepare healthy food on a specific day.*
>
> --Spanish-speaking participant (Female adults)

> *They have free clinics everywhere for flu shots and kids get their immunizations up-to-date and stuff….They even go to the schools on their little buses to get them taken care of. Dental, the tooth doctor goes around to different schools and takes care of those who can't afford dental.*
>
> --Participant (Hispanic/Latino adults)

I use the vaccination service for the kids because they are free and what I have also used is the blood pressure devices in the…Safeway. That's how I found out I had high blood pressure.

--Spanish-speaking participant (Low-income adults)

I think, back to education, knowing what's—we slack. I mean, we all slack. You're supposed to get yearly check-ups and physicals and, "Eh, I feel good. I'm okay." Make sure you maintain and you understand that as you get older there are certain medical conditions.

--Participant (Native American adults)

Another thing that I use to keep my health is being active, having my kids be active in the community. My kids like to do a lot of volunteering. That gets me out there, too, and just knowing my neighbors and what we can do to better our health.

--Participant (Native American adults)

We started growing our own garden at home, so my children will know where the food comes from. Sometimes somebody will ask, [name], where did the milk come from?' and he's like 'from Food City.' He didn't know that it came from a cow.

--Participant (Hispanic/Latino adults)

Participants' Suggestions for Improvement

Participants offered several suggestions for community health and healthcare stakeholders to consider. Participants desired **more educational resources and opportunities**, especially for children in their communities. Further education would be centered on topics such as nutrition, healthcare and sex education. They felt the educational resources available could be improved and that more offline resources and handouts could be made available. Having additional resources in hand may also be tied a desire for more transparency in healthcare as well**,** particularly with insurance, drug side effects, alternative options, toxins, and more.

Participants noted that **access to healthy food** and access to **nutrition information** were important. Ideas included having EBT cards accepted at farmer's markets, offering nutritional education and gardening classes, creating community gardens and food co-ops, and providing more affordable healthy food options (e.g. fresh fruits and vegetables at food banks). Additionally, participants desired children to have healthier food options available at school.

A greater degree of **cultural competency** was desired in health care experiences. A need to increase healthcare access for special populations (e.g., the elderly, disabled, Native Americans, LGBTQ, and children) was noted. Being mindful of cultural issues especially in Spanish-speaking communities was mentioned. Participants also expressed an idea for sharing cultural knowledge. For example, they felt that they could learn from other cultures on how to eat healthier.

Participants felt that **more trained community health workers, navigators, advocates, and aides** were needed to help people navigate the healthcare system. Participants saw these individuals as able to help people access healthcare and better maintain their health. They also saw these trained individuals as ombudsmen or liaisons who could communicate with healthcare providers on behalf of patients.

Improvements in affordability of healthcare services were desired. Participants wished there were ways to **lower the costs of insurance, copays, specialists**, and other items already discussed in this report. They thought sliding scale fees might help. Specific areas mentioned to make more affordable were mental and oral healthcare services.

Participants of low income or those living in low-income communities desired **improved access to physical fitness facilities and activities**. They wanted more free programs and services at libraries and more health fairs as well. They hoped programs could be offered at varying hours so more people could take advantage of the opportunities. They also noted that they desired a **"living wage**."

Overall improvements to community services were wanted. Participants suggested that more affordable and accessible physical, mental, dental, and prevention healthcare services/campaigns should be provided. They wanted **shortened wait times** for medical appointments and at the emergency room. They felt more affordable **medical transportation** services were needed. Greater **cultural competency** in health care experiences was desired. Participants hoped that accommodation could be made regarding **time** of day for their medical appointments because of their work demands/schedule. They also asked that **buildings** be made more accessible for wheelchairs and for persons with other physical impairments.

Research Findings for Specific Populations

After collecting and analyzing the data, findings particular to each of the diverse medically underserved populations in Maricopa County were examined. First, some general themes regarding barriers to health care were identified (see Table 3). Second, the prevalence of these themes was explored among the specific populations in this study. A further delineation of the findings is presented in Appendix F.

Aside from persons who identify as American Indian, **cost was the most prevalent barrier to health care**. Health literacy and inadequate insurance coverage came second to cost across group experiences. Dissatisfaction and/or distrust of the traditional health care system and/or provider followed as next in order mentioned across all groups. More details by each of the unique populations of interest are provided in both narrative and table format.

American Indians

American Indians indicated particular concerns regarding their heath and communities. Health issues included limited access to specialists and/or specialized care and limited opportunity for physical activity and/or exercise. Community issues included limited access to quality and affordable childcare and unhealthy cultural habits or traditions.

Specific mention of American Indians health services occurred in the focus groups. Despite many using the services available in Phoenix, many noted the difficulty getting themselves to and from those services. The Salt River Health Clinic, Sacaton Center (Gila River Indian Community), the Phoenix Indian Medical Center (PIMC) - Indian Health Services and PIMC's Star Clinic are used additionally to cover optometry, dental, and physicals (Salt River serves all tribes). Many American Indians use Native Health services for emergencies or as a supplement to primary insurance when necessary. Finally, more negative rather than positive experiences were discussed regarding PIMC-Indian Health Services.

African Americans

African Americans indicated particular topics regarding their heath and communities. Health issues concerned heat and sun exposure, high blood pressure, heart disease, and limited access to specialists and/or specialized care. Community issues concerned lack of support or feelings of isolation, lack of community or social cohesion, limited access to quality and affordable housing, problems with community hygiene (e.g., litter, pet waste, pests) and unhealthy cultural habits or traditions.

Of particular note, African American males seemed not to experience the friendliness or sense of community that other groups noted. The men commented several times on feelings of mistrust in the community and spoke specifically about poverty and a lack of resources for people of color. These men expressed that nobody was going to help them get where they want to be in life so they have to go it alone.

Table 3. Themes and Descriptions: Barriers to Health Care found Across Populations

Theme	Description
Barriers to Services/Access	Transportation issues. Concerns about ADA accessibility. Perceived lack of access to healthy food (e.g., overabundance of unhealthy options in communities, relatively high cost of healthy options). Fears or concerns related to legal status or residency. Unreliable public or discounted services related to health care (e.g., transportation assistance, mobile clinics).
Cost	Cost of physical and mental health care and prevention services, including copays, deductibles, appointments, services, insurance, prescriptions, medical supplies, dental, and exercise or treatment programs.
Cultural Competency of Health Care Professionals	Perceived discrimination or discomfort caused by medical professionals and insurance providers due to gender, or sexual, or racial/ethnic minority status. Included language barriers as well as fears of embarrassment, shaming, and stereotyping.
Dissatisfaction/Distrust of Traditional Health Care System/ Providers	Distrust of doctors. Lack of confidence in doctor competency or knowledge. Fears of misdiagnosis or no diagnosis. Lack of relationship or concerns about limited time spent with doctors. Perceived lack of coordination among providers. Poor communication with or perceived treatment by health professionals, including impersonal, inhumane, or standardized approach to care. Preferences for natural or holistic care. Concerns about prescriptions (e.g., fears regarding side effects or interactions; perception of "pill pushing"). Previous negative experiences with health care providers. Concerns about turnover in the health care system (e.g., loss of known or trusted doctors/providers).
Health Literacy	Lack of knowledge/awareness of resources. Perceived need for navigation or support. Fear of diagnosis or bad news. Fears of unexpected or unaffordable medical bills. Uncertainty or misunderstanding of coverage. Concerns about care or insurance processes or policies (e.g., confusion or challenges with enrollment, paperwork, referrals, billing, website navigation, preauthorization requirements, and/or policy changes).
Inadequate Insurance Coverage	Lack of medical, dental, or vision insurance. Inadequate, limited, or incomplete coverage. Perceived need but lack of eligibility for public insurance assistance or coverage.
Inadequate Supply or Access to Providers/ Resources	Limited access to providers, services, or resources based on geographic location or scheduling constraints of health care professionals (e.g., long wait times for appointments). Limited choice of covered or in-network providers. Limited providers for specific subpopulations (e.g., transgender, bilingual).
Life Constraints/ Competing Priorities	Concerns about time and/or research required to access covered, competent, trusted, specialized, or preferred health care services. Personal or work-related scheduling conflicts. Issues related to child care or caregiving responsibilities. Prioritization of food, housing, transportation, or other activities over health care.
Personal/Cultural Habits	Factors that prevent individuals from accessing health services on the basis of traditions, habits, and personal affect (e.g., culture of avoidance or self-care, pride concerns, and lack of perceived need for assistance).

Table 4. Most Common Healthcare Barriers by Subpopulation

Health Care Barrier	American Indian	Asian/ Asian-American	Black/ African-American	Hispanic/ Latino	LGBTQ+/ GSM	Low SES	Older Adults	Parents	Young Adults
Barriers to Services/Access									X
Cost		X	X	X	X	X	X	X	X
Cultural Competency of Health Care Professionals					X				
Dissatisfaction/ Distrust of Traditional Health Care System/ Providers	X		X		X		X		
Health Literacy		X		X	X		X	X	
Inadequate Insurance Coverage		X		X		X		X	X
Inadequate Supply or Access to Providers/ Resources			X						
Life Constraints/ Competing Priorities								X	X
Personal/ Cultural Habits	X	X		X					

Asian/Pacific Islanders

Asian/Pacific Islanders indicated particular concerns regarding their heath and communities. Community issues included access and eligibility issues related to their immigration status, concerns about environmental toxins/pollutants, and language barriers. Health-specific issues included concerns about prescription drug use and overmedication.

Hispanics/Latinos

Hispanic/Latino persons indicated particular concerns regarding their heath and communities. Community issues included access and eligibility issues related to their immigration status, concerns about environmental toxins/pollutants, limited access to quality and affordable housing, problems with community hygiene (e.g., litter, pet waste, pests), language barriers, and unhealthy cultural habits or traditions. Health-specific issues included high blood pressure, heart disease, and limited opportunity for physical activity/exercise.

LGBTQ

LGBTQ persons indicated particular concerns regarding their heath and communities. Community issues included concerns about lack of providers and insurance coverage for transgender persons, lack of support and feelings of isolation, and the ADA accessibility of health organizations. Transgendered individuals in one group noted feeling more comfortable with a particular doctor in San Francisco and would sometimes travel to seek more culturally competent services there. Specifically, transgender participants noted a lack of proper reproductive care for transgender patients among the medical services currently provided in this community.

Overall, the LGBTQ persons' stories illustrated a need for cultural competency. They suggested that medical staff working with LGBTQ patients be better educated and trained regarding working with their populations, especially transgender persons. They suggested that more accepting and affirming medical staff be hired. They also suggested that demographic forms be more reflective of LGBTQ diversity (i.e., not just male/female binary options). They hoped that gender-neutral restrooms be provided at medical facilities and other community places. They also expressed the strong desire that the confidentiality of their information and identities (e.g., do not 'out' patients) be better respected.

Low SES

Persons of lower socioeconomic status (low SES) indicated particular concerns regarding their heath and communities. Community issues included concerns about environmental toxins/pollutants, limited access to quality and affordable housing, limited access to quality and affordable childcare, limited access to safe and well-lit streets, traffic, and problems with community hygiene (e.g., litter, pet waste, pests).

Older Adults and Caregivers

Older adults and caregivers indicated particular concerns regarding their heath and communities. Community issues included concerns about ADA accessibility of health organizations, concerns about prescription drug use/overmedication, lack of support and/or feelings of isolation, and limited availability of quality respite services for caregivers. Health-related issues included lack of knowledge/preparation related to aging and disability, limited access to specialists/specialized care, and respiratory issues (e.g., allergies, asthma).

Parents

Parents indicated particular concerns regarding their heath and communities. Health-related concerns included limited opportunities for physical activity and/or exercise as well as concerns over respiratory issues (e.g., allergies, asthma). Community issues included a lack of community and/or social cohesion, limited access to quality and affordable childcare, limited access to safe and well-lit streets, traffic, and problems with community hygiene (e.g., litter, pet waste, pests).

Young Adults

Young adults indicated particular concerns regarding limited access to safe and well-lit streets, concerns regarding traffic, and access and eligibility issues related to immigration status.

Appendix A

Focus Group Protocol

Focus Group Protocol

For the purposes of this discussion, "community" is defined as where you live, work, and play.

Opening Question (5 minutes)

1. To begin, why don't we go around the table and introduce ourselves. State your name (or whatever you would like us to call you) and what makes you most proud of your community.

General Community Questions (20 minutes)

I want to begin our discussion today with a few questions about health and quality of life in your community.

2. What does quality of life mean to you?
3. What makes a community healthy?
4. Who are the healthy people in your community?
    a. What makes them healthy?
    b. Why are these people healthier than those who have (or experience) poor health?
5. What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

    [Prompt]

    i. What are the biggest health problems/conditions in your community?

Family Questions (20 minutes)

Now we are going to transition a bit and focus a bit more on your family and experiences.

6. What types of services or support do you (your family, your children) use to maintain your health?
    a. Why do you use these particular services or supports?
7. Where do you get the information you need related to your (your family's, your children's) health?
8. What keeps you (your family, your children) from going to the doctor or from caring for your health?

    [Prompts]

    ii. Are there any cost issues that keep you from caring for your health? (such as co-pays or high-deductible insurance plans)
    iii. If you are uninsured, do you experience any barriers to becoming insured?

Improvement Questions (20 minutes)

Next I'd like to ask a few questions about ways to improve community health.

9. What are some ideas you have to help your community get or stay healthy?
10. What else do you (your family, your children) need to maintain or improve your health?

    [Prompts]

    What about…

    iv. Services, support or information to manage a chronic condition or change health behaviors such as smoking, eating habits, physical activity, or substance use?

    v. Preventive services such as flu shots or immunizations?

    vi. Specialty healthcare services or providers?
11. What resources does your community have that can be used to improve community health?

Ending Question (5 minutes)

12. Is there anything else related to the topics we discussed today that you think I should know that I didn't ask or that you have not yet shared?

Facilitator Summary & Closing Comments (5-10 minutes)

Let's take a few minutes to reflect on responses you provided today. We will review the notes we took and the themes we observed. This is your opportunity to clarify your thoughts or to provide alternative responses.

[Co-facilitator provides a brief summary of responses for each of the questions or asks clarifying questions if she thinks she may have missed something.]

Thank you for your participation in this focus group meeting. You have all raised a number of great issues for us to consider. We will look at what you have told us and use this information to make recommendations to area hospitals and the Maricopa County Department of Public Health.

Appendix B

Cycle 1 Focus Group Schedule

Cycle 1 Focus Group Schedule

Date	Time	Population	Location
9/25 (Fri.)	9:30-11:30am	Older adults (65-74) [n=10]	Sun City Branch Library (16828 N 99th Ave, Sun City, AZ 85351)
9/28 (Mon.)	5:30-7:30pm	Native American adults (x2) [n=24]	Phoenix Indian Center (4520 N Central Ave #250, Phoenix, AZ 85012)
9/29 (Tues.)	5:30-7:30pm	Adults without children [n=10]	Mesa Main Library (64 E. 1st St., Mesa, AZ 85201)
9/30 (Wed.)	6:00-8:00pm	LGBTQ adults [n=6]	Phoenix Pride LGBT Center (801 N 2nd Ave, Phoenix, AZ 85003)
10/2 (Fri.)	9:00-11:00am	Adults with children under age 18 [Spanish; n=15]	Maryvale Community Center (4420 N. 51st Avenue, Phoenix, AZ, 85031)
10/2 (Fri.)	6:00-8:00pm	Low-income Adults [Spanish; n=15]	Sojourner Center (2330 E Fillmore St, Phoenix, AZ 85006)
10/4 (Sun.)	2:00-4:00pm	Hispanic/Latino adults [English; n=8]	Cesar Chavez Library (3635 W Baseline Rd, Laveen Village, AZ 85339)
10/5 (Mon.)	5:30-7:30pm	Adults with children under age 18 [n=10]	Embry Riddle Aeronautical University, Phoenix Mesa Campus (5930 S. Sossaman Rd., Ste. #102, Mesa, AZ 85212)
10/6 (Tues.)	5:30-7:30pm	Young adults (18-30) [n=10]	Pendergast Community Center (10550 W. Mariposa St., Phoenix, AZ 85037)
10/7 (Wed.)	6:00-8:00pm	African American adults [n=10]	Southwest Behavioral Health Services (4420 S. 32nd St., Phoenix, AZ 85040)
10/8 (Thurs.)	11:30-1:30pm	LGBTQ adults [n=9]	ASU/SIRC (502 E. Monroe St., Phoenix, AZ 85004)

Appendix C

Cycle 2 Focus Group Schedule

Cycle 2 Focus Group Schedule

Date	Time	Population	Location
2/27 (Sat.)	10:00-12:00pm	Older adults (50-64) [Spanish; n=8]	Guadalupe Town Office (9241 S Avenida del Yaqui Guadalupe, AZ 85283)
3/5 (Sat.)	11:30-1:30pm	Adults with children [Spanish; n=12]	Dysart Community Center (14414 N El Mirage Rd, El Mirage, AZ 85335)
3/12 (Sat.)	9:30-11:30am	Adult males [Spanish; n=8]	Glendale Community College (6000 W Olive Ave, Glendale, AZ 85302)
3/12 (Sat.)	1:00-3:00pm	Adult females [Spanish; n=12]	Open Door Fellowship Church (8301 N 19th Ave, Phoenix, AZ 85021)
3/15 (Tues.)	5:30-7:30pm	Lower income adults [n=9]	Escalante Community Center (2150 E Orange St, Tempe, AZ 85281)
3/19 (Sat.)	9:30-11:30am	Older adults [75+] [n=10]	Red Mountain Multigenerational Center (7550 E Adobe Rd, Mesa, AZ 85207)
3/19 (Sat.)	9:30-11:30am	Caregivers [n=8]	Red Mountain Multigenerational Center (7550 E Adobe Rd, Mesa, AZ 85207)
3/22 (Tues.)	5:30-7:30pm	African American adults [n=9]	Tanner Community Development Corporation [TCDC] (700 E Jefferson St # 200, Phoenix, AZ 85034)
3/24 (Thurs.)	5:30-7:30pm	Native American adults [n=6]	Mesa Community College (1833 W Southern Ave, Mesa, AZ 85202)
3/29 (Tues.)	5:30-7:30pm	Adults with children [n=8]	Paradise Valley Community College (18401 N 32nd St, Phoenix, AZ 85032)
4/2 (Sat.)	9:30-11:30am	Asian American adults [n=8]	Chandler Downtown Library (22 S Delaware St Chandler, AZ 85225)

Appendix D

Cycle 3 Focus Group Schedule

Cycle 3 Focus Group Schedule

Date	Time	Population	Location
4/21 (Thurs.)	9:30-11:30am	Adults ages 65 – 74 [Spanish]	Mexican Consulate 320 E. McDowell Rd., Phoenix, AZ 85004
4/21 (Thurs.)	5:30-7:30pm	African American males	Arizona Opportunities Industrialization Center (AZOIC) 39 E. Jackson St., Phoenix, AZ 85004
4/26 (Tues.)	12:30-2:30pm	Adults 75+ [Spanish]	Matthew Henson Senior 1045 S. 8th Ave., Phoenix, AZ 85007
5/3 (Tues.)	5:30-7:30pm	Adults without children [Spanish]	Esther Angulo Community Center 9555 W. Van Buren St. Tolleson, AZ 85353
5/4 (Weds.)	9:30-11:30am	Older adults 50-64	Wickenburg Public Library 164 E. Apache St., Wickenburg, AZ 85390
5/4 (Weds.)	5:30-7:30pm	Adults with children under age 18	Saguaro Library 2808 N 46th St., Phoenix, AZ 85008
5/9 (Mon.)	5:30-7:30pm	Adults without children	Foothills Branch Public Library 19055 N 57th Ave., Glendale, AZ 85308
5/10 (Tues.)	5:30-7:30pm	Adults with low SES	Estrella Mountain Community College 3000 N. Dysart Rd., Avondale, AZ 85392
5/16 (Mon.)	5:30-7:30pm	Young adults 18-30	Gila Bend Family Resource Center 303 E. Pima St., Gila Bend, AZ 85337
5/17 (Tues.)	1:30-3:30pm	Asian American adults [Mandarin]	Chinese Senior Center 734 W. Elm St., Phoenix, AZ 85013
5/17 (Tues.)	5:00-7:00pm	Adults with children under age 18 [Spanish]	Buckeye Downtown Library 319 N. 6th St. Buckeye, AZ 85326
5/19 (Sun.)	9:30-11:30am	Asian American adults [Vietnamese]	Vietnamese Center 2051 W. Warner Rd., Chandler, AZ 85224
6/1 (Weds.)	10:00-12:00pm	Adults who care for senior parents	Church of the Beatitudes 555 W. Glendale Ave., Phoenix, AZ 85021

Appendix E

Map of All Focus Group Locations

Cycle 1 Locations

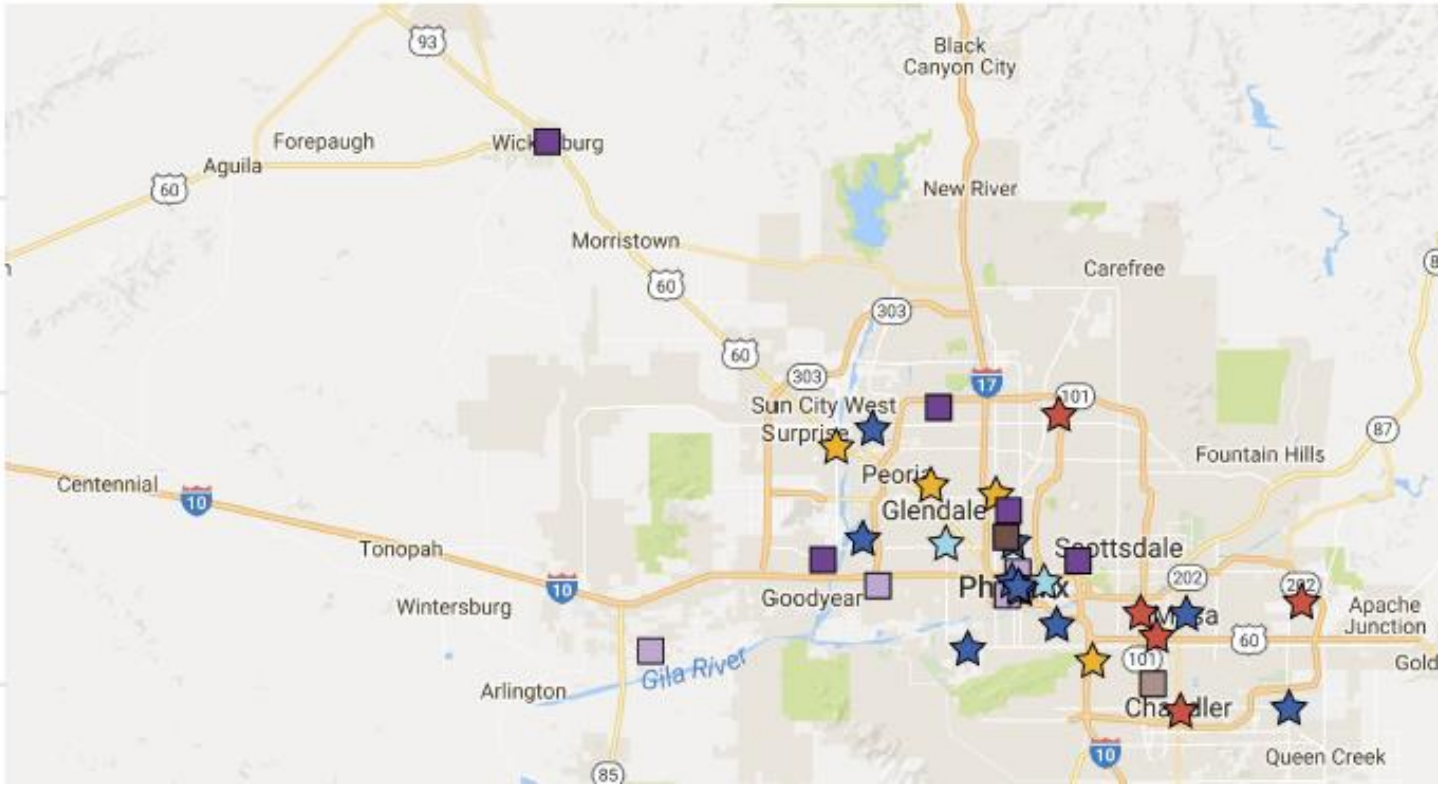
- English
- Spanish

Cycle 2 Locations

- English
- Spanish

Cycle 3 locations

- English
- Spanish
- Mandarin
- Vietnamese



Appendix F

Health Care Barriers and Community Concerns by Subpopulation

Health Care Barriers and Community Concerns by Subpopulation: Major Themes and Concerns	African-American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino	LGBTQ	Low SES	Older Adults/ Caregivers	Parents	Young Adults
Limited access to affordable, quality health care	X	X	X	X	X	X	X	X	X
Limited access to information/awareness of resources	X	X	X	X	X	X	X	X	X
Inadequate insurance coverage/eligibility	X	X	X	X	X	X		X	X
Limited access to healthy, affordable food/nutrition information	X	X	X	X	X	X		X	X
Time constraints/competing priorities	X	X	X	X	X	X		X	X
Limited health literacy		X	X	X	X	X	X	X	
Economic security/low wages/lack of opportunity	X	X		X	X	X		X	X
Transportation barriers (lack of vehicle, public transit, medical transport)	X	X		X	X	X	X		X
Distrust of health care providers	X	X	X	X	X		X		
Limited access to local, affordable community resources, activities and amenities	X	X		X		X		X	X
Neighborhood crime and safety issues		X		X	X	X		X	X
Substance abuse	X	X			X		X	X	X
Oral health/access to affordable dental care	X			X	X	X		X	
Lack of culturally appropriate care/ resources/institutions	X	X	X	X	X				
Mental health issues/access to mental health care	X		X		X				X
Obesity	X	X		X	X				
Diabetes	X	X		X	X				
Discrimination/ racism/stereotyping	X	X			X	X			
Concerns related to the political environment/ public relations (e.g., police, public officials)	X			X	X				X
Stress	X		X	X		X			
Concerns related to homelessness		X					X	X	X
Lack of community health navigators/advocates			X	X	X		X		
Limited access to sexual or reproductive health care/resources	X				X	X		X	