2025 Hazard Vulnerability Assessment (HVA) and Resource Gap Analysis (RGA)

Arizona Coalition for Healthcare Emergency Response

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Executive Summary

Statewide Hazard Vulnerability Assessment and Resource Gap Analysis

To identify Arizona's healthcare system's biggest threats, the Arizona Coalition for Healthcare Emergency Response (AzCHER) conducted its annual Statewide Hazard Vulnerability Assessment (HVA) and Resource Gap Analysis (RGA) July-September 2025. The HVA/RGA analyzes members' capacities and capabilities to respond to regional and statewide emergencies within the healthcare system, as well as the perceived impact and preparedness levels of member organizations. Identified hazards inform AzCHER's preparedness priorities in training, exercising, and planning. Members may incorporate identified risks and hazards into their own HVAs and exercises. This report directly aligns with the standard healthcare hazard vulnerability analysis (HVA) and the public health jurisdictional risk assessment (JRA).

The objective of the HVA/RGA is to represent the whole community and the collective needs through a member-driven process. Members reported their individual HVA results and current resources via statewide survey (Appendix 1). Results were aggregated to perform a comprehensive community analysis and evaluate relative risk scores. Aggregated RGA data was analyzed using Power BI and presented to regional steering committees, who identified and prioritized likely hazards and gaps in plans and resources. The HVA/RGA process engaged 213 respondents representing 509 facilities and consulted each region's steering committees.

Hazard Vulnerability Assessment: Comparison of the top 5 ranked hazards between 2023 and 2025

2025 Hazards	2024 Hazards	2023 Hazards
1. Extreme Heat	1. Extreme Heat	1. Temperature Extreme (Heat)
2. Infectious Disease	2. Monsoon Weather	2. Staffing Shortage
3. Monsoon Weather	3. Communications/ Telephone/ Network Failure	3. Severe Weather
4. Staffing Shortage	4. Staffing Shortage	4. Cyberattack
5. Cyber Attack	5. Cyberattack	4. Communications/ Telephone/ Network Failure

Table 1

Planning Gaps

Top Gaps in Planning (assessed in 2025)
• AzCHER Emergency Response Plan and Annexes
• Hospital Crisis Care/ Crisis Standards of Care Plan
• Healthcare Emergency Operations Plan
• Healthcare Training and Exercise Plan

Table 2

Planning Gaps by Preparedness Topic

Area	Notable Gaps/Needs
Staffing	Shortages, lack of contingency plans, retention/recruitment issues
Supplies	Vulnerabilities in critical medical/non-medical supplies, supply chain interruptions
Infrastructure/Utilities	Gaps in backup systems, facility resilience
Communications	Incomplete radio/MCI alert coverage, inconsistent training/testing
Training/Exercises	Gaps in after-action reporting, infrequent training, unmet training needs
Partnerships	Missing/untested MOUs, need for more collaboration
Underserved Communities	Incomplete planning/support, language and resource barriers
Recovery/Continuity	Missing/untested COOPs, infrequent revisions, resource needs
Data/Reporting	Barriers to reporting, underuse of state data tools
Innovation/Future Planning	Low adoption of new tech, lack of trial processes, incomplete integration of lessons

Resource Gaps Identified in 2023-2025

2025 Resource Gaps	2024 Resource Gaps	2023 Resource Gaps
Language resources	HAZMAT PPE	Transportation resources for specific emergency type (burn, pediatric, HAZMAT)
HAZMAT PPE	Documentation of transportation resources across all member types	Notification platforms for Outpatient, Home Health, and Hospice
Clinical Staff	Advanced ICS training for EOC staff	HAZMAT supplies (patient redress kits, chemical assets)
Back up systems: water, HVAC, and power	Evacuation resources-patient tracking and documentation of transport options	Documentation of transportation resources across all member types
Multi-Casualty Incident alert process	Lack of comprehensive documentation of EMS resources throughout the state	PPE in hospitals for highly infectious disease

Introduction

Hazard Vulnerability Assessment (HVA) and Resource Gap Analysis (RGA)

The Hazard Vulnerability Assessment (HVA) identifies Arizona's most significant risks, both natural and manmade, impacting healthcare services. Administered by AzCHER, the HVA informs coalition priorities annually through a member-engaged analysis of capacities and capabilities. The Resource Gap Analysis (RGA) identifies essential healthcare resources and services for continuity during emergencies, uncovering vulnerabilities that could impede medical care. Both assessments guide future planning, training, and exercises, via the Healthcare HVA/RGA Summary Report.

Purpose: A Foundation for Medical and Healthcare Readiness

The ***HVA*** builds a foundation for medical and healthcare readiness by identifying regional risks and resources, and further strategizing healthcare coalition functions based on the recommendations and requirements of the U.S. Health and Human Services (HHS), Hospital Preparedness Program (HPP) Cooperative Agreement, administered by the Arizona Department of Health Services (ADHS). Organizational perceptions are evaluated in a regional context, representing the collective needs of Arizona's health system.

The ***RGA*** identifies essential healthcare resources and services for continuity during and after an emergency. It highlights resource vulnerabilities that could impede medical care during emergencies, as well as identifies shareable resources. Assessment data is specific to each sector type (hospital, home health, EMS, etc.) but addresses resources required to care for all populations, such as pediatric equipment and long-term care beds.

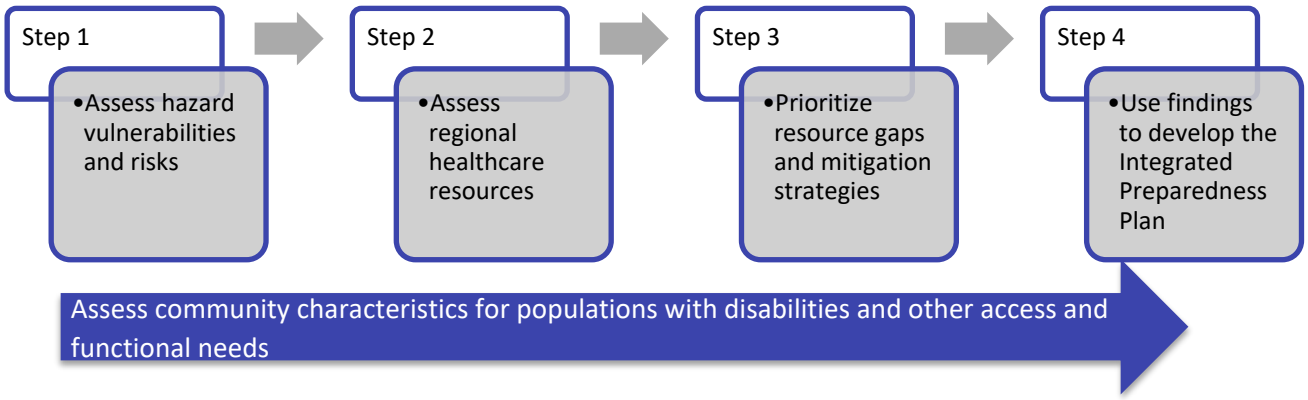


Figure 1: Preparedness Planning Sequence. The HVA represents the first step to build the foundation for medical and healthcare readiness of the risk identification process. The RGA represents the second step of the risk identification process. Populations with disabilities and other access and functional needs (DAFN) are considered throughout the entire process. The full process is outlined in the AzCHER Integrated Preparedness Plan (IPP).

Planning Assumptions

- While there is likely significant overlap between the HVA for AzCHER and the HVA for an individual healthcare organization or jurisdiction, these are separate and distinct processes.
- The HVA/RGA is not a replacement for an organization- or facility-specific HVA or resource assessment.

- A specific vulnerability may not exist across all coalition member organizations; however, coalition members will generally face many of the same hazards.
- The HVA/RGA is based upon responses received by participants and is not a comprehensive assessment of all partners. Survey respondents, while invited to complete the surveys via email, were self-selected based on interest. The data provided by these participants are influenced by their own organizational experience and planning efforts.
- The assessment of hazards and planning gaps across the regions and state are based on a combination of quantitative data (such as the occurrence of naturally occurring events) and qualitative estimations (Low-Medium-High scales).
- This assessment does not provide details regarding the unique attributes and risks for individual counties. Threats and vulnerabilities in this assessment may appear to be more homogenous throughout the state than they are at the local level.
- It must be recognized that this assessment alone cannot represent the coalition's knowledge of the state of plans, threats, and issues in an area and should only be used as a guide, with local leaders and subject matter experts having significant input into the decisions on priority gaps and actions.
- This HVA/RGA process incorporates state and local emergency management organization assessments and other public health hazard assessments, though the primary focus of this assessment is the impact on healthcare.

Arizona's Healthcare Coalition

AzCHER is a statewide healthcare coalition which facilitates collaboration among public health, healthcare, pre-hospital and transport entities, emergency management, and various other community partners to 1) build, strengthen, and sustain a healthcare preparedness and response system in Arizona; and 2) assist Emergency Management and Emergency Support Function 8 (ESF-8) with meeting the National Preparedness Goal's five objectives: prevention, protection, mitigation, response, and recovery as related to healthcare disaster operations. AzCHER has four distinct regions: Central, Northern, Southern, and Western. Each region is described in further detail.

As a sub-recipient of the HPP grant, overseen by ADHS, AzCHER is required to conduct an annual HVA/RGA by the Administration for Strategic Preparedness and Response (ASPR), a division of the US Department of Health and Human Services.[1] ASPR requires core healthcare coalition capabilities for AzCHER, which informs the healthcare coalition's purpose and function.[1] The purpose of AzCHER is to build resilience in the state's healthcare delivery system so that it is prepared to respond to and recover from a large-scale emergency or disaster.

Methods

A cross-sectional survey was administered to designated representatives from various coalition partners to assess hazard vulnerabilities and resource gaps within healthcare facilities across Arizona. The survey covered a range of organizations, including hospitals, EMS entities, public health agencies, tribal nations, emergency management, behavioral health, and volunteer organizations. Hazard probabilities, healthcare impacts, and mitigation measures were assessed, with results aggregated at statewide and regional levels. The survey was distributed to the membership via Microsoft Forms and analyzed in Power BI using formulas provided by the Kaiser Permanente HVA tool.

Once preliminary data was collected, the results were presented to regional steering committees for discussion

to identify top hazards and resource priorities, ensuring a comprehensive and collaborative approach to emergency preparedness and response. The final report was prepared by the Planning Manager and Logistics Manager.

AzCHER Staff, Work Group, and Member Responsibilities

The HVA/RGA process involves AzCHER staff, steering committees, and the general membership as described below.

Figure 2

AzCHER Staff

- Administered HVA/RGA survey via emails and monthly AzCHER newsletter.
- Reviewed/updated the regional vulnerability profile, and participated in HVA/RGA meetings.
- The Statewide Planning Manager and Statewide Logistics Manager outlined the process, providing subject matter guidance, templates, facilitating the work group meetings and general body meetings, analyzing data, and authoring the final statewide summary report.

Steering Committee Work Groups

- Comprised of core member representatives to produce a coalition-specific risk and resource assessment consensus based on the survey results.
- Sort and prioritized hazards and vulnerabilities, considering the likeliness to result in a Coalition-wide response, considering statewide resources, public health statistics, and county hazard mitigation plans.

General Membership

- Volunteered their time to complete the survey with their facility-specific emergency preparedness teams, so their data could be aggregated into a statewide and community perspective.
- Conduct their own HVA and resource assessments.
- Use this report to add a community perspective to their emergency preparedness programs.

Survey Administered to All Coalition Partners

A designated representative from each organization/facility (***Appendix 2: List of Participating Organizations***) was asked to complete an online survey (Appendix 1: HVA/RGA Survey Questions) for each licensed facility. AzCHER's HVA/RGA survey questions facilitate member reporting on their facility's most recent HVA and resources. The HVA survey questions were adapted from previous AzCHER HVAs, using the same scoring scale as the 2017 Kaiser Permanente (KP) HVA. KP HVA employs a worksheet method to systematically evaluate hazard vulnerability based on value-based quantitative inputs. To complete a thorough analysis of the survey data, responses were synthesized in Power BI. Completion of this survey fulfills the Centers for Medicare and Medicaid Services (CMS) and Joint Commission requirements for a healthcare facility's participation in a *Community* HVA.

The RGA survey questions were developed from the ASPR Resource and Gap Analysis Tool. This tool is designed to help coalition partners develop a common understanding of their resources and existing gaps, and strategies for prioritizing which gaps to close. Gaps may include inadequate plans or procedures, staffing, equipment and supplies, skills and expertise, and/or services. AzCHER has modified the tool to reflect its members' resources

and provide a coalition-based perspective.

The survey was administered to designated member representatives through Microsoft Forms from July 31-August 23. All member representatives for organizations/facilities were instructed to report data from their current HVA and resource analysis. Only one response from each member organization/facility was recorded to reduce any duplication.

Member facilities that were invited to participate in the survey include (not limited to):

- Hospitals and healthcare organizations
- EMS / patient transport entities
- Local public health
- Tribal nations
- Local emergency management
- Behavioral health

Survey Data Collection and Analysis

Healthcare facilities and pre-hospital providers were asked to report hazard vulnerabilities and resource gaps based on their organizational perception, including available resources and emergency planning questions specific to their sector (hospital, public health, emergency medical services, etc.). Definitions for rating each HVA measure are present in Table 4. Survey questions specifically examined hazards identified from the 2023 HVA/RGA for the purpose of updating the state's top priority hazards. An updated ranking of the top 10 hazards was identified upon completion of survey analysis. A full list of questions and answers is available in ***Appendix 1: HVA/RGA Survey Questions***.

The survey responses were aggregated statewide and by region to calculate mean scores for each hazard. Commonly perceived hazard vulnerabilities, as well as the historical hazard incident responses, were equally weighted in ranking the top ten hazards by the risk of occurrence and risk of response.

Risk was calculated using the following formulas, where the average score for each element was used to calculate the final risk score:

$$Risk\ Score = Probability\ of\ Occurrence * (Impact + Preparedness + Response)$$

$$Risk\ Percentage = \frac{[Probability\ of\ Occurrence * (Impact + Preparedness + Response)]}{Maximum\ Possible\ Score} * 100$$

Probability, impact, preparedness, and response rating methods are described below.

Measure	Definition	Rating
Probability	Occurrence: Likelihood of the incident to occur	0 = Rare or N/A 1 = Low (Every 10-50 years) 2 = Moderate (Every 1-10 years) 3 = High (Annually)
Healthcare Impact	Percentage of population,	0 = No impact expected

Measure	Definition	Rating
	properties, and business likely to be affected under an average occurrence of the hazard	1 = Low, causes minimal disruption; managed at daily level (<1% affected) 2 = Moderate, causes disruption outside of normal means but does not threaten regional healthcare service delivery (1-10% affected) 3 = High, causes significant disruption and threatens regional service delivery (>10% affected)
Mitigation/Preparedness	Preparedness: Current level of planning, resources, and capacity at the organizational level	0 = Sustainability only- strong capability in place, with regular ongoing planning, testing/training, sufficient resources available 1 = Adequate planning requires minor modifications based on training, exercises, events, or other evaluation; resources are available to procure if needed 2 = Inadequate or possibly adequate planning / training / exercises (i.e. plan has not been evaluated, tested, and/or incomplete training), difficult to procure necessary resources 3 = No planning/training/exercises currently exist or not applicable; unable to procure necessary resources
	Response: healthcare system/ mutual aid staff and supplies required for a hazard response at the community level	0 = Negligible - no response (rare minor injury, no significant effects from information compromise, minor property/economic damage to the community) 1 = Moderate - a few major injuries/hospitalizations in the community, compromise of information with limited impact on community agencies, moderate damage/economic impact (e.g. 1-20% of assets damaged or lost) 2 = Significant - few deaths but multiple major injuries/hospitalizations in the community, significant property damage/economic impact (e.g. temporary closure, 25-50% of community assets damaged or lost) 3 = Extensive - multiple deaths, compromise of information with significant ongoing impact, extensive property damage/economic impact (e.g. potential emergency declaration, >50% loss of assets)

Table 3 -. Definition of HVA measures used in the statewide survey.

Regional Steering Committee Input

Regional steering committees from each region (Northern, Central, Western, Southern) assisted in identifying the hazards and resource gaps to include in the survey. The questions were prior to dissemination and steering committees provided input to the development of the survey questions. Regional Steering Committees represented the coalition's perspective, as opposed to being representatives of individual facilities, to ensure that the data reflected regional and statewide gaps and vulnerabilities. Representatives submitted feedback in an open discussion forum directly to the facilitators to evaluate the top coalition hazards and resource gaps. All core member types were represented in the work groups and contributed to the discussion by adding sector-specific considerations to the hazard vulnerabilities and resource assessment deficiencies.

Prioritization of Resource Gaps and Mitigation Strategies

Assessing resources and identifying current hazards and resource gaps contributes to the prioritization of future activities, fulfilling the first step in the Preparedness Cycle. The list of top hazards assists the coalition in quickly identifying where to focus plans, training, and exercises. The resource gaps include a lack of, or inadequate, plans and procedures, staff, equipment and supplies, skills and expertise, services, or any other resources required to respond to an emergency. The resource assessment provides a way to prioritize needs for various

member types. Members should prioritize gaps based on consensus and determine mitigation strategies based on the time, materials, and resources necessary to address and close any disparities. Deficiencies may be addressed through coordination, planning, training, or resource acquisition, which can be accomplished through Coalition activities. Ultimately, AzCHER will focus its time and resource investments on closing those gaps that affect the Coalition's ability to respond.

Certain response activities may require external support or intervention, as emergencies may exceed established preparedness thresholds. Thus, during the prioritization process, planning to access and integrate external partners and resources (i.e., federal, state, and/or local) is a key part of gap closure. A complete description of AzCHER's prioritization process can be found in the Integrated Preparedness Plan.

Data Inputs

This report provides an Arizona healthcare community perspective by incorporating data from three main inputs: regional vulnerability profiles, member survey, and HVA/RGA work group discussion:

1. The HVA/RGA survey collects data from a wide range of healthcare partners, representing the healthcare community.
2. The regional vulnerability profiles contribute local context and population-based information under a healthcare system preparedness lens for the CHVA/RGA. AzCHER Regional Vulnerability Profiles can be found in ***Appendices 7-10*****.** Below is a list of vulnerability profile contents:
    a. Review of county Multi-Jurisdictional Hazard Mitigation Plans to gather information on physical characteristics and infrastructure capabilities of the region, including geography, weather, roads, transportation, power, water, fuel, information technology, and communication.
    b. Collection of county and regional data on underserved populations such as children, seniors, pregnant women, persons with access and functional needs, persons with disabilities, and those with unique medical needs.
    c. Summary of healthcare facility assets including hospitals, licensed pharmacies, long-term care facilities, and bed capacity.
3. The functional work group discussion and qualitative analysis allows for discussion of unique regional considerations and confirmation of the survey results.

Results

Survey Respondents

The survey captured responses from 225 participants out of 640 member organizations, representing 509 facilities, for a 35% response rate. Prior HVA/RGA surveys captured the number of organizations responding, but not the number of facilities. This resulted in an incomplete understanding of how many facilities were truly represented in the survey. In 2025, the question "How many facilities are you representing?" was added. Responses demonstrated the data represents 509 facilities, twice the number of respondents.
Key findings in response data:

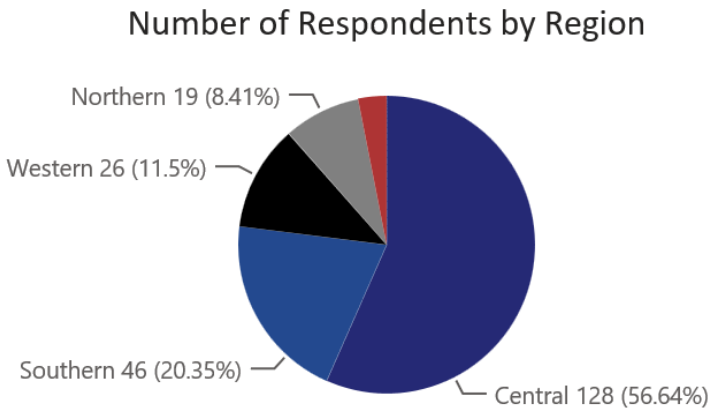
- 6% increase in membership with 640 members in 2025, compared to 603 member organizations in 2024
- 70% increase in HVA/RGA participation (225 in 2025 vs 132 in 2024)
- Ratio of members participating in the HVA increased from 22% to 35% response rate.
- 509 facilities were represented by 225 respondents
- There was a decrease in EMS responses, signaling a need to increase engagement

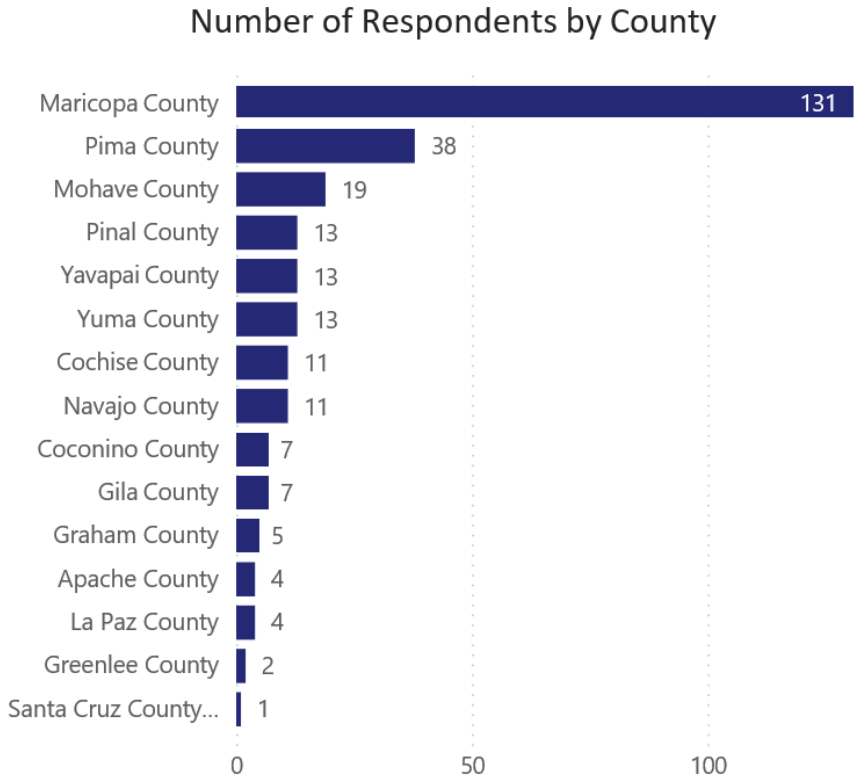
Sector	Number of Respondents	Number of Facilities
Ambulatory Surgery Center	49	68
Behavioral Health Facility	6	26
CERT or MRC Organization	2	0
Community Health Center / Federally Qualified Health Center	5	57
Emergency Management Organization (County or Tribe)	4	3
Emergency Medical Services (EMS) / Fire Dept	3	8
End-Stage Renal Disease Facility	12	27
Health Care Clinic	2	20
Home Health Agency	19	22
Hospice	18	20
Hospital-Acute Care	21	112
Hospital-Behavioral Health	3	9
Hospital-Critical Access	10	16
Hospital-Rehabilitation	7	8
Hospital-Specialty	3	3
Outpatient Clinic	2	13
Public Health Agency (County or Tribe)	11	27
Skilled Nursing or Long-Term Care Facility	48	70
Total	**225**	**509**

Participation by Region

Responses were received by all four regions of Arizona. Central region had 56% of responses, followed by Southern (20%), Western (12%), Northern (8%) and organizations in multiple regions, labelled as "Statewide," representing 3% of respondents.

63 (28%) respondents primarily served rural areas, most of those being in the Western, Northern, Southern, or multiple regions:





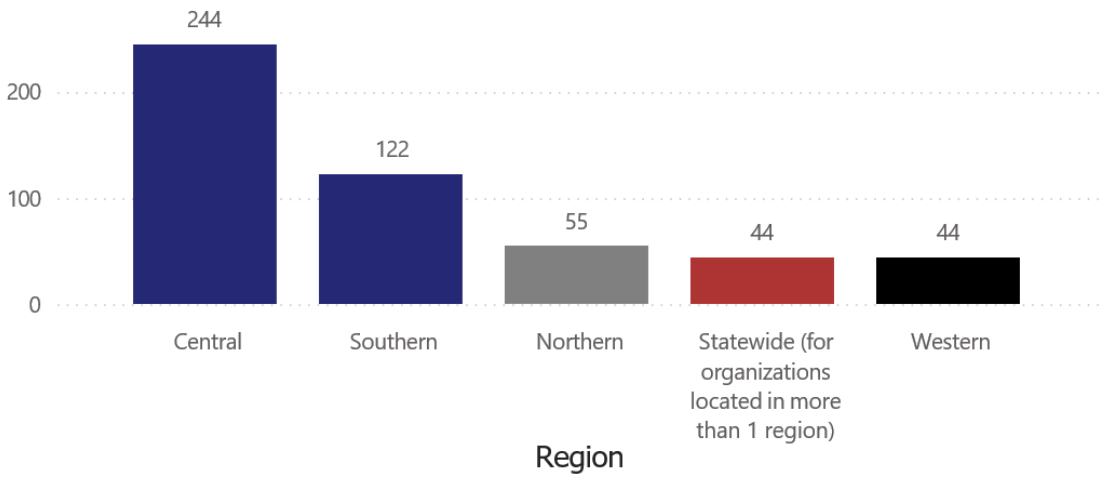
Facility Representation

To accurately reflect the scope of the assessment, the survey included the question, “How many facilities are you representing?” The results showed that 225 respondents represented a total of 509 facilities, demonstrating the broad impact and reach of the HVA/RGA process across Arizona’s healthcare system

Number of Facilities in Urban and Rural Service Areas

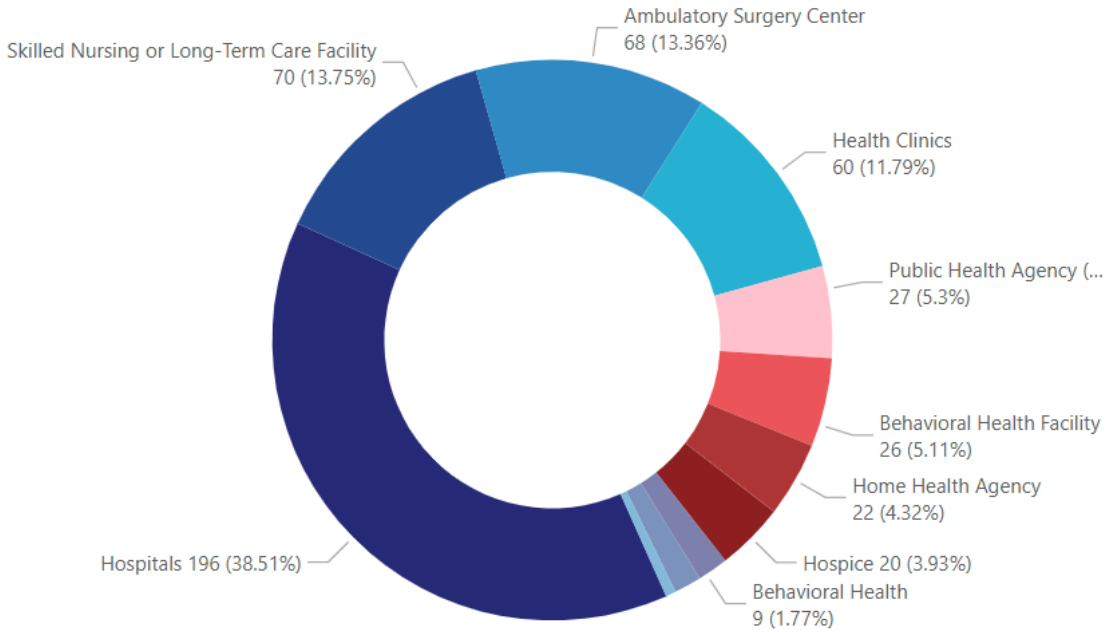
Rural facilities represented were primarily located in the Northern and Western regions, or Statewide (multiple regions)

Number of Facilities by Region



Number of Facilities by Healthcare Sector

Hospitals and long-term care accounted for over half of the facilities, with EMS and emergency management having the fewest number of facilities.



Statewide HVA Results

Hazards are ranked highest to lowest risk score, as determined by the responses from members. Higher scores indicate a higher level of risk of the given hazard.

Hazards chosen to be included in the survey were chosen by the HVA workgroup. As such, it is not a comprehensive assessment of all hazards, all members, or all disciplines and does not provide details regarding the unique attributes and risks for individual counties or facilities. The HVA is not a replacement for an organization- or facility-specific HVA. However, participating organizations may utilize their responses to the HVA for use in their facility's or organization's HVA.

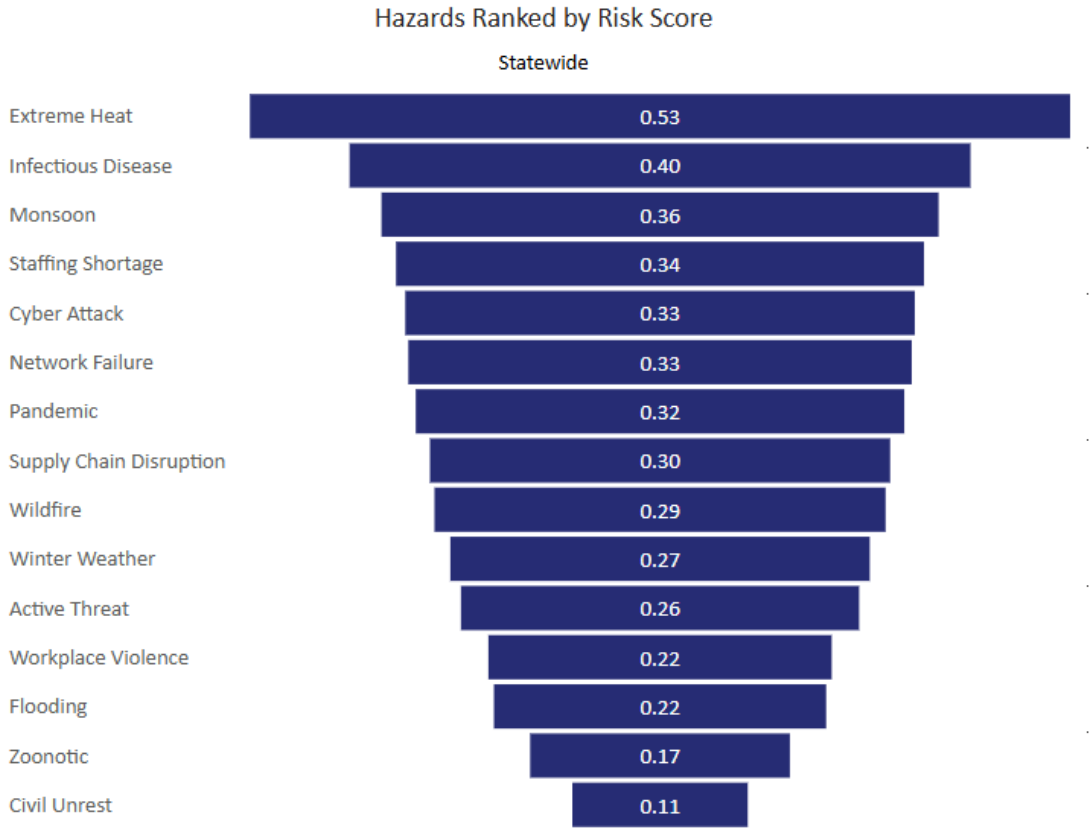
Definitions of Hazards

1. **Active Threat:** An active threat is a dangerous, ongoing incident in a populated area where an individual or individual is actively using deadly force against others, posing an immediate and imminent danger. While an active shooter is a common example, an active threat can also involve other weapons, like explosives or sharp objects, and requires a swift response from law enforcement to neutralize the danger.
2. **Civil Unrest:** Civil unrest encompasses disruptive public disturbances, often violent, stemming from political, social, or economic issues, including riots, demonstrations, strikes, and other forms of public disorder.
3. **Communications, Telephone, and Network Failure:** the complete or partial failure of a component or components in a network because of malfunction or natural or human-caused disasters.
4. **Cyber Attack:** any offensive maneuver that targets computer information systems, computer networks, infrastructures, personal computer devices, or smartphones.
5. **Extreme Heat:** a period of high heat with temperatures above 90 degrees for at least two to three days. Humans may struggle to compensate and regulate their core body temperature, leading to heat-related illnesses and potentially death. Cooling systems and power supply are also tested.
6. **Flooding:** Flooding occurs when a large amount of water overflows beyond its normal confines and may be a result of fire, monsoon, heavy rain, or mechanical/infrastructure failures.
7. **Infectious Disease:** An infectious disease is a condition caused by the invasion and multiplication of pathogenic microorganisms, such as bacteria, viruses, fungi, or parasites, in the body.
8. **Monsoon Weather:** a weather event unique to Arizona which may result in flashfloods, lightning storms, high winds, tornadoes, dust storms, haboobs, and other sudden, extreme weather changes during the summer months.
9. **Pandemic (coronavirus, influenza, etc.):** a pandemic is a disease outbreak that spans several countries and affects many people. Pandemics are most often caused by viruses, like Coronavirus Disease 2019 (COVID-19), which can easily spread from person to person.
10. **Staffing Shortage:** staffing shortage occurs when there is a lack of employees within an industry. Healthcare often sees staffing shortages for physicians and nurses.
11. **Supply Chain Failure:** temporary or permanent loss of a key supplier. This might be due to material shortages or increased taxation, or it might be due to a business continuity issue faced by the supplier, such as production problems and bankruptcy.
12. **Winter Weather:** snow, ice, and extreme cold events which may impact transportation, access to heating, and pose an increased risk to resource-constrained individuals.
13. **Wildfire:** Wildland fires which may cover a large area, threaten homes, hospitals, businesses and infrastructure. Wildland fires may also cause air pollution which may exacerbate allergies and those with respiratory illness.

14. **Workplace Violence:** any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. An active threat incident is a dynamic, quickly evolving situation involving an individual (or individuals) using deadly physical force, such as firearms, bladed weapons, or a vehicle. An active threat incident typically involves an individual (or individuals) presenting an immediate threat or imminent danger to people by displaying a weapon, having made threats, and/or shown intent to cause harm or perform violence.
15. **Zoonotic Disease:** A zoonotic disease is an infectious disease that can be transmitted between animals and humans. These diseases are caused by pathogens, such as bacteria, viruses, parasites, or fungi, that can infect both animal and human hosts.

Hazards Ranked by Risk Score

The average scores provided by respondents were used and categorized by region, sector, county, etc., as noted. The 2025 HVA included scores for both human and financial impact, so no weighted scores were used.

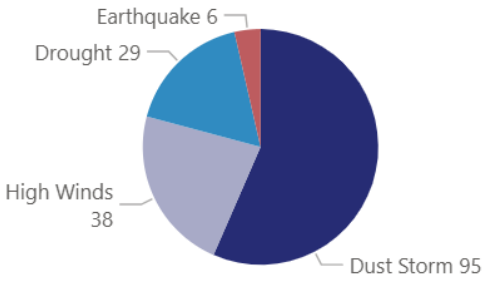


- Extreme heat continues to be the top hazard for the state of Arizona.
- Infectious disease is the second ranked hazard, followed by monsoon weather, staffing shortages, and cyber-attacks ranking in the top 5.
- Civil unrest is a newly identified hazard to include in the HVA and ranked the lowest.

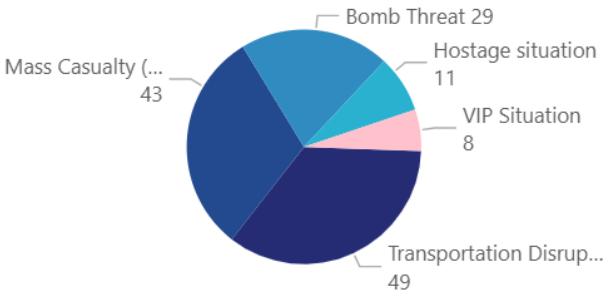
Additional Identified Hazards

While the HVA was developed with the input of various members, participants were asked to identify hazards considered to be a primary hazard but not included in the survey.

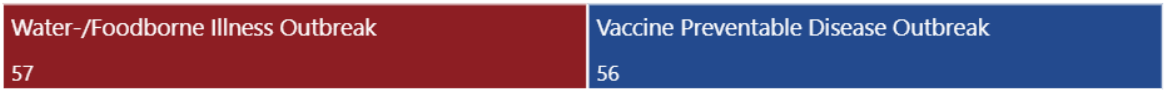
Are there any other naturally occurring hazards not mentioned which you would consider to be a top, primary hazard for your facility?



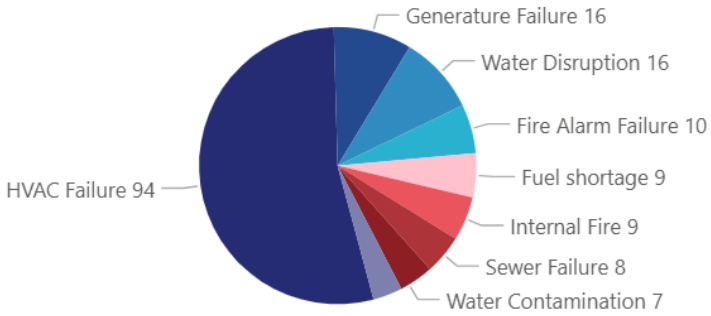
Are there any human caused event hazards not mentioned that you would consider to be a top, primary hazard for your facility?



Select any epidemic or pandemic events we may have missed which you would consider to be a top, primary hazard for your facility.



Are there any technological and utility events we missed that you consider to be a primary hazard for your facility?



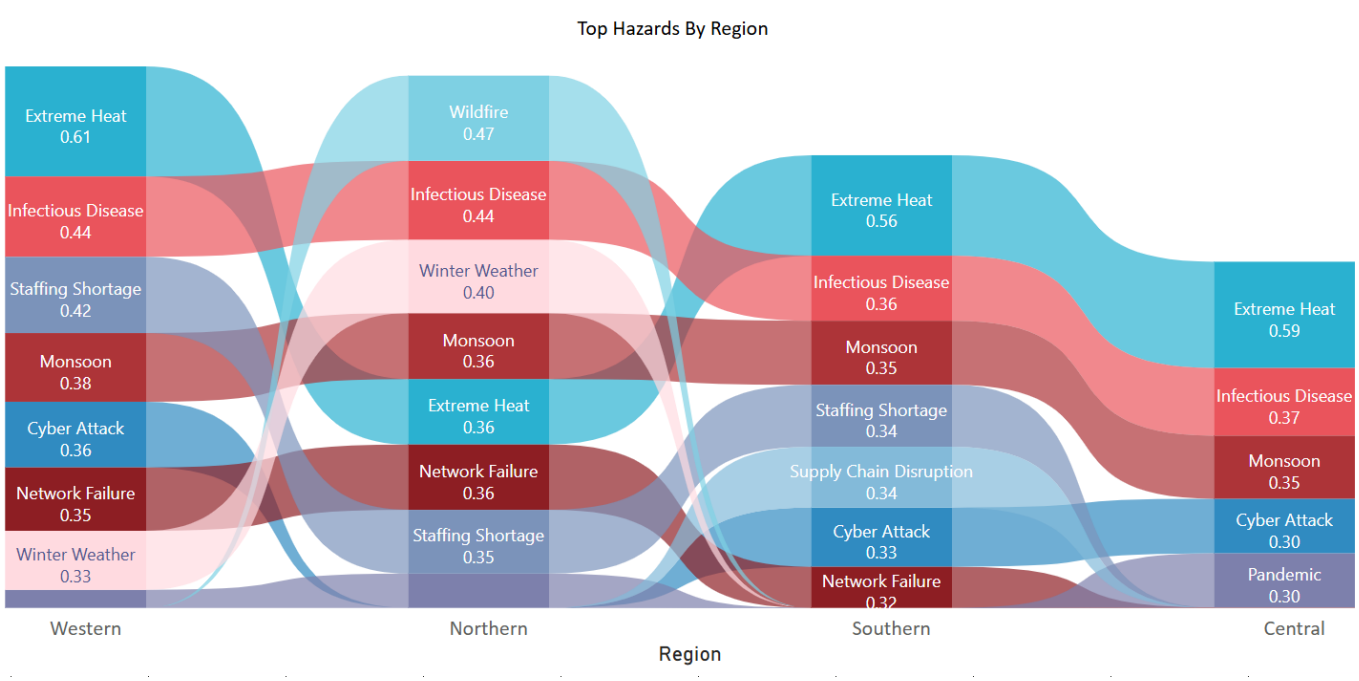
Select any hazardous material events we may have missed which you would consider to be a top, primary hazard for your facility.

Regional HVA Results

While statewide hazard vulnerability assessments (HVAs) identify key threats facing the State of Arizona, the most prominent hazards vary significantly by region. For example, monsoon weather events—characterized by flash floods, lightning, and dust storms—are most prevalent in central and southern Arizona. In contrast, winter weather hazards such as snow, ice, and extreme cold are more likely to impact northern Arizona, where transportation and heating access can be disrupted.

Wildfire risk is highest in regions with extensive wildland areas, especially in northern and western parts of the state, threatening homes, healthcare facilities, and air quality. Staffing shortages and supply chain failures tend to be statewide concerns but may be exacerbated in rural regions where healthcare resources are limited. Similarly, the risk of extreme heat is greater in southern Arizona, where sustained high temperatures challenge both public health and infrastructure. Cyber-attacks and workplace violence are persistent threats across all regions.

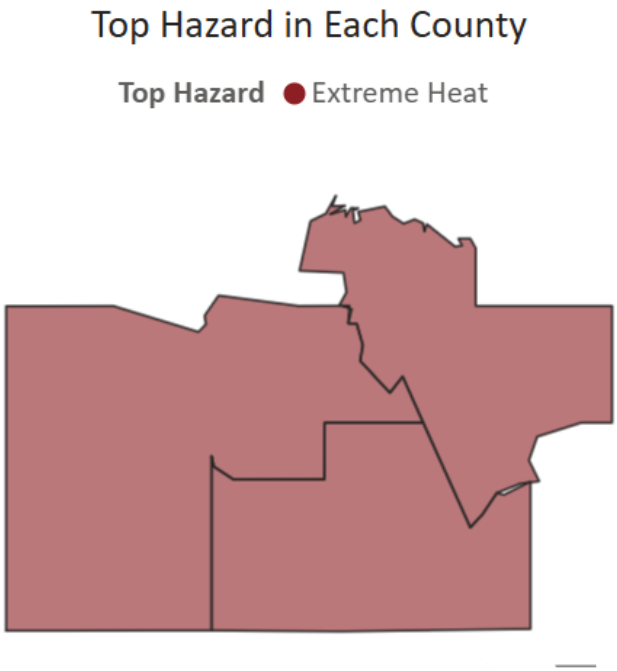
Top Hazards by Region

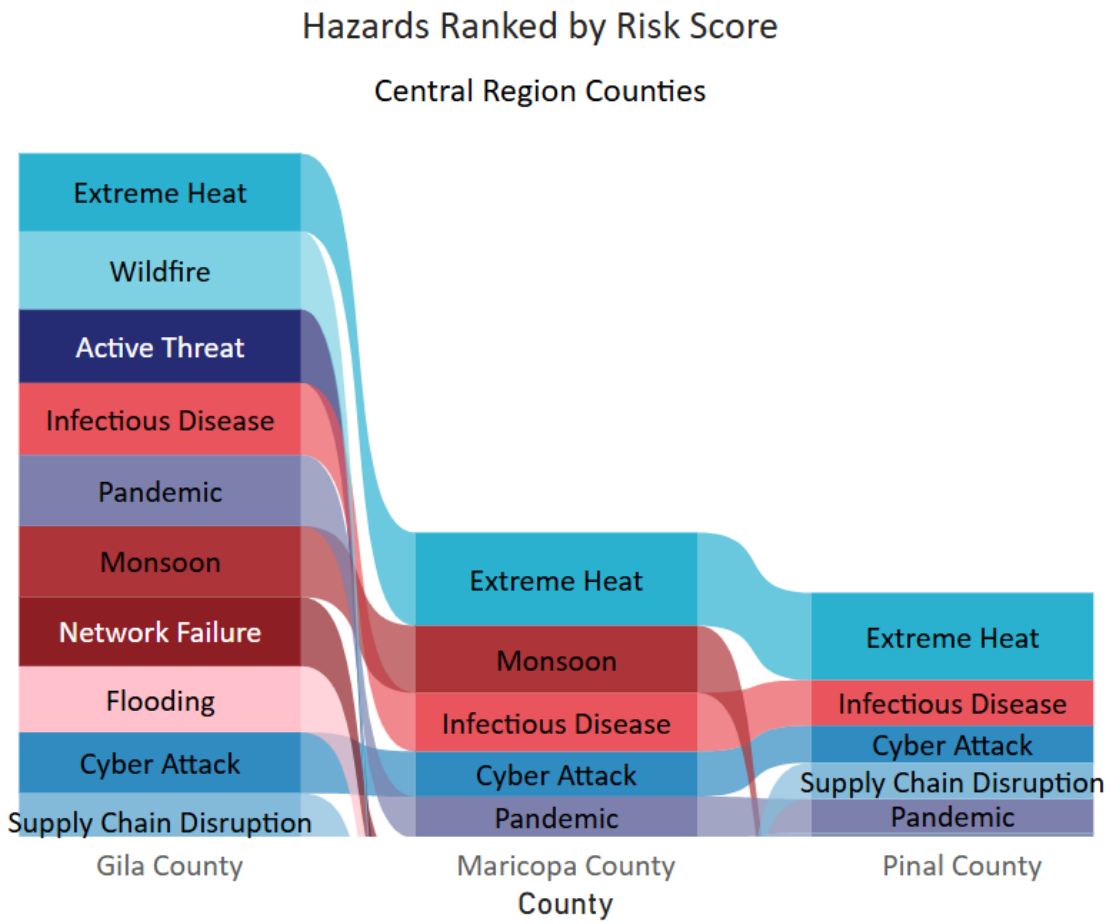


Hazards by County- Central Region

The Central region identified extreme heat as the top hazard across all counties, emphasizing its critical impact on this area. Risk score rankings show extreme heat consistently as the highest threat, followed by monsoon, infectious disease, and cyber-attack. Other notable risks include pandemic, supply chain disruption, network failure, and localized concerns like wildfire, active threat, and flooding in Gila County.

Central counties have a combination of severe climate-related hazards and infrastructure vulnerabilities, requiring comprehensive strategies to address heat mitigation, public health preparedness, and continuity of operations.

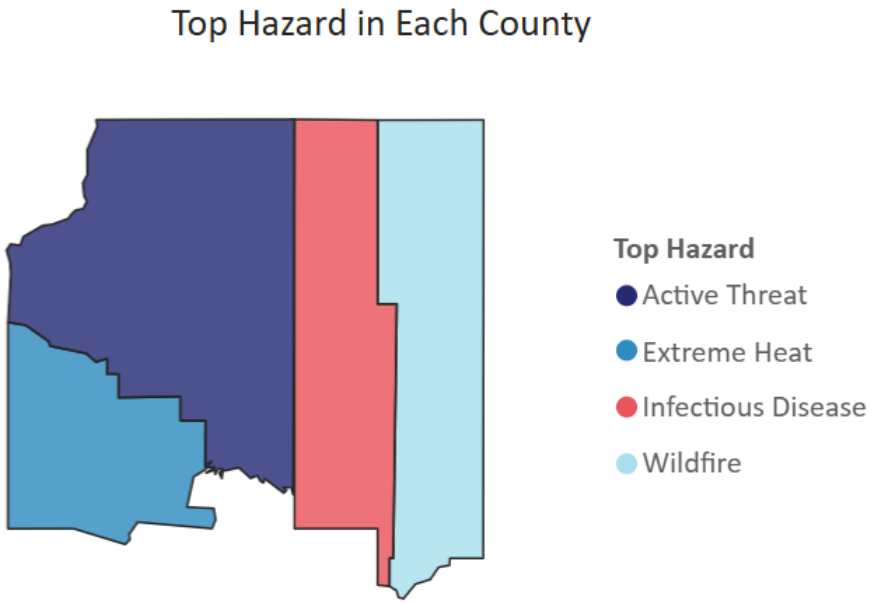


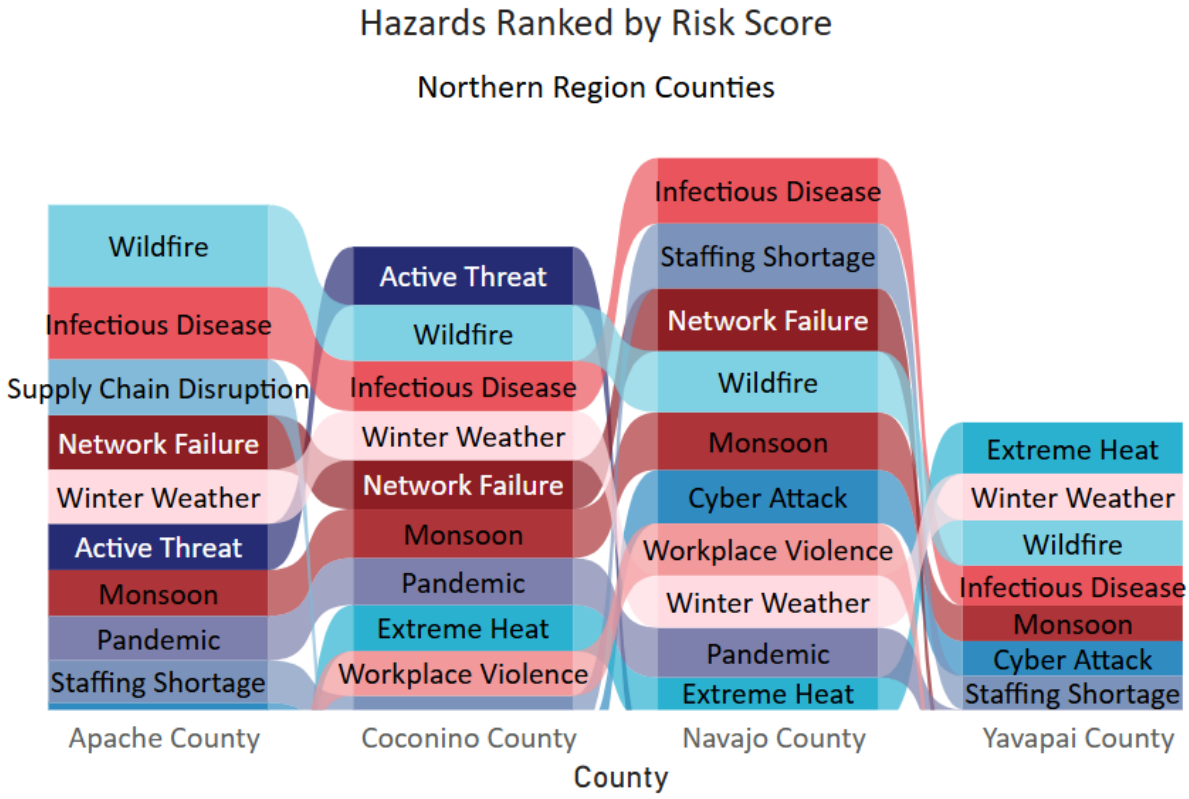


Hazards by County- Northern Region

The Northern region shows a more varied risk profile. Top hazards differ by county: wildfire in Apache, active threat in Coconino, infectious disease in Navajo, and extreme heat in Yavapai.

Risk score rankings highlight recurring threats such as wildfire, infectious disease, extreme heat, and active threat, alongside significant concerns like network failure, winter weather, monsoon, and cyber-attack. Operational vulnerabilities, including staffing shortages, supply chain disruptions, and workplace violence, also appear across counties. This diversity underscores the need for county-specific preparedness strategies addressing both environmental hazards and infrastructure resilience.

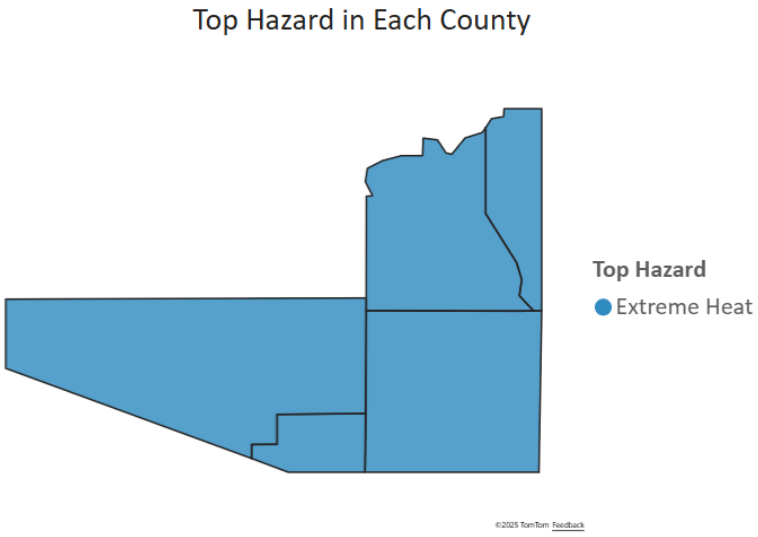


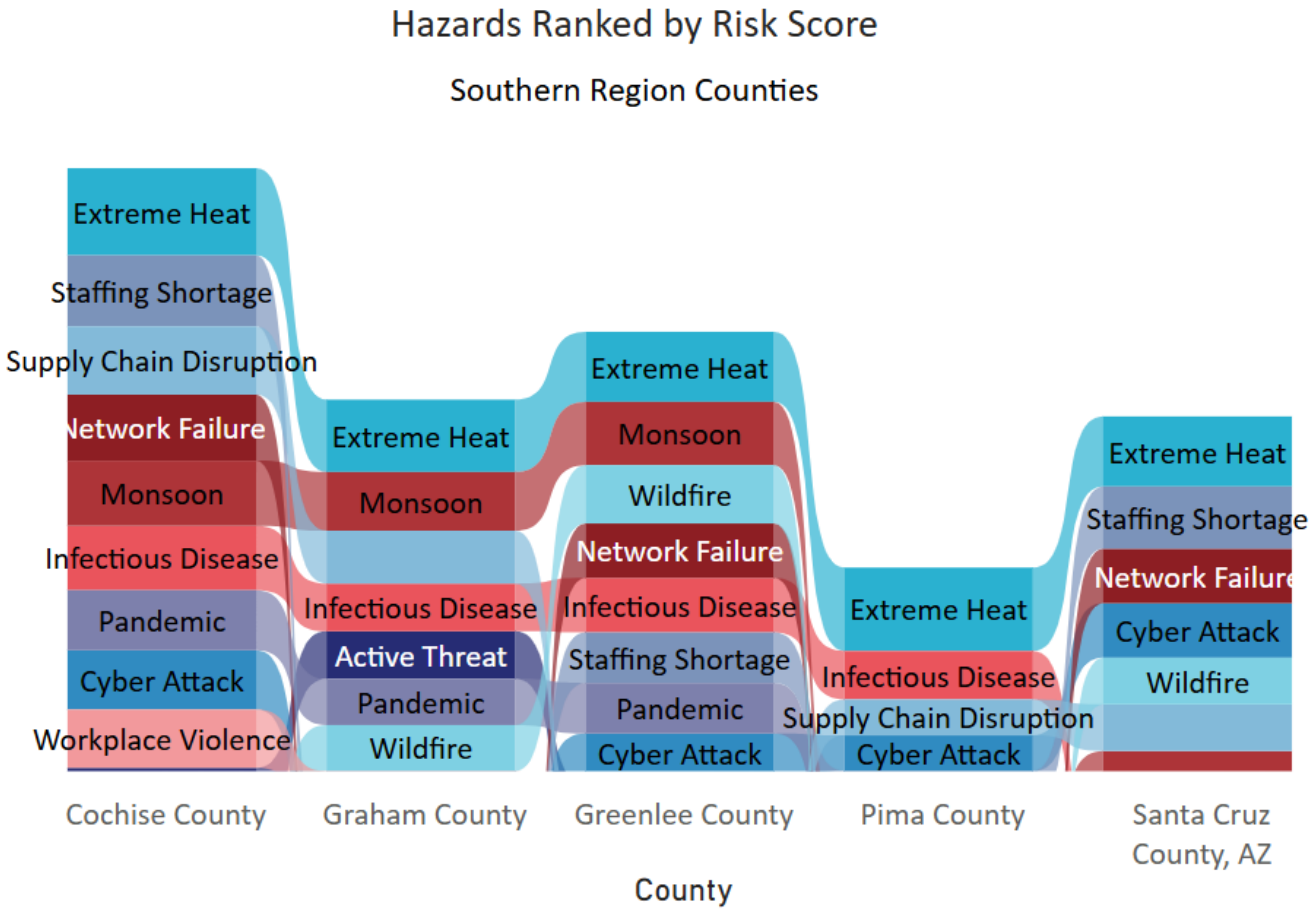


Hazards by County- Southern Region

The Southern region identified extreme heat as the top hazard across all counties, indicating a consistent and significant climate-related hazard. Extreme heat remains the highest priority in every county, followed by other critical threats such as network failure, infectious disease, cyber-attack, and wildfire, with variations by county. Additional concerns include staffing shortages, supply chain disruptions, and monsoon events, reflecting both environmental and operational vulnerabilities.

This pattern underscores the need for robust heat mitigation strategies while also addressing infrastructure resilience and public health preparedness.



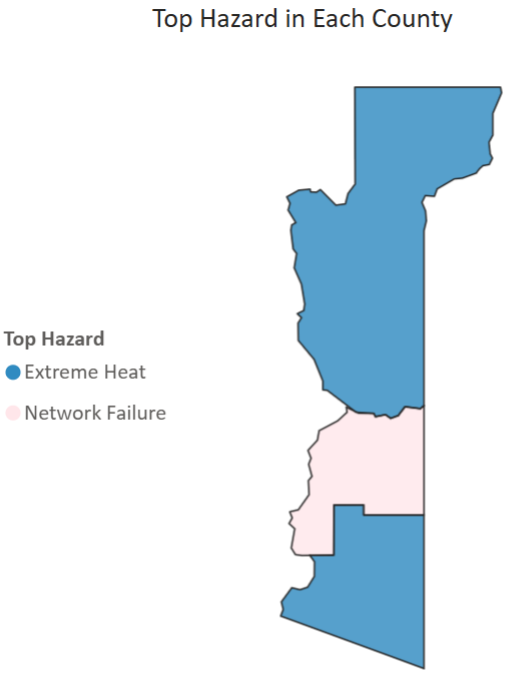


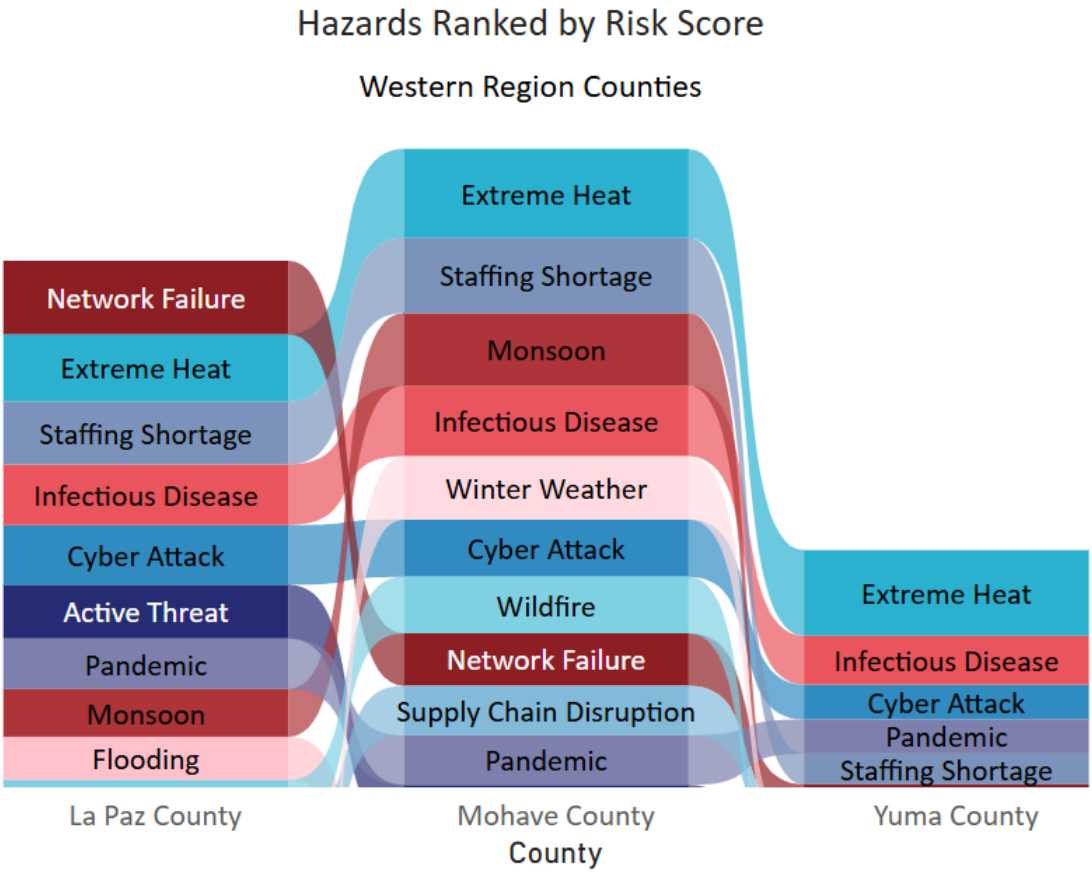
Hazards by County- Western Region

The Western region identified extreme heat as the top hazard for Yuma and Mohave Counties, with network failure emerging as the leading risk in La Paz County.

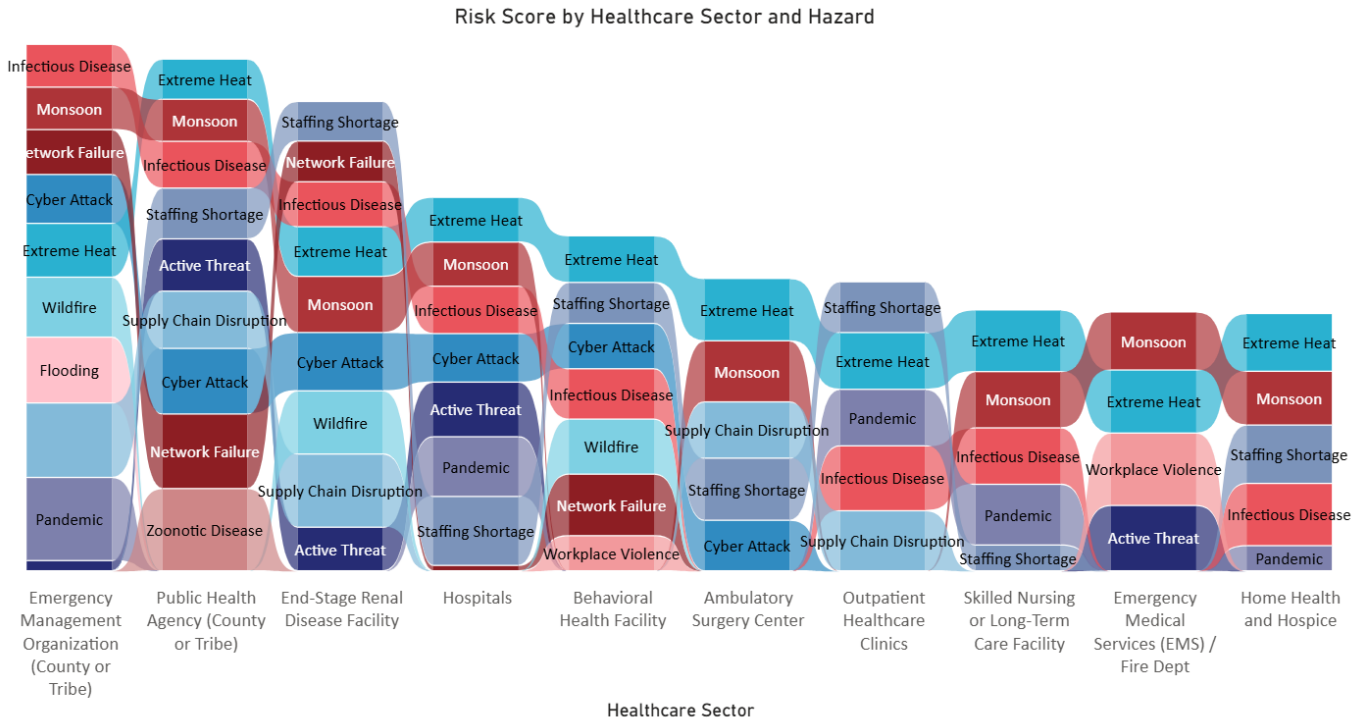
Risk score rankings show extreme heat as a dominant concern across the region, followed by hazards such as staffing shortages, monsoon, and infectious disease. Other significant threats include cyber-attack, pandemic, and winter weather, with localized risks like wildfire, active threats, and flooding appearing in La Paz and Mohave counties.

This mix of climate-related, technological, and operational vulnerabilities highlights the need for integrated preparedness strategies focusing on heat mitigation, infrastructure resilience, and continuity of essential services.





Hazards by Healthcare Sector



Identified top hazards, and how they were scored, varied depending on healthcare sector.

Notable highlights how hazards vary by healthcare sector:

- Emergency management and public health agencies consistently scored hazards higher than hospitals, behavioral health, outpatient clinics, long-term care, EMS, and home health facilities.
- Extreme heat remains a priority hazard for all sectors, reflecting the vulnerability of both patients and infrastructure to heat-related incidents.
- Many sectors learned valuable lessons from the COVID-19 pandemic, and infectious disease ranks among the top hazards for hospitals, skilled nursing/long-term care, outpatient clinics, public health agencies, and EMS.
- Cyber Attack has increased in rank and is a leading hazard for hospitals, behavioral health, and emergency management.
- Network failure is a top hazard for EMS, public health, and hospitals, reflecting the dependence on IT systems for communication and operations. Backup systems, redundancy, and regular testing are needed to ensure continuity during outages.
- Staffing shortages are a top hazard for hospitals, long-term care, EMS, and public health agencies. Workforce gaps threaten the ability to maintain essential services during emergencies. Recruitment, retention, and surge staffing plans are critical.
- Emergency Medical Services (EMS) and fire agencies reported workplace violence as a higher priority

hazard than all other sectors.

Focus on Extreme Heat

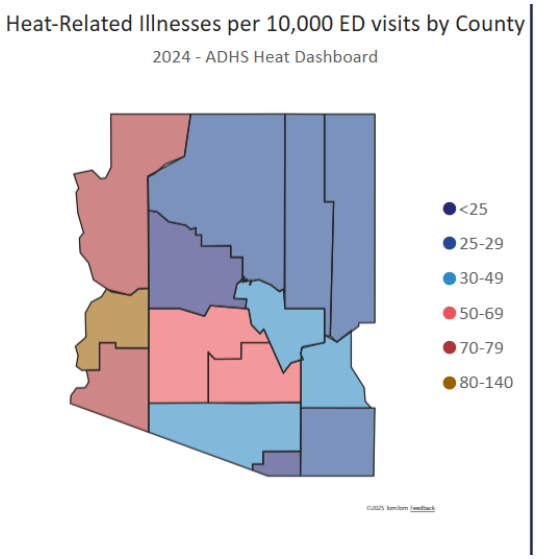
Extreme heat continues to represent the most significant hazard impacting Arizona's healthcare system. Consistently ranked as the top threat across all regions and healthcare sectors, extreme heat presents substantial risks to both patient health and facility operations. The prevalence of heat-related illnesses, coupled with increased strain on infrastructure and essential services, underscores the critical need for comprehensive mitigation and preparedness strategies.

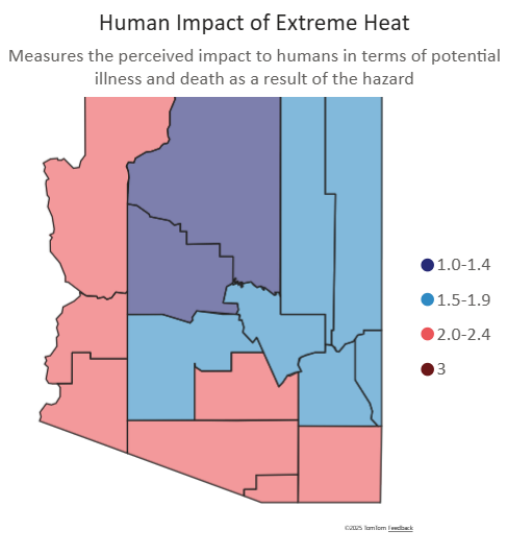
Respondents scored extreme heat with a 51% risk score, including a high score of occurrence probability.

Occurrence Probability of Extreme Heat	2.68
Financial Impact of Extreme Heat	1.72
Human Impact of Extreme Heat	1.86
Preparedness Level for Extreme Heat	1.57
Response Capacity for Extreme Heat	1.57
Extreme Heat Risk Score - Percentage	50.89%

Below, the map on the left shows the number of heat-related illnesses per 10,000 ED visits by county in 2024. Some counties, particularly in the southwest and south-central regions, report the highest rates (70–140 per 10,000), while others, especially in the north and east, have much lower rates (<25 per 10,000). The map on the right reflects how respondents in each county rated the potential human impact of extreme heat, using a scale from 1.0 (lowest) to 3 (highest). Notably, some counties with high actual ED visit rates only rated the perceived impact as moderate, while some counties with lower ED visit rates rated the perceived impact as high.

Perceptions of extreme heat risk may not match emergency department data—either underestimating or overestimating the hazard. Ongoing education and better data sharing are needed to align perceptions with actual health impacts and guide preparedness where it's most needed.

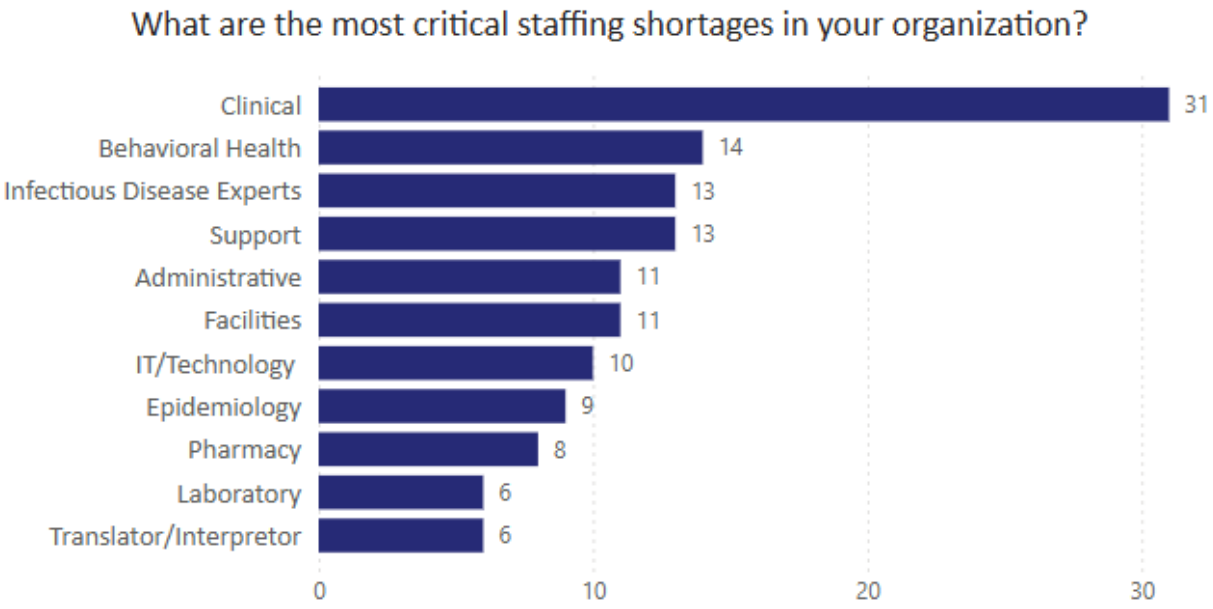


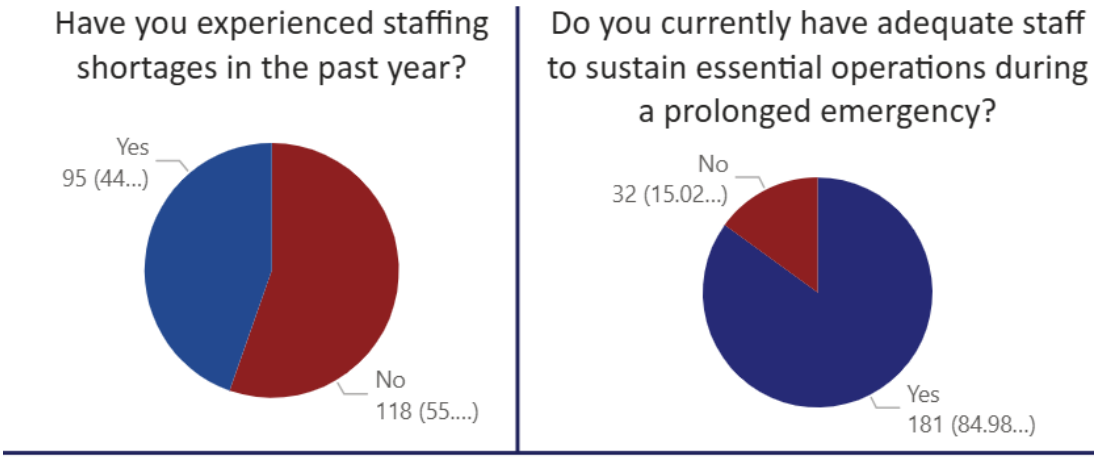


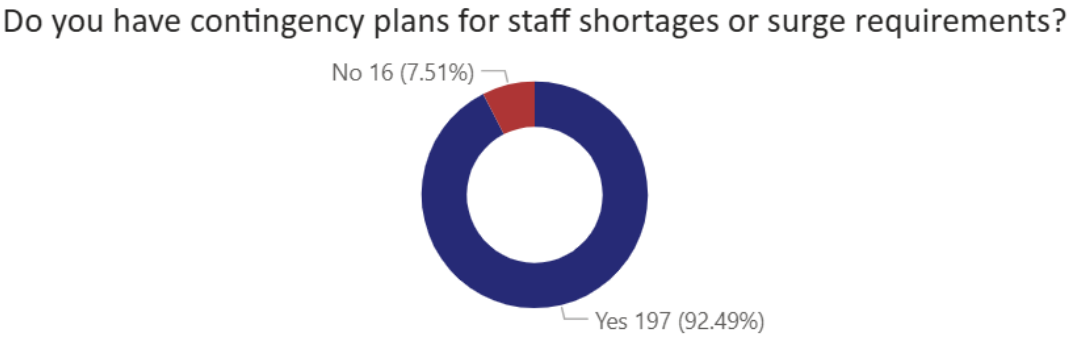
Statewide RGA Results

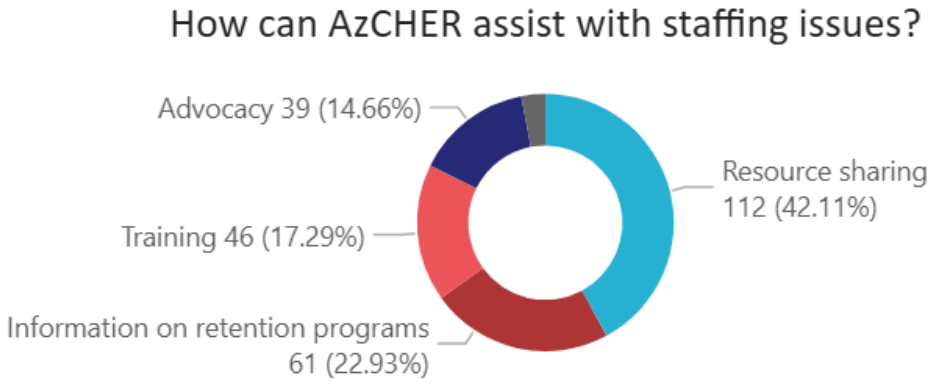
Staffing and Personnel

Staffing and personnel capacity remain foundational to healthcare system resilience across Arizona. Survey findings indicate that many organizations continue to experience critical shortages in clinical, behavioral health, and support roles, with high turnover and limited applicant pools compounding these challenges. While most respondents report having contingency plans for staffing shortages or surge requirements, a notable proportion do not, highlighting ongoing vulnerabilities in sustaining essential operations during prolonged emergencies. Addressing these gaps through targeted recruitment, retention strategies, and workforce development will be essential to ensuring continuity of care and effective emergency response statewide.





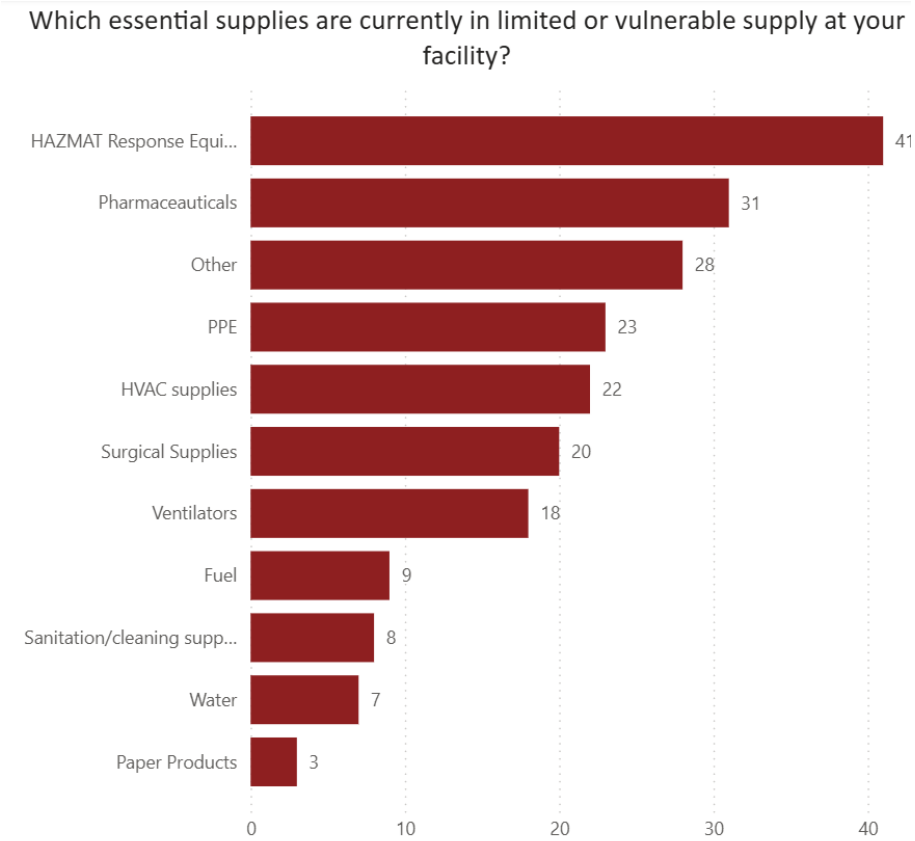




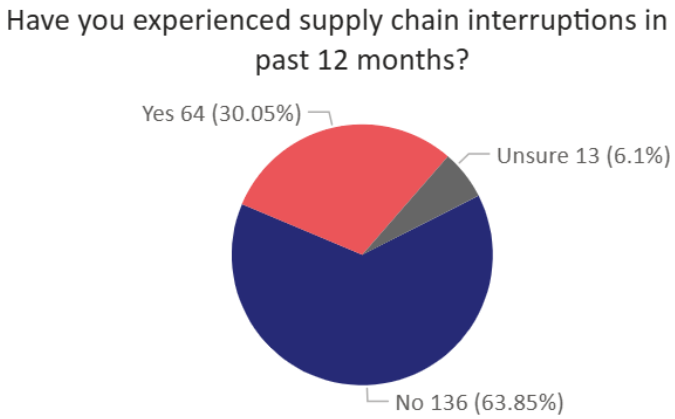
Members were asked to identify the primary ways AzCHER can assist with staffing issues. Resource sharing emerged as the most frequently cited need, representing 42.11% of responses, underscoring the importance of coalition-based support and mutual aid during staffing shortages or surges. Information on retention programs (22.93%) and training opportunities (17.29%) were also identified as key areas where AzCHER can provide value, reflecting ongoing challenges in workforce development and retention across the healthcare system. Advocacy (14.66%) was noted as an additional area where AzCHER's efforts can help address systemic staffing concerns.

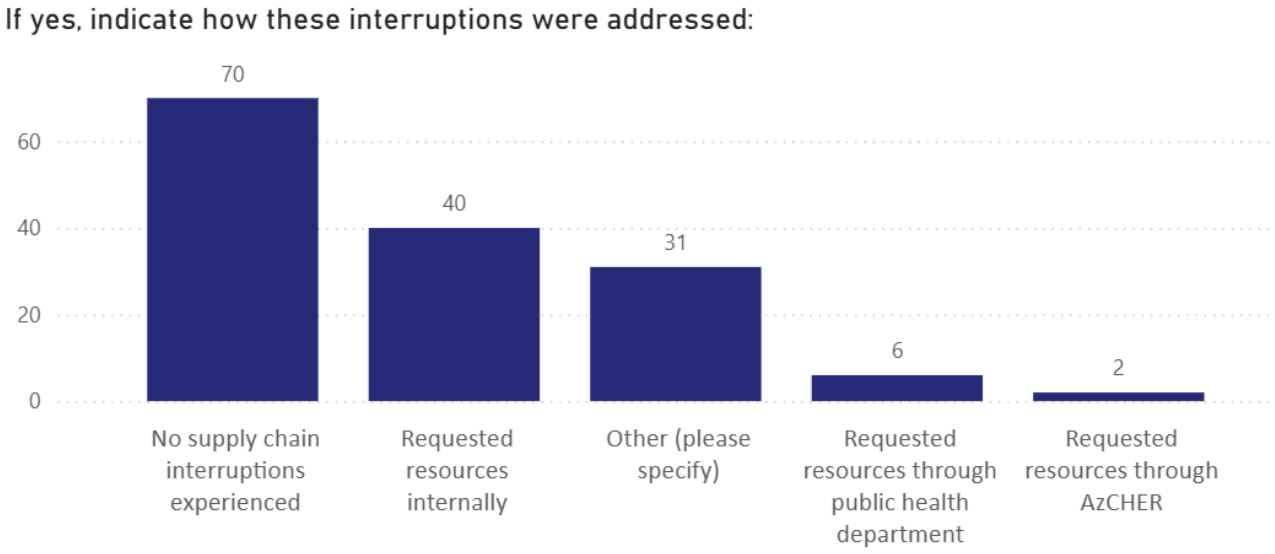
Medical and Non-Medical Supplies

Medical and non-medical supplies remain a critical focus area for healthcare preparedness and response efforts statewide. Survey results indicate that many organizations continue to experience vulnerabilities in the availability of essential supplies, including pharmaceuticals, PPE, HAZMAT response equipment, HVAC components, and other key resources. Supply chain interruptions over the past year have further highlighted the need for robust procurement strategies and resource-sharing mechanisms. Ensuring consistent access to both medical and non-medical supplies is essential to maintaining continuity of care and supporting effective emergency operations across Arizona's healthcare system.



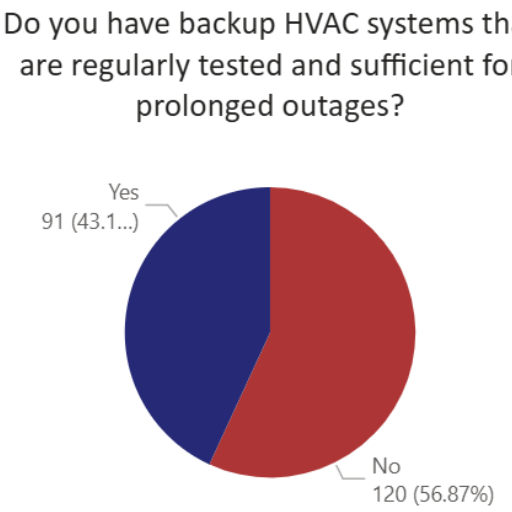
Nearly one-third of respondents reported experiencing interruptions in the availability of essential medical and non-medical supplies over the past year. Organizations addressed disruptions through a variety of strategies, including requesting resources internally, leveraging public and coalition-based resource requests, and seeking support through AzCHER channels. These adaptive approaches underscore the importance of robust supply chain management and the value of coordinated resource sharing to maintain continuity of operations during periods of shortage or delay.

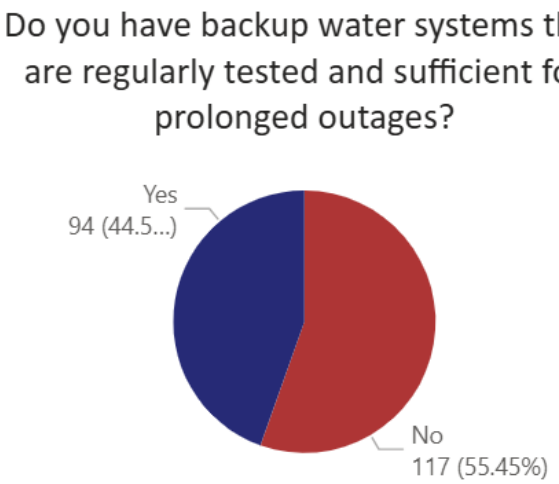


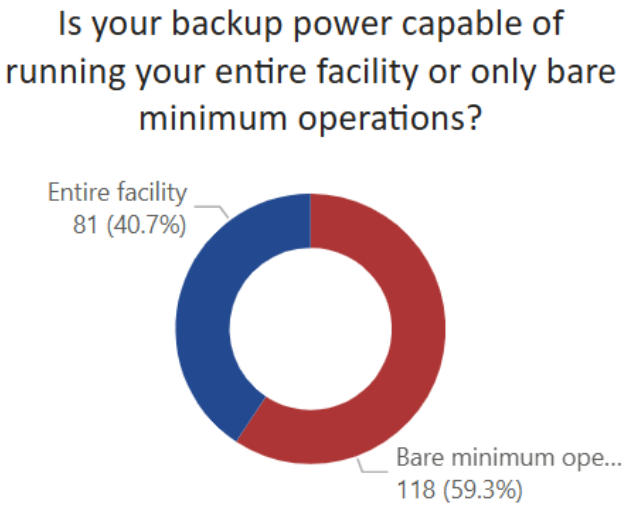


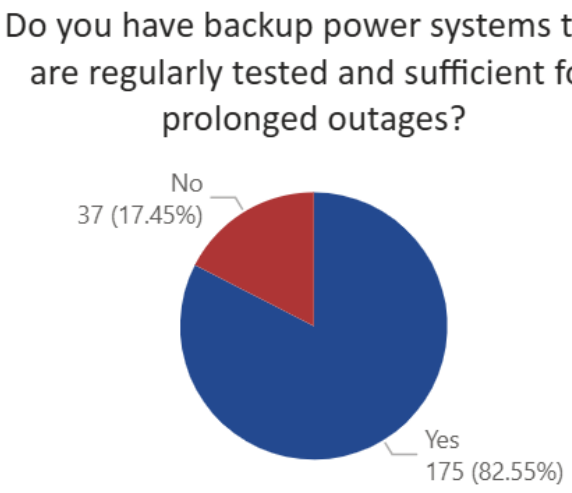
Facilities and Infrastructure

Facilities and infrastructure resilience planning are a primary need for healthcare organizations. While many organizations have strengthened their physical assets, notable gaps persist in the availability and reliability of critical systems. A significant proportion of facilities report lacking regularly tested backup water and HVAC systems, and a smaller, but important segment, do not have backup power capable of supporting full operations during outages. These vulnerabilities highlight the ongoing need for investment in infrastructure upgrades, regular testing of backup systems, and comprehensive continuity planning to ensure healthcare organizations can maintain essential services during emergencies.





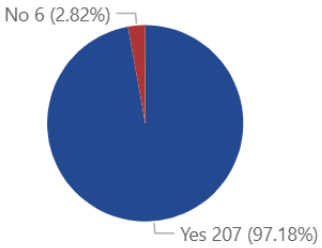




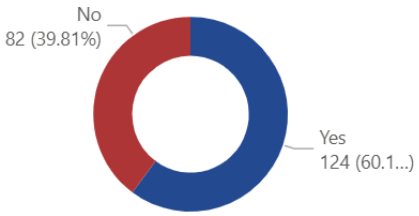
Communications & Information Sharing

While most organizations report the ability to communicate effectively with staff, patients, the public, and coalition partners during a crisis, notable gaps remain. A significant proportion of facilities do not utilize 800mHz radios or lack regular testing and training on these systems, and nearly 40% do not have a Mass Casualty Incident (MCI) alert system in place. These gaps highlight the ongoing need for investment in reliable communication infrastructure, regular training, and the adoption of standardized alerting processes to ensure timely and coordinated response during emergencies.

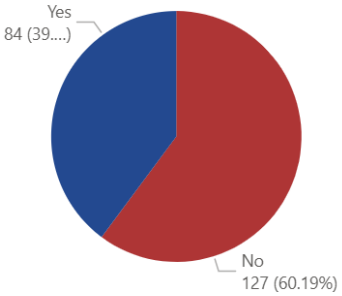
Are you able to communicate effectively with staff, patients, the public, and coalition partners during a crisis?



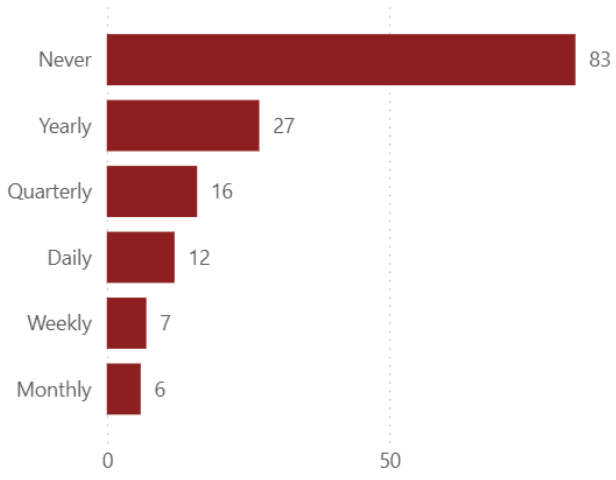
Does your facility have a Mass Casualty Incident (MCI) alert system or process in place for notification of critical incidents?



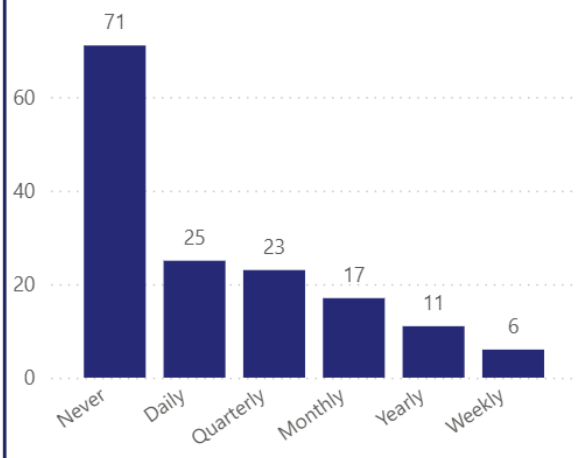
Does your facility utilize 800mHz radios?



How often are the 800mHz radios trained on?



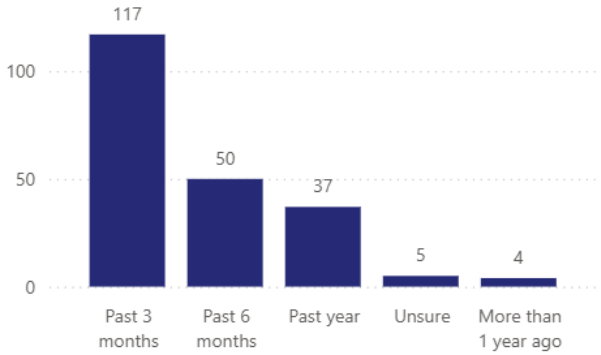
How often are the 800mHz radios tested?



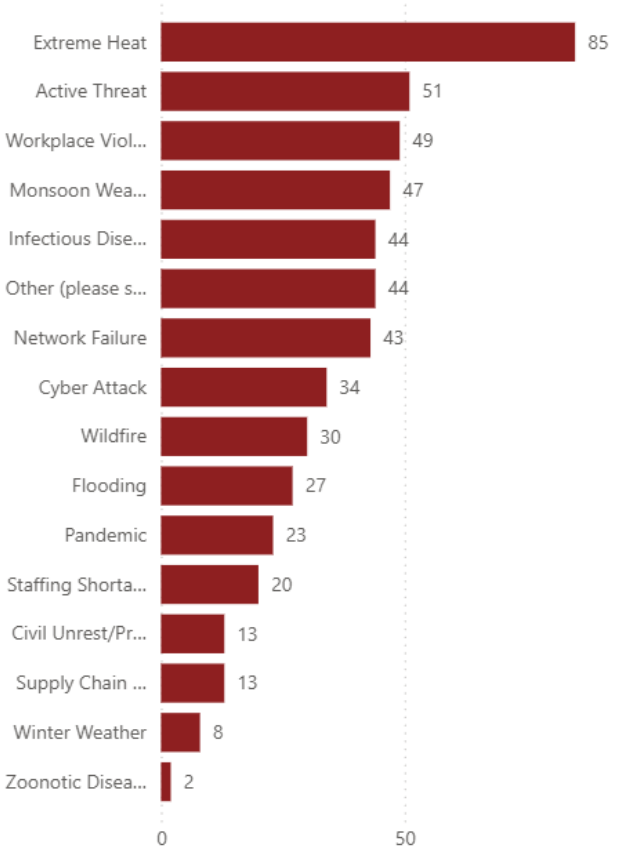
Training, Exercises, and Competency

Organizations throughout AzCHER have established training and exercise programs, with a strong emphasis on hazard-specific preparedness, communication, and active threat response. Most respondents maintain documented after-action reports and improvement plans, supporting a culture of continuous learning and improvement. However, some organizations have not conducted recent training or lack comprehensive documentation, highlighting opportunities to further strengthen workforce competency and readiness.

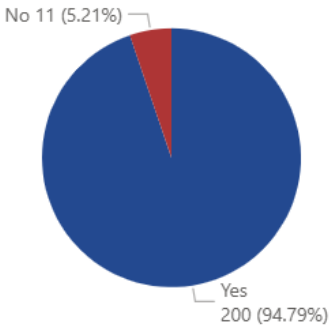
When was your organization's last emergency preparedness training or exercise?



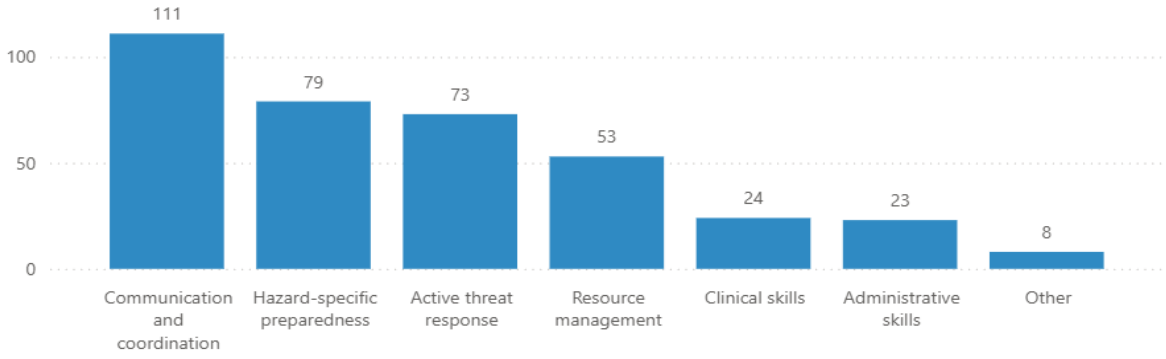
Hazard(s) that your organization trained or practiced for during the last exercise.



Does your organization have documented after-action reports and improvement plans for trainings/exercises?



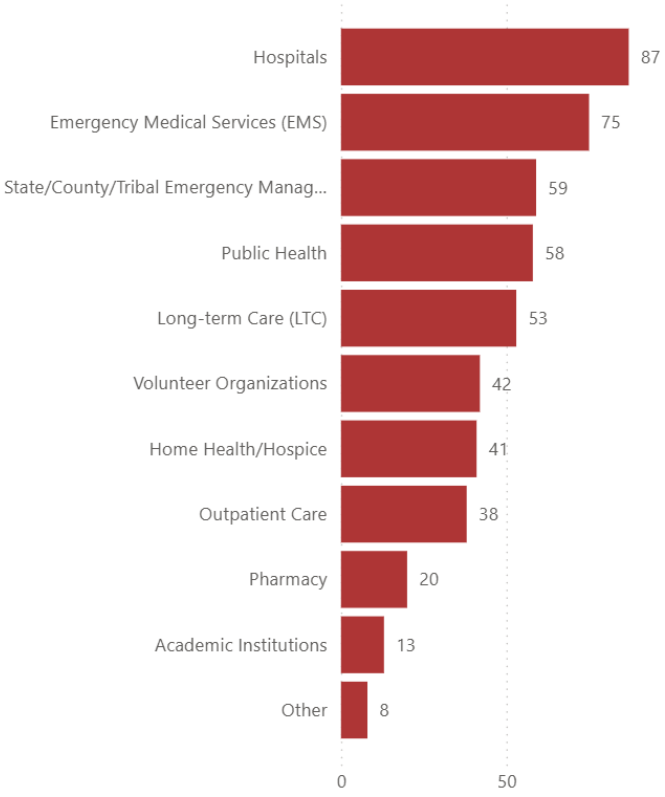
What training topics or skills need greater emphasis for 2025/2026?



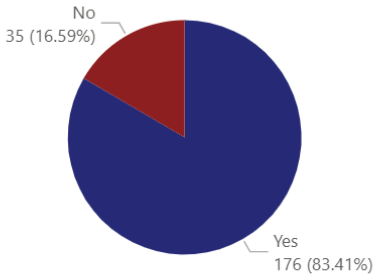
Partnership and Resource Sharing

Most organizations have mutual aid agreements or MOUs with partner agencies for coordinated emergency resource access. Keeping these agreements updated and tested is vital for readiness. Hospitals, EMS, emergency management, and public health agencies are priority partners for future collaboration, highlighting the importance of cross-sector relationships in system resilience. Ongoing partnership development and resource sharing will enhance Arizona's healthcare system's ability to meet evolving threats.

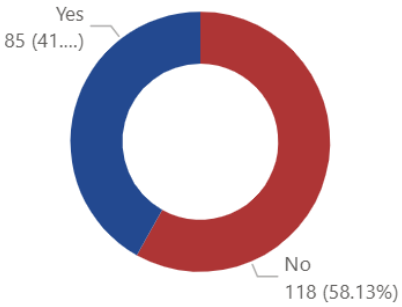
Which sector types would you prioritize for new partnerships or collaborations?



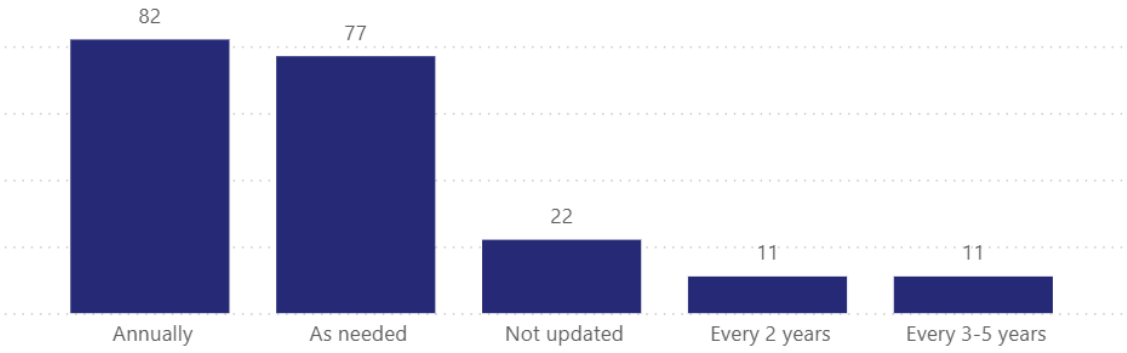
Do you have mutual aid agreements or memorandums of understanding (MOUs) in place with other organizations?



Have any of your mutual aid agreements or MOUs been tested or activated in the past year?

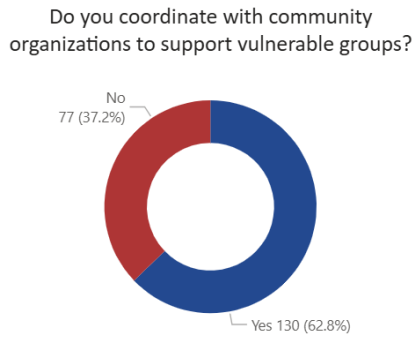


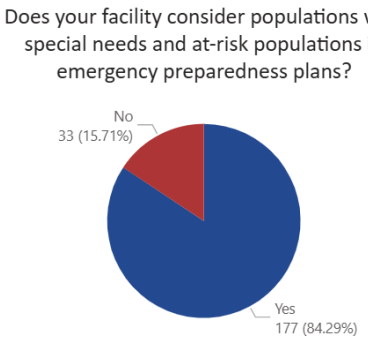
How often do you update your mutual aid agreements or MOUs?

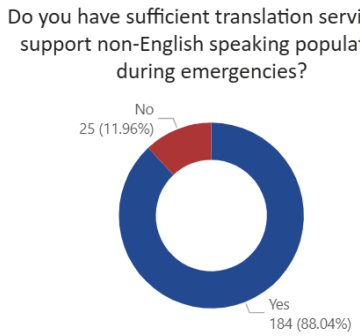


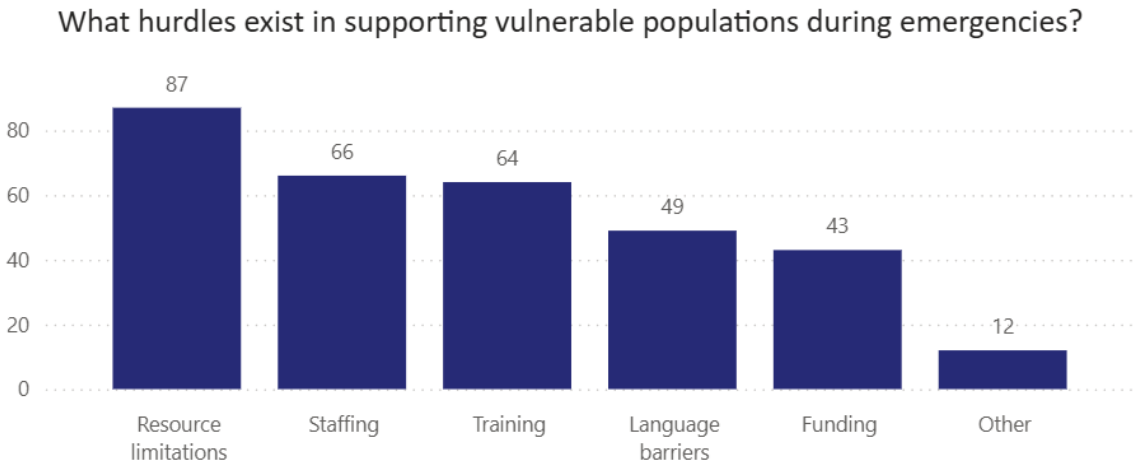
Populations with Increased Risk

Supporting higher-risk populations is a priority for healthcare preparedness and response efforts statewide. Most member organizations incorporate special needs and at-risk populations into emergency plans, but there are notable gaps in resource availability and service delivery. Respondents identified resource limitations, staffing, training, language barriers, and funding as key hurdles to providing effective support during emergencies. Coordination with community organizations and access to translation services are essential to meeting the needs of non-English speaking populations and ensuring equitable preparedness. Continued investment in targeted resources and collaborative partnerships will strengthen the capacity of healthcare organizations to provide services to groups with increased risk during times of crisis.



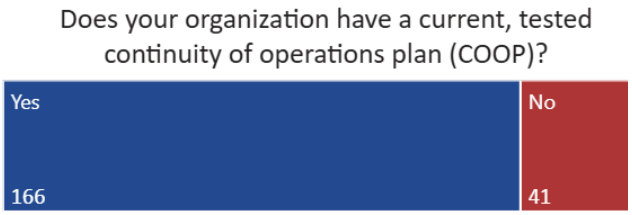


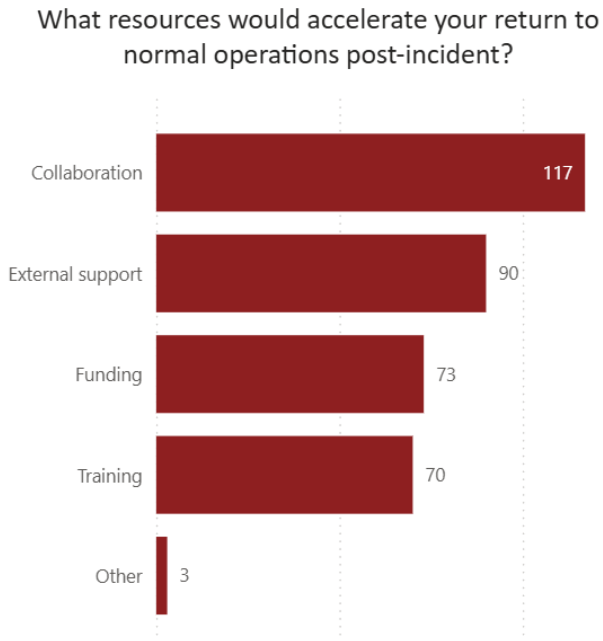


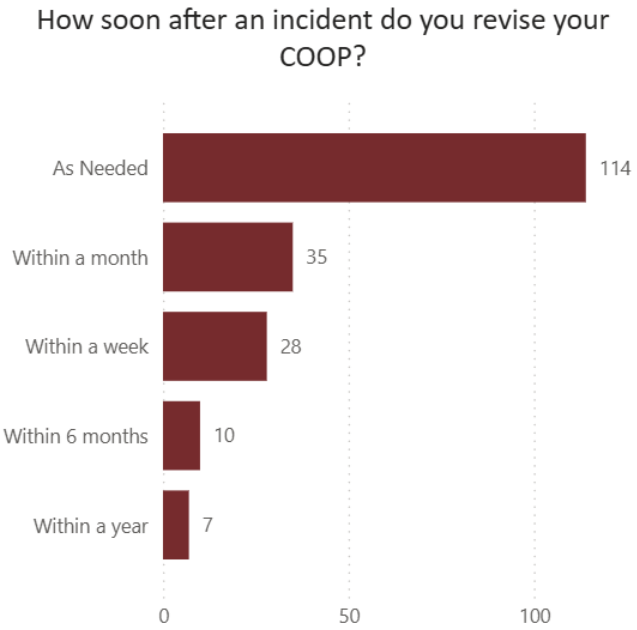


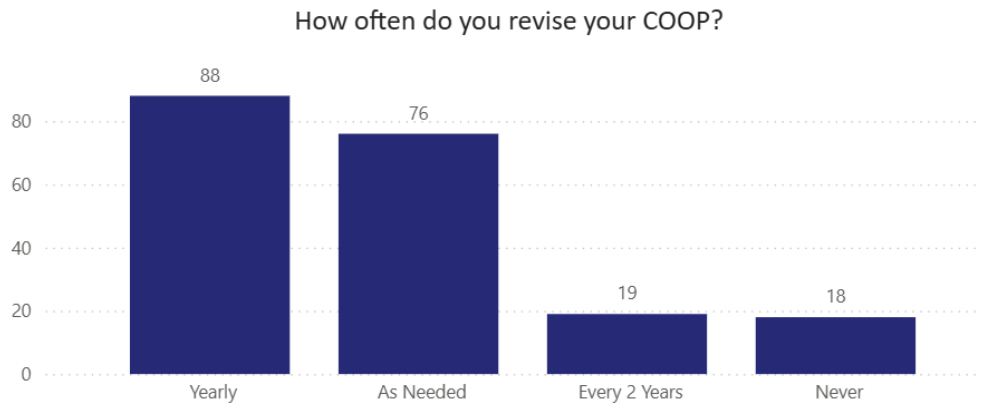
Recovery and Continuity Planning

Continuity and recovery planning are essential components of healthcare system resilience across Arizona. A majority of members maintain current continuity of operations plans (COOPs), but gaps remain in regular testing and timely revision following incidents. Respondents identified collaboration, external support, funding, and training as critical resources to accelerate return to normal operations post-incident. Ensuring that COOPs are routinely updated and integrated into organizational preparedness efforts will strengthen the ability of healthcare organizations to maintain essential services and recover effectively from emergencies.



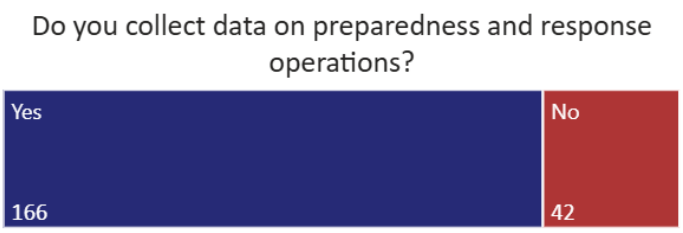


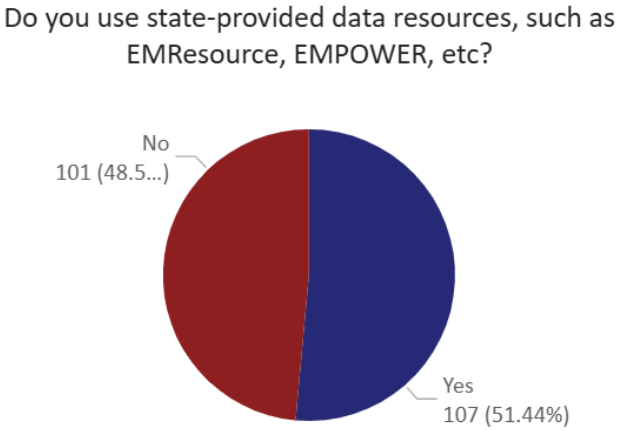


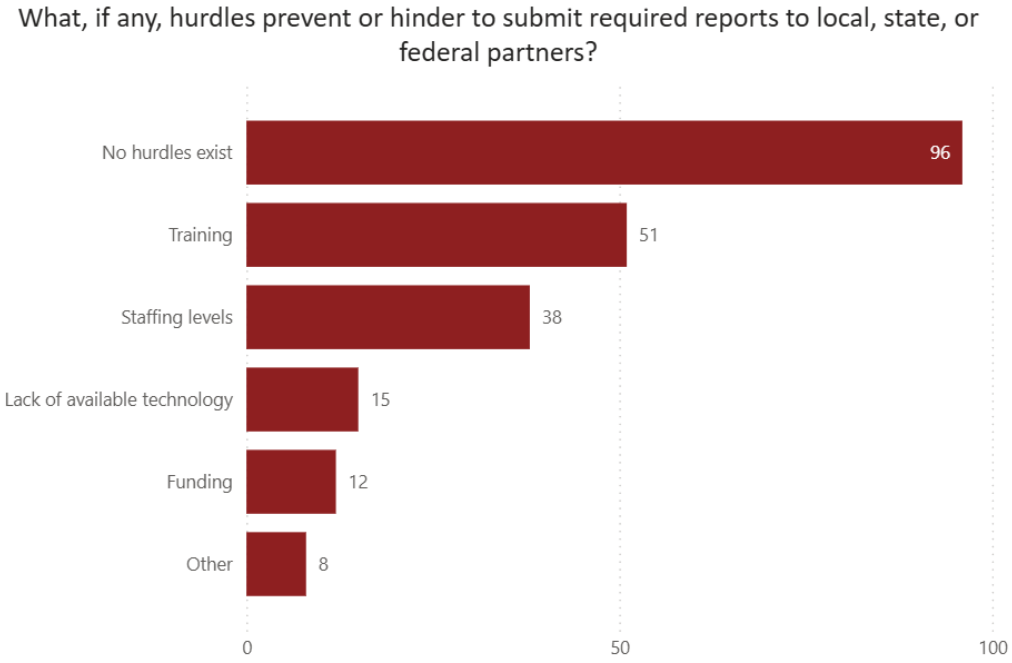


Data Collection and Reporting

Data collection and reporting inform preparedness and response planning across Arizona's healthcare system. While a majority of members collect data on preparedness and response operations, barriers remain in submitting required reports to local, state, and federal partners. Respondents identified training, staffing levels, technology limitations, and funding as key challenges to timely and accurate reporting. Nearly half of organizations do not utilize state-provided data resources, such as EMResource and EMPOWER, highlighting opportunities to strengthen data integration and utilization. Continued focus in data systems and workforce training will support more effective information sharing and enhance statewide situational awareness during emergencies.



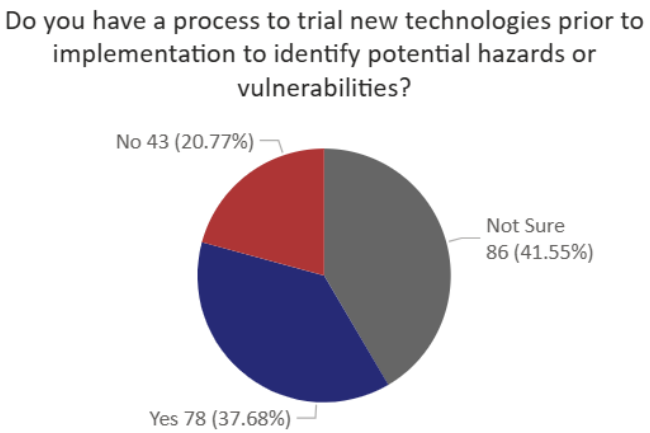


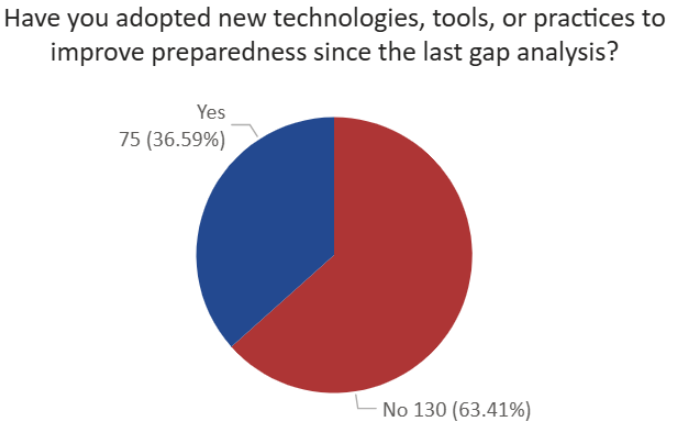


Innovation and Future Planning

With hazards continuing to progress in nature, innovation drives the future planning of healthcare preparedness across Arizona. Many organizations are adopting new technologies or strategies, and there is a need for funding, staff, and equipment to continue the adoption of new technological resources. There is growing recognition of the value of innovation in enhancing resilience. Less than half of respondents report having a formal process to trial new technologies prior to implementation, highlighting an opportunity for more structured evaluation of emerging tools.

Participants were asked what incidents, events, or hazards have impacted their outlook and future planning strategies. Organizations identified cybersecurity and technology risks, persistent workforce and staffing challenges, supply chain vulnerabilities, and climate-related hazards as top priorities for future planning. There is growing emphasis on supporting populations with increased risk, strengthening crisis communication, and maintaining pandemic readiness. Recent incidents—including the COVID-19 pandemic, extreme weather events, wildfires, cyber-attacks, workplace violence, and supply chain disruptions—have directly informed updates to emergency operations plans, infrastructure investments, and training protocols. Opportunities for future planning center on expanding collaboration and partnerships, adopting innovative technologies, and enhancing process improvement. Collectively, this feedback highlights the importance of continuous learning, cross-sector coordination and collaboration, and proactive adaptation to emerging threats to ensure Arizona's healthcare system remains resilient in the face of evolving threats and challenges.





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Glossary

Access and Functional Needs Plan or Appendix	***This plan defines populations in the community at risk of potential access/care based on emPOWER and other databases, demographic information, coordination with renal and other patient networks, liaison with cultural and advocacy groups, and defining challenges.***
Active Shooter/Armed Assailant/Active Threat Plan	This plan documents integration with law enforcement during a response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.
Alerting /Notification Plan	This plan describes alert and notification of the following during an incident for public safety and private sector-based systems: 911 PSAP/dispatch centers, area hospitals, and EMS supervisors/management/ medical direction staff. Should include any indicators/triggers for activation of MCI plan.
ALS Ambulance	Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention. They may include scheduled and 911 assets, critical care transport, scheduled assets, reserve rigs, specialized units (pediatric, bariatric, isolation, etc.).
Alternate Care Systems/Site	In the event of a disaster or public health emergency, Alternate Care Sites (ACS) may be created to enable healthcare providers to provide medical care for injured or sick patients or continue care for chronic conditions in non-traditional environments. It can include telephonic/telemedicine, screening/early treatment, and non-ambulatory care - EM and hospitals will have contributing responsibilities.
Alternate Care Systems/Sites Plan	An ACS plan that includes telephonic/telemedicine, screening/early treatment, and non-ambulatory care – EM and hospitals will have contributing responsibilities.
Ambulatory Surgery Centers	Ambulatory surgery centers—known as ASCs—are modern healthcare facilities focused on providing same-day surgical care, including diagnostic and preventive procedures. ASCs may be used for overflow acute care, overflow outpatient care.
Assisted Living Facilities	Facilities that include the continuity of long-term care services and provide housing, personal care services, and healthcare designed to respond to individuals who need assistance with normal daily activities.
Behavioral Health Plan	This plan includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow-up of at-risk employees after critical incidents.
Blood Bank Plan	This plan details support for hospitals during a mass casualty incident including delivery during access-controlled situations.
BLS Ambulance	Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. These may include scheduled and 911 assets.
Burn Center Beds	A burn recovery bed or burn bed is a special type of bed designed for hospital patients who have suffered severe skin burns across large portions of their bodies. These are dedicated burn beds.

Chempack/SNS Plan	In jurisdictions/organizations hosting Chempack assets, the plan should document hospital and EMS actions related to storage, maintenance, notification mechanism of need for release of assets and authority by whom to release them, accompanying security to a distribution point, resupply method. All jurisdictions should have an SNS receipt and distribution plan. Include SNS receipt, distribution, and replacement.
Closed POD Plans	Plans for internal vaccination/prophylaxis of healthcare personnel. May be helpful to quantify the number of employees who would require vaccination or prophylaxis depending on role/job class.
Communication Assets	These assets may include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system.* Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.
Community Paramedics	This includes other community-based EMS personnel that may assume alternate roles in a disaster (e.g., paramedics are also firefighters, volunteer or paid reserve personnel who can be called to assist with an MCI; those who are BLS or ACLS trained). In large metro areas may summarize / list agencies rather than specific resources.
COOP, Recovery/Business Continuity Plan	Recovery activities and continuity of operations (COOP) response functions including backup for personnel, communication systems, and logistical support (assets).
Crisis Care	Number of cots that could be appropriately placed in flat space areas on hospital premises to create alternate care areas and including utilizing space where patients can be held awaiting treatment, actual treatment space (using cots, chairs, recliners, mobile vans, tents, air mattresses, etc.).
Crisis Standards of Care Plan	This plan details facility and regional approach to coordination of service and resource management, interface with State plans, and plans for on-site and community-based alternate care systems/sites. Including relevant facility and regional triggers where defined. Should also address 1135 waivers, and modifications of other pertinent local/state rules and regulations to address surge issues, ACS, volunteers, etc.
Decontamination Capacity - Ambulatory	Patients / hour based on exercises - assume 10 minutes/person through process (e.g. 6 patients/hour per decon station)
Decontamination Capacity - Non-Ambulatory	Patients/hour based on exercises - assume 10 minutes/person at each decon station
Dialysis Centers	Dialysis does the work of the kidneys by cleansing the blood – removing waste and excess water. There are two types of dialysis: hemodialysis and peritoneal dialysis. In hemodialysis, the patient's blood is passed through an artificial kidney machine, and the procedure is performed in a hospital or similar facility.
Dry Decontamination Kits	Redress kits that allow a patient to disrobe under a large bag/cover and therefore remove contaminated clothing that can then be sealed in another bag. Limits continued exposure and potential for secondary contamination of EMS/hospital assets.
Emergency Department (ED) Capacity	Bed capacity based on usual spaces used for patient care for hospital-based EDs.

ED Isolation (AIIR) Rooms	ED Isolation rooms may be ED Positive /Negative pressure rooms. Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease.
ED Surge Beds	These are beds in addition to usual ED beds – overflow/surge capacity only – may include adjacent procedure or other areas used for ED care.
Emergency Operations Plan	The jurisdictional emergency management plan should specify the lead agency for health and medical issues. Either this plan or the Public Health Emergency Operations Plan should specify the integration of the hospitals and EMS into the jurisdictional plan. This should include how information is shared with and between agencies, the process for resource requests, and the role of Public Health and Emergency Management relative to the coalition partners.
EMS Agencies	Emergency Medical Services (EMS) transport agencies – includes all emergency transport agencies, may consider including scheduled BLS provider services if applicable.
Evacuation Plan	This plan describes the role and coordination efforts during an evacuation of a healthcare facility and its repatriation (when needed).
Evacuation Resources	Equipment (facility or cache-based) including patient movement, triage/tracking supplies (NOTE: this may only apply to ambulatory surgery centers and freestanding emergency rooms for non-ambulatory patients).
Evaluation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evaluation Buses)	These resources may be listed in the Evacuation Plan annex from above. Equipment (facility or cache-based) including patient movement, triage/tracking supplies. Include availability of adult, child, and infant evacuation equipment.
Exercise Plan	Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.
Family Assistance Center Plan	This plan is integrated with hospitals, EOCs, and support organizations (e.g. ARC) – may include physical and virtual operations for re-unification and notifications.
Fixed-Wing Units	Fixed-wing units can respond within 60 minutes response time to the area, specific for flight time to scene/facility. Assure contact information is available for all agencies.
Group Homes	A home where a small number of unrelated people in need of care, support, or supervision can live together, such as those who are elderly or have disabilities and access/functional needs.
Hardware/Connectivity	Computers and other material resources to facilitate virtual or physical coordination center activities, including internet/data access.
HAZMAT Radiation Assets	Assets that include radiation detection/survey equipment.
HAZMAT Response Vehicle/Trailer	HAZMAT response vehicles/trailers include capabilities for agent identification, mass decontamination and throughput for ambulatory/non-ambulatory casualties, storage location, and contact info to request. Consider antidote availability.

HAZMAT/ Decontamination Plan	This plan describes roles of EMS and Fire including agent identification, setting up hot, warm and cold zones, capability for mass decontamination, and use of medical countermeasures for chemical, biological, and radiological incidents. Include use of available antidotes (including CHEMPACK reference). Addresses delivery of contaminated patients to specialty care hospitals when needed and available.
Home Health Agencies / Home Hospice	A Home Health Agency (HHA) is an agency or organization that: Meets the federal requirements in the interest of the health and safety of individuals who are furnished services by the HHA; and. Meets additional CMS requirements necessary for the effective and efficient operation of the program. May approximate in large metro areas.
Infectious Disease Plan	This plan includes guidelines for situational awareness and notification of outbreaks associated with seasonal and emerging infectious disease agents, dispatch communication to crews, hospitals, and PH, personal protective equipment, infection prevention, and control measures, specialized transport and response protocols to tiered levels of treatment facilities.
Inpatient Isolation (AIIR) Rooms	Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Include capacity for AIIR's and cohorting.
Inpatient Psychiatry Beds	Include capacity including for adults and pediatric patients.
Intensive Care Bed Adult	Beds that have availability of mechanical ventilation and some form of renal support and other organ support for adult patients.
Intensive Care Bed Pediatric	Beds that have availability of mechanical ventilation and some form of renal support and other organ support for pediatric patients.
Intensive Care Surge Beds	Intensive care surge beds may include doubling, use of step-down areas (therefore may count stepdown and some monitored beds twice), and procedure areas. Must have dedicated cardiac monitors, appropriate medical gases, etc. Include capacity for NICU, PICU, and Adult beds. Do not include PACU space here (list under PACU-specific line) – include both PICU and adult ICU potential surge beds.
Intensive Care Unit	Bed and staff can support above plus mechanical ventilation, sedation, hemodynamic support (pressor agents), and similar advanced care for unstable or dangerously ill patients. There is not an expectation that the facility has ventilators for each identified ICU surge bed but monitors are expected. Adult and pediatric beds are bundled together as a listed resource for disaster planning purposes. Coalitions may wish to break out pediatric ICU beds for their regional planning efforts to understand conventional capabilities.
IS/IT System Failure/Compromise Plan	This plan outlines response to downtime, cyberattacks (e.g. denial of service attack on 911), redundancy measures, training, PHI substitutions, and recovery measures.
Legal Regulatory Plan	This plan defines powers of State vs. local jurisdictions and local ordinances that may affect disaster response (e.g. disaster declarations, emergency orders, seizure powers, isolation and quarantine, changes to usual rules/requirements in disasters).
Level 1 / Level 2 Trauma Centers	Level I Trauma Center is a comprehensive regional resource that is a tertiary care facility central to the trauma system. A Level I Trauma Center can provide total care for every aspect of injury – from prevention through rehabilitation.

	A Level II Trauma Center can initiate definitive care for all injured patients.
Level 3 / Level 4 Trauma Centers	A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations. May include other/non-designated in this category if receive trauma. A Level IV Trauma Center has demonstrated an ability to provide advanced trauma life support (ATLS) prior to the transfer of patients to a higher level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients.
Long-Term Acute Care Facilities	Long-term acute care hospitals (LTACs) provide inpatient services for patients with complex medical problems requiring extended hospital stays. LTACs are defined by their average duration of stay, not by the type of patients admitted or the services provided. For prolonged, high-intensity management of chronic conditions.
Long-Term-Care Beds	Long-term care beds in skilled nursing facilities are hospital beds accommodating patients requiring long-term care due to chronic impairments and a reduced degree of independence in activities of daily living.
MAC/EOC	Emergency Operations Centers (EOCs) are the entity from which the coordination of information and resources to support incident management at the Incident Command Post (on-scene or field level activities) occurs. Multi-Agency Coordinating (MAC) Groups are policy setting entities typically comprised of agency administrators/executives, or their designees. Physical and backup location for coordination efforts.
Mass Mortuary / Body Bags	A body bag, also known as a cadaver pouch or human remains pouch, is a non-porous bag designed to contain a human body, used for the storage and transportation of shrouded corpses. Body bags can also be used for the storage of corpses within morgues, including processing / identification / storage.
Mass Mortuary / Fatality Plan	This plan includes the role of the facilities, medical examiner/coroner and roles and responsibilities of the local agencies.
Mass Transit	Buses (school, public) and other contingencies should be documented – does not require a specific number. Assure points of contact and timeframe available. Include mass transit and paratransit assets and their capacities, contact info, and potential timeframe to mobilize them.
MCI Bus/Vehicle	Mass Casualty Incident (MCI) Bus/Vehicles include contents, the estimated number of casualties that can be treated/transported, location, contact agency.
MCI Trailers	Mass Casualty Incident (MCI) trailers include contents, the estimated number of casualties that can be treated, location, contact agency.
Medical Countermeasures Administration/Distribution	Physical assets that support Chempack, antidote, vaccination/prophylaxis operations, and distribution of other countermeasures from SNS and state and local assets that may include databases and electronic systems as well as physical resources (signage, badging systems, coolers, etc.).
Medical Countermeasures Plan	This plan includes mass vaccination/prophylaxis (closed and open PODs), Chempack, and plans for receipt and distribution of other countermeasures from the SNS and other assets.

Medical/Surgical Beds	General medical/surgical ward bed - bed and staff can provide basic interval vital sign monitoring, oxygen, inhaled, oral, and intravenous or intramuscular medications. Patients on these units are generally stable with limited potential for acute deterioration. Pediatric and adult beds are bundled together.
Mental Health Providers	Mental health providers are professionals who diagnose mental health conditions and provide treatment. Most have at least a master's degree or more-advanced education, training, and credentials. Document interface of major associations/provider groups/MRC or other assets with coalition activities.
Military Assets	Include assets that can be state or federally activated to support a medical response (National Guard, ground/air assets including ambulances, CERF-P units, CST, etc.). Key resources may be activated by the state.
Mutual Aid Plan	This plan specifies the request process, commitment, notification, etc. between agencies and details other services/assets. Include any written MOA/MOU and other agreements.
NICU Beds	Beds that provide neonatal intensive care unit (NICU) care. Consider Level in the case of evacuating NICU to other NICUs.
Notification Platform	Electronic systems that provide notification to leadership and partners. These systems are designed for event notification only, distinct from communication platforms listed below which are designed for ongoing, interactive information sharing.
Number of Hospitals Include Critical Access Hospitals	Total hospitals in coalition providing emergency care/acute care services.
Operating Rooms	Operating rooms are specially equipped rooms, usually in a hospital, where surgical procedures are performed.
Other Response Vehicles	Other response vehicles may include, supervisor, physician, 'jump' vehicles, etc. In large metro areas may summarize/list agencies rather than specific resources.
Outpatient Clinics	An outpatient department or outpatient clinic is the part of a hospital designed for the treatment of outpatients, people with health problems who visit the hospital for diagnosis or treatment but do not at this time require a bed or to be admitted for overnight care. These also include clinics not at hospitals.
Patient Distribution Plan	This plan specifies role in conducting inter-facility transports and patient distribution to hospitals and other healthcare facilities – coordinated to minimize overload on a single facility when possible. Integrated with hospital MCI plans.
Patient Redress/Dry Decon Kits	Redress kits allow a patient to disrobe under a large bag/cover and therefore remove contaminated clothing that can then be sealed in another bag. Limits continued exposure and potential for secondary contamination of EMS/hospital assets.
Patient Tracking and Movement Plan	This plan documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular, and marine options.

Pediatric MCI Plan	This plan includes local and regional supplies and patient distribution, pediatric referral centers, and resources. Detail the hospital's level of preparedness to manage pediatric casualties.
Personal Protective Equipment (PPE) - Infectious Disease	Infectious disease PPE includes baseline stocks that should be maintained and identify resources/caches that could be used and/or purchase caches if reasonable. Consider an acceptable par level of 20% above daily use. Includes surgical masks and N-95 masks. Consider adding the number of PAPR kits (Butyl and Biospecific), spare Tyvek suits of various sizes, and Bio hoods.
PPE HAZMAT	PPE ensembles for the decontamination team including respiratory protection.
Pre/Post Anesthesia Beds (PACU)	To be used for trauma, ICU overflow/boarding.
Public Health Agencies	A Public Health Authority is an agency or authority of the United States Government, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, that is responsible for public health matters as a part of its official mandate.
Resource Plan/Annex	This plan describes the resource request and sharing process. This includes a list of specific assets purchased with federal or state funds or under the direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.
Response Equipment and Supplies (e.g., PPE, Evacuation, Medications, ventilators, mass casualty and specialty equipment)	These resources may be tracked through inventory management systems – these should be coalition-owned/managed resources.
Response Plan	This plan describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.
Retail Pharmacy	A pharmacy in which drugs are sold to patients, as opposed to a hospital pharmacy. Also known as a community pharmacy. Number optional – document major chains and interface with coalition activities.
Risk Communications Plan	A plan that is integrated with community/state JIS and coalition partners
Rotor-Wing Units	Rotor-wing units respond within 60 minutes response time to the area, specific for flight time to scene/facility. List contact information/agencies and priority ring down based.
Security Plan	Facility Security plans may be supported by jurisdictional EM and law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence, active shooter, suspected explosive devices, and civil unrest.
Shelter Support Plan	This plan outlines the provision of medical care/support in shelter environments.
Skilled Nursing Facilities	A skilled nursing facility is an in-patient rehabilitation and medical treatment center staffed with trained medical professionals.
Skilled Nursing Facility as Part of Hospital	SNF (included in the total above) that are physically connected to an acute care hospital.

Specialty Hospitals	Specialty hospitals include long-term care hospitals, psychiatric or other specialty hospitals that do not provide emergency services.
Specialty Mass Casualty Plans (e.g., MCI, Pediatrics, Burn)	Plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.
Staff and Resource Sharing Plan	This plan details how staff and resources will be shared between facilities and policies/protocols. Include a written plan for how needed assistance will be reported to others (phone, information-sharing platform, etc.) and the hospital's role in HCC MOU/MAA to support emergency staffing and resource support.
Stepdown	Stepdown beds and staff can provide cardiorespiratory monitoring (cardiac monitor, oxygen saturation monitoring) and intravenous medications and fluid support for currently stable patients with significant oxygen or other needs and potential for dangerous rhythm disturbances and deterioration. Pediatric and adult beds are bundled together.
Stepdown (Intermediate Care) Beds	Stepdown (intermediate care) beds refer to intermediate care including cardiovascular drip medications, potentially BiPAP but not mechanical ventilation or pressor support.
Stepdown Surge Beds	Stepdown beds that can be used during a disaster event. These must include cardiorespiratory monitoring capability including remote telemetry.
Surge Beds	Beds that can be used during a disaster event. This may involve making appropriate single rooms double, using observation, pre or post-anesthesia care areas, or opening closed units. The facility should only declare the number of beds it has on hand and could achieve within 24 hours, though the Coalition may wish to track potential additional beds that could be opened with leased/supplied beds and over a longer timeframe (e.g. some remodeling / temporary walls would be constructed, etc.).
Surge Discharge Potential (beds)	The number of beds that could be made available via early discharge based on exercises or real-world events.
Surge Discharge Potential (patients)	The number of patients that could safely be moved to a discharge holding area/out of their usual rooms pending discharge to make room for incoming patients. A hospital needs to have a process for selecting these patients and generate a point estimate of the number of beds that could be made available based on exercises or real-world activation of the process. The aggregate number of beds made available across the coalition hospitals should be listed.
Surge Supplies	Surge supplies do not need to include specifics of facility supplies but each facility should be accountable to be prepared according to their role in a disaster.
Surgical/Burn MCI Plan	This plan includes local and regional supplies and patient distribution and protocols and training policies. Surgical burn mass casualty incident (MCI) plans can address events such as active shooter or bombings.
Technical/Swiftwater/Collapse Rescue	Resources and agencies that may be engaged locally or regionally to assist with technical / US&R situations. List point of contact and timeframe for rescue missions.
Telephone / Web-Based Care	Local system providers are documented and describe how they interface with coalition activities.

Urgent Care Center / Freestanding Emergency Rooms	Urgent care is a category of walk-in clinics in the United States focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. They are not at hospitals and can be approximated in large metro areas – note they may have significant differences in the level of service/capabilities, particularly for imaging. May also include the number of ORs.
Ventilators (Hospital Owned)	A ventilator is a machine that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe or breathing insufficiently. Do not include anesthesia machines in OR. Include transport ventilators with high/low pressure and other alarms suitable for longer-duration simple ventilation situations. Quantify adult & pediatric vents. Also, ECMO.
Virtual Coordination	A platform for virtual coordination.
Volunteer Management Plan	This plan includes capabilities, deployment parameters/priorities, and processes inclusive of Medical Reserve Corps as applicable.
Wheelchair Vans	Wheelchair vans should include private services.

Appendices

Appendix 1: HVA/RGA Survey Questions

1. What is the occurrence probability of extreme heat for your facility?
2. What is the potential financial impact of extreme heat?
3. What is the potential human impact of extreme heat?
4. What is your organization's level of preparedness for extreme heat?
5. What is your organization's response capacity for extreme heat?
6. Has your facility experienced extreme heat in the past year?
7. What is the occurrence probability of workplace violence for your facility?
8. What is the potential financial impact of workplace violence?
9. What is the potential human impact of workplace violence?
10. What is your organization's level of preparedness for workplace violence?
11. What is your organization's response capacity for workplace violence?
12. Has your facility experienced workplace violence in the past year?
13. What is the occurrence probability of supply chain disruptions for your facility?
14. What is the potential financial impact of supply chain disruption?
15. What is the potential human impact of supply chain disruption?
16. What is your organization's level of preparedness for supply chain disruptions?
17. What is your organization's response capacity for supply chain disruptions?
18. Has your facility experienced supply chain disruptions in the past year?
19. What is the occurrence probability of flooding for your facility?
20. What is the potential financial impact of flooding?
21. What is the potential human impact of flooding?
22. What is your organization's level of preparedness for flooding?
23. What is your organization's response capacity for flooding?
24. Has your facility experienced flooding in the past year?
25. What is the occurrence probability of staffing shortage for your facility?
26. What is the potential financial impact of staffing shortages?
27. What is the potential human impact of staffing shortages?
28. What is your organization's level of preparedness for staffing shortages?
29. What is your organization's response capacity for staffing shortages?
30. Has your facility experienced staffing shortage in the past year?
31. What is the occurrence probability of monsoon weather for your facility?
32. What is the potential financial impact of monsoon weather?
33. What is the potential human impact of monsoon weather?
34. What is your organization's level of preparedness for monsoon weather?
35. What is your organization's response capacity for monsoon weather?
36. Has your facility experienced monsoon weather in the past year?
37. What is the occurrence probability of winter weather for your facility?
38. What is the potential financial impact of winter weather?
39. What is the potential human impact of winter weather events?
40. What is your organization's level of preparedness for winter weather events?
41. What is your organization's response capacity for winter weather events?
42. Has your facility experienced winter weather events in the past year?
43. What is the occurrence probability of cyber attack for your facility?
44. What is the potential financial impact of cyber attacks?
45. What is the potential human impact of cyber attacks?
46. What is your organization's level of preparedness for cyber attacks?
47. What is your organization's response capacity for cyber attacks?
48. Has your facility experienced a cyber attack in the past year?

49. What is the occurrence probability of network failure for your facility?
50. What is the potential financial impact of network failure?
51. What is the potential human impact of network failure?
52. What is your organization's level of preparedness for network failure?
53. What is your organization's response capacity for network failure?
54. Has your facility experienced a network failure in the past year?
55. What is the occurrence probability of wildfire for your facility?
56. What is the potential financial impact of wildfires?
57. What is the potential human impact of wildfires?
58. What is your organization's level of preparedness for wildfires?
59. What is your organization's response capacity for wildfires?
60. Has your facility experienced a wildfire, or impacts from wildfire, in the past year?
61. What is the occurrence probability of infectious disease for your facility?
62. What is the potential financial impact of infectious disease?
63. What is the potential human impact of infectious disease?
64. What is your organization's level of preparedness for infectious disease?
65. What is your organization's response capacity for infectious disease?
66. Has your facility experienced an infectious disease in the past year?
67. What is the occurrence probability of pandemic for your facility?
68. What is the potential financial impact of pandemic?
69. What is the potential human impact of pandemic?
70. What is your organization's level of preparedness for pandemic?
71. What is your organization's response capacity for pandemic?
72. Has your facility experienced a pandemic in the past year?
73. What is the occurrence probability of zoonotic disease for your facility?
74. What is the potential financial impact of zoonotic disease?
75. What is the potential human impact of zoonotic disease?
76. What is your organization's level of preparedness for zoonotic disease?
77. What is your organization's response capacity for zoonotic disease?
78. Has your facility experienced a zoonotic disease in the past year?
79. What is the occurrence probability of active threat for your facility?
80. What is the potential financial impact of an active threat?
81. What is the potential human impact of an active threat?
82. What is your organization's level of preparedness for active threat?
83. What is your organization's response capacity for an active threat?
84. Has your facility experienced an active threat in the past year?
85. What is the occurrence probability of civil unrest/protests for your facility?
86. What is the potential financial impact of civil unrest/protests?
87. What is the potential human impact of civil unrest/protests?
88. What is your organization's level of preparedness for civil unrest/protests?
89. What is your organization's response capacity for civil unrest/protests?
90. Has your facility experienced civil unrest/protests in the past year?
91. What are the most critical staffing shortages in your organization (clinical, administrative, support)?
92. Have you experienced staffing shortages in the past year?
93. What impacts staffing levels in your organization?
94. Do you have contingency plans for staff shortages or surge requirements?
95. How can AzCHER assist with staffing issues?
96. Which essential supplies are currently in limited or vulnerable supply at your facility?

97. Have you experienced supply chain interruptions in the past 12 months?
98. If yes, please indicate how these interruptions were addressed:
99. Additional comment on medical and non-medical supplies:
100. How resilient are your facilities (buildings, IT, utilities) to identified hazards in 2025?
101. Do you have backup power systems that are regularly tested and sufficient for prolonged outages?
102. Do you have backup water systems that are regularly tested and sufficient for prolonged outages?
103. Do you have backup HVAC systems that are regularly tested and sufficient for prolonged outages?
104. Is your backup power capable of running your entire facility or only bare minimum operations?
105. Are you able to communicate effectively with staff, patients, the public, and coalition partners during a crisis?
106. Does your facility utilize 800mHz radios?
107. How often are the 800mHz radios tested?
108. How often are the 800mHz radios trained on?
109. What options are available for statewide communications with hospitals?
110. What backup or interoperable communication tools do you maintain in case of primary system failure?
111. Are there barriers to timely information exchange with external partners or public agencies?
112. Does your facility have a Mass Casualty Incident (MCI) alert system or process in place for notification of critical incidents?
113. When was your organization's last emergency preparedness training or exercise?
114. Select the hazard(s) that your organization trained or practiced for during the last exercise.
115. Does your organization have documented after-action reports and improvement plans for trainings/exercises?
116. What training topics or skills need greater emphasis for 2025/2026?
117. Do you have mutual aid agreements or memorandums of understanding (MOUs) in place with other organizations?
118. Have any of your mutual aid agreements or MOUs been tested or activated in the past year?
119. How often do you update your mutual aid agreements or MOUs?
120. What new partnerships or collaborations would strengthen your preparedness posture?
121. Which sector types would you prioritize for new partnerships or collaborations?
122. Does your facility consider populations with special needs and at-risk populations in emergency preparedness plans?
123. Are there gaps in your ability to deliver accessible, culturally competent care during an emergency?
124. What hurdles exist in supporting underserved populations during emergencies?
125. What populations are you less prepared to support during an emergency?
126. Do you coordinate with community organizations to support underserved groups?
127. Do you have sufficient translation services to support non-English speaking populations during emergencies?
128. Does your organization have a current, tested continuity of operations plan (COOP)?
129. What resources would accelerate your return to normal operations post-incident?
130. How often do you revise your COOP?
131. How soon after an incident do you revise your COOP?
132. Do you collect data on preparedness and response operations?
133. Do you use state-provided data resources, such as EMResource, EMPOWER, etc.?
134. What challenges do you face in collecting, analyzing, or reporting preparedness and response data?
135. What, if any, hurdles prevent or hinder to submit required reports to local, state, or federal partners?
136. Do you report these hurdles? If so, how?
137. Have you adopted new technologies, tools, or practices to improve preparedness since the last gap analysis?
138. If yes, please describe the innovations, technologies, or practices your organization has adopted.
139. Do you have a process to trial new technologies prior to implementation to identify potential hazards or vulnerabilities?
140. Are there any emerging threats or opportunities your organization is considering for future planning?

141. What lessons from recent events (e.g., pandemics, natural disasters) have directly influenced your planning for 2025?
142. What types of recent incidents have influenced your planning for 2025?
143. Any final comments or questions you would like to add?

Appendix 2: List of Participating Organizations

Participating organizations are listed alphabetically by organization name as provided by the participant.

Abrazo
Acacia Home Health
Acacia Hospice Care of Lake Havasu
Acacia Hospice Care, INC
Accucare Home Health Services
Agave Healthcare, LLC
Alta Mesa Health and Rehabilitation
Alumus
American Advanced Management
Amsurg
Apache County Emergency Management and Preparedness
Apricus Hospice and Palliative Care dba Legacy Hospice LLC
Archstone Care Center
Arizona Department of Veteran Services
Arizona Eye Institute
Arizona Home Care
Arizona Institute of Medicine and Surgery
Arizona Joint Specialty Center
Arizona Kidney Disease and Hypertension Center
Arizona Pain
Arizona Pain Treatment Centers
Arizona Skin Cancer Surgery Center
Arizona Specialty Hospital
Arizona Spine & Joint Hospital
Arizona State Hospital
Arizona State Veteran Home - Yuma
Arizona Sunset Hospice
Arrowhead Endoscopy Center
Arroyo Gardens, LLP.
Aspire Home Healthcare
Assisted Home Health and Hospice
Avenir Behavioral health Center
A-Z Home Care Options
Bandara
Banner Health System
Beatitudes Campus
Benson Hospital
Brookdale Senior Living
Canyonlands Healthcare
Caremedix Hospice
Carl T Hayden VA Health Care System
Carrot Eye Center
Casa de la Luz
Casa Grande Fire Department
Catalina Surgery Center LLC
Chandler Surgical Center, PLC
ChangePoint Integrated Health
CHS
City of Tucson - Tucson Water Utility

ClearSky Health
Cobre Valley Regional Medical Center
Cochise County Health and Social Services
Cocopah Indian Tribe
College Medical Center Phoenix
Copper Queen Community Hospital
Copper State Hospice
Coronado Surgery Center
Covenant Home Health
DCI
Desert Cliffs Surgery Center, LLC
Desert Valley Hospice
Destiny Springs Health Care
Devon Gables Rehabilitation Center
Dialysis Clinic Inc/DCI
Dignity Health
EAST VALLEY OUTPATIENT SURGERY
Eden Home Health of Sierra Vista, LLC
El Rio Health
Elements Of Elder Care
Encompass Health
Ensign Services
Exceptional Community Hospital Prescott
Exceptional Healthcare Inc.
Four Peaks Surgery Center
Freedom Plaza/Sun Health
FRESENIUS
Fresenius Kidney Care
Fresenius Kidney Center
Fresenius Medical Care
Friendship Retirement Corporation
Genucare Home Health
Gila County Health and Community Services
Hacienda Healthcare
Havasu Nursing Center #2, Inc
Haven Management Group
Health Group Management
Home Health Care, LLC dba Covenant Home Health Agency
HonorHealth
Horizon Health and Wellness
Hospice of Havasu, Inc.
Human Good Arizona
Inbalance Home Health
Indian Health Service
Innovative Renal Care
Integrity Home Health Care Services
Kaibab Band of Paiute Indians
Kingman Healthcare Inc
La Paz County Emergency Management & Preparedness
La Paz Regional Hospital
Laser Surgery Center
Life Care Centers of America

Life Care Services
LifePoint
Maricopa County Department of Public Health
Mayo Clinic
MCDPH
Medical Reserve Corps of Southern Arizona
MERIDIAN HEALTH CARE PROVIDERS, INC.
Minimally Invasive Spine Surgery Center of Paradise Valley
Mission Palms Post-Acute
Mohave County Department of Public Health
Mount Graham Regional Medical Center
Mountain Park Health Centers
Mt Graham Regional Medical Center
MY HOME HEALTH INC DBA VANURA HOME HEALTH SERVICES ARIZONA
Noble Hospice and Palliative Care
Northern Cochise Community Hospital
Northwest Eye Specialists
Northwest Medical Center
Nurses Network by Quality Home Health Care
Omegalife Hospice of Arizona Inc
Onvida Health Yuma Medical Center
Outpatient Surgical Care, Ltd.
Ovation Hospice
Palliative Care Alliance & Faith Hospice
Phoenix Fire Dept
Phoenix Indian Medical Center
Phoenix Spine and Joint
Phoenix Spine Goodyear ASC
Pima County Health Department
Pinal County Public Health Services District
Prestige Home Health Care LLC
Puerco Valley Fire District
Quiburi Mission Nursing and Rehab
Riviera Surgical Center
Rummel Eye Care
Sage Hospice and Palliative Care
Sage Memorial Hospital
San Luis Walk-In Clinic, Inc.
Sanctuary Recovery Centers
Sante of Mesa
Sapphire Hospice
SCA
Scottsdale Center for Robotic Surgery
Scottsdale Eye Institute
Select Medical
Select Specialty Hospital - Tucson East
Shanti Hospice
Southern AZ VA Healthcare System
Sovereign Healthcare
Splendido
Summit Healthcare
Summit Home Health

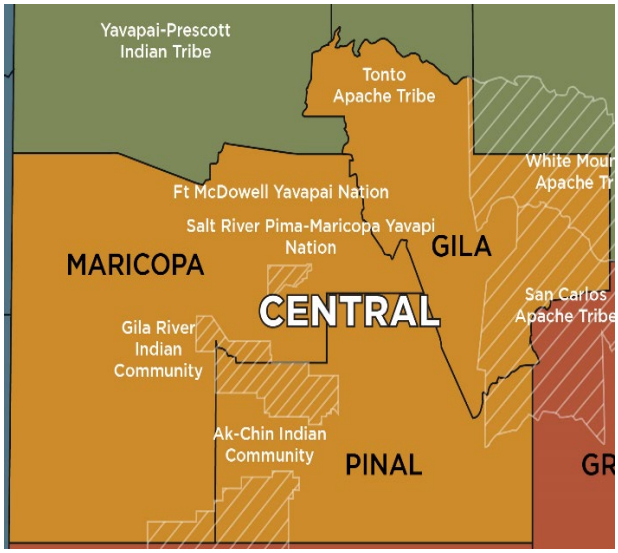
Sun City Endoscopy Center, Amsurg
Sun Health
Sun Health/Freedom Plaza
Sun Life Health
Swagel Wootton Eye Surgery Center
Swan Surgery Center
The Core Institute
The Guidance Center
TMC Health
Tri City Surgery Center
Tuba City Regional Healthcare Corporation
Tucson Gastroenterology
UHS
United Surgical Partners International
US Renal
Valley View Medical Center
Valleywise Health
Virtuous Health Centers
White Mountain Regional Medical Center
Wickenburg Community Hospital and Clinics
Winslow Indian Health Care Center, Inc.
Winslow Memorial Hospital dba Little Colorado Medical Center
Yavapai County Community Health Services
Yuma Advanced Surgical Suites
Yuma County Public Health

Appendix 7: Central Region Vulnerability Profile

AzCHER
Arizona Coalition for Healthcare Emergency Response

Central Region Vulnerability Profile
2025-2026

The Central Region Vulnerability Profile provides an updated overview of the demographics, healthcare infrastructure, and hazard risks for the Central Region of the Arizona Coalition for Healthcare Emergency Response (AzCHER). The region includes three (3) counties and eight (8) Tribal Nations, which are medically underserved and geographically isolated from other healthcare services. It highlights the population characteristics, healthcare utilization, and regional resources critical for emergency planning and response.



Counties[1]:

Gila, Maricopa, Pinal

Tribal Nations[1]:

Gila County - San Carlos Apache, Tonto Apache, White Mountain Apache
Maricopa County – Gila River Indian Community, Salt River Pima-Maricopa, Fort McDowell Yavapai, and the Tohono O'odham Nation
Pinal County – Gila River Indian Community, Ak-Chin Indian Community, Tohono O'odham Nation, and San Carlos Apache

Primary Care Areas

Primary Care Areas (PCAs) in Arizona are geographic planning units used to evaluate access to primary healthcare service and to identify communities that may be underserved or at risk for provider shortages. They are a key tool in healthcare planning, workforce analysis, and public-health decision-making, to include emergency preparedness in these communities.

Indian PCAs:

Maricopa County – Fort McDowell Yavapai Nation, Salt River Pima-Maricopa Indian
Pinal County – Gila River Indian Community

Rural PCAs:

Gila County – Globe, Payson
Maricopa County – North Gateway/Rio Vista Village, Desert View Village, Deer Valley Village, Paradise Valley Village, Scottsdale North, Surprise North & Wickenburg, Surprise South, Peoria North, New River/Cave Creek, Anthem, Fountain Hills/Rio Verde, Sun City West, Glendale North
Pinal County – Saddlebrooke, Coolidge, Eloy

Urban PCAs:

Maricopa County – Ahwatukee Foothills Village, Alhambra Village, Anthem, Apache Junction, Avondale, Buckeye, Camelback East Village, Central City Village, Chandler Central, Chandler North, Chandler South, Deer Valley Village, Desert View Village, El Mirage & Youngtown, Encanto Village, Estrella Village & Tolleson, Fountain Hills/Rio Verde, Gilbert Central, Gilbert North, Gilbert South, Glendale Central, Glendale North, Glendale West, Goodyear & Litchfield Park, Laveen Village, Maryvale Village, Mesa Central, Mesa East, Mesa Gateway, Mesa North, Mesa West, New River/Cave Creek, North Gateway/Rio Vista Village, North Mountain Village, Paradise Valley, Paradise Valley Village, Peoria North, Peoria South, Scottsdale Central, Scottsdale North, Scottsdale South, South Mountain Village & Guadalupe, Sun City, Sun City West, Sun Lakes, Surprise North & Wickenburg, Surprise South, Tempe North, Tempe South, Queen Creek

Pinal County – Apache Junction, Casa Grande, Coolidge, Eloy, Florence, Gold Canyon, Maricopa, Queen Creek, Saddlebrooke, San Tan Valley

Population and Vulnerable Groups

An estimated 5.24 million[1] people currently reside in the region, with significant seasonal population changes. Vulnerable groups include people with disabilities (16.8%), those below 150% federal poverty level (22%), Medicare beneficiaries (60.2%), and a large inmate population (53% of state inmates), with rural counties showing higher poverty and Medicare rates.

Risk Factors	Central Region	Arizona
Persons with Disabilities (%)[2]	16.8%	13.6%
AHCCCS (Medicaid) Population[3]	1,128,059 (63.2%)	1,786,199
Medicare Beneficiaries[4]	920,900 (60.2%)	1,529,229
Electricity-Dependent Medicare Beneficiaries[5]	34,968 (52.8%)	66,172
Medically Uninsured (%)[6]	23.7%	23.5%
Population below 150% FPL (%)[7]	22%	20.8%
Correctional Facilities[8]	9	15
Correctional Facility Inmate Capacity (prisons only)[8]	18,947 (53%)	35,273

Healthcare Utilization

The Central Region has one outpatient health treatment center per 2,684 residents, accounting for 67% of Arizona's providers. It also accounts for 67.1% of emergency room visits and 66% of acute care and critical access hospital beds statewide, indicating significant healthcare demand.

Utilization	Central Region	Arizona
Total Outpatient Health Treatment Centers (%)[9]	1,953 (67%)	2,914

Outpatient Health Treatment Centers (population: provider)[9]	2,684:1	2,602:1
Total Emergency Room Visits (%)[10]	1,629,746 (67.1%)	2,427,318
Acute Care and Critical Access Hospital Beds/1000 Residents*[9]	1.8	1.9

*Federal Hospitals are *excluded* from the bed counts, as their data *is not* reported in the Arizona Department of Health Services dashboard.

Healthcare Infrastructure

The region hosts 46 general hospitals (59.7% of state total), 11 Level I trauma centers, 221 assisted living centers, 9,732 nursing home beds, and 149 home health agencies. There are 35 ground ambulance providers statewide, which service cover multi-regional areas.

Healthcare Infrastructure	Central Region	Arizona
Acute Care Hospitals*[9]	46 (59.7%)	77
Critical Access Hospitals*[9]	5 (29.4%)	17
Level I Trauma Centers[11]	11	15
Level III Trauma Centers[11]	2	9
Level IV Trauma Centers[11]	10	28
Behavioral Health Hospitals[9]	17	23
Long-Term Care Hospitals[9]	3	6
Assisted Living Centers[9]	221 (66.4%)	333
Long-Term Care/Nursing Home Beds[9]	9,732 (62%)	15,698
Home Health Agencies[9]	149 (66.8%)	223
Ground Ambulance Providers[12]	39 (30.4%)	127
Air Ambulance Providers[13]	Varies**	12

* Federal Hospitals are *included* in the hospital counts, as their data *is* reported in the Arizona Department of Health Services dashboard.

**There are twelve (12) air ambulances providers registered to provide care and transport patients within Arizona, most of them helicopters. Air ambulance coverage areas often span large, multi-regional areas, and therefore cannot be broken down by region.

County Hazard Identification

County Multi-Jurisdictional Hazard Mitigation Plans identify key risks including climate change, dam inundation, drought, flooding, hazardous materials incidents, severe wind, transportation accidents, wildfire, winter storms, earthquakes, fissures, levee failure, and subsidence. These plans are updated every five years to evaluate risks to people and key facilities. Hazards are identified through a Threats and Hazard Identification Risk Assessment (THIRA), with each county's process shaped by team expertise, risk assessment, history, mitigation options, state plan alignment, and overlapping hazard effects.

Central Region Hazard Lists (Referenced from County Multi-Jurisdictional Hazard Mitigation Plans):

Gila County (2019)[14]	Maricopa (2022)[15]	Pinal (2022)[16]
• Climate Change • Dam Inundation • Drought • Flooding/Flash Flooding • Hazardous Materials Incident • Severe Wind • Transportation Accident • Wildfire • Winter Storm	• Dam Inundation • Drought • Extreme Heat • Fissure • Flood/Flash Flood • Levee Failure • Severe Wind • Subsidence • Wildfire	• Dam Failure • Drought • Earthquake • Extreme Heat • Fissure • Flood/Flash Flood • Levee Failure • Severe Wind • Subsidence • Wildfire

Special Considerations for Vulnerable Populations

Emergency planning should consider individuals who are elderly, very young, have disabilities, face transportation or language barriers, or have low socioeconomic status. The large inmate population is particularly vulnerable due to communal living and limited healthcare access.

Resources

1. Arizona's Counties, Tribal Nations, and Population. Arizona Disability Data for Arizona - Arizona-Demographics-Counties by Population Link. Published August 7, 2025. Accessed December 20, 2025.
2. Arizona Developmental Disabilities Planning Council. Persons with Disabilities Arizona Development Disabilities Planning Council-Disability Data for Arizona Link. Published and accessed December 2025.
3. Arizona Health Care Cost Containment System (Medicaid) Population - AHCCCS Population Statistics Link
4. Medicare Beneficiaries in Arizona. Centers for Medicare & Medicaid Services Data Link. Published September 2025. Accessed December 20, 2025.
5. HHS emPOWER Map Medicare At-Risk Populations by Geography. HHS emPOWER Map Electricity Dependent Link. Published and Accessed December 20, 2025.
6. Arizona Medically Underinsured Areas. Arizona Medically Underserved Areas Biennial Report Link. Published October 2024. Accessed December 20, 2025.
7. Arizona Population below 150% Federal Poverty Level. National Institute on Minority Health and Health Disparities Link. Published and accessed December 20, 2025.
8. Arizona Department of Corrections Facilities and Correctional Facility Inmate Capacity. ADC Data/Reports Link. Published October 2025. Accessed December 20, 2025.
9. Arizona Department of Public Health Licensing. Provider & Facility Database Link. Published December 1, 2025. Accessed December 20, 2025.
10. Statewide Emergency Room Visits. Arizona Department of Health Services Population Health and Vital Statistics Link. Published 2022. Accessed December 20, 2025.
11. Arizona Department of Public Health Designated Trauma Centers. Arizona State Designated Trauma Centers Link. Published October 21, 2025. Accessed December 20, 2025.
12. Arizona Department of Health and Services Emergency Medical Services & Trauma System. Bureau of Emergency Medical Services & Trauma System Ground Ambulance Provider Link. Published August 7, 2025. Accessed December 20, 2025.
13. Arizona Department of Health Services Bureau of Emergency Health Services & Trauma System. Bureau of Emergency Medical Services & Trauma System Air Ambulance Provider Link. Published April 29, 2025. Accessed December 20, 2025.
14. Gila County Emergency Management Division. 2019 Gila County Multi-Jurisdictional Hazard Mitigation Plan Accessed December 20, 2025.
15. Maricopa County Department of Emergency Management. 2022 Maricopa County Multi-Jurisdictional Hazard Mitigation Plan. Accessed December 20, 2025.
16. Pinal County Department of Emergency Management. Pinal County Multi-Jurisdictional Hazard Mitigation Plan. 2022 Pinal County Multi-Jurisdictional Hazard Mitigation Plan. Accessed December 20, 2025.

Appendix 8: Northern Region Vulnerability Profile

AzCHER
Arizona Coalition for Healthcare Emergency Response

Northern Region Vulnerability Profile
2025-2026

The Northern Region Vulnerability Profile provides an updated overview of the demographics, healthcare infrastructure, and hazard risks for the Northern Region of Arizona Coalition for Healthcare Emergency Response (AzCHER). The region includes four (4) counties and nine (9) Tribal Nations, which are medically underserved and geographically isolated from other healthcare services. It highlights the population characteristics, healthcare utilization, and regional resources critical for emergency planning and response.

Counties[1]:

Apache, Coconino, Navajo, Yavapai

Tribal Nations[1]:

Apache County – Navajo Nation, White Mountain Apache Tribe, Zuni Indian Tribe
Coconino County – Navajo Nation, Hopi Tribe, Havasupai Tribe, Kaibab Band of Paiute Indians, San Juan Southern Paiute Tribe
Navajo County - Navajo Nation, Hopi Tribe
Yavapai County - Yavapai Apache Nation, Yavapai Prescott Tribe

Primary Care Areas (PCAs) in Arizona are geographic planning units used to evaluate access to primary healthcare service and to identify communities that may be underserved or at risk for provider shortages. They are a key tool in healthcare planning, workforce analysis, and public-health decision-making, to include emergency preparedness in these communities.

Indian PCAs:

Apache County – Navajo Nation
Coconino County – Navajo Nation, Hopi Tribe
Navajo County – Navajo Nation, Hopi Tribe, White Mountain Apache Tribe

Rural PCAs:

Apache – Springerville
Coconino County – Grand Canyon Ville, Page
Navajo County – Snowflake/Heber, Show Low, Winslow,
Yavapai County – Black Canyon City, Chino Valley, Cottonwood\Sedona, Prescott, Prescott Valley, Williamson

Urban PCAs:[1]
Coconino County – Flagstaff
Yavapai County – Prescott, Prescott Valley

Population and Vulnerable Groups

About 571,490 people live in Arizona's Northern Region, the state's largest area with varied climates that can cause both heat and cold health risks. This region has higher rates of residents with disabilities (15.5%) and Medicare recipients (28.4%) than the state average.

Risk Factors	Northern Region	Arizona
Persons with Disabilities (%)[2]	15.5%	13.6%
AHCCCS (Medicaid) Population[3]	161,201 (9%)	1,786,199
Medicare Beneficiaries[4]	16,091 (28.4%)	1,529,229
Electricity-Dependent Medicare Beneficiaries[5]	12,749 (19.3%)	66,172
Medically Uninsured (%)[6]	17.9%	23.5%
Population below 150% FPL (%)[7]	32.9%	20.6%
Correctional Facilities[8]	1	15
Correctional Facility Inmate Capacity-prisons only[8]	847 (2.4%)	35,273

Healthcare Utilization

The Northern region has one provider for every 2,646 residents. These communities have fewer ambulatory care sites per elderly resident and lower hospital inpatient days than the state average.

Utilization	Northern Region	Arizona
Total Outpatient Health Treatment Centers (%)[9]	216 (7.4%)	2,914
Outpatient Health Treatment Centers (population:provider)[9]	2,646:1	2,602:1
Total Emergency Room Visits (%)[10]	183,850 (7.6%)	2,427,318
Acute Care and Critical Access Hospital Beds/1000 Residents*[10]	1.8	1.9

*Federal Hospitals are *excluded* from the bed counts, as their data *is not* reported in the Arizona Department of Health Services dashboard.

Healthcare Infrastructure

The region hosts 9 general hospitals (11.7% of state total), 1 Level I trauma center, 33 assisted living centers, 1,234 nursing home beds, and 21 home health agencies. There are 35 ground ambulance providers statewide, which service cover multi-regional areas.

Healthcare Infrastructure	Northern Region	Arizona
Acute Care Hospitals[9]	7 (9.2%)	77
Critical Access Hospitals*[9]	6 (3.5%)	17
Level I Trauma Centers[11]	1	15
Level III Trauma Centers[11]	1	9
Level IV Trauma Centers[11]	6	28
Behavioral Health Hospitals[9]	2	23
Long-Term Care Hospitals[9]	0	6
Assisted Living Centers[9]	221 (66.4%)	333
Long-Term Care/Nursing Home Beds[9]	9,732 (62%)	15,698
Home Health Agencies[9]	22 (9.6%)	223
Ground Ambulance Providers[12]	28 (1.7%)	127
Air Ambulance Providers[13]	Varies**	12

* Federal Hospitals are *included* in the hospital counts, as their data *is* reported in the Arizona Department of Health Services dashboard.

**There are twelve (12) air ambulances providers registered to provide care and transport patients within Arizona, most of them helicopters. Air ambulance coverage areas often span large, multi-regional areas, and therefore cannot be broken down by region.

County Hazard Identification

County Multi-Jurisdictional Hazard Mitigation Plans identify key risks including flash flooding, severe wind, wildfire, mudslides, winter storm, drought, pandemic, excessive heat, hazardous materials incidents, dam failure, earthquakes, and levee failures. These plans are updated every five years to evaluate risks to people and key facilities. Hazards are identified through a Threats and Hazard Identification Risk Assessment (THIRA), with each county's process shaped by team expertise, risk assessment, history, mitigation options, state plan alignment, and overlapping hazard effects.

Northern Region Hazard Lists (Referenced from County Multi-Jurisdictional Hazard Mitigation Plans and 2019 AzCHER CHVA):

Apache (2017)[17]	Coconino (2021)[18]	Navajo (2017)[19]	Yavapai (2023)[20]
• Flood/Flash Flood • Severe Wind • Wildfire • Winter Storm	• Wildland Fire • Flood/Flash Flood and Post Wildfire Flood/ Debris Flows • Drought • Public Health Outbreak/ Pandemic • Excessive Heat • Hazardous Materials/ Pipeline Failure/ Transport Accident • Dam Failure • Earthquake and Seismic Hazards • High Winds/ Tornado	• Dam Failure • Drought • Flood/Flash Flood • Hazardous Materials Incidents • Levee Failure • Severe Wind • Wildfire • Winter Storm	• Earthquake • Flood • Landslide/ Mudslide • Severe Wind • Wildfires • Winter Storm

*The list of hazards is alphabetical and not listed by threat level.

Special Considerations for Vulnerable Populations

Emergency planning should consider individuals who are elderly, very young, have disabilities, face transportation or language barriers, or have low socioeconomic status.

Resources

17. Arizona's Counties, Tribal Nations, and Population. Arizona Disability Data for Arizona - Arizona-Demographics-Counties by Population Link. Published August 7, 2025. Accessed December 20, 2025.
18. Arizona Developmental Disabilities Planning Council. Persons with Disabilities Arizona Development Disabilities Planning Council-Disability Data for Arizona Link. Published and accessed December 2025.
19. Arizona Health Care Cost Containment System (Medicaid) Population - AHCCCS Population Statistics Link
20. Medicare Beneficiaries in Arizona. Centers for Medicare & Medicaid Services Data Link. Published September 2025. Accessed December 20, 2025.
21. HHS emPOWER Map Medicare At-Risk Populations by Geography. HHS emPOWER Map Electricity Dependent Link. Published and Accessed December 20, 2025.
22. Arizona Medically Underinsured Areas. Arizona Medically Underserved Areas Biennial Report Link. Published October 2024. Accessed December 20, 2025.
23. Arizona Population below 150% Federal Poverty Level. National Institute on Minority Health and Health Disparities Link. Published and accessed December 20, 2025.
24. Arizona Department of Corrections Facilities and Correctional Facility Inmate Capacity. ADC Data/Reports Link. Published October 2025. Accessed December 20, 2025.
25. Arizona Department of Public Health Licensing. Provider & Facility Database Link. Published December 1, 2025. Accessed December 20, 2025.
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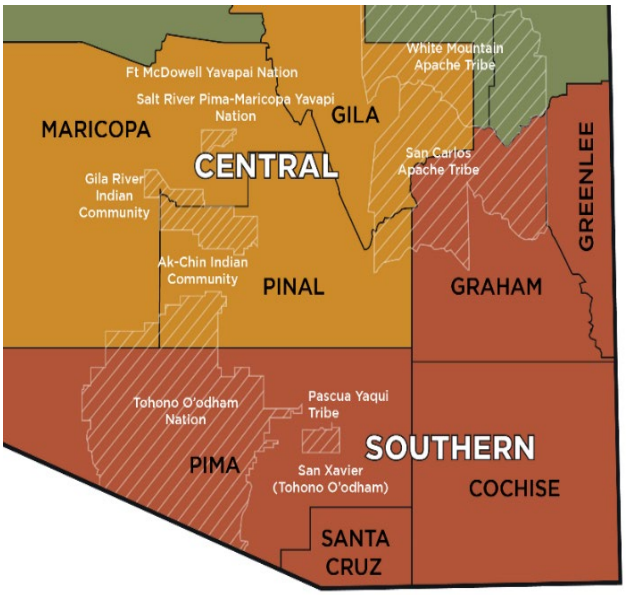
Appendix 9: Southern Region Vulnerability Profile

Southern Region Vulnerability Profile
2025-2026

The Southern Region Vulnerability Profile provides an updated overview of the demographics, healthcare infrastructure, and hazard risks for the Southern Region of the Arizona Coalition for Healthcare Emergency Response (AzCHER). The region includes four (4) counties and eight (8) Tribal Nations, which are medically underserved and geographically isolated from other healthcare services. It highlights the population characteristics, healthcare utilization, and regional resources critical for emergency planning and response.



Counties[1]:

Cochise, Graham, Greenlee, Pima, Santa Cruz

Tribal Nations[1]:

Graham County – San Carlos Apache Tribe
Pima County - Tohono O'odham Nation, Pascua Yaqui Tribe, San Xavier Reservation

Primary Care Areas

Primary Care Areas (PCAs) in Arizona are geographic planning units used to evaluate access to primary healthcare service and to identify communities that may be underserved or at risk for provider shortages. They are a key tool in healthcare planning, workforce analysis, and public-health decision-making, to include emergency preparedness in these communities.

Indian PCAs:

Graham County – San Carlos Apache Tribe
Pima County – Tohono O'odham Nation, San Xavier, Pascua Yaqui Tribe

Rural PCAs:

Cochise County – Benson, Douglas & Pirtle Ville, Willcox & Bowie, Bisbee, Sierra Vista
Graham County – Safford, Thatcher
Greenlee County - Morenci
Pima County – Ajo, Green Valley, Sahuarita
Santa Cruz County – Nogales, Rio Rico

Urban PCAs:

Pima County – Casas Adobes, Catalina Foothills, Drexel Heights, Flowing Wells, Marana, Oro Valley, Picture Rocks, Tanque Verde, Tucson Central, Tucson East, Tucson Estates, Tucson Foothills, Tucson South, Tucson South East, Tucson West, Vail, Valencia West

Population and Vulnerable Groups

The Southern Region has about 1,306,082[1] residents, though this varies due to the seasonal visitors and migrant workers. The area has higher rates of people with disabilities (14.9) and Medicare Beneficiaries (24.3) than the state average. Special attention should be given to vulnerable groups, including older adults, children, rural residents, those with transportation or language barriers, low-income individuals and people with limited access to health care. Notably, 24.6 live below 150% of the federal poverty level, and 21.9 of Arizona's total prison inmates are housed here, making both populations particularly vulnerable.

Risk Factors	Southern Region	Arizona
Persons with Disabilities under age 65 years (%)[2]	14.9%	13.6%
AHCCCS (Medicaid) Population[3]	341,734 (19.1%)	1,786,199
Medicare Beneficiaries[4]	317,671 (24.3%)	1,529,229
Electricity-Dependent Medicare Beneficiaries[5]	12,773 (19.3%)	66,172
Medically Uninsured (%)[6]	22.2%	23.5%
Population below 150% FPL (%)[7]	24.6%	20.8%
Correctional Facilities[8]	3	15
Correctional Facility Inmate Capacity (prisons only)[8]	7,760 (21.9%)	35,273

Healthcare Utilization

The Southern Region has one outpatient health treatment center per 2,561 residents. This represents a share of Arizona's providers as well as emergency rooms visits and hospital beds, highlighting a high healthcare demand. Hospitals in the southern region are impacted by unpaid care for migrant patients.

Utilization	Southern Region	Arizona
Total Outpatient Health Treatment Centers (%)[9]	502 (18.1%)	2,914
Outpatient Health Treatment Centers (population:provider)[9]	2,561:1	2,602:1
Total Emergency Room Visits (%)[10]	388,753 (18%)	2,427,318

Acute Care and Critical Access Hospital Beds/1000 Residents[10]	1.8	1.9

*Federal Hospitals are *excluded* from the bed counts, as their data *is not* reported in the Arizona Department of Health Services dashboard.

Healthcare Infrastructure

The region hosts 15 general hospitals (19.5% of state total), 3 Level I trauma centers, 59 assisted living centers, 3,492 nursing home beds, and 34 home health agencies. There are 35 ground ambulance providers statewide, which service cover multi-regional areas.

Healthcare Infrastructure	Southern Region	Arizona
Acute Care Hospitals Hospitals*[9]	15 (19.5%)	77
Critical Access Hospitals[9]	5 (29.4%)	17
Level I Trauma Centers[11]	3	15
Level III Trauma Centers[11]	4	9
Level IV Trauma Centers[11]	8	28
Behavioral Health Hospitals[9]	3	23
Long-Term Care Hospitals[9]	3	6
Assisted Living Centers[9]	59 (17.7%)	333
Long-Term Care/Nursing Home Beds[9]	3,492 (22.2%)	15,698
Home Health Agencies[9]	34 (15.2%)	223
Ground Ambulance Providers[12]	34 (26.8%)	127
Air Ambulance Providers[13]	Varies**	12

* Federal Hospitals are *included* in the hospital counts, as their data *is* reported in the Arizona Department of Health Services dashboard.

**There are twelve (12) air ambulances providers registered to provide care and transport patients within Arizona, most of them helicopters. Air ambulance coverage areas often span large, multi-regional areas, and therefore cannot be broken down by region.

County Hazard Identification

County Multi-Jurisdictional Hazard Mitigation Plans identify key risks including building collapse/mine subsidence, drought, earthquake, fissure, flash flood, severe wind, wildfire, dam failure, levee failure, extreme cold and heat, and landslide. These plans are updated every five years to evaluate risks to people and key facilities. Hazards are identified through a Threats and Hazard Identification Risk Assessment (THIRA), with each county's process shaped by team expertise, risk assessment, history, mitigation options, state plan alignment, and overlapping hazard effects.

Southern Region Hazard Lists* (Referenced from County Multi-Jurisdictional Hazard Mitigation Plans):

Cochise County (2022)[14]	Graham County (2021)[15]	Greenlee County (2022)[16]	Pima County (2022)[17]	Santa Cruz County (2018)[18]
• Building Collapse/ Mine Subsidence • Drought • Earthquake • Fissure • Flood/Flash Flood • Severe Wind • Wildfire	• Dam Failure • Drought • Fissure • Flood/Flash Flood • Severe Wind • Wildfire	• Drought • Flooding/ Flash Flood • Levee Failure • Wildfire	• Drought • Earthquake • Extreme Cold • Extreme Heat • Flood • Landslide • Severe Wind • Wildfire	• Dam Failure • Drought • Flooding/Flash Flooding • HazMat Incidents • Wildfire

*The list of hazards is alphabetical and not listed by threat level.

Special Considerations for Vulnerable Populations

Emergency planning should consider individuals who are elderly, very young, have disabilities, face transportation or language barriers, or have low socioeconomic status.

Resources

34. Arizona Counties, Tribal Nations, and Population. Arizona Disability Data for Arizona - Arizona-Demographics-Counties by Population Link. Published August 7, 2025. Accessed December 20, 2025.
35. Arizona Developmental Disabilities Planning Council. Persons with Disabilities Arizona Development Disabilities Planning Council-Disability Data for Arizona Link. Published and accessed December 2025.
36. Arizona Health Care Cost Containment System (Medicaid) Population - AHCCCS Population Statistics Link
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39. Arizona Medically Underinsured Areas. Arizona Medically Underserved Areas Biennial Report Link. Published October 2024. Accessed December 20, 2025.
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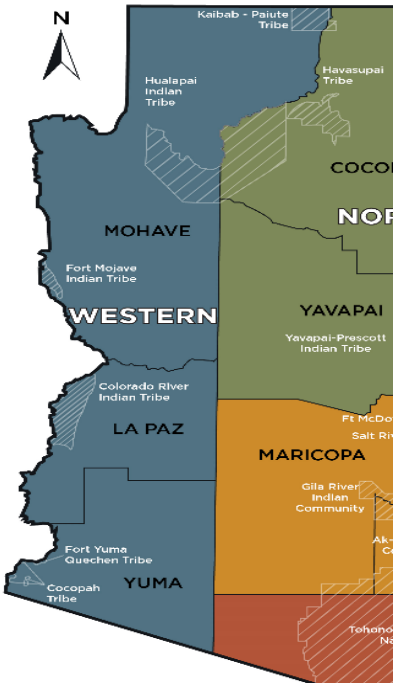
51. Santa Cruz County Office of Emergency Management. 2024 Santa Cruz Multi-Jurisdictional Hazard Mitigation Plan. Published 2024. Accessed December 22, 2025.

Appendix 10: Western Region Vulnerability Profile

Western Region Vulnerability Profile
2025-2026

The Western Region Vulnerability Profile provides an updated overview of the demographics, healthcare infrastructure, and hazard risks for the Western Region of the Arizona Coalition for Healthcare Emergency Response (AzCHER). The region includes three (3) counties and eight (8) Tribal Nations, which are medically underserved and geographically isolated from other healthcare services. It highlights the population characteristics, healthcare utilization, and regional resources critical for emergency planning and response.



Counties[1]:

Mohave, La Paz, Yuma

Tribal Nations[1]:

Mohave County – Fort Mojave Tribe, Hualapai Tribe, Kaibab-Paiute Tribe
La Paz County – Colorado River Indian Tribes
Yuma County – Cocopah Indian Tribe, Quechan Tribe

Primary Care Areas

Primary Care Areas (PCAs) in Arizona are geographic planning units used to evaluate access to primary healthcare service and to identify communities that may be underserved or at risk for provider shortages. They are a key tool in healthcare planning, workforce analysis, and public-health decision-making, to include emergency preparedness in these communities.

Indian PCAs:

La Paz County – Colorado River Indian Tribe

Mohave County – Hualapai Tribe

Rural PCAs:

La Paz County – Parker, Quartzsite
Mohave County – Bullhead City, Colorado City, Golden Valley, Kingman, Lake Havasu City
Yuma County - Fortuna Foothills, San Luis, Somerton, Yuma

Population and Vulnerable Groups

The Western Region's population is about 463,781[1], with seasonal changes due to winter visitors and migrant workers. Disabilities affect 20.1% of residents and 8.6% are Medicare beneficiaries, both above state averages. Special attention goes to the elderly, young children, rural residents, those with transportation or language barriers, low socioeconomic status, and limited access to health care. About 28.4 live below 150% of the federal poverty level, and the region houses 22% of Arizona's prison inmates. Hospitals in the southern portion of the western region are impacted by unpaid care for migrant patients.

Risk Factors	Western Region	Arizona
Persons with Disabilities under age 65 years (%)[2]	20.1%	13.6%
AHCCCS (Medicaid) Population[3]	155,205 (8.7%)	1,786,199
Medicare Beneficiaries[4]	128,567 (8.6%)	1,529,229
Electricity-Dependent Medicare Beneficiaries[5]	5,682 (8.6%)	66,172
Medically Uninsured (%)[6]	22.9%	23.5%
Population below 150% FPL (%)[7]	28.4%	20.8%
Correctional Facilities[8]	2	15
Correctional Facility Inmate Capacity (prisons only)[8]	7,719 (22%)	35,273

Healthcare Utilization

The Western Region has one outpatient health treatment center per 2,684 residents, accounting for 67% of Arizona's providers. It also accounts for 67.1% of emergency room visits and 66% of acute care and critical access hospital beds statewide.

Utilization	Western Region	Arizona

Total Outpatient Health Treatment Centers (%)[9]	207 (7.5%)	2,914
Outpatient Health Treatment Centers (population:provider)[9]	2,191:1	2,602:1
Total Emergency Room Visits (%)[10]	151,715 (7%)	2,427,318
Acute Care and Critical Access Hospital Beds/1000 Residents*[10]	2.3	1.9

*Federal Hospitals are *excluded* from the bed counts, as their data *is not* reported in the Arizona Department of Health Services dashboard.

Healthcare Infrastructure

The Western Region has 7 acute care hospitals and 2 critical access hospitals.

The Western Region has 2.3 beds per 1,000 residents, which is higher than the state average. Regional facilities and resources that serve specific populations, including pediatrics, are crucial for the overall community response. The Western Region has 20 assisted living centers, 1,240 long-term care/nursing home beds, and 19 home health agencies.

Healthcare Infrastructure	Western Region	Arizona
Acute Care Hospitals*[9]	7 (9.1%)	77
Critical Access Hospitals[9]	2 (11.8%)	17
Level I Trauma Centers[11]	0	15
Level III Trauma Centers[11]	2	9
Level IV Trauma Centers[11]	3	28
Behavioral Health Hospitals[9]	0	23
Long-term Care Hospitals[9]	0	6
Assisted Living Centers[9]	20 (6%)	333
Long-Term Care/Nursing Home Beds[9]	1,240 (7.9%)	15,698
Home Health Agencies[9]	19 (8.5%)	223
Ground Ambulance Providers[12]	15	127

Air Ambulance Providers[13]	Varies**	12

* Federal Hospitals are *included* in the hospital counts, as their data *is* reported in the Arizona Department of Health Services dashboard.

**There are twelve (12) air ambulances providers registered to provide care and transport patients within Arizona, most of them helicopters. Air ambulance coverage areas often span large, multi-regional areas, and therefore cannot be broken down by region.

County Hazard Identification

County Multi-Jurisdictional Hazard Mitigation Plans identify key risks including dam failure, drought, flooding, hazardous materials incidents, severe wind, wildfire, biological disease event, extreme heat, power failure, and earthquake. These plans are updated every five years to evaluate risks to people and key facilities. Hazards are identified through a Threats and Hazard Identification Risk Assessment (THIRA), with each county's process shaped by team expertise, risk assessment, history, mitigation options, state plan alignment, and overlapping hazard effects.

Western Region Hazards (Referenced from County Multi-Jurisdictional Hazard Mitigation Plans):

La Paz County (2020)[14]	Mohave County (2022)[15]	Yuma County (2019)[16]
• Dam Failure • Drought • Flooding/Flash Flooding • Hazardous Materials Incident • Severe Wind • Wildfire	• Biological/Disease Events • Dam Failure • Drought • Extreme Heat • Flood/Flash Flood • Hazardous Material Incidents • Power Failure • Severe Wind • Wildfire • Earthquake	• Drought • Extreme Heat • Flooding • Severe Wind • Wildfire

*The list of hazards is alphabetical and not listed by threat level.

Special Considerations for Vulnerable Populations

Emergency planning should consider individuals who are elderly, very young, have disabilities, face transportation or language barriers, or have low socioeconomic status. The large inmate population is particularly vulnerable due to communal living and limited healthcare access.

Resources

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